Implementing Cross-Cutting Policy in New Zealand: Health and Safety for Aircraft in Operation

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Cross-cutting policy issues have been defined as issues 'involving or affecting the work of more than one agency or sector' (Review of the Centre Advisory Group, 2001). It has not always been straightforward to make progress with these types of issues, partly because of the artificial boundaries created by legislative regimes, budget vote structures, agency administrative structures and differences in professional paradigms and boundaries. One method of implementing cross-cutting policy that has been used in New Zealand is to designate an agency to administer a statute for a particular sector, where the act is normally administered by another agency. An example of this is the designation of the Civil Aviation Authority of New Zealand (CAA) to administer the Health and Safety in Employment Act 1992 (HSE Act) for 'aircraft in operation'.

A case study by the author (Matsas, 2005) of the CAA's implementation of the HSE Act for aircraft in operation indicates that:

- it is difficult to design a perfect implementation structure when applying law across agencies and sectors where the relevant expertise to administer the law competently and safely resides in different agencies;
- bottom-up implementation processes such as negotiation are essential to achieve cross-cutting policy objectives in the cross-cutting implementation environment;
- a skilful performance on the part of the implementing officials is essential to achieve cross-cutting policy outcomes; and
- agencies implementing cross-cutting policy need to evolve to accommodate the new policy objectives they pick up through mechanisms such as agency designation.

This article will look at the background to this policy issue, and discuss these factors in more detail.

Occupational health and safety in aviation – the policy problem and proposed solutions

The issue of occupational health and safety for transport workers has been discussed for some time. The landmark Robens Committee in the United Kingdom in the early 1970s expressed some irritation at transport workers being excluded from the terms of reference of their review of the British occupational health and safety system, because of the 'many obvious connections between safety and health at work, public safety, transport safety and environmental pollution'. (Robens et al., 1972, p.xiv). They nevertheless noted in their conclusions that occupational health and safety and transport safety regimes should be kept separate.

In New Zealand, the 1988 Advisory Committee on Occupational Safety and Health recommended that all workers be covered by occupational health and safety legislation (ACOSH, 1988). However, due to a concurrent review of the civil aviation system and the enactment of the Civil Aviation Act 1990, crew on aircraft were excluded from both the 1989 Health and Safety at Work Bill and the Health and Safety in Employment Act 1992.

The policy problem was that although aviation safety legislation covered the safety of the aircraft, it did not give the employers of aircrew a legal duty to protect them from harm that was not directly related to the safety of the aircraft. Aviation workers' unions were concerned that aircrew could experience poorer health and safety outcomes because of the lack of legal duties of obligation on their employers.

The government acknowledged this in 1997, in its response to a select committee inquiry into the administration of the HSE (Department of Labour, 1997). The response stated that 'the Government notes that the basic issue is that flight attendants and other aircrew do not have the same rights and obligations as other employees in New Zealand, and that their employers do not have the same responsibilities as other employers in respect to occupational safety and health'.

Following this, the Department of Labour sought a solution to the problem. Initial options included administrative solutions and statute amendment. Administrative solutions were quickly discarded, as they had been tried unsuccessfully in the period following the commencement of the HSE Act. At that time the government requested the CAA to include occupational health and safety requirements in civil aviation rules, but did not amend the Civil Aviation Act 1990 to make such additions to the rules legal. As a result, no additions to rules were made.

The only remaining option was to amend existing law. Most of the debate between 1997 and 2001 centred on whether the Civil Aviation Act 1990 or the HSE Act should be amended, whether the Department of Labour or the Civil Aviation Authority should administer the requirements, and which agency should provide support.

The issue of expertise was also considered. The Department of Labour had expertise in occupational health and safety, but not in aviation safety. Aviation industry representatives were concerned that if the Department of Labour were the agency administering health and safety law for aircrew, they would not understand aviation in general, or the links with the existing aviation safety system. The CAA likewise did not have expertise in occupational health and safety, and aviation unions were concerned that, if the CAA were the lead agency, health and safety issues for groups such as flight attendants would not be treated as seriously as overall flight safety.

The proposed structure that emerged following the consultation period involved an amendment of the HSE Act to include aircrew, to be administered by the Department of Labour with expert assistance from the CAA. The Minister of Labour introduced the Health and Safety in Employment Amendment Bill in Parliament in 2001. A memorandum of understanding was drafted between the Department of Labour and the CAA for the provision of expert advice on aviation to the Department of Labour.

This implementation structure was changed after the Amendment Bill was introduced into Parliament. The new bill also repealed parts of the Maritime Safety Act that replicated HSE Act provisions. To allow the Maritime Safety Authority (now Maritime New Zealand) to retain their occupational health and safety role on ships, a new Cabinet paper recommended an 'Agency Designation' option, whereby Maritime New Zealand could be designated to administer the HSE Act for ships. Agency designation essentially gave the designated agencies' chief executives the same powers under the HSE Act as the Secretary of Labour, but only for that agency's specific area of expertise. It was not long before aviation sector stakeholders recommended that the designation option also apply to the CAA, and this became the final recommendation of the select committee considering the legislation.

The final result of this process was that Parliament passed an amendment to the HSE Act in December 2002 to include aircrew, and the Prime Minister designated the CAA to administer the HSE Act for 'aircraft in operation' in May 2003. Dedicated funding was provided to the CAA for their HSE Act role, and two experienced health and safety inspectors were seconded to assist with the implementation.

The achievements of the policy process

The policy process achieved some essential outcomes. Legislation was passed that placed new requirements on aviation employers in terms of health and safety practice. A government agency was made responsible and accountable for implementing the new law. Expertise in occupational health and safety was made available to CAA through staff secondment and the signing of a memorandum of understanding between the Department of Labour and the CAA. Dedicated funding was provided to the CAA for HSE Act administration, so funds would not need to be diverted from aviation safety administration for the new policy venture.

The amendment also changed the 'one act, one authority' philosophy recommended in the Robens Report in 1972, and which had been adopted in New Zealand. Instead it created a system of multi-agency

administration of the HSE Act for both general and specific sectors.

From the perspective of the CAA, it created a 'one authority, two act' system, where the CAA administers two statutory safety systems established under the Civil Aviation Act and the HSE Act. Implementing the HSE Act in this environment is different from ground-based sectors, where there is no other safety legislation to take into consideration. The main implementation problems are to reconcile the differences, overlaps and boundaries between the two statutes, and the differing philosophies and practices between aviation safety and occupational health and safety.

From the perspective of the aviation operators, both a 'one authority, two act' and 'two authorities, one act' system was created. Aviation employers have two safety statutes to comply with, with the HSE Act being administered by two different agencies for ground- and air-based activities. Problems for the implementing agencies are centred on the quest for efficient, effective and error-free delivery of services.

The policy development process therefore solved the initial policy problem regarding occupational health and safety coverage for aircrew. The price for this was the creation of a potentially complex administrative system, a situation that arguably could not have been avoided, even if other policy options had been adopted. This being the case, how can an implementation system such as this be made to work to achieve the desired policy outcomes of both a safe civil aviation system and safe and healthy aircrew?

The solution to implementation is through 'bottom-up' mechanisms such as negotiation. The role of the implementers, those people described by Lipsky (1980) as 'street level bureaucrats', is to negotiate their way through the complexity and apparent contradictions, and end up doing the right thing in order to achieve the desired outcome. This supports theories of implementation such as those proposed by Sabatier (1993) and Lane (1993), which acknowledge both top-down and bottom-up implementation mechanisms.

The role of implementing officials in cross-cutting implementation

The role of the officials in implementing cross-cutting policy solutions such as agency designation includes:

- reconciling conflict and overlap in statutory and administrative regimes;
- managing stakeholder expectations;
- achieving effectiveness and efficiency in service delivery;
- managing the risks inherent in the implementation system; and
- making fair, balanced and unbiased decisions.

Reconciling conflict and overlap in statutory and administrative systems

One of the difficulties with the implementation of the HSE Act in the aviation environment was that an aviation safety system established by the Civil Aviation Act already existed. The government clearly did not intend the HSE Act to override the Civil Aviation Act, and neither did it intend that the HSE Act, as applied to aircrew, remain unused. The question for the implementer is how to manage the boundaries, overlaps and potential contradictions between the two statutory regimes, and decide when one act or the other should be used.

Conflicts can arise over the application of the different legal tests in the two acts. It is possible to apply the HSE Act's legal test of 'all practicable steps' to a situation covered by a civil aviation rule made under the (now changed) test of 'safety at reasonable cost', and find that the rule does not meet the same standard. Taking into account the HSE Act's 'non-designation' clause, the implementing officials need to decide whether there is a conflict between the two statutes, and if so, determine how it can be resolved.

Legislation is also an enabling instrument, and as such it creates possibilities for dealing with particular issues. One possibility identified early in the implementation of the HSE Act in the aviation sector, for which a guideline is being developed, regarded fatalities in agricultural aviation. An agricultural aviator died in late 2001 after the load of damp lime he was attempting to sow became stuck in the aircraft hopper. The lime was damp due to inadequate protection from the weather in storage on the farm airstrip.

Under the Civil Aviation Act, the responsibility rests with the 'pilot in command' to refuse to sow the lime if he or she is not satisfied the situation is safe. This can mean the aviator loses business if another aviator accepts

the risk. If the HSE Act is applied, responsibility for safety can also rest with the farmer requiring the service, as the farmer has duties as a 'principal' under the HSE Act that he or she did not have under the Civil Aviation Act. These duties could include ensuring adequate protection from the elements for bulk materials stored at the airstrip prior to use. The HSE Act can therefore be used in a way not possible with the Civil Aviation Act to deal with what is essentially an aviation safety issue rather than an occupational health and safety issue.

How far does the implementer go in exploring these possibilities? If an action is possible under the HSE Act that does not override the Civil Aviation Act, is it ethical not to use that provision? At what point, however, is there a risk of undermining the already established aviation safety system? This presents a dilemma for the implementing officials, and some caution is needed.

Reconciling tensions in stakeholder expectations

Reconciling tensions in stakeholder expectations is normal business for any government agency. In the labour market there is tension between the expectations of employer groups and the expectations of unions of how a government agency will formulate or implement policy.

In a cross-cutting situation such as agency designation, the government itself as a stakeholder can create tensions in what is expected of an agency in terms of policy outcomes. This is demonstrated by the expectation for the CAA to implement new processes to achieve health and safety outcomes while maintaining and improving the effectiveness of the civil aviation system. While these tensions can lead to smarter ways of working, which improve the efficiency and effectiveness of government agencies, they do need to be recognised and managed by the implementing officials.

Effective and efficient delivery of services

The 'one act, multiple authorities' and 'one authority, two acts' situations outlined above have a direct impact on service delivery. Cross-cutting policy issues are arguably inherently inefficient to deal with - they do not fit neatly into a single agency's service delivery system, and require the skills, knowledge and networks of other agencies. The goal of the implementer of cross-cutting policy is therefore to deliver *effective* services as *efficiently* as possible.

Effectiveness is achieved through skilful interaction and intervention by the people visiting aviation employers. Efficiency is dealing with the areas of overlap in the service delivery systems that bring the right skilful people to the client.

To improve the efficiency of service delivery, some analysis has to be made of the different agencies that have an interest in a workplace, and the contact that people with differing expertise need to have with the employer. As we have seen, both the CAA and the Department of Labour have an interest in an employer for administering the HSE Act for both 'aircraft in operation' and all other business operations. The CAA also has an interest in the employer as an aviation operator under the Civil Aviation Act and rules. This potentially means three different groups visiting a single employer at different times, and, in a worst case scenario, placing contradictory requirements on an employer. Efficiency can be improved in two ways: through better coordination and communication between these groups, and possibly through some amalgamation of service delivery.

The coordination and communication option is relatively easy to put in place, both formally through memoranda of understanding between agencies, and informally through developing and maintaining well-functioning internal and external relationships.

Amalgamation of service delivery is harder to achieve. Within the CAA, some amalgamation of HSE Act and Civil Aviation Act requirements can be achieved – for example, in the accident reporting required by both acts. Quality systems required by the civil aviation rules can be extended to include HSE Act hazard management.

CAA auditors could be trained to carry out health and safety audits during the same visit. Although it is efficient, and many aviation operators would prefer one visit from the regulator, it may not be effective, as aviation safety issues could dominate the visit, leaving little time for occupational health and safety issues. Expertise and interest in health and safety issues on the part of auditors primarily employed to carry out aviation safety functions may be variable.

Alternatives include training CAA auditors to carry out 'screening' HSE audits, and for specialist staff to also visit clients and carry out fuller inspections. This

diminishes returns on efficiency and the reduction in compliance costs for operators, but delivers the service more effectively.

Redesigning the system to minimise or prevent inter-agency overlaps is problematic. The Prime Minister's designation of the CAA to administer the HSE Act could be extended so that all activities of an aviator were administered by the CAA. However, this would shift the CAA from their core role of aviation safety, and mean that they would need to administer the HSE Act for areas removed from their expertise, creating a significant business risk. They would probably be less than enthusiastic about such a prospect.

Management risks

Potential areas of risk in the implementation of the HSE Act for 'aircraft in operation' include risks of unintended consequences, implementation failure and error.

The aviation industry raised concern about the risk of unintended consequences in the form of a catastrophic aviation event in the early stage of the policy formulation process. Aviation safety is based to a large degree on the philosophy of open reporting of errors to the regulator and other aviators as a means of learning about situations that could have led to an accident. Aviators were concerned that the HSE Act was inappropriate to regulate aviation, particularly because of the fear that it would be enforced aggressively in that environment, would close down the open reporting system as a consequence, and ultimately increase the risk of accidents. The notion of the regulator as a contributor to accidents is supported by Reason (1997), whose model of accident causation forms the theoretical basis of air accident investigation in New Zealand and overseas.

How seriously should an implementer take these arguments? There is obviously little value in an implementer vigorously enforcing occupational health and safety law if it compromises aviation safety culture. There is also little value in overcompensating for this risk and achieving nothing in implementing the new policy. The ideal of course is to achieve both aviation safety and occupational health and safety, and to implement the HSE Act in aviation in a way that at worst is neutral in its effects on aviation safety, and at best complements and reinforces aviation safety.

The main mechanism for the implementing officials to find their way through this is to negotiate with both aviation safety people and other stakeholders to establish the appropriate standards that can be used if enforcement is contemplated.

Tied in with this is the risk of error. With cross-cutting issues, there is an almost complete certainty that erroneous views or assumptions will be held by stakeholders, policy actors and implementers at some stage of the policy formulation or implementation process. The way in which policy developers and implementers deal with the risk of error can determine whether this is a short-lived or persistent phenomenon.

Reason categorises error into 'active' and 'latent' failures. Active failures include skill-based slips and lapses, such as losing attention and not hearing vital information, or forgetting to tell someone something important. Active errors also include mistakes such as the misapplication of a rule, or making decisions based on wrong or incomplete information.

Active failures on their own can cause serious consequences, but are most dangerous when combined with latent failures. Latent failures are the failures of the organisation itself rather than the individual people in it, and can include sustained management failures such as not building the right capability into an organisation, or the failures with communication and learning within an organisation.

An active knowledge-based error could occur in the form of a health and safety inspector writing an improvement notice for an issue where the 'improvement' violates a civil aviation rule requirement. Although many aviators would detect this immediately and would complain, a latent failure would be the inability of the CAA to correct the knowledge deficit of the health and safety inspector to ensure that the mistake would not occur again.

The best defence against error in policy development or service delivery is having people who are open and frank in their communication, who are careful with the assumptions they make, who do not cover up mistakes, who have good organisational and cross-organisational awareness and will go the extra mile to open and reopen communication with regulatory partners and stakeholders.

Making fair, balanced and unbiased decisions

As we have seen, implementing officials need to exercise considerable judgement to arrive at the appropriate decisions and actions in implementing cross-cutting policy. What can affect the way those decisions are made?

Organisations such as the CAA have a centre of gravity created by the work they have carried out over a period of years, the professional groups within the organisation, and the norms of professional practice. This creates what writers such as Halperin (1974) describe as an organisation's 'essence'; that is, the views of the organisation's dominant group of its missions and capabilities, and the expertise, experience and knowledge necessary for the organisation to fulfil its mission.

A potential dilemma for an organisation such as the CAA is where people with an aviation background judge a new policy through the lens of their professional mind-set. However, this is not a black-and-white issue. The CAA employs aviation experts precisely for that background, and the advice these people can give. To ignore that advice because it disagrees with a policy direction is foolish.

At the grass-roots level, the designation of the CAA to administer the HSE Act for aircraft in operation is not about overlap or conflict in statutory regimes, or the efficiency or effectiveness of service delivery systems. It is mostly about two professional paradigms, practices and the accompanying knowledge sets interacting one with the other. For any measure of real success to occur with this type of implementation, both aviation safety people and occupational health and safety people have to be able to learn to think inside and outside their professional 'world-views'. A mechanism of negotiation between these world-views is necessary so that if a decision on implementing the HSE Act is required, all factors will receive a fair and open hearing.

Good decision making in a cross-cutting policy environment will therefore draw from both professional paradigms, and will take legal possibilities, risks, stakeholder expectations, and desired organisational and whole-of-government outcomes into account. This requires skilful performance from implementing officials. It also provides an evolutionary stimulus for both professional groups and the organisations they work for. Perhaps an indicator for the successful implementation of the HSE Act for aircraft in operation is the degree to which occupational health and safety becomes part of the CAA's essence in the medium term.

Conclusion

The case study of the implementation of the HSE Act for aircraft in operation shows some of the difficulties with designing a policy solution for cross-cutting policy problems. Because of the legislative systems already in existence, and the location of wells of expertise in separate agencies, policy solutions such as agency designation will result in a certain degree of overlap and conflict between possible legislative requirements and administrative systems.

This can be resolved by the implementer acting as a negotiator, where negotiation is needed to resolve legal overlaps and conflicts, stakeholder expectations, the balance between effectiveness and efficiency of service delivery, the management of risks, and the ability to make fair and balanced decisions. The implementing officials need to exercise their role with skill and care to balance these and arrive at the right decisions and actions to achieve policy outcomes.

Agency designation also provides a stimulus for agency evolution, in that to fulfil these new roles competently, the agency needs to adapt to the changing nature of the work it is required to perform.

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