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The robustness of New Zealand's policy advisory system

the case of the Oversight of Oranga Tamariki System and Children and Young People's Commission Bill

Abstract

Recent legislation reforming the oversight of Oranga Tamariki and the role of the children's commissioner was met with all but universal opposition. A key concern was that locating monitoring of the care and protection of children with a government department (and not the commissioner) was too close to ministers to ensure the level of independence required for such a function. This article suggests that the public sector policy advisory system was not robust enough to come up with the optimal policy solution when, in effect, all others said it was wrong. The case gives cause for the public sector to reflect upon the quality of its advisory function.

Keywords policy advisory systems, child care and protection, statutory independence, learning systems

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Disclosure: David King is a friend of the former children's commissioner, Judge Andrew Becroft. In forming his views on the bill he did not discuss its merits with Judge Becroft, to ensure the independence of his analysis.

The care and protection of children and young people at risk of or the object of abuse is a critical public policy issue. Children have the right to live free from abuse and the trauma it inflicts. Abuse is associated with increased risk factors for poor outcomes across a wide range of life domains.

The performance of Oranga Tamariki (New Zealand's care and protection agency) and its predecessor organisations has been the subject of ongoing scrutiny and review since at least 1988. Successive governments have undertaken reform to 'fix' the issues, but to date these reforms have not delivered results sufficient to enjoy public confidence.

In November 2021 the majority Labour government introduced a bill designed in major part to support improvement of the performance of Oranga Tamariki: the Oversight of Oranga Tamariki System and Children and Young People's Commission Bill. The legislation was given royal assent on 29 August 2022.

The bill can rightly be considered one of the most controversial passed by the government during its term so far. It is one of the few bills to have been opposed by all other parties in Parliament (extraordinarily, Green MP Jan Logie and Act MP Karen Chhour advocated together in the media in opposition to the bill). The overwhelming majority of submissions were opposed to it (311 opposed, 8 in favour) and submitters included numerous organisations working with children and young people, academics, eminent Māori, former public servants, and young people who had been in the care of Oranga Tamariki (through their representative organisation, VOYCE Whakarongo Mai).

The bill, therefore, is an important case study of the robustness of the policy advisory system in New Zealand. Can government policymakers (policy advisors and ministers) have delivered the optimal solution for children and young people when everyone else in effect said they had it wrong? Exploring the answer to this question may provide a number of insights into, and lessons for, New Zealand's system of policymaking.

In addition, the bill raised a number of important issues about institutional design, in particular the degree of independence that can be expected from various institutional forms (departments compared with independent Crown entities, in particular) and the degree to which statutory independence guarantees actual independence.

The author brings a relatively uncommon perspective to this issue. He was for many years a senior public servant, intimately involved in the policymaking process. He left the public service in 2020 and from the beginning of 2022 played an active role in opposition to this bill during its passage through the House. He therefore got to see a system he knew well from the outside. This experience led him to gain a fresh perspective on the policy advisory system's character.

Background to the bill

Oversight of Oranga Tamariki on behalf of the children, young people and families (tamariki, rangatahi and whānau) affected by its actions or non-actions is a critical part of ensuring the optimal performance of Oranga Tamariki, including preventing abuse in care. The position of children's commissioner was created in 1989 to play a critical role in the oversight of care and protection, as well as to advocate on behalf of all children. Overall, children's commissioners have been highly regarded by the public and the children's sector. Commissioners have consistently highlighted inadequacies in the performance of Oranga Tamariki and its predecessors, and have also played critical roles in bringing about change in a number of important areas (such as physical punishment of children, the age of criminal responsibility and child poverty).

Beatie stated that such was the need for increased and improved oversight of Oranga Tamariki that the government should not wait for the report of the Royal Commission of Inquiry into Historical Abuse ... then scheduled to report in over four years' time.

Oversight of the Oranga Tamariki system[1] includes the functions of:

- investigation of individual complaints (for example, by children and young people);
- monitoring the system's performance;
- wider investigations into system-level issues; and
- advocacy on behalf of children covered by the system.

The bill's origins lie in the commissioning of a review of oversight functions by the then Labour–New Zealand First government in August 2017. The review was driven by a broad desire by the government to improve the performance of Oranga Tamariki. A particular factor was the introduction (for the first time) in July 2018 of national care standards for those in care or custody. Under the Oranga Tamariki Act 1989, the responsible minister was required to appoint a monitor independent of Oranga Tamariki. There was wide agreement that these standards required a significant increase in the level of monitoring; the question was who should perform the monitoring and other oversight functions.

This review resulted in the Beatie report in August 2018 (Beatie, 2018). The Beatie report did not reach definitive conclusions about which agencies should perform each function (the report's conclusions were 'preliminary', to inform detailed analysis). However, in the broad Beatie supported co-locating the monitoring and advocacy functions within the Office of the Children's Commissioner (OCC). The report identified that changes to governance may be necessary to accommodate increased monitoring.

Beatie stated that such was the need for increased and improved oversight of Oranga Tamariki that the government should not wait for the report of the Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions before proceeding with changes. The royal commission was then scheduled to report in over four years' time.

Overview of the bill

The government made its decisions in relation to the bill in a number of stages, with final decisions in May 2021, two and a half years after the Beatie report. There was a long period between December 2019 and May 2021 where the policy system was focused on the issue of which agency should perform the monitoring function. By May 2021 there were two key options.

Table 1: Allocation of oversight functions before and after the bill

Function	Before the bill	After the bill
Investigation of complaints	Children's commissioner (with the power to refer to other agencies as appropriate)	Office of the Ombudsman (with the power to refer to other agencies as appropriate)
Monitoring of Oranga Tamariki	Children's commissioner	Independent monitor
System-level investigations	Children's commissioner and Office of the Ombudsman	Children and Young People's Commission and Office of the Ombudsman
Advice arising from monitoring	Children's commissioner	Independent monitor
Advocacy	Children's commissioner	Children and Young People's Commission

The first was the Children and Young People's Commission (the government had in December 2019 decided to change OCC from a commissioner-sole model to a more common Crown entity structure with a governance board). The second option was the independent monitor. The monitor was then a business unit within the Ministry of Social Development, with an in-principle decision having been made by Cabinet in March 2019 to transfer the function, once established, to the children's commissioner. However, Cabinet in the end decided that the monitoring function should be located in a new departmental agency (in effect, a government department), hosted by the Education Review Office; the chief executive of the independent monitoring agency (the monitor) would be a statutory officer.

Table 1 describes which agencies performed the various functions covered by the legislation before its enactment and which agencies will perform the functions when the legislation comes into effect (1 July 2023, or earlier by order-in-council). An additional function, advice arising from monitoring, is included in this table. An advisory function, which was not emphasised by Beatie or in public debate about the bill, was the subject of significant consideration by Cabinet alongside the monitoring function.

To understand the policy decisions given effect to in the bill, it is important to note that in regard to:

- *the complaints function*: OCC had not launched a statutory investigation since 2010, resolving most complaints informally and, where it judged it appropriate, referring others to the ombudsman or other complaints bodies; Beatie concluded that the complaints function was significantly underfunded;
- *the monitoring function*: OCC, while having a statutory function for monitoring Oranga Tamariki, had never been funded to perform the function fully and generally limited its monitoring activity to that required to meet international treaty obligations (covering only about three per cent of those in care or custody) and any system-level investigations;
- *the advocacy function*: the government's rationale for moving to a board structure was that a board could bring greater diversity to the table (including Māori and the disabled) and enable there to be a greater focus on the rights and needs of all children and not just those within the Oranga Tamariki system.

In addition to these key features of the bill, the bill also required the Children and Young People's Commission, the monitor and the ombudsman to work together and share information as appropriate.

The passage of the bill

Key stages in the passage of the bill are outlined in Table 2. The Social Services and Community Committee formally called for submissions in mid-November 2021, with submissions due on 26 January 2022. However, there was a widespread impression among submitters that the call for submissions was made on 22 December; certainly, that is when most submitters became aware of the bill, and, consequently, there was a widespread perception that the government was giving inadequate time for submissions, particularly given the holiday period.

The select committee reported back the bill with three key changes:

- naming the chair of the Children and Young People's Commission the chief children's commissioner, so that there would continue to be a visible individual recognised as the voice for children;
- inserting into the bill a specific ability for the commission to make reports directly to the prime minister (this had been contained in the Children's Commissioner Act 2003 and omitted because it was seen by officials as being allowed for regardless); and
- inserting into the bill a clause stating explicitly that the monitor was required to perform its statutory functions independently.

The government (led by the minister responsible for the bill, Carmel Sepuloni) argued that these changes showed that the select committee had listened and responded to submitters' concerns. Key submitters and other political parties argued that while these changes were welcome, their key concerns remained. They were not confident that the monitor, as a departmental agency, could be truly independent of government (it was, they said, the government monitoring itself - a 'lapdog', not a 'watchdog' – and that this had been a key factor in the past abuse in care now being examined by the royal commission). They also considered that the key functions of monitoring, complaints and advocacy should be combined within the Children and Young People's Commission, so that children and young people knew there was one place for them to go if they had concerns about their rights, interests and wellbeing.

Once the bill was reported back from select committee, it passed through its further stages very rapidly. It is clear that passing the bill was a very high priority for the government at the time.

The quality of the policy analysis

Method for assessment

In assessing the quality of the policy analysis undertaken for the bill, it is

important to acknowledge that:

- not all papers released proactively or under the Official Information Act 1982 had been reviewed at the time of writing (batches of papers were in the process of being released at that time); however, a sufficient number of key departmental and Cabinet papers had been reviewed to make an objective assessment of the policy analysis feasible;
- a high standard for policy analysis is set in assessing the papers; on matters of considerable public interest, it is not reasonable to expect anything less from the public sector or from Cabinet;
- this article draws heavily on a larger paper analysing the bill by the author and Jonathan Boston (King and Boston, 2022); this paper was produced during the passage of the bill.

Assessing the quality of the analysis is made more difficult by there being no one place where officials set out the analysis undertaken for locating the specific functions for oversight of the Oranga Tamariki system. The Treasury gave the Ministry of Social Development (the lead advisor on the bill, with support from the Public Service Commission) an exemption from requiring a regulatory impact assessment, on the basis that these were machinery of government changes and, it concluded, did not have impacts on individuals. This was clearly an error of judgement, as different options could potentially have significantly different impacts on outcomes for children and young people. As a result, the overall analysis has to be reconstructed from a large series of papers dating back to 2017.

The core analysis

The policy analysis undertaken for the bill can be expressed as follows. First, it was asserted that in order for outcomes to be maximised for children coming into contact with the Oranga Tamariki system, a learning system of continuous improvement needed to be established. Second, high-quality monitoring and advice arising from it was considered critical to system learning. Third, for the system to learn through monitoring, the entity undertaking monitoring had to be able to work effectively with ministers as a trusted and responsive advisor. Fourth, there had to be public confidence in the monitoring entity, particularly from Māori (Māori constitute well over 60% of those in care), if the entity was to be able to undertake high-quality monitoring and, therefore, to be trusted by ministers.

Table 2: Timing of the legislative process

Date	Stage in the legislative process
8 November 2021	Introduction
16 November 2021	First reading – referred to select committee
17 November 2021	Social Services and Community Committee calls for submissions
26 January 2022	Submissions to select committee close
13 June 2022	Select committee reports back to Parliament
27 July 2022	Second reading
11 August 2022	Committee of the Whole House – splits bill into two separate bills
23 August 2022	Combined third reading of the two bills
29 August 2022	Royal assent given to the two bills

Fifth, there was a balance to be struck between working effectively with ministers and being trusted by the public: the closer the monitoring entity was to ministers, the less trusted it would be, because of perceptions by the public of a lack of independence. Sixth, this balance was best achieved by creating a statutory officer position (the monitor) as chief executive of a departmental agency (effectively a government department) to undertake the monitoring function. By having statutory duties, the monitor would be seen to be sufficiently independent of ministers to enjoy adequate public confidence to undertake effective monitoring. Seventh, the balance could be further strengthened by ministers not having the power to stop the monitor undertaking any activity, but having the power to direct the monitor to undertake particular activities.

Eighth, a less effective learning system would be established if the monitoring function was located with the commission; advocacy could colour monitoring and not be useful to ministers because monitoring activity and advice arising from it may not be consistent with government policy and policy priorities (there was, in effect, a 'tension' between monitoring and advocacy).

Ninth, the complaints function was best located with the ombudsman because building capability in handling complaints (as the commission would have to do if it took on the function) was more challenging than building a child-friendly complaints process (as the ombudsman would have to do). Tenth, as previously outlined, a board structure instead of a commissioner-sole would bring greater diversity to the advocacy function as the commission focused more on the needs of all children. Finally, it was important to system learning that the monitor, ombudsman and commission worked together and shared information, including by providing clear information to children and young people about where to go for what.

The first problem to note with the policy analysis is that the above is effectively all the analysis that was done. Despite all the papers written since 2017 and the consultation undertaken (as described in the next section of this article), there was little substantive analysis undertaken to support any of these conclusions.

King and Boston (2022) agreed that it was appropriate to adopt a learning systems framework to identify the optimal policy option, and to identify monitoring and advice arising from it as critical functions to improving outcomes for children. However, they considered it crucial to model such a learning system to identify the learning channels and the impacts of different options on those channels. Their model identified the crucial importance of public confidence in monitoring and the impact of low public confidence on media and political coverage and, thereby, on what they called 'system stability'. Without system stability (i.e., Oranga Tamariki not operating in crisis mode), it would be very challenging for the system to be in a position to learn. Also, without system

stability a feedback loop would diminish public confidence further through ongoing crises and continuing media and political focus on Oranga Tamariki.

King and Boston agreed, therefore, that public confidence in the monitoring function being perceived to be sufficiently independent of ministers was critical. They did not, however, agree that it was important for the statutory monitor to be a trusted and responsive advisor to ministers. Such a monitor and advisor could not enjoy the public confidence necessary to undertake effective monitoring and provide system stability for learning to take place. Key reasons for this lack of public confidence included:

- statutory requirements notwithstanding, the monitor, as a departmental agency, could not be sufficiently independent if it played the trusted and responsive advisory role because, unlike other statutory officers, the monitor was operating in the 'purple zone',[2] where the boundary between politics and policy and administration becomes blurred;
- the monitor was in effect being in the position of monitoring the performance of fellow chief executives, among whom peer pressure was a significant influence; and
- the 'can't stop, but can direct' restraint could not work in practice, as ministerial priorities would inevitably crowd out current or planned work; officials all but agreed that in practice the monitor's work programme would be agreed between the minister and the monitor, and in King and Boston's view this meant the monitor did not enjoy meaningful political independence.

As a result, King and Boston considered that there was not a meaningful balance to be struck between two factors (ministerial confidence and public confidence), as officials and ministers argued. The two factors were to all intents and purposes irreconcilable with one another and to claim otherwise was to try to have a cake and eat it too. The result was that not only would system learning not be optimised, but there was a real risk of, at best, insufficient transparency or, at worst, abuse in care not being detected and, if detected, potentially being covered up.

... there was no substantive analysis of why monitoring and advocacy were in tension with one another, and why the government saw them to be compatible when it established the Mental Health and Wellbeing Commission ...

King and Boston concluded that the optimal solution from a learning systems perspective would be for the statutory monitoring function to be located with the commission. Ministerial confidence in the monitoring function may not be as high initially by virtue of the commission's higher degree of independence and advocacy role; however, confidence was likely to increase over time as better quality information came through by virtue of that independence.

Tellingly, there was no substantive analysis of why monitoring and advocacy were in tension with one another, and why the government saw them to be compatible when it established the Mental Health and Wellbeing Commission, but not for the Children and Young People's Commission. King and Boston identified that monitoring and advocacy were eminently compatible so long as monitoring was robust, such that advocacy was evidence-based; the commission could even play something of a trusted advisor role, only advocating publicly when its advice was not taken (strange as that may sound, the same conundrum faces the monitor – if there is to be public confidence, its most free and frank advice should be made available to the public and that is not far short of an advocacy position).

As part of their solution, King and Boston proposed that if trusted and responsive advice from a monitor was so important to ministers, then ministers should establish a non-statutory monitoring function aligned with their interests and policy, potentially in a unit within the Department of the Prime Minister and Cabinet (given its current focus on children's issues). Such a unit would not be unnecessary duplication, in effect compensating for ministers' apparent lack of trust in Oranga Tamariki's internal monitoring capability.

In addition to these analytical issues, there was also an illogical sequencing approach to the government's decision making about two key policy decisions. A robust framework would have made the decision about where to locate the complaints function – with the commission or the ombudsman – after the decision about where to locate the monitoring function; this is so the system learning impacts of the two options could have been compared. Instead, the decision was made to locate the function with the ombudsman before a decision about the location of the monitoring function. King and Boston concluded that locating the complaints function with the commission made sense on its own merits, as well as having the system benefits of children having one place to go for all their needs.

Further, the decision about whether to have a commissioner-sole or a board should also have been made after the decision about where to locate the monitoring function, as the breadth of the functions to be undertaken would have been clearer. Instead, wider Public Service Commission advice that commissioners-sole should be phased out was influential earlier in the process.

Overall, these are important and complex issues and merited deep and substantive analysis. The analysis fell below that standard. As a result, it appears that some other factor was at work in the

decision to locate the monitoring function with a departmental agency and not with the commission. This was widely perceived to be that the government was annoyed with public criticism by the children's commissioner. More charitably, a judgement may have been made, but was certainly not made explicit, that public criticism from the advocate was not helpful in enabling the Oranga Tamariki system to learn and improve.

Clearly, it is not satisfactory for there to be such a significant lack of depth in analysing a matter of such importance, and such a lack of transparency in what factors were decisive. If, as submitters suspect, this was a purely political decision, then that needs to be made obvious (at least, by omission) through clearer analysis.

Other issues

Much of the media coverage of the bill focused on the 'fact' that the government was 'getting rid of' or 'defanging' the role of the children's commissioner (in particular, by removing the statutory monitoring and complaints functions). As outlined above, there was no substantive analysis of a commissioner-sole versus a board model. In particular, there was no consideration given to how effective the single voice model had been in putting new issues on the policy agenda, the nature of commissioners' relationships with Oranga Tamariki, or the constraints a board may place on an advocacy role.

In the end, King and Boston concluded that a board model can work effectively if funded appropriately, and that a board model would better address any 'tension' between monitoring, advice and advocacy than a commissioner-sole. There remains, however, an open question about how effective the board model will be in practice; the performance of the Mental Health and Wellbeing Commission will be important in this regard and may provide useful lessons.

Another key concern of submitters was that the changes were being made in advance of the royal commission's report due in June 2023. It was necessary, they argued, to wait and consider the royal commission's recommendations for oversight arrangements so that those arrangements had legitimacy. The minister argued that Beatie had said not to wait for the royal commission. It did not seem to be relevant that Beatie had said this in 2018 when the report was years away; when the bill passed, the royal commission's final report was due in less than a year. Ironically, Oranga Tamariki appeared before the royal commission on the day of the bill's third reading, and how it was monitored was a focus of questioning.

While the minister said the bill took into account the findings of the recent Waitangi Tribunal report into childcare and protection ... there was no analysis of whether the core finding of the Tribunal, that the Crown had no role in uplifting tamariki and rangatahi .... should be accepted or not.

A further point worth highlighting is that at no time was the appropriateness of an officer of Parliament, the ombudsman, in effect working as part of the executive considered (this was the effect, in particular, of the clause requiring the ombudsman to work and share information with the commission and the monitor).

One effect of this is that when the legislation is reviewed (no later than three years after enactment) the ombudsman will commission a review of its own performance, rather than the executive commissioning the review. The incentives for a quality review do not appear to be in alignment. Another effect is that elements of the new oversight regime are now exempt from the Official Information Act (the ombudsman is not subject to the OIA).

A very important issue in the public debate (but not, it is acknowledged, a key focus of King and Boston) was whether the bill took te Tiriti o Waitangi sufficiently into account. While the minister said the bill took into account the findings of the recent Waitangi Tribunal report into childcare and protection (Waitangi Tribunal, 2021), there was no analysis of whether the core finding of the Tribunal, that the Crown had no role in uplifting tamariki and rangatahi (in effect, it was a denial of tino rangatiratanga over kāinga), should be accepted or not.

The quality of the policy process

Excellent policy processes consist of early and ongoing engagement with those who have a stake in getting the policy right. The policy is in effect co-designed, although ministers retain ultimate decision rights.

The most striking feature of the consultation process leading up to the bill is that it largely relied on the consultation undertaken by Beatie in 2018. This consultation consisted of one hui and targeted discussions with a range of stakeholders. Beatie did not talk directly with children and young people, but relied upon input from children gathered for earlier processes by Oranga Tamariki and OCC. The Ministry of Social Development did commission some consultation with a small number of mainly care-inexperienced young people, which reported post Beatie.

The children and young people's sector felt strongly that the Beatie consultation had been very preliminary in nature and that a specific problem definition and clear options were not put before them. Most importantly, the idea that monitoring and advocacy did not sit together comfortably seems to have been taken by officials to have emerged from the Beatie process. In fact, Beatie did not identify this as a particular tension, focusing largely on the organisational and financial challenges for

the commission of being required to address the interests of both all children and children within the system. Some submitters had a sense that this was actually a tension identified by officials, and which they were primed to affirm in a general sense without full information about the implications of such affirmation.

Using even a low standard for consultation, it may reasonably have been expected that a detailed discussion document would have been issued following Beatie, particularly given the preliminary nature of the Beatie report. Such a document would have fleshed out the problem definition, options for addressing the problem, the options' advantages and disadvantages, and a recommended solution. Importantly, the controversial uplift incident in Hawke's Bay occurred in May 2019 and generated a number of inquiries with adverse findings, including from the Waitangi Tribunal, the children's commissioner and the ombudsman. In this context, it seems particularly unreasonable to have relied on consultation from 2018 and earlier for decisions about the bill. Instead, the children and young people's sector were given the clear impression in March 2019 that the monitoring function was going to the children's commissioner, were not talked to any further, and were largely taken by surprise when it became clear with the introduction of the bill that a departmental agency was to perform the monitoring function.

The government did take a more nuanced approach to engagement with Māori. A number of hui were held in July and August 2019. The Ministry of Social Development also established the Kāhui Group, consisting of five Māori of standing, which it said worked with the ministry to inform its work as policy was developed and finalised. The May 2021 Cabinet paper said that the Kāhui Group would have preferred the monitoring function to be with an independent Crown entity, but 'accepted' the decision to go with a departmental agency. The minister said the Kāhui Group had been specifically involved in the drafting of te Tiriti provisions. No member of the Kāhui Group spoke in favour of the bill during its passage.

Perhaps the most striking feature of the difference between stakeholders' and the government's approach to engagement was on the need to put children and young people and their rights and voices at the centre of the policy design process. A constant theme of the children and young peoples' sector and of care-experienced young people in submissions on the bill was that the oversight system could not work if children's voices were not being listened to in its design, and consequently it did not position them to be active participants in the oversight system in the future. The minister stated consistently that the Beatie report and the bill had incorporated children's voices. All opposition parties in the third reading of the bill emphasised that the bill was fundamentally flawed, given that it did not have the trust and confidence of care-experienced young people who knew the system.

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The select committee process was particularly egregious with respect to good practice. Individual submitters (many of them people of considerable expertise in the area) were given five minutes to submit orally, and organisations 15 minutes. In these time frames there was limited opportunity to have meaningful representation of views by submitters or meaningful questioning by committee members. In addition, the children's commissioner while policy decisions on the bill were being made, Judge Andrew Becroft, had returned to the bench and was, therefore, constrained from providing his views on the bill to the committee or the public.

One final point worth noting is that the minister consistently said that submitters had misunderstood the bill and that the select committee changes cleared up the confusion. Nothing could be further from the truth. Submitters clearly understood the bill and what was at stake. They understood well the select committee changes and that, while an improvement, they did not address their fundamental concerns. It is a considerable failure that at this point in the process there could be such a gap in perspectives between a minister and the sector.

Potential insights into the policy advisory system

There are a number of insights into the policy advisory system arising from this case which should be reflected upon as part of the continuous improvement of the system.

Overall quality of policy analysis and policy process

From the prior sections of this article it should be clear that, looking from the outside in, the quality of the policy analysis and policy process fell well below the standards such an important issue deserved, particularly in the lack of substantive analysis on key issues and the discontinuity in engagement with stakeholders from mid-2019 on.

Conceptualisation of the policy advisory system

This case illustrates that there is still a strong tendency by officials to view the policy advisory system to be the public sector policy advisory system, rather than a system of many participants among whom the public sector is one, admittedly very important, player. This is an outdated

conceptualisation of the system and proper conceptualisation emphasises the importance of external parties and engagement with them as an integral part of the system for policy production (Craft and Halligan, 2020). The public sector is not the only entity to think about the public interest and does not have a monopoly on wisdom, but this reality does not appear to have been internalised.

The influence of political power on the policy system

It is clear from this case study that the children and young people's sector has limited political power. Some conversations with the media and the sector indicate that there is relatively limited public interest in child abuse (despite the seemingly regular sensational stories) and that government performance in this area is not a matter on which many people's votes turn. In addition, because of dependence on government funding and its fragmented nature, the children and young people's sector faces some limits on what it can do by way of advocacy.

By comparison, it is hard to imagine that in economic policy domains, any such bill would have proceeded without a serious rethink if it had been so strongly opposed. It was also striking that the government did a rapid U-turn on the KiwiSaver fees GST proposal shortly after the passage of the bill: the hip pocket of middle New Zealand was being hit and that mattered dramatically in the government's mind.

This lack of relative power suggests that there is an obligation on the public sector element of the policy advisory ecosystem to apply extra rigour in its policy analysis and policy processes in relation to child abuse policy, not less as appears to be the case with this bill.

The obligation to give ministers full and accurate advice

It was striking to observe with fresh eyes just how often a minister defending a bill in the House and publicly avoided answering questions directly or substantively. She repeatedly communicated important information relating to the bill that appears to have been significantly in error and which had been communicated erroneously to her and the select committee by officials (considerably overstating the number of complaints OCC had referred to the ombudsman). She also stated in the House that a potentially important supplementary order paper by Jan Logie MP aimed at strengthening the independence of the monitor was 'not necessary' when she had received no advice upon it.

A long-promised review of the Official Information Act (OIA) is overdue. This case raises significant questions about whether public policy processes, including its legislative stages, are best served by the timelines the OIA (and proactive release) allow.

These circumstances suggest that even in the heat of the political battle (when officials often consider the hard work has been done and the job is now the minister's to do) it is important to provide accurate information and full advice to the minister. The risk of moving as an official from explaining policy to defending or (by omission) advocating for it could be better guarded against.

Accessibility of policy analysis

Even knowing the system well, it was extremely challenging to access and get to grips with the analysis that had been undertaken in relation to this bill. It was difficult to identify all the papers that had been publicly released (either proactively or under the Official Information) on both the Ministry of Social Development's and Public Service Commission's websites. General website design and search engine effectiveness have a long way to go before accessibility standards have been met.

In addition, there is no way the public should be required to make its way through a long sequence of papers over a number of years in order to understand what has driven policy decisions on important issues. Regulatory impact assessments, when properly done, address this issue in regard to regulatory matters. Such one-stop statements of the policy analysis should be mandatory for all significant policy issues; even where departments do not provide a preferred option, such statements generally make clear (by implication) where some other factor (potentially political) is critical in the policy decision.

Independent Crown entities

This case appears to have significant implications for independent Crown entities. In the absence of quality analysis showing otherwise, widespread suspicion exists that overt criticism of the government by children's commissioners lay behind the removal of its monitoring and complaints roles (as well as the establishment of a board). This will have a potentially chilling effect on independent Crown entities, such as the Mental Health and Wellbeing Commission. There is a leadership challenge for the public sector and ministers to accept robust advocacy from independent Crown entities; equally, independent Crown entities must ensure that such advocacy is based on solid assessment and analysis.

The effectiveness of the Official Information Act 1982

A long-promised review of the Official Information Act (OIA) is overdue. This case raises significant questions about whether public policy processes, including its legislative stages, are best served by the timelines the OIA (and proactive release) allow. Understanding the nature of advice being given to ministers matters most when an issue is being discussed or debated in the public arena and as soon as a minister has chosen to speak definitively on an issue. The OIA does not allow this to happen and proactive release remains a

prerogative. There is a significant question about whether advice should be released in real time so that it can be scrutinised as public debate takes place.

There is also a significant issue about the use of the free and frank exemption under the OIA. The public is generally entitled to know, it is suggested, what factors are taken into account in any policy decision. Withholding information under the free and frank provision of the OIA seems to be used far too much, with the result that potentially important analytical factors are not known. In addition, the argument that free and frank advice will not be provided in writing if it will be publicly released needs to be tested further. There is a prima facie case that public servants should be legally required to put all substantive advice in writing in the public interest, and that the free and frank standard should be lowered considerably.

The role of the ombudsman

There are important issues to reflect upon about the role of the ombudsman in the light of this case (in addition to the issue of the appropriateness of the ombudsman playing a role in the executive identified earlier). First, the ombudsman appears to have had a clear conflict of interest in considering appeals under the OIA in this case, given that the function of the Office of the Ombudsman (and associated resources) were at stake. The ombudsman, however, concluded that there was no conflict. This is worth further inquiry should similar circumstances arise.

Second, it appears that there are no prioritisation criteria to inform the office's work programme (the ombudsman stated that everyone considers their issue to be important). It seems likely that any such framework would prioritise appeals in regard to such a contentious matter. This also merits further inquiry.

Third, there is no substantive evaluation of the ombudsman's performance. The office's practices were observed to be slow and bureaucratic, as submitters fear will be the case in regard to children and young people's complaints. While Parliament's Officers of Parliament Committee clearly has an oversight role in regard to the ombudsman, the extent to which it actually plays this role must be questioned. Interestingly, the royal commission asked the ombudsman no questions about the office's historical performance in relation to children in state care during his appearance before the inquiry. The ombudsman should not be immune from scrutiny.

Conclusion

The starting question of this article was whether the (public sector) policy advisory system is robust enough to come up with the optimal policy solution in the face of all but universal opposition (including from across the political spectrum). The answer that emerges from the foregoing analysis should be clear: it is not. The quality of the policy analysis and of the policy process fall well short of the standards that should be met to merit the policy advisory system being described as robust.

To be clear, this judgement is not a reflection on the individuals involved, but on the level of confidence that can be had in the system as a whole. This case gives considerable occasion for the whole public sector to reflect upon itself.

As for the specific issues involved in this case, they are not settled. The royal commission reports in mid-2023, and there is a general election soon after which is unlikely to result again in a majority government (ensuring that at least one party that opposed the bill vigorously will likely be in government). The issues are, therefore, almost certain to be revisited. In the meantime, the performance of the monitor and ombudsman, and government decisions in regard to the funding and composition of the board of the Children and Young People's Commission, can be scrutinised by those who are outside the public sector policy advisory system but are committed to seeing the Oranga Tamariki system perform as well as possible for children and young people.

1 The Oranga Tamariki 'system' refers not just to the Oranga Tamariki care and protection and youth justice systems, but also to agencies, such as the ministries of Health and Education and their contracted service providers, who provide support and services under the Oranga Tamariki Act 1989.

2 The purple zone is a term first applied to the public sector in Matheson, Scanlan and Tanner, 1997.

Acknowledgements

The author thanks Jonathan Boston and Andrea Jamison for feedback on this article. However, he takes full responsibility for its contents and any errors within.

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