
# Submission of the
# New Zealand Council of Trade Unions
# Te Kauae Kaimahi

**to the**

# New Zealand Productivity Commission

**on its inquiry into**

## Regulatory Institutions and Practices

**P O Box 6645**

**Wellington**

**25 October 2013**

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## 1. Introduction

1.1. This submission is made on behalf of the 37 unions affiliated to the New Zealand Council of Trade Unions Te Kauae Kaimahi (CTU). With 340,000 members, the CTU is one of the largest democratic organisations in New Zealand.

1.2. The CTU acknowledges Te Tiriti o Waitangi as the founding document of Aotearoa New Zealand and formally acknowledges this through Te Rūnanga o Ngā Kaimahi Māori o Aotearoa (Te Rūnanga) the Māori arm of Te Kauae Kaimahi (CTU) which represents approximately 60,000 Māori workers.

1.3. We regard the role of the state as fundamentally important in advancing the social and economic development of New Zealand. Its power of regulation is a crucial aspect of its role. Effective regulation is a requirement of a civilised society. Recent events, both internationally with the Global Financial Crisis and locally with numerous examples of serious regulatory failure resulting from an excessively light-handed approach to regulation, show how great the risks are. They also show that market failure is ubiquitous, not an exception, and is a risk even in apparently well-performing markets.

1.4. The market cannot be relied on to self-regulate in the broader interests of society (and sometimes not even its own). Many markets cannot function without strong regulation. In fact it is not unreasonable to state that all markets benefit from regulation. For example the access to limited liability structures (particularly the limited liability company) is a socially permitted construct and privilege which, despite being open to abuse, allows firms to take risks their owners would not otherwise take and hence is a regulation which encourages entrepreneurship and underpins markets. Indeed, the

scale and scope of intervention of the state in financial markets and subsequently in 'real economy' markets as a result of the Global Financial Crisis confirms that capitalism cannot function without a strong state and strong regulatory institutions.

1.5. In New Zealand, examples of the failure of light-handed regulation include

a. Finance company failures, leading to losses estimated by Interest.co.nz to be $3.112 billion[1] to the government and investors;

b. High short-term foreign indebtedness and currency mismatches in the major banks operating in New Zealand led to severe threats to their liquidity at the height of the Global Financial Crisis, requiring the Reserve Bank to obtain access to funding to assure liquidity and the government to guarantee their wholesale borrowing (through the Wholesale Deposit Guarantee) to the value of approximately $10 billion as well as a retail deposit guarantee (e.g. Reserve Bank of New Zealand, 2012). The crisis also exposed the vulnerabilities resulting from the lack of retail deposit guarantees in the face of a systemic crisis and the availability of guarantees elsewhere (especially Australia); and the difficulties in applying guarantees in the face of a wider financial sector with very uneven levels of risk (notably the finance companies).

c. Leaky buildings, resulting in costs estimated at $11 billion, but possibly as much as $33 billion (Easton, 2012) in addition to social and personal losses in stress and loss of health and security for householders affected;

d. High rates of injury, illness and death in employment, as identified by the Pike River Royal Commission and the Independent Taskforce on Workplace Health and Safety, costing several hundred lives when compared with similar countries, and according to the Taskforce report, a financial cost which in 2010 was "estimated to be about $3.5 billion a year – around two percent of gross domestic product (GDP) in today's terms … [but] estimated to be as high as $15 billion a year and $21

[1] http://www.interest.co.nz/saving/deep-freeze-list, accessed 15 October 2013.

billion a year, depending on how the costs are measured and the extent to which indirect costs are included."(Independent Taskforce on Workplace Health and Safety, 2013, p. 12). In the words of the Taskforce's report: "the model of occupational health and safety regulation implemented through the HSE Act in the early 1990s may be seen as an object lesson in how not to implement legislation." (Independent Taskforce on Workplace Health and Safety, 2013, p. 21);

e. An industry training system which failed to provide sufficient skilled workers, leaving a significant deficit by the early 2000s which has since reduced but not closed. The problems include low returns in wages to increased qualifications (e.g. Crichton & Dixon, 2011; Zuccollo, Maani, Kaye-Blake, & Lulu Zeng, 2013) and the problems are reinforced by the absence of industry collective bargaining or other tripartite coordination (e.g. McLaughlin, 2009), legislative support for weak hiring practices such as 90-day trials, immigration policies which do not encourage employers to train staff, and weak management skills, particularly in management of people (e.g. de Serres, 2013; Procter, 2011);

f. An employment relations legislative framework which has failed to ensure wages match productivity increases or to encourage productivity development, and has reinforced the problems in workplace health and safety and industry training.

1.6. We could identify many others.

1.7. These examples have in common that they are based on principles of what is often called 'light-handed' regulation and based on an assumption that the private sector ('the market') will self-regulate. It is clear that this experiment, in New Zealand and internationally, has failed with enormous financial and social loss.

1.8. We would strongly oppose any outcomes from this inquiry which suggested that this type of regulation is in any sense 'best practice'. New Zealand is backing out of such forms of regulation in numerous areas. Whether it is

going far enough we have yet to see, but that direction should not be reversed.

1.9. In most cases inadequate legislative and regulatory frameworks were accompanied by weakened, underfunded or unwilling regulators which in many cases had insufficient people with the knowledge, experience and rigour required to adequately oversee the activities needing regulation (e.g. Independent Taskforce on Workplace Health and Safety, 2013; Mumford, 2011; Office of the Auditor-General, 2011; Royal Commission on the Pike River Coal Mine Tragedy, 2012). It is important that regulators are properly resourced, have political support for (or at least absence of resistance to) the decisions they must make, and must be, and be seen to be even-handed, expert in the industry they are regulating, and able to provide useful advice. Expertise may need to be multidimensional: for example expert in safety matters and in the industry which is being regulated.

1.10. In a number of examples, representational structures which gave those at risk from the activities some influence and involvement were dismantled or not created.

1.11. In some (such as in occupational health and safety), prescriptive regulation was necessary to ensure accepted state-of-knowledge practice was followed and to give certainty to both those who are regulated and those who are at risk. In the case of occupational health and safety it was never developed as a result of political decisions in the 1990s, lack of resources and appropriate personnel, and resistance from business and politicians.

1.12. In some, the self-regulation was overseen by various forms of auditing, inspection, certification or review processes paid for by the entities being regulated. While there may be a continuing role for such structures, they are riddled with risks of the 'Piper Principle' ('he who pays the piper calls the tune') as has been exemplified in the failures by credit rating agencies in the US to accurately identify high risk financial instruments they had been paid to rate by the marketers of the products, and in New Zealand, the failure of finance company trustees (paid for by the companies) to act as watchdogs

for investors. There have also been numerous examples of failures of auditors of company accounts to identify misleading statements in the accounts, with similar concerns regarding conflicts of interest.

1.13. On the other hand, this inquiry will have little use if it cannot demonstrate how its recommendations would have at the least substantially assisted in avoiding these regulatory failures.

1.14. We believe too much emphasis has been placed on the economic (and in practice often just the commercial) costs of regulation, often with inadequate consideration or knowledge of broader and longer term economic impacts, and insufficient emphasis on non-financial social, environmental and longer term benefits. Structures that have been set up to evaluate such impacts (such as regulatory impact statements) have become regulatory burdens in themselves and it is valid to wonder whether some of them have been devised as a barrier to regulation. Their conclusions are frequently ignored.

1.15. We are of course not arguing that it is undesirable to improve the quality of regulation, but in our view the quality has frequently suffered from the approaches, and often ideologies, applied in the last three decades. It would be entirely unacceptable to take similar approaches or to apply irresponsible principles such as those proposed in the Regulatory Standards Bill (earlier, the Regulatory Responsibilities Bill) which are heavily stacked towards commercial interests.

1.16. We appreciate that the direction of the inquiry is in considering institutions and practices rather than regulatory frameworks, and that therefore it is not likely to go too far down these paths, but New Zealand's experience should be borne in mind in designing institutions and practices.

1.17. We do however appreciate the reasons for approaches that allow flexibility in responding to risks. The quid pro quo is that they must be accompanied and balanced by effective and influential involvement of those put at risk by the regulated activities and a well-resourced, capable regulator, and may at times require prescriptive regulation or similar requirements. The Robens system for occupational health and safety provides such a model when applied in full

(not in a partial and unbalanced way as it has been in New Zealand until now).

1.18. The Commission has asked for suggestions as to case studies. We suggest occupational health and safety as one which has a wealth of lessons and for which there is now considerable documentation, some of which we refer to in this submission. (An additional resource not otherwise mentioned in this submission is Armstrong, 2013.)

1.19. In the following we respond to some of the questions raised in the issues paper.

1.20. However we make the following general points.

a. The issues paper does not mention a number of useful aspects of regulatory regimes and regulators (cf Box 2 on p.1, “Defining regulatory regimes”). Other ways to achieve compliance with desired standards include through changing motivation (or incentives), through education (such as public education campaigns and the provision of appropriately targeted material and advice to those being regulated) and through influence by gaining the support of respected people in the area that is regulated. It would also be useful to explore how modern technology could assist companies and others to comply with a wide range of regulations where a firm could conform to a standard template for reporting information and in the course of that meet compliance requirements for a range of areas.

b. A further type of regulator not covered is private agencies acting with legislated or delegated authority, of which there is a growing number. In a sense there is a spectrum of such organisations ranging from those with enforcement authority to those which provide certification or other “seals of approval”. There are specific issues with such organisations, some of which we have already alluded to in 1.12 above. The Piper Principle applies. Regulatory capture is more likely. A review of such organisations and the delegation of state authority to them is long overdue and in many

ways more urgent than for public agencies for which there are well established principles and practices.

c. Regulation does not take place in a neutral environment. Conflicting interests frequently apply, such as between production and profit objectives of employers and health and safety expectations of workers or between profit-seeking suppliers chasing market dominance and their customers. It is naïve to think that they will not have consequences or can be wished away by denying that bad behaviour occurs. It is better to design systems that balance such conflicts through regulatory, governance and other structures. In occupational health and safety for example, the Independent Taskforce and the Pike River Royal Commission recommended tripartite governance structures, tripartite representation in development of regulations, codes of conduct and guidance and in advisory groups, and strengthened provision for worker participation in health and safety matters in the workplace itself. These are recognised internationally through the International Labour Organisation (ILO) and in many jurisdictions as good practice.

d. On p.9, the issues paper states that "Regulatory failure is more likely where complexity is added to regulations to respond to specific incidents". While complexity is of course to be avoided if possible, in practice simplicity frequently leads to 'one size fits all' which is also strongly resisted and can lead to avoidance. In practice a balance must be struck between simplicity and ensuring fairness and fitness for purpose.

e. The assertion is made on p.12 that because we are a small and isolated country we need to have an "exceptionally good regulatory environment". This is not an unusual assertion about New Zealand. In general, and especially in the present context, it is a meaningless statement as it begs the very question the inquiry is asking: 'what is a good regulatory environment?' The recent Symposium run by the Commission on the 'Productivity Paradox' highlighted this issue. The OECD has frequently stated that we are "close to best practice" in regulation, yet it is not

having the predicted beneficial effects. Two questions arise and were addressed to some extent at the Symposium: is what the OECD regards as best practice (and the principles followed in New Zealand over the last 30 years) really what is best for New Zealand? And is this constant focus on 'quality' of regulation justified when weighed against other possible measures such as industry policy, funding of education and training, wage levels, quality of management or the level of exchange rate? We answer "no" to both questions, and papers presented at the symposium provide support for this.

f. We also note numerous regulators are not mentioned.

## 2. Response to questions

### *Q1. What sort of institutional arrangements and regulatory practices should the Commission review?*

2.1. We do not have strong views on this, but suggest consideration be given to including private agencies acting with legislated or delegated authority referred to in paragraph 1.20.b.

### *Q3. Does New Zealand have (or need) a unique 'regulatory style' as a result of our specific characteristics?*

### *Q4. What influence has New Zealand's specific characteristics had on the way regulation is designed and operated in New Zealand?*

2.2. We agree there are many global issues that require regulation. However we are wary of global regulation that constrains our freedom to regulate and to change regulatory approaches as we learn from experience. International commercial agreements such as the Transpacific Partnership Agreement (TPPA) currently under negotiation have increasingly broad agendas which have that effect, either directly through provisions which limit regulatory settings, or by providing avenues (especially Investor State Dispute Settlement, but there are many others) which allow corporate interests to challenge regulatory, court and other government actions and decisions. We

note that the Australian Productivity Commission has advised against Australia accepting Investor State Dispute Settlement provisions in its international agreements (Australian Productivity Commission, 2010, sec. 14.2). The strong corporate influence in the design of these agreements brings them into conflict with domestic regulatory settings which are negotiated in a more balanced way.

2.3. As to whether New Zealand has a unique regulatory style, the answer may well be that it does, in that it has gone further than most other countries in deregulation and adopting 'light-handed' regulatory design. We have noted a strong aversion to regulation as prescriptive as that in Australia among New Zealand regulators for example, despite the record of the failure of non-prescriptive, 'light-handed' regulation in New Zealand and elsewhere.

2.4. However New Zealand is finding that these past 'certainties' of regulatory design are being proven wrong by costly experience. Being locked into such settings comes at a high cost. In this sense our 'unique regulatory style' is not worth defending, but our ability to change it through democratic processes most certainly is. Similarly our ability to implement it in the interests of New Zealand residents, and include active involvement of those among them who are affected, is crucially important.

2.5. What is crucial to preserve is the substance: the ability to regulate in a way that recognises local needs (such as our remoteness, our geology, our social priorities and values, changing priorities, and the Treaty of Waitangi) and is able to adapt to experience and changing circumstances. Our local needs may be different and they may change in different ways to other parts of the world.

***Q5. What other ways of categorising New Zealand's regulatory regimes and regulators would be helpful in analysing their similarities and differences? How would these categorisations be helpful?***

2.6. We don't have an answer to this, but note the great variety of regulators and the very different contexts in which they work. It is likely to be futile to attempt

to categorise them too tightly, let alone try to do so in a legal or institutional sense which is likely in fact to be counterproductive and damaging.

***Q9 Can you provide examples of where a single agency is responsible for both industry promotion and the administration of regulations? What processes are in place to align the incentives of the regulator with the desired regulatory outcomes? What evidence is there of success or failure of these processes?***

2.7. The creation of the Ministry of Business, Innovation and Employment (MBIE) as a "business-facing" organisation with responsibility for both regulating businesses on the one hand and business promotion and economic growth on the other is highly risky. The Ministry combined the Ministry of Economic Development (MED), the Department of Labour (DOL), the Department of Building and Housing (DBH) and the Ministry of Science and Innovation (MSI), the first three of which had regulatory functions and the last administered programmes and funds in which businesses – among many others – have an interest. These regulatory functions are extensive: for the MED alone, the December 2011 'Guide to the Ministry of Economic Development' which provided a short paragraph on each of its functions and listed the legislation it administered, covered 27 pages.

2.8. In most of the areas which MBIE regulates there is a potential conflict between business interests and the wider interests of society. To give just some examples: the Intellectual Property Office of New Zealand which grants and registers patents, plant variety rights and other – sometimes contentious – rights to exclusive use of knowledge; the Official Assignee which administers personal bankruptcies and provides liquidators in corporate insolvencies; prospecting, exploration and mining permits for mining oil and other minerals; and enforcement of consumer product safety and accuracy in weighing products. It provides advice on corporate law, competition, trade rules, the regulation of telecommunications (such as Telecom and broadband), energy markets (such as the electricity sector), and much more. It has multiple regulatory functions in building and housing, and also covers employment (see below) and immigration.

2.9. In every area, there are far wider than business interests at stake. Public safety, provision of important services at reasonable prices, development of infrastructure where the private sector has failed to do so, and enforcing rules governing corporate behaviour are among them. Controversies over off-shore oil drilling, the safety of buildings and the creation of affordable fast broadband services are just some current examples.

2.10. In areas related to employment (labour and occupational health and safety, though the latter will be moved to a new standalone agency in December) a business-oriented agency, MBIE, is administering and regulating matters in which business priorities and interests frequently conflict with other members of society who also have a vital interest – their employees. MBIE maintains labour inspectors, mediators, the Employment Relations Authority and a contact centre. In addition to concerns about the adequacy and performance of these services, every one of these should be objective and neutral in the employment relationship. Labour inspectors must determine whether employment rules have been broken and if so take action against employers, mediators must work even-handedly between workers and employers, and so on. It is very hard to see how a "business-facing" government organisation can maintain that neutrality and be seen to do so.

2.11. Similarly the health and safety inspectorate must be objective and willing to take employers to task. The Pike River Royal Commission's findings made exceptionally clear the potentially fatal dangers of a 'business-facing' inspectorate. International experience is that that is impossible unless the process is at least as much 'worker-facing' as 'business-facing'. This was stated succinctly by Australian occupational health and safety experts Professor Neil Gunningham and Darren Sinclair from the National Research Centre for OHS regulation at the Australian National University, Canberra:

> The issue of regulatory capture is more straightforward. There is considerable evidence from a number of jurisdictions that agencies are particularly vulnerable to capture under particular institutional arrangements. Specifically, the location of an OHS inspectorate in a government agency whose primary responsibility is the economic

> success and productivity of the very industry it purports to regulate is a prescription for disaster. It gives rise to tensions that are not readily resolved and all too often results in OHS being sacrificed to considerations of short term profit and production (Gunningham 1987; Carson 1981). At the very least, mines inspectorates should be removed from this sort of pressure. The transfer in 2005 of the Western Australian inspectorate from the Department of Industry and Resources to the Department of Consumer and Employment Protection should accordingly be applauded. (Gunningham & Sinclair, 2007, p. 14)

2.12. Whether or not staff of the agency manage in reality to maintain independence from this business orientation (and we believe it will be very difficult), from an external perspective there will always be suspicion that their decisions are biased towards the agency's objectives and those it sees as its primary clients. In reality it is likely to be very difficult for staff to go against the intended culture of the agency if a dissonant approach is required to provide sound advice and regulatory decisions. Certainly the public visibility of what used to be the Department of Labour has been virtually lost, and when all health and safety material is on the business web site www.business.govt.nz[2], with no material oriented towards workers apparent, it is hard for the public to believe that neutrality has been maintained, whatever the reality. This must in the end reduce the effectiveness and respect for the agency.

2.13. We are well aware that the operational health and safety section of the Ministry is working on new ways of working and towards transfer to the new agency, so we are hopeful that these issues will soon be resolved. But putting aside the reforms that are in progress there were major and growing problems, of which we could give other more substantive examples.

2.14. We are not arguing that organisations or regulators should not have multiple objectives. There can be major benefits from such arrangements, and it can help avoid narrow thinking which fails to take wider issues into account. To

[2] To see this, go to the former Department of Labour web site dol.govt.nz and click on 'Health and Safety'. Clicking the 'Health and Safety' link on the www.mbie.govt.nz web site gives the same result.

an extent there will always be some tensions between such objectives. But great care must be taken to ensure that the tensions are not conflicts which undermine the ability of the regulator to act independently, judiciously and decisively, or lead to it not being seen to be acting in this way, and/or destroy the confidence of the public or affected communities in the regulator.

***Q10 Are there examples of where regulators have clearly defined policy functions? Conversely, are there examples of where the policy functions of a regulator are not well defined? What have been the consequences?***

2.15. MBIE as a Ministry obviously mixes these functions in numerous areas. The Independent Taskforce on Workplace Health and Safety recommended that the new agency (now called WorkSafe) should have the lead policy function in this area, based on international experience. This has not been accepted by the Government, though it will have an 'operational' policy role. MBIE is retaining the policy role and the lead in writing new regulations in the area. While understanding the rationale given for this, we do not agree, and are concerned that the separation of responsibilities will reduce the effectiveness of WorkSafe in leading ongoing improvements in occupational health and safety, and will not help both workers and employers maintain confidence in the independence of regulatory decisions.

2.16. Another example of a regulator which at times has had policy functions is the Tertiary Education Commission (TEC). It has an 'operational' policy function, but its higher level policy activities have varied widely depending largely on the Minister in charge of it. When it was established, the legislation gave the Ministry of Education a continuing role in policy, but it was often unclear where boundaries lay. Under Michael Cullen the TEC undertook most of the policy development and implementation of another round of tertiary education reforms with very little involvement of the Ministry. Currently most high level tertiary policy has been moved back into the Ministry of Education. This instability is a problem in itself: the Ministry had to establish a new policy function where virtually none existed. Experienced people in the TEC lost their jobs and their experience was lost to the system. This cycle has

repeated itself a number of times. But more fundamentally, the issue reflects views on whether there should be contestability of advice, and on whether there should be a split between policy and implementation.

2.17. A degree of contestability is desirable, but we believe that the second consideration is more important. The experience of implementing and working day-to-day with policies must inform their development or they will be forever repeating previous mistakes. That is much easier done in one organisation, with 'Chinese wall' separation where necessary. In addition, in a country of the size of New Zealand, finding the expertise and experience required for effective policy advice as well as for effective implementation can often be difficult or impossible without thinning both to an unwise level. We believe that the principle of a policy/implementation split should be reviewed.

2.18. A much more important matter than whether policy and implementation should be split is the objective of the organisation carrying out the policy and/or implementation role. The objective (such as being 'business-facing') can threaten the independence, or perception of independence, of either role.

***Q11 Can you provide examples where two or more regulators have been assigned conflicting or overlapping functions? How, and how well, is this managed?***

***Q12 Are there examples of where regulators are explicitly empowered or required to cooperate with other agencies where this will assist in meeting their common objective?***

2.19. There are and will continue to be multiple regulatory agencies in occupational health and safety: MBIE, WorkSafe, the Environmental Protection Authority (EPA), the Civil Aviation Authority, Maritime New Zealand, the New Zealand Transport Authority (for Rail, as well as working with the Police on road safety), and the Commercial Vehicle Investigation Unit of the Police. ACC also acts as a quasi-regulator. The Ministry for the Environment has a policy role in hazardous substances and noxious organisms which the EPA implements.

2.20. The Independent Taskforce on Workplace Health and Safety recommended that WorkSafe have a clear lead role in occupational health and safety including for the transport and hazardous substances areas. It proposed that the regulatory responsibility for all occupational health and safety should be with WorkSafe but that in transport it should delegate responsibility to the current agencies through service level agreements. That would ensure that their expertise would not be lost while bringing consistency to enforcement policies and approaches which is currently lacking. That would not prevent the retention of stronger requirements which exist in some of those agencies. The Taskforce also proposed that WorkSafe take responsibility for the regulation and enforcement of the use of hazardous substances in the workplace while the EPA continues to maintain responsibility for substance approval and general controls on use (Independent Taskforce on Workplace Health and Safety, 2013, pp. 64–65).

2.21. The recommendations regarding the transport agencies and the lead role of WorkSafe have not been accepted by the Government; that regarding the EPA has been. We are concerned that the lack of a clear lead regulatory agency and continuing inconsistency between regulators' approaches will detract from the effectiveness of the otherwise commendable reforms.

***Q14 Are the dimensions of regulator independence discussed in Figure 4.2 helpful in thinking about New Zealand regulators?***

***Q15 Which of these dimensions of independence is most important to ensure a regulator is seen to be independent?***

***Q16 Can you provide examples of where a lack of independence or too much independence according to one of these dimensions undermines the effectiveness of a regulatory regime?***

2.22. There was extensive discussion of the form of Crown agency that was most suited as regulator for occupational health and safety. Some of it can be found in the reports of the Royal Commission and the Independent Taskforce. A crucial issue was the balance between the agency's policy and

regulator roles. It was considered that a substantial degree of independence was vital to regain public confidence and to distant it from the suspicion of political interference. This was particularly important given the history of workplace safety and health. On this criterion the most independent Crown Entity, an Independent Crown Entity, would have been best. On the other hand if the agency was to exert leadership in occupational health and safety, including a substantial policy role, a form of agency over which there was more Ministerial control was considered to be needed as it was unlikely a Minister would entrust policy development to an entity over which s/he had less control. Normally policy is carried out by a Department or Ministry, though the new form of Departmental Agency was also considered. The form of Crown Agent was a compromise between the two. Whether this was wise has yet to be seen in the light of the decisions the Government has made in implementing the reforms, including leaving the most substantial policy role, design of regulations and monitoring of the agency with MBIE.

2.23. One of the Cabinet papers recommending the form of the implementation of the reforms describes the 'accountability' of the new agency as follows (directly quoted from Bridges, 2013, pp. 29–30). It indicates a high degree of Ministerial control which may prove to be a barrier to the agency establishing its independence and standing in the public mind:

a. The Chair and Members of a Crown Entity Board serve at the discretion of the Minister of Labour. Hence, it is possible for Ministers to control the composition of the Board (including removing members if that is necessary).

b. The Crown Entities Act provides the power for the accountable Minister to direct a Crown Agent to give effect to government policy that relates to the agency's objectives and functions. Under this provision, I could specifically direct WorkSafe to meet the outcomes Government is seeking to achieve (for example, to focus on high risk sectors) and follow the Best Practice Regulation model. This model requires consideration of the principle of proportionality, and that economic objectives are given an appropriate weighting relative to other specified objectives.

c. The legislatively required strategy for health and safety is also a vehicle for the responsible Minister and Government to establish priorities and direction for WorkSafe and to require them to report, and evaluate progress.

d. Appropriate checks and balances on each function and power of the regulator have been included in the design of legislative changes. These will include a requirement for consultation and consideration of costs and benefits where appropriate.

e. The State Sector and Public Finance Reform Bill includes changes that will bring Crown entities within the influence of the proposed new leadership arrangements across the state sector and improve their ability to align with Government priorities while retaining Crown entities' self-governing autonomy. The proposed changes will support coordination and collaboration between Crown entities and other agencies by amending the collective duties of Crown entity boards, so that board members ensure their entity collaborates with other entities where practicable. The changes also support functional leadership by expanding the scope for the use of whole-of-Government directions.

f. The Annual Letter of Expectations, along with the Statement of Intent and output agreement will focus WorkSafe's activities in relation to its functions, and can be adjusted over time as needed. They will also ensure the sgency is transparent about the intended outcome from its activities and how it is measuring its performance.

g. MBIE will have a primary role in monitoring the performance of WorkSafe. This role includes providing advice on the agency's performance and on-going capability to deliver.

2.24. As previously mentioned, the Royal Commission, Independent Taskforce and CTU had recommended that the Board of the new agency be tripartite, including representatives of workers and employers (e.g. Independent Taskforce on Workplace Health and Safety, 2013, pp. 48–50), but this was not accepted by the Government despite successful tripartite models

elsewhere, including the U.K. and Australia, and strong recommendations for tripartism from the ILO.

2.25. The independence, effectiveness and public confidence in a regulator can be enhanced by having balanced representation of affected interests in its governance structures. The balance is essential to prevent any suggestion of capture, but the presence of such parties can give assurance that the regulator is constantly reminded of the realities on the ground and there is monitoring of undue political influence or influence from any one party. It is thus a means to resist regulatory capture. It can also assist in creating a cooperative atmosphere for ongoing work despite differing interests.

2.26. We also note that the degree which a regulator has discretion to set and adjust rules and regulations is closely aligned to their having a policy role.

***Q19 Is regulatory capture more or less likely in a small country? Can you provide examples of capture in New Zealand?***

2.27. Regulatory capture certainly occurs. The conclusions of the Pike River inquiry showed that regulation of occupational health and safety in mining had in effect been captured by employers. Unions had noted similar examples on many occasions before the tragedy that led to the inquiry. As one example, a CTU affiliated union was forced to take a (successful) private prosecution when the Department of Labour failed to address a serious safety situation which was far from being an isolated incident with the employer.

2.28. The state of the electricity sector has many symptoms of regulatory capture with excessive power prices for those with least bargaining power (households) and high profit levels continuing to be tolerated alongside lack of incentives and encouragement for the development of alternative energy sources or energy saving. With a small number of powerful parties in the industry, regulatory capture is a greater risk.

2.29. There was also widespread criticism of the Securities Commission for its failure to control unacceptable behaviour among investors and companies,

contributing to lack of confidence in the share market and other forms of investment. There was continuing opposition to greater regulation from some powerful and vocal parties, such as the Business Roundtable, which in turn discouraged enforcement. It is difficult to distinguish the effects of weak legislation, weak regulator and regulatory capture, but the outcome of feeble standards and enforcement certainly suited some interests despite being to New Zealand's long term detriment.

***Q20 Are there other institutional forms for government-established regulators?***

2.30. Officers of Parliament such as the Office of the Auditor General and the Ombudsman are regulators or monitors of regulators. There are also private standards setting bodies which de facto write regulations, such as the New Zealand Institute of Chartered Accountants formerly did for accounting standards (now the responsibility of the Crown Entity the External Reporting Board).

***Q23 Are there aspects of regulatory independence that are more or less important in regulating state power or government-provided/funded services?***

2.31. We are not convinced that the concept of regulatory capture is meaningful in the context of government provided services. It appears to arise when such a service has private competitors. When a service is provided only by government agencies we would expect that they have their own quality assurance processes, perhaps described in statute or regulation. When private competitors are introduced, the need for regulation may reflect the difference between a quality-focused service (when publicly provided) and a price-focussed one (when provided on a commercial basis). To characterise the public provider as "capturing" the regulator reflects privatisation of public functions and forcing of the public provider into a commercial straitjacket. Like the relationship between policy and regulatory responsibilities, there may be benefits when a public provider can bring influence for higher quality

services. In very many government services, quality is a fundamental and often immeasurable characteristic of the service.

***Q25 What type of governance and decision-making structures are appropriate for different types of regulatory regime?***

2.32. See paragraph 2.22.

***Q26 How effective and consistent are the review and appeals processes provided for in New Zealand regulatory regimes?***

***Q27 Can you provide examples where the review and appeals processes provided for are well-matched or poorly suited to the nature of the regulatory regimes?***

***Q28 What are the advantages and disadvantages of a general merits review body like the Australian Administrative Appeals Tribunal?***

2.33. We note only that specialist expertise is often important in such processes (e.g. labour matters). Low level, less formal processes can be valuable.

2.34. We would oppose a general merits review body. It cannot have the specific knowledge required for each area of regulation, either in subject matter or in the type of approach required. For some areas, cases will be so rare that such a body would find it difficult to build up experience and expertise. There is already a problem of this kind, identified by the Independent Taskforce on Workplace Health and Safety (2013, pp. 91–92) with regard to court cases dealing with occupational health and safety.

2.35. On the other hand there may be a case for specialist, less formal, low cost specialist tribunals in specific areas of regulation. The Taskforce suggested considering an ‘independent regulatory challenge panel’ for occupational health and safety cases, of the kind that exists in Australia. Such a structure “could provide the public with a mechanism for raising issues about regulatory performance, e.g. the ability to challenge the accuracy of guidance material or to challenge enforcement decisions. The panel could provide recommendations to the regulator with which it may not be required to

comply but to which it should be required to respond."(Independent Taskforce on Workplace Health and Safety, 2013, p. 63.)

***Q29 Can you provide examples of regimes where risks are borne by a regulator, regulated party, or the public/consumers, but they are not best-placed to manage those risks?***

2.36. Occupational health and safety is an example. There is an inherent principal-agent problem where, as recognised in Robens-model legislation, the agent (the employer) has the power to control the environment that determines the health and safety of the principal (the employee). The employer is recognised explicitly as being best placed to managed the risks and thus is given the primary duty to eliminate, isolate or minimise those risks. The primary task of the regulator is therefore to ensure that the employer is carrying out its responsibility.

***Q30 Can you provide examples of where the mix of funding sources contributes to the effectiveness or ineffectiveness of a regulatory regime?***

***Is the mix of funding sources for individual regulators consistent with their stated funding principles?***

***Which New Zealand regulators (or regulatory regimes) provide good examples of open and transparent funding arrangements? Can you provide examples where the transparency of funding needs to be improved?***

***Q33 Can you provide examples where a regulator's funding arrangements support or undermine its independence?***

2.37. Where a regulator is carrying out a controversial or unpopular role (perhaps unpopular only with one interested party) there is pressure to reduce its activity by underfunding. Again, that was demonstrated in the occupational health and safety system. The Pike River Royal Commission inquiry documented the falling resources made available to the regulator with

demonstrated but long term impacts on accidents, injuries and deaths. The regulator was unable to do its job properly as a result of the falling funding, which increased the attractiveness of taking short cuts including relying on employer processes or their word rather than carrying out proper inspections and investigations. This meant the regulator was highly reliant on employer goodwill, undermining its independence.

2.38. For this and other reasons, there is an argument for longer term funding for regulators. It would give them greater independence, and allow them to take the longer term view which is frequently required. Industry levies (like the Health and Safety in Employment Levy) and charges to recover costs in certain circumstances should also be options that are considered as they also give some certainty and autonomy to the regulator.

***Q34 What approaches are there to identifying, building, and maintaining workforce capability? How effective have they been?***

***Q35 What restrains or enables a regulator to develop the capability they need in the New Zealand context?***

***Q36 Where are there gaps in regulator workforce capability? Can you provide examples?***

***Q37 What is the potential to improve capability through combining regulators with similar functions, compared with other alternative approaches?***

2.39. See the report of the Independent Taskforce on Workplace Health and Safety (2013, pp. 22–24, 105–111), and paragraph 1.9 above. It is important that regulators are properly resourced, have political support for (or at least absence of resistance to) the decisions they must make, and must be, and be seen to be even-handed, expert in the industry they are regulating, and able to provide useful advice. Expertise may need to be multidimensional: for example expert in safety matters and in the industry which is being regulated.

2.40. It is important that specialist expertise is retained. Experience and institutional knowledge can be crucial in gaining and keeping the confidence of those affected, in effective investigations, and in learning from incidents to make long term improvements. While there are certainly some generic skills among inspectors and similar officers (such as requiring professional investigative techniques) we would resist any suggestion that there could be a pool of regulators to carry out these roles. It would quickly undermine their credibility.

***Q42 Can you provide examples of where a regulator has too much or too little discretion in enforcing regulations? What are the consequences?***

2.41. There are numerous examples in occupational health and safety in New Zealand of regulators failing to enforce regulations, leading to greater rates of injury and death, and confidence among employers that they were unlikely to be inspected, let alone required to comply with statutes or regulations.

***Q43 Can you provide examples of where risk-based approaches have been used well? What are the critical pre-conditions for effective implementation of risk-based approaches to compliance monitoring and enforcement in New Zealand?***

***Q44 What are the challenges to adopting risk-based approaches in New Zealand?***

2.42. Given that the decisions on priorities for monitoring and enforcement are inherently matters of judgement, it is important that wherever possible, compliance/enforcement strategies which codify those judgements are consulted on with the people being protected by the regulation.

2.43. A significant barrier (at least in the area of occupational health and safety) is sufficient data and information of the right quality and the right form to make the decisions necessary for risk-based approaches. In some cases there are privacy and confidentiality issues that must be addressed. Well designed information systems are also necessary.

***Q45 Can you provide examples of where regulatory regimes require too much or too little consultation or engagement? What are the consequences?***

***Q47 What forms of engagement are appropriate for different types of regulatory regime? When do formal advisory boards work or not work well?***

2.44. Rather than too much/too little consultation, we would draw a distinction between consulting with those being protected by regulation and those being regulated. An example of too little consultation with those being protected is occupational health and safety (at least until now): worker participation at the workplace was not enforced or encouraged; consultation by the regulator on regulations, approved codes of practice, guidance, compliance strategy and general advice was rare or non-existent (in contrast, there are cases of standards being accepted despite being drawn up by industry groups without effective, or any, worker participation); and ineffective mechanisms for participation at a governance level. There has been a pattern of inspectors when visiting workplaces talking only to the employer. There have been recent examples of approved codes of practice being approved without worker representatives being involved.

2.45. Another example is in electricity supply regulation where household consumer representation has been significantly reduced.

2.46. We would also distinguish between *consultation* on one hand and *involvement* or *participation* on the other. In occupational health and safety, there are well established international principles in favour of the latter. We suggest it should be the preferred approach for those being protected, but recognise that it is more difficult where they have no clear representatives.

2.47. Regarding advisory boards, we are sceptical. As the Independent Taskforce on Workplace Health and Safety recorded (2013, p. 49):

> Nor do we support the alternative approach of an independent board that is not constituted on a tripartite basis but that is supported by a

tripartite advisory group. The Royal Commission similarly concluded, "In summary, New Zealand lacked effective shared governance, despite its importance being recognised in the DoL 10-year strategy. As Robens concluded 40 years ago, advisory committees have little influence; an executive board is required if there is to be effective participation in decision-making".

2.48. While advisory boards may have a place, they cannot be seen, as they too often have, as substitute for effective involvement of interested parties in decision making. When they have marginal influence they can disillusion people rather than encourage their involvement. We consider that New Zealand has moved much too far down the path of stripping governance boards of representatives of those affected. That should be reversed. In addition there should be requirements that where regulations, codes of practice, compliance strategies and the like are being developed or reviewed, their involvement is mandatory.

2.49. Our emphasis is on representation of those needing protection. We recognise that there can be advantages in consulting the parties being regulated. However that should not be allowed to give them unbalanced access to or influence over the regulator. This is a difficult task particularly when the regulated parties are large, wealthy, influential and powerful. Great care must be taken to ensure that 'consultation' does not in the end mean regulatory capture.

2.50. Regarding engagement, we consider that the issues paper underestimates the importance of providing education and advice on compliance with regulation, on the rights of those needing protection, and on the reasons for the regulator's decisions and activities.

***Q46 What are the characteristics that make some regulations more suited to prescriptive consultation requirements than others?***

2.51. The Robens principles (as described by the Pike River Royal Commission) included that

> First, employers should be provided with more prescriptive guidance through regulations and codes of practice which could be easily amended. Such guidance was expected to be necessary for general matters relating to most forms of employment, specific types of hazards and particular industries such as agriculture, mining or construction.(Royal Commission on the Pike River Coal Mine Tragedy, 2012, p. 251)

2.52. The principles saw prescriptive regulation as an essential complement to legislation that encouraged self-regulation in order to give more certainty and spread good practice. It of course depends on regular reviews which enable regulations to be updated as needs and knowledge changes.

2.53. The Royal Commission made numerous recommendations for more prescriptive regulations (e.g. Royal Commission on the Pike River Coal Mine Tragedy, 2012, p. 310ff). In general a much greater degree of prescription is necessary for major hazard industries and facilities.

2.54. We have proposed that for occupational health and safety, there should be a statutory requirement that provides for the mandatory promulgation of regulations and/or approved codes of practice where they will manifestly improve safety. This would limit the regulator's discretion, and ensure better accountability for this work.

2.55. Alongside strengthening the requirement for regulation, the process for standard setting needs to be more robust. There are many industries in which the hazards, and the control measures, are so well known that a strong case exists for more prescriptive regulation. This includes the case where hazards are associated with high-consequence/ low-probability events but also where standards are known to improve safety even when accidents maybe less severe (e.g. falls from ladders, working at heights).

2.56. Experts in the field agree with this proposal (the following are cited in New Zealand Council of Trade Unions, 2012, p. 21). Professor Michael Quinlan, in a report to the Department of Labour on the Pike River tragedy, stated that

Where control measures are clearly known in relation to hazard, a requirement that they should be applied is unambiguous and assists management in terms of compliance.

2.57. Elizabeth Bluff and Professor Neil Gunningham of the National Research Centre for OHS regulation at the Australian National University note that the specification of standards is particularly important where there is a high degree of risk, control measures that are applicable in all circumstances and where risks have acute and significant consequences. They also note that there are a number of advantages associated with specification standards, including the clear identification of preventative measures to be taken by employers, administrative simplicity, ease of enforcement and the creation of a level playing field in highly competitive industries.

2.58. While we do not suggest that identical principles apply in all areas of regulation, we do consider that New Zealand has moved too far from more prescriptive regulation and suggest that some of the criteria for prescriptive regulation are:

a. Significant complexity or uncertainty and/or there are advantages in administrative simplicity and ease of enforcement; or

b. Significant or irremediable consequences of failure; or

c. The existence of accepted solutions ("control measures are clearly known"); or

d. An industry where competition is likely to lead to a breach of acceptable standards and a 'level playing field' could help prevent that; or

e. Because of issues of mistrust, complexity or conflicting interests it is important that those requiring protection have clear information on the steps being taken to protect them and can ascertain whether or not they are in fact being taken.

***Q50 How well do regulatory agencies ensure consistency of approach between or amongst regulatory staff, so that individual variations are minimised?***

***Q51 Can you provide examples where the culture or attitude of the regulator has contributed to good or poor regulatory outcomes? How?***

***Q52 Can you provide examples where the culture within a regulator supports or inhibits staff in making difficult decisions, particularly where those decisions may be unwelcome to government, regulated parties or the general public? How?***

***Q53 Can you provide examples where a regulator places too much value on managing risks to itself, relative to other priorities (such as the regulatory objective, or customer service)? What are the consequences?***

2.59. The problems within the Department of Labour, in its role of regulating occupational health and safety, have been well documented. Inability and under-resourcing to retain experienced staff, lack of enforcement strategies, lack of political and high-level management moral support for regulatory activities, and demoralisation all played a part.

2.60. A high priority must be placed on retaining and developing staff with experience and expertise in the area being regulated and in the role of regulator.

2.61. The role of unions in supporting staff to exercise their statutory roles when there is resistance from political or high level management levels should not be underestimated. Affirming and strengthening this public good role of unions would be a useful outcome of this inquiry.

2.62. Top management support for activities, an emphasis within the agency on independence in exercising authority, and a sound compliance strategy are also essential.

2.63. Examples where this has been lacking include labour as well as occupational health and safety.

2.64. The inquiry into the collapse of the CTV building in Christchurch provided an example of the City Council as building consents regulator apparently buckling under pressure from a building developer. The leaky building disasters are unlikely to have happened if a more robust approach had been taken to builders and developers by central and local government.

2.65. In food safety, some local governments appear to put excessive emphasis on protecting eateries rather than protecting those eating at them. For example, Wellington City Council only began publicly naming those in breach of hygiene regulations in 2012 despite problems dating back to 2007 (Lane Nichols, 2012).

2.66. Political 'risk management' is unfortunately ubiquitous in the public service. This is encouraged by public service management structures including the relationship to the Minister, and Ministerial attitudes. It results in regulators being reluctant to do their jobs where difficult decisions may be resisted by the Minister, or the response is uncertain.

***Q55 Can you provide examples of how accountability or transparency arrangements improve or undermine the effectiveness of a regulatory regime?***

***Q56 What types of accountability or transparency arrangements are appropriate for different types of regulatory regimes?***

2.67. The issues paper understates the importance of empowering those needing protection in holding regulators to account. That can be in the public domain or in institutional structures of the regulator. In some cases there are organisations of affected people which perform a public service in doing so. Unions are among a number of these. Board representation of these people can be a potent means of strengthening accountability.

2.68. As already mentioned, ‘transparency’ which gives those who are regulated greater influence over the regulator should be treated with suspicion.

***Q60 Can you give examples of indicators or proxies that are effective as early warning signs of regulatory noncompliance or failure?***

2.69. We note that in addition to independent reviews, academic activity and good journalism potentially assisting in learning from regulatory failure, union activity can also, and does so frequently in the regulatory areas of labour, health and safety and accident compensation.

2.70. Indicators can include increased volumes of complaints by individuals or by organisations representing them that indicate they are not being sufficiently protected.

***Q61 Can you provide examples of regulatory regimes with effective processes for formally or informally raising concerns about potential regulatory failures? What examples are there of regimes that handle this poorly? What are the consequences?***

2.71. Processes include ombudsmen (Parliamentary or specialist), confidential or anonymous reporting facilities, low cost and less formal tribunals such as employment mediation, and disputes tribunals.

## 3. Conclusion

3.1. We have provided responses to some of your questions. We can provide further clarification if required.

3.2. We do wonder whether the task the Commission has been set is unobtainable. In reality the number and types of regulators are so varied that any categorisation, let along attempt to force them into the same mould, could do damage to their effectiveness and public support.

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