Regulation, Oversight, and the Risk Regulation Reflex

An Essay in Public Administration in the Context of the Dutch Risk and Responsibilities Programme

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Introduction

The Risk Regulation Reflex: The Story

Many things start with stories, even in public administration. Professionals use stories to create some order in their own experiences and those of others. Stories are passed on, as examples of good practices or as nightmare scenarios. Stories are useful in that they select, highlight and lend meaning to experiences. Researchers use the stories that are being told to acquaint themselves with the environment in which they are being told.

This is also how the insights in the risk regulation reflex got started. There were stories, originally from public administration in Great Britain, about government responses to public safety incidents that could be categorised as disproportionate (‘using an elephant gun to kill a mosquito’), having a contrary effect (‘the cure is worse than the disease’) or as a vicious cycle (‘if the medication fails, increase the dose’). In all these stories the root causes of the negative consequences are an overestimation of the public risks and an exaggeration of the government’s responsibility for such risks – at the expense of citizens’ individual responsibility for the risks. Similar stories, about an exaggerated desire by the government to extirpate all public safety risks, were making the rounds in the Netherlands. The standard example has been public policy in the fight against legionella after an outbreak in 1999 at a flower exhibition in Bovenkarspel. The outbreak was serious enough (thirty-two fatalities) to justify government intervention. However, within a few years stories started circulating that the utilisation of people and resources for this one public health risk had got out of hand and was jeopardising management of other, less visible threats to health and public safety. These complaints came particularly from staff at the governmental bodies charged with fighting legionella. A few years later the Netherlands National Institute for Public Health and the Environment (RIVM) concluded that the measures had had very little effect.

Researchers and reflective practitioners can distil patterns, interpretations, and presumptions out of practical stories. A standard example for this is the monograph by Hall, which dates from a time that government intervention in society came primarily in the form of planning. A somewhat comparable Dutch study from the same era is Regeren in Modderland by Aquina. This study contains three stories about infrastructure projects the policy development of which could be considered irrational.

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5 The RIVM calculated the cost effectiveness of the general measures to combat legionella to have been in the same order as neurosurgery for a malignant brain tumor, i.e. between € 100,000 and 1,000,000 per saved year of life, weighted by quality of life. Cf. RIVM, Nuchter omgaan met risico’s, RIVM report 251701047 (Bilthoven, 2003), 34.
6 Peter Hall, Great Planning Disasters (Oakland: UC Press, 1982).
and even unacceptable with hindsight. Nevertheless, the researcher stressed, each of the relevant policymakers separately had acted rationally.

A pattern of irrational collective choices is also a key factor in the way experiences with the risk regulation reflex have been systematised over the past ten years. The core problem is an overreaction by government to a risk or (public safety) incident by issuing more regulation and more oversight than necessary to control the risk at an acceptable level. Other elements are circumstances that could contribute to such an overreaction, such as:

1. The development of a media hype;
2. The desire to score politically;
3. Professional group think;
4. Misconceptions within the government about citizens’ willingness to accept risks; and
5. Overestimation of risks that have no definable incident as their immediate cause.

In order to test the validity of such interpretations it is necessary to reformulate the observed patterns into general theoretical formulae. The main question for research in this area could be: Under what circumstances and under the influence of which factors will government react to an incident, calamity or perceived risk in such a way that the costs of such a reaction (in the shape of increased regulation or oversight) would exceed, even disproportionately exceed, its benefits? Subordinate questions could address the specific meaning of the five circumstances mentioned above, as well as the influence of other factors on the creation and development of risk regulation reflex processes. The DRRP has studied several of these factors, for instance the risk perception of the Dutch populace, partially in order to verify whether their willingness to accept risks is truly as slight as the media and politicians seem to think. Other research has focused on the frequency of the risk regulation reflex. However, systematic (explanatory) research into the creation, development, and results of risk regulation reflex processes is still lacking. Formalising the problems in theoretical terms also has not progressed much past the stage of systematising and interpreting the collection of stories.

**Oversight and the Risk Regulation Reflex: The Study**

This study of the risk regulation reflex represents an attempt to formulate a theory about (collective) policy making. Within the field of policy studies there are two central models (with multiple variants) for describing and explaining the formulation of policy: the rational model and the arena model. In the first model the policy leader is an actor who analyses a problem, proposes measures (including doing nothing), runs calculations to assess the positive and negative consequences of the proposed measures, and then chooses the optimal measure. In the arena model a policy choice is often the unexpected and unintended result of the efforts of a large number of actors operating in a policy arena each with their own standpoints and in pursuit of specific interests. The risk regulation reflex approach can be seen as a specialisation of the arena model. Regulatory agencies can be actors in a policy arena where a risk regulation reflex takes place. The central question for the current investigation of the literature was:

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8 Particularly in the work done under the umbrella of the DRRP by the Netherlands Ministry of the Interior and Kingdom Relations. Cf. e.g. the Ministry’s brochure Dialogen risico’s en verantwoordelijkheden (The Hague, 2012).
9 Elmara Bemer, Sibolt Mulder, and Dieter Verhue, Burgers over risico’s en verantwoordelijkheden (Amsterdam: TNS-Nipo, 2012). Cf. also the research report ‘Risico’s en gevaren in de Drechtsteden’ (research performed by Crisislab on behalf of RandV) and Netherlands Institute for Social Research, ‘Continue Onderzoek Burgerperspectieven’, 2nd Quarter 2014.
What role does oversight and the regulatory agency play in risk regulation reflex processes in various risk domains?

This general question has the following subordinate questions:

a) What do regulatory agencies and oversight structures contribute to creating, exacerbating (or diminishing), and preventing of overreactions to risks and incidents?

Under this view, the regulatory agency is an actor in the policy arena that has influence on the way policy in that arena is formulated.

b) What consequences do risk regulation reflex events have for the regulatory agencies?

Under this view, the regulatory agency is an object (‘victim’) of events and decisions in the policy arena.

The original plan for the study was to answer these questions based on an evaluation of the literature. This approach was based on the following assumptions:

a) that case materials about risk regulation reflex processes were available in abundance;
b) that the role of regulatory agencies and oversight would be sufficiently visible in the available case materials;
c) that the case would be based on an adequate and broadly accepted conceptualisation.

However, an extensive investigation of the literature proved these assumptions wrong. Assumption b) was most seriously wrong: there proved to be very few cases materials of risk regulation reflex processes in which the role of the regulatory agencies or oversight phenomena had been documented. Assumption c) also could not survive a closer evaluation: terminology in the area of risk regulation reflex phenomena proved to be little systematic and inadequate.

Given these limitations another approach was chosen for this study, in consultation with the client. The original approach of the study was inductive: general insights about the role and meaning of oversight would be drawn from descriptions of concrete risk regulation reflex processes. The new approach had to become deductive: general insights about policymaking processes and about the way complex organisations function in that type of process, to be taken from the secondary literature, would be used to deduce specific conclusions concerning the behaviour of regulatory agencies in risk regulation reflex processes. The research question was adjusted accordingly:

Given the insights into processes of policymaking and bureaucratisation, what could be the role of oversight and the regulatory agencies in risk regulation reflex processes in a risk domain?

The research then focused on the first subordinate question:

In what ways could regulatory agencies and oversight structures contribute to creating, exacerbating (or diminishing), and preventing of overreactions to public safety incidents?

In the discourse below these questions will be answered as follows. Our argument has four parts. The first part is theoretical. Chapter 1 contains a description of a rough outline of the risk regulation reflex. This chapter also discusses the question of the rationality of policy considerations. In chapter 2 we then discuss the nature of regulation and oversight.

The second part contains an analysis of problems that may arise in regulation. The various insights will be discussed according to:

1. the bureaucratic mechanism that a risk regulation reflex process might engender;
2. the specific risk regulation reflex problem that this mechanism might produce;
3. a practical example of such a mechanism in action; and
4. a proposal for an approach that might solve the problem.
The third part similarly treats the insights that have been gained into the problems of bureaucratic organisations such as regulatory agencies. In the fourth part we recapitulate how the problems of bureaucracy and regulation can be addressed by the regulatory agencies. This guideline is illustrated with several more detailed examples in which inspection agencies within the policy arena ran into risk regulation reflex processes.
Section I
The Risk Regulation Reflex and Oversight

Chapter 1
The Risk Regulation Reflex and Rational Policymaking

The Bare Outline
As mentioned in the introduction, our understanding of the phenomenon of the risk regulation reflex has not progressed so far that there is a systematic terminology for it. We still lack an unambiguous conceptualisation of the phenomenon which would lend itself to operationalisation and empirical research. From the available texts we can deduce, however, the bare outline of a description, an indication of the key elements of the risk regulation reflex processes.11

The bare outline of the risk regulation reflex approach can be formulated as follows:

- Each highly developed society has public safety risks that may be an unintended consequence of the application of technology, broadly understood;
- in some cases a public safety risk will manifest itself as an event with a relatively extensive effect on the safety of civilians and, concomitant with it, relatively extensive material and immaterial damage (public safety incident);
- society (whether the government or individuals, groups of civilians, or organisations) reacts to the public safety incident with collective or individual measures that are intended to prevent the occurrence of similar public safety incidents in future;
- sometimes the collective public safety measures are disproportionate in the sense that the social costs of the measures are higher, sometimes considerably higher, than the material and immaterial damage in the event of a recurrence of a similar incident.

In order to identify the risk regulation reflex processes the following elements of this bare outline will need to be operationalised.

Risks and Incidents
Each highly developed society has public safety risks that are the unintended consequences of the application of technology. In exchange, however, technology has contributed enormously to the reduction of usually much larger public safety risks.

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A public safety incident has both a technical component and a behavioural component; both contribute to the public safety risks. For example, technology produces an abundance of various different food products. As a result consumers have access to foods with excessive sugars and fat contents resulting in obesity. The public safety risk is a threat to public health due to obesity. Both technology (the legal limits for sugar and fat contents) and behaviour (education) are points of departure for collective public safety measures.12

Responses

Community responses to a public safety risk or incident can be individual or collective. As individuals, citizens can insure themselves against future damage. There are limitations: insurance policies against risks with unknown probabilities and unknown consequences are often unaffordable and are not available on the market. Individual citizens can also improve their own material circumstances in order to prevent individual damage arising from an intrusion on personal safety (by not living in flood plains or by taking personal measures to strengthen the structure of one’s house to withstand the consequences of an earthquake). Individual measures are based on the assessment of individual risk factors. This avoids the kind of moral hazard (taking fewer personal precautions, or more than necessary) that is bound up in collective measures.

Collective measures reflect the principle of ‘bearing each other’s burdens.’ When risks end up being distributed unevenly and in a random fashion, collective measures effect equality of risk burdens. They are more cost effective to the extent that the collective burdens exceed the sum of individual investments aimed to reach the same effect (one dike is more efficient than a thousand raised mounds). Collective facilities run the risk of encouraging moral hazard and freeloading. When collective measures come in the shape of regulation, oversight, and enforcement (command and control) they may lead to the unintended consequences of an increased regulatory burden and retarded innovation (the exclusion of new parties). Regulation and oversight become disproportionate when the communal cost (all unintended consequences cumulatively) becomes significantly greater than the communal benefits measured in terms of risk reduction.

Disproportionality and Rationality

Disproportionate collective safety measures are at their core irrational responses to public safety incidents. The underlying assumption is that rational responses are possible. A rational response is either a new safety measure or the decision against new measures, based on an integral assessment of all costs and benefits to society of both the proposed measures and the public safety risk. Rationalisation of government policy is the goal of a movement in policy studies that flourished almost a century ago, during the Great Depression, as exemplified by Keynesian Macroeconomics, the centrally planned economic policy of pre-war Holland, and the post-war Policy Sciences Movement in the United States.13 The point of departure was always that government measures could be rooted in scientific knowledge and that their posited functioning could be evidence based. Initially rationalisation focused on the development of new policy (planning), later it also included policy implementation. Additionally, since the 1990s there has been a growing desire in the Netherlands to

12 The RIVM has estimated that annual mortality resulting from the health risk ‘obesity’ is about four times higher than from traffic accidents and one hundred times higher than from legionella infestations in drinking water infrastructures. RIVM, Nuchter omgaan met risico’s, Report 251701047 (Bilthoven, 2003), 17.

13 This typical post-war renewal movement was a direct heir of eighteenth-century positivism, including the expectation that, ultimately, one integrated scientific theory would be able to describe the laws of motion of both nature and society, allowing man to manipulate them. See e.g. D. Lerner and H. Lasswell, eds, The Policy Sciences, Recent Developments in Scope and Method (Stanford: Stanford University Press, 1951).
provide a more rational foundation for government oversight (viewed as a special form of policy implementation).

The idea of rationalising government policy faced increasing criticism during the 1950s. The most important point of criticism was that people are principally limited in their rationality, that is, they are not capable of knowing all relevant facts, foreseeing all possible events, and anticipating all consequences of their actions or lack thereof. Decision-makers, ‘rather than being confronted with a limited universe of relevant consequences, (...) face an open system of variables, a world in which all consequences cannot be surveyed.’

A second criticism was regarding the problem of making an objective comparison between alternatives and their consequences. Critics claimed that policy centres could not avail themselves of a uniform, unambiguous, and generally accepted set of norms against which policy measures (or a decision against them) could be tested and compared. The alternative proposed by these critics was the incrementalist approach (Lindblom) or piecemeal engineering (Popper). The core idea was that there would never be one single correct set of measures for any given problem – usually, the best we can hope for is a ‘never-ending series of attacks’ on the problem (Lindblom). Small steps in a certain direction, and corrected at appropriate times in case the direction turns out to be wrong, are better than great leaps with the possibility of irreversible consequences. In practice government policy often shows characteristics of some form of mixed scanning (Etzioni) in which a priori, integral considerations are supplemented by trial-and-error corrections in the implementation of concrete measures.

Collective policy, aimed at preventing collective risks, can be called safeguarding public interests. A relatively recent step in the desire to further rationalise decisions for or against government intervention is the so-called calculus of public interest. Around the turn of the twenty-first century there were extensive debates in the Netherlands about the choices in safeguarding public interests. The history of this debate teaches that rationalising government policy is as elusive a prospect as it is alluring. With our toolbox full of policymaking instruments, decisions for or against certain policy measures can be more rationally substantiated than in the past, but fundamental limitations remain.

Public safety measures serve to prevent, at some point in the future, events that correspond to public safety incidents from the past. One of the lessons from the debate within policy studies is that the future is fundamentally unknowable. This does not detract from the various methods that have been developed to estimate the probability of certain events, for instance based on past experience or using models with reconstructed devices. The econometric model used by the Netherlands Bureau for Economic Policy Analysis (Centraal Planbureau, or CPB) is an example of the latter, as are the geological models of the earth’s crust used to estimate the probability of earthquakes.

A public safety risk is calculated as the probability that a certain event takes place multiplied by its consequences. The methods used to establish a relative weight to the consequences are subject to the second point of the incrementalists’ criticism. Do we have a set of norms against which the positive and negative consequences of policy measures (including the option of doing nothing) can be

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compared? Techniques for cost-benefit analysis have been developed to add at least a certain level of intersubjective rationality in the decision-making process. However, in order to function properly such techniques must be accepted by all parties involved. Emotional arguments must be excluded.

Thus, there are fundamental limitations to the rationality of policy considerations. This includes considerations that involve the question whether or not policy measures should be taken after a public safety incident. If so, how can then be determined whether collective public safety measures are disproportionate? This question is important for both the policymaker responding to a public safety incident and for the researcher trying to establish after the fact whether disproportionate measures were taken.
Chapter 2
Regulation and Oversight

Regulation

One of the most important policy instruments available to the government for securing public interests is that of regulation and enforcement. In the various (Western) countries there are several modes of regulatory power. Roughly summarised, there are three types.\(^\text{17}\) The origins of our modern regulatory system lie undoubtedly in the United States where in the first half of the twentieth century a type of government intervention was developed which has come to be characterised as ‘the administrative technology of controlling business through law-backed specialized agencies, rather than through public ownership.’\(^\text{18}\) The latter was more common in Europe: public utilities, mines, and railway transport were normally firmly controlled by the government. The knowledge at the root of the American form of government intervention stemmed from the experience gained during the Great Depression and had led to the conviction that the government was not only capable of intervening in markets, but was obligated to do so to correct market failures and protect citizens from dangers and risks. This regulation had taken the shape of what economists would later call disparagingly ‘command and control’: regulatory agencies were authorised by the legislature to promulgate and apply rules by means of licensing, oversight, and if necessary, intervention.

The second kind of regulatory power, which dominated on the European continent, was heavily influenced by the corporatist experiences. Often this was self-regulation within the various industries; employers and employees granted legitimacy to the authorities issuing the rules, albeit within a legal framework created by the government. In the second half of the twentieth century this model was gradually replaced by a more legalistic style of regulation: detailed government legislation, enforced by inspection services supervised by a minister. Around the turn of the twenty-first century the so-called market regulators were created; in more than one respect these resemble more the American paradigm than traditional government inspection services.

A third model of regulatory power has its origins in the legal tradition of the United Kingdom. The Thatcher revolution, which liberalised and privatised large parts of the British economy, did not effectively replace old-style government control with regulatory oversight. Private business was expected to continue the tradition of self-regulation (cooperative regulation).\(^\text{19}\) The original form of cooperative regulation included little legislation combined with a market inspector or regulatory agency with a lot of leeway to form his or her own judgements but little or no authority to sanction. The art of regulating according to the British point of view was the art of negotiation and persuasion. Under New Labour the concept of the risk society climbed to the top of the agenda and inaugurated an era of more authoritarian regulation and oversight. Nevertheless, an emphasis on ethical

\(^{17}\) A. Haan-Kamminga, *Supervision on Takeover Bids* (Deventer, 2006).
standards and personal responsibility among the regulated groups remain part of the core of the British style of regulation.\textsuperscript{20}

\textbf{Oversight}

Oversight commonly accompanies regulation. A practical way to define government oversight as a phenomenon is to view it as a relationship.\textsuperscript{21} An oversight relationship is a formal relationship between two actors in which one actor (the regulatory agency) has the formal authority to intervene in the choices and decisions of the other actor (the regulated party). To exercise oversight is a secondary activity; the primary responsibility for performing the duties that are the object of oversight by definition belongs to the regulated party: this distinguishes an oversight relationship from a hierarchical relationship. The ideal regulatory agency has no authority to give instructions to the regulated party. And there is no other way in which one can speak of an authority relationship or of undue influence.

A second feature of the ideal oversight relationship is that the oversight is exercised for the sake of protecting a specific, well-defined interest. The reasoning behind an oversight relationship is that the decisions and activities of the regulated party could harm that interest. The interest and the acts that would violate that interest are usually codified in rules. While the regulated party will make decisions based on the integral considerations of all relevant interests, the regulatory agency only has to protect the one interest under its purview. In other words, the regulated party makes integral considerations and the regulatory agency tests the results of those considerations against the specific public interest it is charged to protect.

No matter how specific and limited inspections, market regulators and other regulatory agencies may be, they have by now acquired a considerable task in exercising this responsibility. The challenge lies less in the temptation to intervene than in the regulatory agencies’ need for information. How can a regulatory agency get sufficient data about the way in which the many regulated parties, sometimes hundreds of thousands of parties, safeguard the specific public interest in the regulatory agency’s charge? Regulatory agencies have developed ingenious methods to acquire this information. Yet they face the constant challenge of selection. Let us examine this problem. We will assume that the willingness to comply with regulations in a certain oversight domain is distributed as follows. A common formula is that between ten and twenty percent of the target group will comply voluntarily.\textsuperscript{22} Between ten and twenty percent are seriously delinquent. Those in the middle, that is to say, the remaining sixty to eighty percent of the target group, typically require no more than infrequent mild incentives (including social pressure) in order to remain in compliance. This distribution varies considerably in reality, depending on the various oversight domains, but no matter the actual distribution, the regulatory agencies are faced with the task of selecting the relatively small group of delinquents from the large total population. This always requires information on all the members of the population and entails a considerable regulatory burden, including for those who consider themselves compliant.

One solution to the selection problem is a quasi-denial of it: simply assume compliance by the target group. Give them an ‘oversight holiday’, but be prepared to respond quickly and forcefully in case this

\textsuperscript{20} This can be seen in the work of the British Better Regulation Commission (1997-2008) and the Hampton Report which led to the formation of that commission.


\textsuperscript{22} “Target group” includes all actors, whether individuals or organisations, subject to a certain regulation. Sometimes the members of the target group are clearly definable, such as in the “Directives Regarding the Quality of Child Care and Nursery Schools 2012” (Netherlands), while at other times the members are indeterminate: the “Traffic Signs Regulations and General Directions 2002” (UK) regulates the behaviour of all persons on the public road.
trust is abused. This approach is employed in the current *Kaderstellende Visie voor Toezicht* (*Netherlands Guideline for Government Oversight*) and in the *Hampton Report* (a 2005 UK report on administrative burdens). It contains an implied premise, namely that it is possible to identify the rotten apples relatively easily without inconveniencing the good apples. This ignores the selection challenge. This approach, sometimes called a ‘secured confidence’ (*geborgd vertrouwen* in Dutch), is now past its heyday. Another solution is risk-specific oversight: using risk profiles regulatory agencies could identify the apples most likely to be rotten based on a limited number of data points, preferably publicly accessible information.

**The Ideal Kind of Regulation and Oversight**

Regulation and oversight have always been controversial. There has always been the suspicion that it was ineffective and inefficient and produced perverse consequences. The experiences and the debate about them, especially in the last few decades, have resulted in an image of what ideal regulation and oversight should be like. At the core of that ideal is the notion that exercising oversight should aim towards protecting public interests and not on punishing violators of rules. Regulation intended to limit a public risk should be based on a balanced consideration of all relevant circumstances and factors. Oversight as an extension of this type of regulation is intended to address concrete safety risks in the internal processes of companies and organisations and enforce compliance from that perspective. Verifying compliance and, if necessary, penalisation of non-compliance are among the many means available to the regulatory agency within this framework. Regulation and oversight, when based on these principles, should prevent disproportionality in oversight and put the responsibility for risks where it is most appropriate.

An early proponent of such an approach was Sparrow who called it *problem solving.*\(^{23}\) The practical policies resulting from this approach can be found in documents such as the *Netherlands Guideline for Government Oversight*, mentioned above (with its motto: ‘Lower Burden, Greater Effectiveness’) and the work of the British *Better Regulation Commission*. A good example of the practical outworking is the Hampton Report\(^{24}\) (see Text 1 below).

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\(^{23}\) A well-known example of this approach is Malcolm K. Sparrow, *The Regulatory Craft. Controlling Risks, Solving Problems and Managing Compliance* (Washington [DC], 2000). Sparrow is an English academic, shaped by the British tradition of cooperative regulation, who emigrated to the US and is attempting to introduce that tradition to the American command and control culture.

The Hampton Recommendations

- reducing inspections where risks are low, but increasing them where necessary;
- making much more use of advice, applying the principle of risk assessment;
- substantially reducing the need for form-filling and other regulatory information requirements;
- applying tougher and more consistent penalties where necessary;
- reducing the number of regulatory agencies that businesses deal with from thirty-one to seven;
- entrenching reform by requiring all new policies and regulations to consider enforcement, using existing structures wherever possible; and
- creating a business-led body at the centre of government to drive implementation of the recommendations and challenge departments on their regulatory performance.

The Hampton Principles

Key principles that should be consistently applied throughout the regulatory system:

- regulatory agencies, and the regulatory system as a whole, should use comprehensive risk assessment to concentrate resources on the areas that need them most;
- regulatory agencies should be accountable for the efficiency and effectiveness of their activities, while remaining independent in the decisions they take;
- no inspection should take place without a reason;
- businesses should not have to give unnecessary information, nor give the same piece of information twice;
- the few businesses that persistently break regulations should be identified quickly and face proportionate and meaningful sanctions;
- regulatory agencies should provide authoritative, accessible advice easily and cheaply; and
- regulatory agencies should be of the right size and scope, and no new regulatory agency should be created where an existing one can do the work.

From the Hampton Review

A Dutch document that is comparable in many ways is the second Netherlands Guideline for Government Oversight (‘Lower Burden, Greater Effectiveness’). It contains, among others, the following principles for good oversight:

1. a selective approach by the government in ensuring the exercise of oversight;
2. form and scope of oversight should be determined by a consideration of risks, costs, and benefits; and
3. the exercise of oversight should be agile, cooperative, independent, transparent, and professional.

A significant step towards a more balanced way of regulating in the Netherlands was the replacement of prescribed means with prescribed goals; this moved the responsibility of adequate choices by corporate management to safeguard the requisite public safety more towards the regulated target groups. Simultaneously, regulatory agencies have started to be more assertive in calling out the target groups on their personal responsibility regarding collective public interests. In the context of these first steps various larger and smaller improvements of regulation and oversight have been attempted. There are plenty of good ideas, yet regulatory agencies do not always manage to avoid the risk regulation reflex. Reality is proving to be very inflexible. In the remainder of this paper we will discuss
a number of factors and circumstances that may form a barrier to implementing these good principles and ideas.
Section II
The Problems of Regulation

Chapter 3
Experiences with Regulation

Modern regulation – ‘the administrative technology of controlling business through law-backed specialized agencies rather than through the technique of public ownership’ – has its origins largely in the United States of the 1920s and 1930s. Regulation initially meant formulating and enforcing rules of behaviour (commands and prohibitions) for private actors in the various branches of industry. The reasoning behind it was to protect public interests: preventing companies from inflicting the negative external consequences of their business practices on society as a whole. Regulating the financial markets and financial institutions at the time of the Great Depression, for instance, was seen as a weapon to prevent new financial crises. An early and somewhat comparable example of regulation in the Netherlands was the Life Insurance Companies Act (1923) with the Verzekeringkamer (Insurance Chamber) as the regulatory agency. Another kind of regulation is aimed at safeguarding specific public interests, not in individual branches of industry but in the economy as a whole. A standard example is the existence of workplace accidents and illness: the first type of labour inspection agency in the Netherlands dates to 1890. The American Food and Drugs Administration began in 1906. The question that received the most attention in connection with industry-specific regulation was agency capture (see chapter 4).

A second topic that attracted the attention of political scientists and policy study experts from the 1950s onwards was the phenomenon of non-decision-making. In some sense this is the polar opposite of the risk regulation reflex: while the latter calls attention to excess policy burdens as experienced in the modern era, back then the problem was rather that many societal problems remained invisible to the public and political debate. A good deal of the large-scale regulation of specific public interests for the economy as a whole (environment, external security) does not come into being until the 1970s. Resistance also developed quickly: administrative burdens and deregulation became a political issue. The secondary literature of the last few decades dismissed


27 The American federal regulatory agencies OSHA (occupational safety) and EPA (environment) were both founded in 1970. In the late 1970s the first Dutch environmental laws were passed.

the command and control system of regulation as old-fashioned, ineffective, and inefficient. Authors also wondered whether the costs of regulation to society were always justified by the benefits to society in terms of securing the particular public interest in question. Practical experiments with new forms of regulation arose which should allow for greater flexibility and customisation and result in more selective interventions.

The experiences with regulation of the past nearly one hundred years, as briefly outlined above, produces insights into a number of problems or dilemmas inherent in oversight and regulation.

Chapter 4
Agency Capture

The Mechanism

Regulatory capture is the phenomenon in the American regulatory sphere that the regulated parties or target groups manage to deflect regulation and oversight in favor of their own interests and at the expense of the public interests that the regulation is supposed to safeguard. In order to understand how that works the model of the iron triangle of lobby groups, politicians, and civil servants was developed—three parties, each with their own incentive to regulate for the benefit of the interests of the regulated parties. This kind of process has a strong negative influence on the public benefits of regulation. The introduction of newcomers in the market is severely limited which then limits competition. The public interests that ought to be safeguarded are relativised in favor of the interests of insiders.

Agency capture means that the regulatory agency is so heavily under the influence of the regulated parties that it allows the latter’s interests to prevail when enforcing the rules. In the American context, where the regulatory agency is not only responsible for oversight and enforcement but to a large extent also for legislation, both phenomena often coincide. In general it means a serious infringement of the principle of independent oversight.

Within the Dutch context the phenomenon appears in two specific ways. The first form of capture develops because the regulatory agency and the regulated parties have an inherent tendency to limit the distance between them. Both actors in the oversight relationship have an incentive to avoid costly and complicated conflicts. This may lead a regulatory agency to intervene at an early stage in the choices of the regulated party, using terminology such as compliance assistance. The regulated party has incentives to request the opinions of the regulatory agency at an early stage under the reasoning that the regulatory agency is a partner, a friend, an adviser. The end result may be that the regulatory agency becomes in effect partly responsible for the choices of the regulated party. The balance between distance and involvement – both can be expected from a regulatory agency – is tricky. The Dutch Safety Board (Onderzoeksraad Voor Veiligheid or OVV) suggests in its reports about

33 This is also known within Dutch policy studies as the Second Law of Oversight. Cf. J. de Ridder, Een goede raad voor toezicht (The Hague, 2004).
Chemiepak and Odfjell that the regulatory agencies allowed themselves to be guided too much by the interests of the regulated companies. The second way in which the phenomenon often manifests itself in the Netherlands is what could be called political capture. Especially in local affairs, imposing sanctions tends to be within the jurisdiction of a political body, usually the municipal or provincial executive. The natural position of such political bodies is to make an integral consideration of all the various interests at issue when deciding on possible sanctions. Not infrequently the public interest that is to be safeguarded (for instance, environmental safety) loses out against other interests. Apart from the fact that the guarantee of legal recourse and that of equal justice (a ‘level playing field’) are compromised in such cases of arbitrary behaviour, such political considerations are rarely the best integral assessment of the societal costs and benefits that might justify an occasional deviation from the rules.

The Problem

At first, one might expect that the aforementioned violations against the independence of the regulatory agencies would lead to the tempering of the risk regulation reflex among regulatory agencies. Disproportionately heavy interventions are, after all, avoided across the board. The problem is, however, that interventions are also avoided when the principles of proper oversight demands them (applying tougher and more consistent penalties where necessary). In the secondary literature from the Netherlands the avoidance of adequate sanctions is referred to as the enforcement deficit (handhavingstekort). Enforcement avoidance is just as disproportionate as exaggerated penalties: it undermines the credibility of the relevant norms. Examples of this phenomenon can be found in the empirical literature on the topic.

Proposals

In order to avoid disproportionate levels of intervention all sorts of measures of varying intensity can be taken. The secondary literature mentions these frequently:

- Systematically protecting the independence of the regulatory agency
  This is the most drastic precaution which is intended to protect the exercise of oversight from the fickleness of political judgements.

- Transparency and openness
  If the judgements of regulatory agencies are, in principle, public, this creates a basis for a public debate about the acceptability of the observed public safety risks and about the usefulness and necessity of any interventions.

- Consultation of the industry
  Companies and other parties are consulted about the risks and their correlated problems in the industry, as well as about possible solutions including regulation and enforcement. This creates clarity about the distribution of responsibility and reinforces the distance between regulatory agencies and regulated parties.

- A thorough knowledge of the oversight domain and use risk analyses to exercise oversight
  Apart from the efficient advantages produced by this approach, risk-specific oversight can prevent responsibility from shifting from the regulated party to the regulatory agency.

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34 For more information regarding these cases see part 4 of the relevant report.
36 F.C.M.A. Michiels, Handhaven op niveau (Deventer, 2001).
37 For example, see J. de Ridder, N. Struiksma, and H.B. Winter, De effectiviteit van bestuurlijke en strafrechtelijke handhaving van milieuwetgeving, WODC, 253 (The Hague: WODC, 2007).
Never impose penalties before getting a second opinion—always enforce penalties
The principle of a second opinion (the practical outworking may vary depending on the oversight relationship) can prevent the regulatory agencies and the regulated parties from becoming ‘partners’.

Interventions and penalties are always tailored to the violator and enforced with an eye towards a swift and effective resolution of the problem in question
The nature of an adequate intervention is determined by circumstances. Gross negligence with serious consequences ought to lead to criminal prosecution. An observed potential risk with unknown probabilities and unknown consequences will require consultation of the various actors in the oversight domain in order to reach a joint risk analysis. A remedial penalty can be imposed to repair any damage caused. Etc.

A Practical Example
One case in which the proactive role of the regulatory agency has had a dampening effect on the risk regulation reflex is that of the Netherlands Mine Authority (Staatstoezicht op de Mijnen or SodM) in the period after the Deepwater Horizon oil spill in the Gulf of Mexico in 2010. At the request of SodM all regulated companies performed internal checks and submitted reports to SodM. These reports showed that there were no shortcomings in the preventive safety procedures. SodM also performed its own investigation regarding the circumstances in the Gulf of Mexico in comparison with those in the North Sea. This investigation concluded that the risk profiles varied greatly. When the Dutch Lower House of parliament (Tweede Kamer) questioned the responsible minister about the possibility of an incident similar to the Deepwater Horizon explosion in the North Sea (an invitation to engage in the risk regulation reflex), the minister could stifle this impulse by referring to the data gathered by the SodM.
Chapter 5
The Principle of the *Rechtsstaat*

*The Mechanism*

The criticism of the classic command and control type of regulation has not been without effect. Across the globe there have been many experiments with new forms of regulation intended to deliver flexibility and individualised solutions, and with risk-directed and problem-oriented oversight. 38 Briefly summarised, there are three types of alternatives to traditional regulation. The first alternative can be called soft law. The traditional *rechtsstaat* approach requires the binding rule of law, determined by democratically elected legislators. 39 This alternative type emphasises the involvement of the regulated parties and other stakeholders. Included in this category are cooperative regulation and responsive regulation, 40 as well as self-regulation, whether or not under the threat of government-imposed regulation.

The second alternative targets the application and enforcement of rules. In the traditional approach principles of good governance, such as the principle of equal justice and the prohibition of arbitrariness, are very important. In the alternative approach the treatment of individual cases, each with their own merits, are central. The goal is problem solving. Following rules is of lesser importance than solving the problem for which the rule was intended. Experiments in this vein have names such as ‘interactive implementation’, ‘compliance assistance’, ‘testing best practices’, and ‘benchmark evaluation.’

The third alternative essentially comes down to utilising market forces. As a first resort, violations of norms and harmful practices are not penalised but rather publicised. Transparency, naming and shaming, and similar public humiliation techniques are used to incentivise economic actors to make more responsible choices.

*The Problem*

All these experiments with freer forms of regulation are completely in accord with the general approach as described in chapter 2. They should contribute to an optimal effect in society at a minimum cost. However, in practice many of these alternatives quickly run into severe limitations. 41 Government interventions of any kind whatsoever are by definition limited by the principles of the *rechtsstaat*: the principle of legality, the principle of equal justice, and the prohibition of arbitrariness.

39 Translator’s Note: The Dutch word *rechtsstaat* is a Dutch legal term referring to the limitation of government power by the principle of legality. This view shares important features with the principles expressed in the British Bill of Rights (1689) and related documents in the Anglo-American tradition, notably the American Constitution (1787). However, to avoid the danger of unwarranted conflation of the situation in the Netherlands with the separate developments of the Anglo-American legal tradition, this translation retains the Dutch term *rechtsstaat* for the situation in Dutch law.
41 The volume edited by Gráinne de Búrca and Joanne Scott (*Law and New Governance in the EU and the US*), with reflections on the experiences with a large number of the alternatives mentioned in our text, shows clearly what the limitations are.
If the legislature or regulatory agencies were to ignore these principles, citizens can still have legal recourse in the judicial branch of government. In short, the rechtsstaat limits the reach of cooperative regulation. Or rather, the rechtsstaat draws sharp boundaries. Government interventions always require a legal basis, regarding both the authority to intervene in the first place and the norms that the regulated parties have to adhere to. If there are material norms and the government is responsible for enforcing them, there exists in addition a ‘principled duty to enforce’: the government cannot simply decide to enforce in some cases but not in others.

**An Example**

The regulation of daycares in the Netherlands offers an example of attempts to introduce alternative forms of regulation that quickly ran into boundaries. The Daycare Act 2004 (Wet op de kinderopvang 2004) introduced extensive regulation of daycares in the Netherlands. Child safety is a sensitive topic and legislators decided not to be satisfied with half measures. One might be justified in concluding that the legislature removed the primary responsibility for child safety in this area from the parents and moved it rather lopsidedly to the government. However, the legal structure also included a provision to temper this one-sided command and control approach. The Daycare Act itself, which is the basis for the regulation, contains primarily formal rules regarding the oversight of daycare facilities and childminders. The material norms that daycare facilities must adhere to were initially formulated through a type of self-regulation: an agreement between the associations of clients and daycare facilities (the Brancheorganisatie Kinderopvang, MOgroep Welzijn & Maatschappelijke Dienstverlening and BOinK—Belangenvereniging van Ouders in de Kinderopvang).

However, rules contained in such an agreement, drawn up by interest groups by mutual consent, are not automatically binding for individual parties in the target group. As a result, this arrangement was struck down as unconstitutional the very first time a legal challenge regarding the enforcement of the policy regulations was brought to the Council of State (Raad van State), the highest court of appeal in the Netherlands, seven years after enactment of the law. The plaintiff, an independent entrepreneur, made the argument, with which the court agreed, that the norms he had to adhere to lacked a legal basis. Why should random parents and competitors have any authority over the way he conducted his business? In other words, such agreements are not necessarily a viable alternative to conventional regulation. But if that is so, what is available?

**Proposals**

The rechtsstaat limits the flexibility in regulation and individualising solutions. There are two ways to acknowledge these limits without completely sacrificing the problem-solving approach. The first way is to institute true private regulation. Such regulation already exists on a large scale (e.g. the industrial norms from the NEN, the Dutch standardisation institute) and the market has shown itself to be capable of enforcing that type of norm, for instance by means of systems of certificates and accreditation. It would seem possible to replace the public oversight of building regulations, at least to a large extent, by a system of private norms and self-regulation.

In those areas where government regulation is appropriate, the rechtsstaat does not completely prohibit flexibility and individualised solutions. The principle of legality designates the legislature as

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42 More extensively in J. de Ridder, Toezicht op de kinderopvang. Rapport van een onderzoek naar aanleiding van enige vraagpunten van de commissie-Gunning over de inrichting van het toezicht op de kinderopvang (Groningen, 2012).
43 Ruling by the Netherlands Council of State, Court of Justice Div., 21 December 2011, 201103651/1/H2.
the authority that establishes binding regulations. Nevertheless, public consultation of the industry is a principal requirement for government regulation in all its forms. The same is true for the more detailed norms contained in risk analyses, policy regulations, and oversight contexts. Formal penalisation should ideally be the last resort of enforcement by regulatory agencies. A flexible gradation of interventions – starting with informative consultations and ‘nudges’, and ranging to official warnings and the issuance of cease-and-desist orders – is essential for public regulatory agencies. There are already many examples of this kind of regulation and oversight in the Netherlands. If public-private consultation does not take place when establishing rules or executing interventions the danger of disproportionate enforcement lurks. At the same time, the example of regulating daycares in the Netherlands also shows that too much involvement of interested parties in the establishment of material norms can lead to lopsided regulations.
Section III  
Problems of the Bureaucracy

Regulatory agencies are organisations – often large, complex organisations. Over the past fifteen years the Dutch regulatory apparatus has been under pressure from a political movement that desires to merge regulatory agencies, leading to a smaller number of regulatory agencies. However, each organisation has thus acquired more tasks, a greater number of specialisation, and hence greater complexity. Large complex organisations have their own internal dynamics and mechanisms. In principle, these mechanisms can contribute to the problem of disproportionate regulation as well as to tempering it.

Chapter 6  
The Vicious Circle

The Mechanism

One of the first mechanisms inherent in the bureaucratic manner of regulation and oversight is known by the term “vicious circle of bureaucracy”, coined by the Frenchman Crozier.\(^{45}\) Other terms are regulatory creep and regulatory spiral.\(^{46}\) Although regulatory creep has additional causes, it refers to feedback effects, sometimes automatic ones, in the application and enforcement of rules. A typical response to the observation that execution of regulation has serious deficiencies is to add further rules to counteract this. These new rules will also turn out to have deficiencies or produce unintended negative consequences, which again leads to further regulation and stricter oversight. Judicial interventions can also contribute to this effect. This dynamic originates in the circumstance that universal rules will never be completely applicable in each individual incident. It is one of the professional competencies of agents enforcing the rules to classify concrete cases under general rules. If agents do not have an adequate command of this competency or if the professional pressures on the so-called street-level bureaucrats lead to incomplete enforcement, the deficiencies are created that will invite new regulations. The more the amount of ‘programming’ increases in this way, the more reality will come to be at odds with the rules.

The Problem

The vicious circle leads to the creation of much more regulation than is justified by the original public interest that the regulation is supposed to safeguard. For the execution of oversight such a disproportionate administrative burden can have two divergent consequences. The first is that the rules are largely ignored. In that case there is such a great chasm between the rules and the reality

that the rules were supposed to influence that the regulatory agencies start taking recourse to their own interpretations of rules, and even their own rules. A second, entirely different consequence might be that the regulatory agency starts adopting the strategy of going by the book – enforcement becomes the central goal of the regulatory agency and given the abundance of rules, some violation will always be found.\textsuperscript{47} Naturally, this type of enforcement is the exact opposite of the problem-oriented approach to oversight. Too intrusive regulation undermines the possibility to produce individualised solutions, unless the regulatory agency should act \textit{contra legem} (in violation of the law). In short, too many rules are the enemy of good oversight.

\textbf{An Example}

The case study of oversight of daycare in the Netherlands is a good example here, too.\textsuperscript{48} The legislation contains several general norms for daycare facilities. These norms are then defined more precisely and expanded in regulatory policy promulgated by the minister. Then, the regulatory agency, in this case the GGD (Public Health Department), creates an extensive evaluatory framework, based on the legislative norms and the regulatory requirements. The national association of local public health departments has a specialised division which produces measures of ever-increasing precision which local regulatory agencies can utilise to evaluate daycare facilities. Local enforcement has increasingly turned into an exercise in ticking boxes on standard forms. There is a clear feedback loop between the deficiencies observed in the field and the increasing development of norms. It was, in fact, so obvious that the national public health association perceived the need to weed out and simplify the convoluted mass of norms and measures. After a sexual abuse case in a daycare facility in Amsterdam specific deficiencies in the existing regulations were noted.\textsuperscript{49} These gave rise to new, probably disproportionate rules, such as the so-called “four-eyes principle” and screening of daycare staff.\textsuperscript{50}

\textbf{Proposals}

In contrast to the practice in the United States as described by Malcom Sparrow, regulatory oversight by ticking off boxes was never as common in the Netherlands. Nevertheless, one can find plenty of examples of a self-propagating increase in the number of rules and their increasing specificity in various specific regulatory domains (e.g. the Dutch Working Conditions Act).\textsuperscript{51} The prevention or breaking of the vicious circle requires a conscious applications of rules and their function. One example from the domain of environmental enforcement is the system of core provisions (Dutch \textit{kernbepalingen}).\textsuperscript{52} In its most developed form the core provision approach meant that from the totality of applicable rules regulatory agencies would always select those provisions with the most direct connection to the public interest that is to be safeguarded or to the risk to be guarded against. The regulatory checks were primarily focused on threats to the public safety risk in question and not


\textsuperscript{48} J. de Ridder, \textit{Toezicht op de kinderopvang. Rapport van een onderzoek naar aanleiding van enige vraagpunten van de commissie-Gunning over de inrichting van het toezicht op de kinderopvang} (Groningen, 2012).

\textsuperscript{49} Independent report by the Gunning Committee (Commissie Onderzoek Zedenzaak) charged with investigating a sexual abuse case at daycares (Amsterdam, 2011).

\textsuperscript{50} Ira Helsloot, Arjen Schmidt, and David de Vries, ‘Quick scan voorgenomen en staand rijksbeleid op proportionaliteit’ (Renswoude: Crisislab, 3 December 2012).

\textsuperscript{51} For a number of specific examples within the jurisdiction of local government, cf. A. Tollenaar, \textit{Gemeentelijk beleid en beleidsregels: de toegevoegde waarde van beleidsregels van de gemeentelijke beschikkingverlening} (The Hague: Boom Juridische Uitgevers, 2008).

\textsuperscript{52} J. de Ridder and N. Struiksma, \textit{De kern van de zaak?} (The Hague: WODC, 2008).
on detecting regulatory violations. As a general rule, it is to be recommended to place the defence of the public interest at the centre of regulatory oversight.
Chapter 7
Standard Operating Procedures

The Mechanism

Administrative agencies thrive on stability and avoiding insecurity. This has important advantages: the predictability of government actions benefits from it, large numbers of more or less routine cases can be handled in a uniform way, and the risk of arbitrary enforcement is diminished. In order to produce predictable regulatory enforcement regulatory agencies, like all professional organisations, influence and check the behaviour of their staff.\textsuperscript{53} They do that using standard operating procedures (SOPs): programmes of action and tried and tested repertoires.\textsuperscript{54} SOPs are not only to be observed – not even in the first place – in systems of explicit rules and hierarchical instructions (obtrusive controls) but often take the shape of unobtrusive controls. Agency staff consider this second type of behaviour control less direct than rules and instructions. What is meant by this is subtle influencing techniques such as selection, education, initiation, and even indoctrination. They are designed to steer the infinite number of choices of staff members in the right direction by imprinting them with the underlying premises of these choices. Under optimal circumstances staff will experience their own culturally-directed behaviour as natural. By this means of socialisation and social control organisations manage to effect a sometimes large measure of behaviour control.

Discretion

In contrast to efforts to limit the freedom of choice by staff members through the use of SOPs and socialisation, as discussed above, there is also the bureaucratic tendency to permit the enforcing civil servants in the field a certain amount of discretion. This introduces the so-called problem of the street-level bureaucrat. The enforcement agents, confronted with an excessive number of cases and an insufficient capacity for adequately processing them, will develop various strategies to clear their desks. Among them are selective enforcement (or cherry picking), eradicating excess case loads the easiest way (no intervention) or they take their refuge in the first option: automatic processing according to standard operation procedures.\textsuperscript{55}

In the 1980s there was a boom in empirical research into the phenomenon of discretion of civil servants in the Netherlands.\textsuperscript{56} The discretion of enforcing agents was relatively large at the time. This was also true of inspecting agents at the standard inspection services. They often had their own districts, knew who the troublemakers were, and inspected, judged, and penalised to a large extent as they saw fit. Inspectors at services such as the Healthcare Inspectorate and the Inspectorate of Education generally limited their interventions to cosy chats among peers. One might imagine that

\textsuperscript{54} Graham T. Allison, ‘Conceptual Modes and the Cuban Missile Crisis’, \textit{The American Political Science Review}, 63/3 (1969), 689-718.
\textsuperscript{56} A precursor was the doctoral thesis by A.B. Ringeling, \textit{Beleidsvrijheid van ambtenaren} (Alphen aan den Rijn: Samson, 1978). In the rear guard of this trend was A.J.G.M. van Montfort, \textit{De regels van het huis. Ambtelijke regeltoepassing bij de gemeentelijke woonruimteverdeling} (Groningen: Wolters-Noordhoff, 1991).
such discretion gave enforcement agents carte blanche to institute excessive and disproportionate interventions (or ‘riding hobby horses’) but there is very little evidence of this.

Since then, the inspection services in the Netherlands have seen three waves of changes: the General Administrative Law Act (Awb) in the 1980s,\textsuperscript{57} New Public Management (NPM) in the 1990s,\textsuperscript{58} and the oversight reforms of the new century. Implementation of the Awb also entailed that the inspection services started applying the general principles of good administration—arbitrary enforcement by inspectors was not compatible with that approach. Among others, NPM meant a shift from input control to output control and, linked with it, performance reviews: meeting targets became more important. The introduction of performance reviews within the bureaucracy has changed the interpretation of discretion completely: it has become more important to explain after the fact what was done and why.

**The Problem**

Standard operating procedures can stand in the way of more problem-oriented oversight and proportionate intervention. This kind of procedures and programmes entails the risk that the discretion of individual agents is limited to such a great extent that critical reflection is stifled and assessment after the fact is neglected. Compliance problems are then treated as standard cases and individualised solutions do not happen. When checking compliance with speed limits by motorists a high degree of routine is an efficient approach. However, a problem such as managing the environmental risks of prawn fishing in the Wadden Sea requires an individualised approach. In yet other oversight domains combinations of SOPs and individualised solutions are required.

A certain level of discretion for inspectors in the field can provide a counterbalance to rigorous regulation and further proportional interventions. However, as has been argued, both the new administrative law act and the new approach to oversight are irreconcilable to too great a degree of latitude for street-level enforcement agents. The challenge is to develop a task description for regulatory agencies that combines proportionality with justifiability and efficiency; a dynamic balance between professional discretion and organisational regulation of behaviour. In reality this perfect balance remains elusive in a wide variety of oversight domains.


Chapter 8
Professional Passion

The Mechanism

Regulatory bodies such as inspection services and market authorities are professional bureaucracies. Enforcement agents have a wide variety of specific knowledge and expertise that, when the agency is functioning properly, is utilised to realise the agency’s goals. To what extent the agency succeeds depends among other things on the effectiveness of the SOPs as discussed above. As agency staff are more strongly socialised in the agency their professional attitudes and the organisational culture of the agency will start to coincide more. In extreme cases the professional regulatory enforcement agent continually sees violations of the public interest that the agency is charged to safeguard (vigilance). Under these circumstances the enforcement agents in the agency – and the agency as a whole – are strongly incentivised to overestimate the importance of the agency’s goals. One consequence of this organisational identification is the phenomenon of budget maximisation: agency staff will always consider the means allocated to the agency to be insufficient to realise the ambitions and pretentions of the agency.

The Problem

This mechanism contains the risk that the agency goals or the interests that the agency aims to safeguard are absolutised. This in turn can cause the risks to be systematically overestimated while society’s ability to control these risks is underestimated. Incidents that appear to support this perception of reality are exaggerated and data or events that contradict this dominant attitude are played down. In other words, it can lead to cognitive dissonance (ignoring facts or insights not in accord with a predetermined interpretation of reality) and groupthink (the thinking of the members of an organisation that makes striving for common attitudes so crucial that realistic considerations of alternatives is undermined). It is self-evident that this mechanism is diametrically opposed to the desire for proportionality in decision making regarding regulation and intervention. When incidents seem to support an organisation’s position the responses of such an organisation may initiate or strengthen the risk regulation reflex process.

60 In traditional organisational theory such an attitude was the ideal organisational personality; Chester Barnard, The Functions of the Executive (Cambridge, MA: Harvard University Press, 1933).
64 An empirical study into the effect of these and similar mechanisms on an oversight domain is M. Wiering, ‘Contexts of Enforcement: Differences in Style and Position of Agencies Enforcing the Manure Legislation in the Netherlands and Flanders’, F. van Loon and K. van Aeken, eds., 60 maal recht en 1 maal wijn (Leuven: Acco, 1999), 347-58.
An Example

The development of the Security Regions in the Netherlands during the last decade shows many aspects of professional dominance. The Security Regions, designed as a response to national disasters in 2000 (the Enschede fireworks disaster and the Volendam New Year’s fire), were initially intended as low-level cooperative structures between municipalities in a region in order to coordinate the operation of emergency services during large-scale public safety incidents, such as the two disasters mentioned. As a result of pressure from professional experts the Security Regions have since developed into relatively independent regional authorities that consider it their task to protect public safety in the region. “The main goal of the Dutch Security Agency (the national association of Security Regions) is to make the Netherlands safer by preventing and counteracting (repairing) social disruption,” according to the Security Agency; the strategic goals of the Security Regions are published in the recent Strategische Agenda Versterking Veiligheidsberaad 2014 – 2016 (Strategic Agenda for the Strengthening of a Common Security Policy 2014-2016). Over the past twelve years the budget of the Security Regions has doubled but a clear insight into the social benefits of this financial investment in terms of greater security remains lacking. There are indications that the professional advice from the Security Regions tends to overestimate general safety and fire safety risks.

Proposals

The secondary literature (including the early publications by Irving Janis) contains various suggestions to prevent or correct groupthink and related organisational mechanisms. To a large extent they agree with the general (ideal) approach of regulation and oversight as proposed in chapter 3. A healthy self-critical organisation ensures that reflection, weighing of alternatives, and checks and balances have been incorporated into the decision-making structure of the organisation. Some recommendations in this context:

- have different groups, who are working independently from each other, prepare the policy decisions about important decisions;
- encourage individual members of the organisations to discuss the analyses and interpretations of the problem with confidential outside advisers;
- have individual members of the policy development team prepare written reports of their ideas without sharing them within the team;
- always look for alternatives and ensure that realistic alternatives receive serious consideration;
- invite outside experts to participate in the decision-making process;
- appoint a devil’s advocate;
- accept conflict as a necessary element of the decision making process.

These and similar techniques are fairly obvious; the challenge lies in incorporating them systematically into the decision-making structure of the organisation.

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Chapter 9  
Jurisdictional Compartmentalisation

The Mechanism

Large, complex organisations are formed to make division of labour and specialisation possible on a larger scale. It is the function of the executive to make all these various tasks and specialisations function in coordinated organisational processes to further the goals of the organisation. However, specialisation also entails an inherent impulse to compartmentalise that specialisation. This impulse is considerably more forceful in specialised organisations. It is certainly not the case that the Inspector for Education will, as a matter of course, collaborate with his colleague from the Working Conditions Inspection Service in solving safety problems faced by educational staff. The mechanism that incentivises specialised services towards isolating themselves is reinforced by the typical bureaucratic mechanism of reducing uncertainty: defending one’s own turf—‘either it’s your jurisdiction or it isn’t.’ On the other hand, this demarcation of jurisdiction, to the extent that it affects formal authority, is also a necessity in administrative law, known as the principle of specialisation. In short, rational complex organisations have all sorts of obstacles deterring interventions across formal boundaries.

The Problem

The ‘mind your own business’ principle will not usually lead to large complications. The Dutch project Programma Andere Overheid investigated the burdens resulting from inspections by multiple regulatory agencies and conflicting regulatory directives. One of the findings was that the regulated parties did not experience the separate inspections by different regulatory agencies as a huge burden. However, they did consider the increasing reporting requirements and the lack of expertise on the part of some inspectors onerous (‘inexpert inspections are a nuisance’). Nevertheless, an absence of congruity between the interventions of different regulatory agencies and other public institutions as well as jurisdictional disputes can sometimes lead to complications. Sometimes practical problems contain so many different, mutually related facets that a coordinated approach is necessary lest the interventions by the different public institutions lead to unbalanced and disproportionate consequences.

An Example

One example of jurisdictional compartmentalisation is the decision making process regarding the Amsterdam underground system in 2012. After the new safety requirements for underground train tunnels came into effect it turned out that the East Line of the Amsterdam underground did not yet meet these new requirements. The relevant regulatory agency, the municipal Environmental and Building Oversight Department, alerted the city council to the violations and recommended that the underground tunnel be closed. However, the Amsterdam city alderman (municipal executive official) responsible for public transport decided against closure. He reached this decision after weighing all the ramifications, not only of keeping the tunnel operational but also of a closure. If the underground

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67 Programma Andere Overheid, Samen werkt! Gezamenlijke bedrijfsbezoeken door rijkinspecties, 2005. The conclusions can be found on page 11.
East Line were to be shut down, passengers would be forced into other transport options. The expectation was that the majority would opt to ride bicycles instead. In the opinion of the alderman, an increase in the number of bicyclists in the city of Amsterdam of that magnitude would be between 1,000 and 10,000 times less safe than tolerating an underground line that did not meet the latest requirements. In this case, the regulatory agency only had oversight over a small part of the rules, while the executive official had the opportunity to examine the full spectrum of factors.68

Proposals
The congruity problem can be solved in three ways. The first is structural: the organisational merger of inspection services and market authorities into larger public institutions. This solution – holistic oversight – was one of the ideals at the centre of the oversight reforms over the past decade. The Hampton Report argued in favour of an extensive consolidation of the various regulatory agencies. The reforms were not as far-reaching as the legislative motion by Dutch politician Aptroot, which would have formed one national inspection service for all regulatory oversight. Nevertheless, the Dutch reforms were characterised by a large measure of consolidation. The underlying assumption is plausible: fewer inspection services would mean fewer separate inspections (and therefore, a lower oversight burden), fewer conflicting requirements, and less redundancy. This approach has the advantage of simplicity: at the very least, it looks straightforward. However, it underestimates the power of specialisation and the division of labour. The single inspector with jurisdiction over all matters does not know enough about all areas and his inspections will be considered mostly a nuisance.

A second way is procedural. This includes all sorts of collaboration between inspection services: shared organisational processes and risk analyses, integration of databases, etc. The transaction costs of this approach may well be higher than organisational merger but this is hardly inevitable. Precise, structural collaboration also has advantages over organisational mergers. One is that independent organisations that collaborate are forced to perform a thorough analysis of the overlap of their respective domains in order to come to less burdensome oversight. They will also have to come to terms with any mutually contradictory and conflicting norms in the oversight domains.69

A third way is cultural. We have mentioned above that organisations socialise their members so that their attitude – their understanding of the professional environment and of their own role in it – is in accord with the goals of the organisation. The premises undergirding the behavioural choices among inspectors and other regulatory agents might also be shaped in such a way that a broader orientation, across the boundaries of the agency’s own oversight domain, becomes a matter of course.

69 Contrary to what might be expected, physical integration is not the necessary result of an organisational merger. For an example, cf. A. Tollenaar, H.B. Winter, and J. de Ridder, Handhaving Verkeer en Waterstaat: instrumenten voor de handhaving van V en W toezichtsdomeinen en het gebruik daarvan (Groningen, 2011).
Section IV
Proposals

Chapter 10
Recapitulation

Inspection services and market authorities (henceforward simply: regulatory agencies) are complex organisations working in a regulated environment with the goal of ensuring that the regulations in that environment are effective. In the preceding sections we have discussed a number of risks and pitfalls of regulation and bureaucratisation, especially those that might lead the agency from being pushed into a risk regulation reflex process resulting in disproportionate interventions. When we discussed those risks we also mentioned some means to avoid pitfalls. Below we present a recapitulation of the most important conclusions:

1. An effective regulatory agency is an independent authority within the regulatory domain. Both qualities are not primarily the result of formal rules (although a clear legal position is helpful), but of characteristics such as expertise, purposefulness, integrity, and courage. The regulatory agency will be thoroughly familiar with the domain and will have the ability to make authoritative pronouncements about public safety risks and the threat of dangerous behaviour within the domain.

2. Within an effective regulatory agency there is a dynamic balance between professional discretion and the regulation of staff behaviour. This is necessary for critical self-reflection and checks and balances in the decision making structure of the agency, as a counterweight to the risks of standard operating procedures and professional passion.

3. An effective regulatory agency is aware of the limitations a constitutional democracy imposes on government interventions. Ideally, the regulatory agency is capable of producing individualised solutions within those limitations when responding to public safety threats and solving compliance problems. To that end the regulatory agency has a wide range of influencing instruments at its disposal, with formal penalties always a distinct possibility.

4. The regulatory agency can prevent or break a vicious circle of rules upon rules (regulatory creep, a typical risk regulation reflex component) by not taking as its point of departure the enforcement of rules but the public interests that those rules and the oversight are supposed to safeguard.

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Text 2

Case Study: Salmonella in smoked salmon

In the summer of 2012 smoked salmon from the Dutch company Foppen was found to be contaminated with salmonella. The Netherlands Food and Consumer Product Safety Authority (Nederlandse Voedsel- en Warenautoriteit or NVWA) started an investigation and the smoked salmon was recalled. They were unable to prevent customers from being affected: thousands fell ill and four people died. In a broader debate regarding the effectiveness of the NVWA in November 2012 and
January 2013 the Dutch Lower House of parliament (Tweede Kamer) responded to this incident and several similar ones in two ways.

On the one hand parliament requested more information about NVWA's enforcement capacity and the frequency of inspections by NVWA. This response was tantamount to political pressure to increase oversight, which could have meant the start of a risk regulation reflex process. Alternatively, the debate could also be interpreted as a parliamentary reconsideration of the drastic cut-backs at NVWA in the preceding years.

On the other hand the debates also revealed that many members of the Dutch parliament held NVWA responsible for the contaminations – some openly questioned NVWA's oversight practices – despite the fact that this assertion was not supported by evidence. The minister’s initial response was to place the incident in a broader perspective, saying that there was enormous stability in the Netherlands regarding salmonella outbreaks and that the government was taking all possible steps to prevent them. The minister's response can be viewed as a dampening of a risk regulation reflex process. A second such dampening contribution followed: in a response to a report by the Dutch Safety Board (Onderzoeksraad voor de Veiligheid or OVV) about the incident the minister argues that producers and dealers bear primary responsibility for food safety.

In the meantime the NVWA had completed an evaluation of its internal processes and implemented several improvements. The regulatory agency was proactive and acted without waiting for media reports or requests from politicians. This self-evaluation provided the minister with ammunition to counteract a possible risk regulation reflex from parliament. A regulatory agency that immediately carries out such a self-analysis following an incident can supply accurate information to the public debate and so prevent a risk regulation reflex process.

5. An effective regulatory agency has the ability to look outside its own oversight domain and so prevent or counteract the risk of jurisdictional compartmentalisation. It is important that the enforcement agents in the agency (the inspectors) develop the habit to always consider factors outside the limits of the oversight domain and the public interests entrusted to the agency.
Chapter 11
In Practice

In chapter 1 we observed that the risk regulation reflex is typically a category of policy processes that take place in an interactive system: the policy arena. Within this arena there are multiple parties, sometimes a large number, involved in a policy problem. Each party has its own goals and will act in accordance with those goals. Often this produces unpredictable output and sometimes no party is happy with it. Under ideal circumstances the regulatory agency in that policy domain fulfils the role of an independent authority that preferably anticipates and, when necessary, responds to incidents; a respected organisation that evaluates the facts and circumstances and reports them with authority and if needed recommends or implements measures. In this way the regulatory agency can make an important contribution to the rationalisation of the policymaking process.

This allows the regulatory agency to steer the debate by analysing an incident as a more general problem. One example of this – discussed in chapter 4 – is the response by the Netherlands Mine Authority after the explosion during gas drilling in the Gulf of Mexico. Another example is the case of the salmonella outbreak. After the Netherlands Food and Consumer Product Safety Authority (NVWA) had discovered smoked salmon contaminated with salmonella at the Foppen plant, they started analysing the case in the context of preventing salmonella contamination as a general task in the food industry. This response by the regulatory agency prevented the Foppen case from becoming a hype and devolving into a risk regulation reflex process.

Case Study: Chemiepack Moerdijk

On 5 January 2011 a fire broke out at the chemical storage plant Chemiepack on an industrial estate of the Dutch city of Moerdijk. Afterwards a large number of people – residents, firefighters, and emergency response personnel – needed medical assistance as a result of the fire. A substantial portion of the soil and the groundwater was polluted by the chemicals released in the fire as well as during the fire extinguishing operations. The Dutch Lower House (Tweede Kamer) responded promptly by scheduling an emergency debate for 13 January 2011, eight days after the fire. The tenor of the emergency debate was to call for closer oversight and stricter regulation. Parliament’s focus on closer oversight related to a passage in the governing contract between the coalition partners in the First Rutte cabinet that annoyed a substantial number of members of the Lower House:

Starting on 1 January 2011 there will be a so-called ‘inspection holiday’ for the business community. With adequate self-regulation (certification) fewer inspection interventions per company will be sufficient.

Despite explanations by the state secretary that the so-called inspection holiday did not apply to companies subject to the Major Accidents Risks Decree (BRZO), parliament insisted that a centralised control of oversight was required. During a committee meeting of the Lower House Committee on Enforcement and Licensing in September 2011 the state secretary reported that he was seeking a centralisation of oversight as well as a functional separation between licensing on the one hand and enforcement on the other.

The report from the Dutch Safety Board (OVV), which was published in February 2012, showed that the company gave little attention to safety and that the government agencies had not been sufficiently vigilant when issuing licences, providing oversight, and enforcing regulations. In their
response to the OVV report both the minister and the state secretary stressed that Chemiepack was the party with primary responsibility and that much progress had already been made. During Lower House debate about the report a motion was proposed to require at least annual unannounced inspections and provide for stricter regulations. The state secretary recommended against passing the motion because oversight was taking place based on risk analyses. This tempered the risk regulation reflex.

The Lower House (Tweede Kamer), on the other hand, reinforced the risk regulation reflex in this case. The House debated and constantly came to decisions based on limited information, drawing conclusions about causes before solid investigations had been completed. The proposed measures were, probably, disproportionate. Greater oversight and enforcement were seen as the ultimate solution to detected risks and centralisation seemed to be considered a panacea. The regulatory agency functioned as a scapegoat and does not seem to have been able to play an active role in this risk regulation reflex process.

Disproportionate responses to a public safety incident are frequently encouraged in the public debate in the media and in parliament. Often the public debate portrays tightening of the existing regulatory regime as the solution to all problems. Common demands are ‘a higher frequency of inspections’, ‘stiffer penalties for proven non-compliance’, and ‘more unannounced inspections’. The notion that a different, stricter regulatory regime could have prevented the incident was prominently present after the salmonella contamination case, the fire in Moerdijk, and the safety incidents at the Odfjell storage facility. In the Foppen case parliament demanded that the NVWA check for salmonella contaminations more frequently and hand out stiffer penalties. In the two other cases it was demanded that all relevant companies receive an unannounced inspection at least once a year, and here, too, stricter penalties were insisted upon. In the end, the policymaker succumbed to this pressure for companies subject to the Major Accidents Risks Decree (so-called BRZO companies).

As we remarked in chapter 1, oversight is by definition a derived responsibility. The primary responsibility for defending the relevant public interests and compliance with the relevant regulation lies with the regulated parties themselves. By putting such emphasis on the role of regulatory agencies, as is common in public debates, the danger arises that the responsibility of companies for their own internal and external safety is minimised. The case studies illustrate several instances where the regulatory bodies in the various policy domains do stress primary responsibility of the regulated parties. The Dutch Safety Board (OVV) pointed out in their reports on both the Chemiepack Case and the Odfjell Case that the responsibility for safety and compliance with the relevant regulation is with the companies themselves in the first place. In the formal responses to the reports by the OVV the Dutch cabinet echoed these sentiments.

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**Text 4**

**Case Study: Oil Leaks at Odfjell**

In September 2011 the media reported about leaks in oil storage tanks belonging to Odfjell in the Dutch Botlek area. This company consists of a large industrial estate with storage tanks that Odfjell bought in 2000. By that time, a number of the tanks was already between forty and fifty years old and nearing the end of its lifespan. Major maintenance was required and this necessitated large-scale investments. Feeling the need to remain profitable, the company limited expenditures on safety measures. According to media reports the relevant regulatory agency, the Joint Environmental Protection Agency in the Rijnmond region (Milieudienst Rijnmond or DCMR), was aware of frequent leaks. Members of the Dutch Lower House (Tweede Kamer) were shocked and demanded answers
from the cabinet. The state secretary calmed tempers: he informed the House that no extensive inquiry was needed and that the company was under constant supervision.

For two years after the first media reports the House continued to ask questions about and debate the matter at regular intervals. As a rule parliament’s actions were inspired by – sometimes speculative – media reports. Dutch MPs demanded immediate measures: a tighter control on the licensing process and oversight as well as stricter penalties if companies do not comply with regulations. On the whole, the parliamentary actions can be considered a catalyst for the risk regulation reflex. Successive Dutch cabinets gave tempering responses by indicating that the problems are under control and improvements are in the works.

In June 2013 the Dutch Safety Board (OVV) presented its report about the problems at Odfjell. One of the board’s conclusions was that the regulatory agency knowingly allowed the undesirable circumstances at the company to persist. Safety was not an integral component of business operations and there was a lack of urgency regarding safety at Odfjell, according to OVV. The cabinet adopted the Odfjell report and then proposed a set of measures. The cabinet believed that companies needed more stimuli to take more responsibility; they proposed a national enforcement strategy, a broader array of possible penalties, and greater centralisation by giving the state secretary for Infrastructure and the Environment greater authority.

After several hearings in parliament the total set of measures was completed at the end of 2013. This programme included, among others, increased centralisation and strengthening of the licensing process, oversight, and enforcement, as well as heavier penalties, and a more intense effort to cultivate a corporate culture of safety among companies working with dangerous chemicals, as mentioned above. In addition parliament insisted on an investigation (a so-called ‘quick scan’) of the public safety situation in all other companies subject to the Major Accidents Risks Decree (BRZO). MPs also demanded to be kept abreast of further developments. It cannot be ruled out that this set of measures may turn out to be disproportionate relative to the actual risk.

In chapter 8 we argued that professional passion introduces the risk that the regulatory agency will absorb too much responsibility. The regulatory agency may come to feel so responsible for and involved in the industry under its jurisdiction that the task of fostering the regulated parties’ primary responsibility falls by the wayside. One might expect that regulatory agencies that perform an internal inquiry after a public safety incident are prone to fall into this trap. The salmonella case we cited shows that this is not inevitable. The NVWA performed a critical evaluation its own actions preceding the outbreak and concluded that improvements were possible. This conclusion gave the state secretary ammunition to temper the risk regulation reflex in debates. The state secretary’s announcement that the regulatory agency had already concluded an internal inquiry and implemented reforms proved to be sufficient to prevent parliament from demanding far-reaching measures in the initial stages of the debate. MPs were prepared to await further inquiries.

It is remarkable that two of the incidents we discussed arose after deficiencies in enforcement (see chapter 4). In both the Chemiepack Case and the Odfjell Case the Dutch Safety Board concluded that the fire (Chemiepack) and the leaks (Odfjell) had been partly made possible because the responsible regulatory agency did not act after ascertaining non-compliance with regulations. In the report about the problems at Odfjell the Safety Board concluded that the Environmental Protection Agency (DCMR) was aware of the problem at the company and knowingly allowed this unsafe situation to continue. About the actions of the city of Moerdijk, the government body with oversight jurisdiction over Chemiepack, the board remarked that the city acted slowly both during the licensing phase and during the oversight and penalty phase even when the company failed to submit the correct documentation and after detecting non-compliance with regulation. Such deficiencies in enforcement can result from a shortage in enforcement capacity, a lack of safety and security awareness, a lack of expertise within the regulatory agency, as well as from interference from interests other than
environmental safety. The risk one runs with enforcement deficiencies is that it may lead to public demands for excessive enforcement. Efficient regulatory agencies will prevent enforcement deficiencies from occurring.

When, finally, a public debate leads to a set of policy measures, these should ideally be the product of mature consideration of an incident and its contributing circumstances. Proportionate measures are an indication that there was no risk regulation reflex or that a risk regulation reflex process did not prevail. Ideally the proposed measures are based on a cost-benefit analysis. In the case studies we presented it is difficult to put one’s finger on the origin and thought processes involved in the resulting policy measures. It is unclear on the basis of what analysis measures were developed. In the case of the Moerdijk fire and the problems at Odfjell it is also difficult to conclude whether the policy measures were based on solid investigations and a well-rounded consideration of all possibilities and available resources. We are not in a position to label the measures disproportionate, yet it is simply unclear whether they were the result of adequate consideration of all costs and benefits.
Chapter 12
Learning by Experience

In chapter 1 we discussed the concept of muddling through: the notion proposed by Lindblom that step-by-step policymaking is, in the end, the most rational form of government intervention. Don’t make drastic changes all at once, if you want to prevent big mistakes. If the intervention backfires the policymaker can make timely corrections. It is better to perform a controlled policy experiment first than immediately implement a new measure in its entirety. An incremental approach during the development and implementation phase of oversight policies could also promote the rationality of those policies—and hence the proportionality of oversight interventions.

Text 5
Case Study: The NODO Procedure

On 1 October 2012 a new directive requiring further inquiries into the cause of death of minors, the so-called NODO procedure (Nader Onderzoek Doodsoorzaak), went into effect in the Netherlands. This procedure was intended to establish the cause of death of minors. However, as of 31 December 2013 the procedure was abolished. It had taken six years of research, negotiation, and political and public debate before the directive came into effect. In 2006, when the responsible policymakers started developing the directive, the idea was that in case of a so-called ‘unexplained death’ of a minor further inquiries into the cause of death should take place. The local coroner could then start the NODO procedure. This autopsy would be paid for by the national government and, out of consideration for the next of kin, would be carried out by specialised medical experts. If the autopsy should lead to the conclusion that death was the result of non-natural causes, the public prosecutor would be notified. Thus, these further inquiries were initially only intended to determine a medical state of affairs. The suspicion of criminal conduct was possible, but only as a by-product.

During the development of the final policy, which was a rather chaotic process, the goals of the policy shifted. Gradually, the judicial goal (tracking down and prosecuting infanticide) became more prominent, at the expense of the medical goal. This shift was the result of research – among others by the Dutch Safety Board – and sensationalistic media reports about child death from non-natural causes, in particular as a result of child abuse. A large number of those deaths was alleged to go undetected. Changes that were made to the procedure led to the requirement that each unexplained death of a minor should be treated as if there were suspicions of criminal conduct. The NODO forensic expert, who was in charge of the further medical inquiry, would take legal possession of the remains which were then transferred to a NODO centre. Parents and other next of kin would be completely excluded from this procedure.

The available means for the NODO inquiries did not keep pace with the growing sense of urgency about this procedure. A plan for implementation, proposed in 2010, proved to be financially unsustainable. As a concession to the social sense of urgency the responsible policymaker decided to implement a light version of the plan. Instead of the planned five NODO centres only two were approved (in Amsterdam and Utrecht), leading to longer travel times and an extension of the time limits placed on the NODO inquiries. There was a lot of resistance against this version of the plan. Medical experts in particular warned about the drastic consequences for the next of kin. In view of this pressure the policymaker decided to implement the plan for a probationary period of one year during which the plan would also be continually evaluated.

Among the conclusions of the final report of that evaluation, published 11 October 2013, was the finding that the NODO inquiries were barely effective in detecting child abuse. In addition, it was
found that the NODO procedure was very time-consuming for the institutions performing the inquiries and that they entailed an unacceptable emotional burden for next of kin and caregivers. The real costs of the procedure were fifty percent higher than budgeted. In short, it was concluded that the NODO procedure was a disproportionate measure, considering the social costs and benefits. The responsible policymaker therefore suspended the implementation of the NODO procedure effective 1 January 2014. It remains unclear how treating physicians and forensic medical experts are now supposed to act in case of an unexplained death of a minor.

The experiences with the NODO procedure is a recent example of policy development in which the policymaker finally came to the conclusion that a bird in the hand is worth two in the bush. This measure was aimed to fight infanticide (see Text 5). The NODO procedure, a government directive enabling further investigations into the cause of death of minors, was initially conceived to gain greater medical insight into unexplained deaths of minors, such as cot death (SIDS). Social unrest about child abuse and infanticide caused criminal prosecution to become a more prominent component of the policy. It was telling that the Netherlands Ministry of Security and Justice increasingly started taking the lead, at the expense of the role of the Ministry of Health, Welfare, and Sport. Seen in this light, the developments surrounding the NODO procedure resemble those of a risk regulation reflex: the government’s approach became increasingly strict and intrusive as it responded to a series of alleged incidents.

The development and implementation of the policy was not incremental. On the contrary, the intention was to roll out the system across the country. A lack of funding forced the policymaker to a much more modest and experimental implementation, with an evaluation after one year. The evaluation showed that even the more modest version of the procedure was disproportionate: against very slight benefits in terms of crimes detected stood a high cost, both in terms of human resources and means required and the emotional burdens placed on parents and caregivers.

In the period preceding the implementation of the NODO procedure there were pleas for a monitored test in several regions. However, this would not have been permissible under prevailing law. This does not change the fact that it would have been wise to start with such a policy test. As early as 2006 there were differences of opinion about the exact number of cases of unexplained death of minors and of the number of cases of death from non-natural causes.

Some experts were convinced that the ‘dark numbers’ were high, while others believed that nearly all unexplained deaths were being reported. As a result there was no agreement about the level of effectiveness that should be expected from the measure in detecting otherwise unreported cases of child abuse and infanticide. In short, the theory behind the policy was not solid. Given such a high level of uncertainty a policy experiment can be a helpful tool to test measures incrementally. This took place de facto with the NODO procedure, albeit in an uncontrolled manner and probably against much higher costs than would have been the case with a proper policy test.
Chapter 13
Conclusion

In the discussion above we have tried to incorporate the most important elements of the role that regulatory agencies play in risk regulation reflex processes in a theoretically supported analysis. Among our points was the insight that the risk regulation reflex is not an isolated phenomenon. On the contrary, risk regulation reflex processes are a manifestation of the classic tensions that arise when defending public interests: the tension between justifiability and effectiveness; the tension between flexibility and equality before the law; the tension between individual and collective goals; and especially the tension that arises from the principled limitations inherent in all attempts to rationally justify government policy. This brings us, finally, to one important element of risk regulation reflex processes on which we have not yet touched: the tension between technical and political reality, expressed in the relationship between politicians and the civil service.

In the preceding chapters we have portrayed effective regulatory bodies as independent authorities, institutions capable of evaluating and controlling the risks within their policy domain with authority and unencumbered by specific interests. This idealistic portrait must be completed with the comment that independent regulatory agencies are ultimately under the oversight of other, political bodies: and only the legislature can change the laws that undergird the oversight activities. Political bodies have their own rationality, as we saw in the case study discussed in the previous chapter. The regulatory agency has the task to always serve the political authorities in an adequate manner, by informing, advising, and warning them. The dynamics of this relationship between politicians and the civil service are, perhaps, the thorniest area in the sphere of operation of regulatory agencies. These dynamics are usually invisible to the outside world. Nevertheless, what is valid for the relationships between the regulatory agency and the oversight domain is also valid here: the power to persuade derives from a moral authority based on knowledge and insight.
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