

THE PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA

# **THROUGH A GLASS, DARKLY**

## **Evaluation in Australian Health and Welfare Services**

**Report from the Senate  
Standing Committee on Social Welfare**

**VOLUME ONE**

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Evaluation of the adequacy of Australian health and welfare services with particular reference to:

1. standards of performance and provision of health and welfare services;
2. the pattern of current practice in the provision of such services in terms of need and demand;
3. mechanisms for evaluation of the effectiveness and efficiency of health and welfare services; and
4. requirements for ongoing evaluation as an integral part of the development of health and welfare service programs.

*(Referred by the Senate on 2 June 1976)*

For now we see through a glass, darkly; but then face to face: now I know in part; but then shall I know even as also I am known.

1 Corinthians 13:12

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## AN OVERVIEW

Ignorance is not innocence, but sin.

*Robert Browning*

Those who have studied the Australian health and welfare scene closely have noted the piecemeal, arbitrary state of the provision of human services. The system is like a giant jelly: it can be moved out of shape only with the maintenance of constant pressure; if the pressure is removed, the jelly resumes its usual and comfortable form.

In the following chapters, we discuss what has been occurring in evaluation and what has not; what has been done, what has been omitted and what is needed; and we discuss ways by which one can assess different health and welfare interventions. Mostly, these methods of assessment are not used in Australia, and we have little idea of whether our health and welfare efforts are appropriate, effective, efficient or equitable.

One sees in health and welfare in Australia a system out of control—part of a larger crisis in administration; certainly out of the control of the individuals it is supposed to serve and of the institutions and political agencies to which we look for national management. It is also probably out of the control of the public servants immediately responsible for its management and of the agencies actually delivering the services. This judgment, however, must be viewed in the context of what appears to be a more general problem which probably extends beyond health and welfare and beyond the public sector.

The 'arts' of administration and organisation are currently going through a process of great upheaval and adjustment. Modern government and business are raising problems of diversity, size and technical complexity never before encountered. Evaluation may be seen in this general context of helping organisations adapt to what is certainly a changing environment.

A generally poor framework of social theory is possessed by many politicians, bureaucrats and agency managers and by the community in general. This background deficiency may lead us unwittingly and far too often to inappropriate, unsympathetic, ungenerous and ineffective interventions in our social system. These prospects are not helped by many powerful managers who possess an associated thinly veiled 'poor law' philosophy, and cling to concepts of 'deserving' and 'undeserving' poor and of welfare as a charity—all inappropriate in a nation undergoing the structural and functional changes that we see in Australia today. There are good grounds for believing that present needs differ markedly from those of a decade ago. Today's needs, again, are likely to bear only approximate similarity to needs a decade hence. Too many decision makers are unaware of these changing needs and are certainly not equipped to respond to them.

Evaluation is one tool to help us understand what is going on. It is a tool becoming better appreciated and recognised in Australia today, but it is still far too little applied and seldom funded. Further, there is not an appropriate context—nor are there the structures and processes needed—for development of evaluation activity. Thus present evaluation activity is not part of a coherent approach, nor yet one step along the road to the solution of great social problems.

We should not expect evaluation by itself to rationalise health and welfare services; nor should we on the other hand assign it too little value. It can, however, be seen as part of a more general effort to provide better, more responsive and more accountable services.

It is the belief of the Committee that the health and welfare system, unless it gains in rationality, will not meet the requirements of the Australian people at an acceptable standard or with the degree of comprehensiveness of services and support that they desire and deserve.

Further, we need to acknowledge the value frame that we, as a Committee, bring to this exercise. There are those who would seek the destruction of the present social system, and there are others who assert that governments have no role in health and welfare. We have in fact accepted as valid for our task the present framework in which society operates. We have assumed that the system is, at least in the short and medium term, stable as regards its basic structure. We therefore accept that the funding and provision of health services and of social welfare will continue to be major government activities, whether the total resources of manpower and money, and the depth of commitment, increase or decrease. We seek, in short, to address the question of how the present system of health services and social welfare can be made more equitable, more rational, more efficient and more effective.

## PART ONE

# THE RATIONALE OF THE REPORT

This report asserts that, in order to achieve an efficient, effective, rational and equitable health and welfare system, it is necessary to conduct ongoing evaluation.

Evaluation need not be confining. There is a wide range of possible evaluation methods and no need for any program to be confined to one prescriptive format. Evaluation reports can make it possible to improve programs and rectify mistakes and, at times, they may indicate a need for program termination.

The benefits derived from evaluation include increased accountability of decision makers, improvement in the decision-making process, more effective use of resources, and enhancement of the capacity of organisations to strengthen their bids for additional resources. The consequences of not evaluating are possible indiscriminate cuts in funds, indiscriminate handing out of funds, continuance of the present ad hoc decision-making process, perpetuation of the present inadequacies in the health and welfare system, and a possible lack of alternative solutions to problems in health and welfare.



## Why evaluate

The aim of this chapter is to examine efficacy and accountability, which are the two critical aspects of evaluation. Without evaluation we cannot know whether a particular program is achieving anything at all or whether, for example, its effects are the reverse of its stated objectives. We assert that evaluation is an essential tool of the decision maker.

There are several types of decision maker who require information. Funding bodies need to know the degree of success of an innovation so that they can make decisions about whether funding should continue. Program staff need data on the effectiveness of a program so that they can modify it if necessary. Interested groups need information to judge the worth of a program so that they may make decisions about the appropriateness and likely effects of taking similar action. Program clients and the community in general may indirectly affect decision making and would also be interested in the information provided by evaluation.

Evaluation is also a check on the decision maker. It increases the total amount of accountability. Without it, those who supply resources for programs, by either taxes or donations, cannot know whether those resources are being used effectively or efficiently. Without evaluation, we cannot be sure whether those to whom we entrust much power and great resources are acting responsibly.

In 1976–77, health and welfare services consumed about \$13 000m or some 16 per cent of gross domestic product (GDP) (see Table 1.1, page 9). Recent reports have shown that this money is not always used effectively (see pages 7–8). It is therefore particularly important that ongoing evaluation be an integral part of health and welfare programs. Only by the delineation of objectives determined by measurement of community need, and the setting of standards for progress toward those objectives, can we establish a process of assessment that will allow us to increase the total level of accountability and know how effectively we are spending such vast sums of money.

In the final analysis, we need to acknowledge that health and welfare policies, their development, their implementation and their evaluation, occur in relation to similar activities in other sectors. Activity in these other sectors affects the opportunities for, and the outcomes of, health and welfare programs. For example, a policy designed to improve health by decreasing smoking in the community may conflict with a policy to give subsidies to tobacco growers. The two policies may seek to use the same resources and may be mutually incompatible in the goals they seek to satisfy. Policies developed in employment, corrective services and many other areas may enhance or impede the attainment of health and welfare goals. To some extent, then, we need to be aware of activity, goals and achievements across many sectors if we are to reach a comprehensive understanding of our achievements in any one sector.

### What is evaluation?

We have accepted as a good working definition of evaluation the following statement:

Social program evaluation is the process of thoroughly and critically reviewing the efficiency, effectiveness and appropriateness of any program or group of programs.<sup>1</sup>

Evaluation activities range from a rigorous, scientific exercise to an informal thinking process on the part of some or all of the persons involved in a particular program. A discussion on this range of activities is found in Chapter 8.

The purpose of evaluation is 'to provide evidence of the outcome of programs so planners can make wise decisions about those programs in the future'.<sup>2</sup>

The essential prerequisites for programs and their evaluation are:

1. the formulation of statements of *needs*;
2. the formulation of statements of *objectives and strategic goals*;
3. the formulation of statements of criteria or *standards* for evaluating progress toward those objectives;
4. the development of a *data* base for providing measures of those criteria.

A full discussion on each of these prerequisites is found in Chapters 4, 5, 6 and 7 respectively.

Throughout this report, we shall work from this understanding of evaluation. We are, of course, aware of other understandings.

### **Evaluation and accountability**

The broad definition of accountability is 'responsibility for something to someone with definite consequences attached'.<sup>3</sup>

The Committee commences this consideration of accountability by examining it at the highest level—that is, at the level of ministerial accountability. The principle of accountability is fundamental in a democratic government. The doctrine of accountability in government—generally referred to as ministerial responsibility—contains, in an ideal situation, two propositions:

1. Each Minister is responsible to Parliament for the operations of his department.
2. Cabinet is collectively responsible to Parliament and the electorate for the conduct of government.<sup>4</sup>

The concept of ministerial responsibility has been modified, however, by a number of developments, including the following:

1. A minister can be responsible for an area of administration so vast that it covers a wide range of subjects, a large, scattered geographic area and a client group with many interests.
2. Decisions have become more complex, for technical and political reasons.
3. The number of public measures implemented has grown vastly and problems of implementation and enforcement have increased.
4. The demands for public consultation and participation have grown rapidly, reflecting an increase in the number of groups and people who expect to be consulted and a change in the notion of democracy and its processes.

These factors have particular implications for public servants. It is not easy to dismiss the popular notion that there is a vacuum in which no one takes responsibility for many decisions. If ministerial accountability has been modified, where has the missing element gone? One possibility is that public servants have been put in a situation in which their level of decision making has increased without a commensurate increase in their level of accountability. This situation is illustrated by a comment made by the Royal Commission on Australian Government Administration:

The theory of the Westminster system asserts that the minister is wholly responsible for all actions in matters within his department, but in fact much responsibility lies with officials. It is important that this be acknowledged, the nature and extent of the responsibility be clarified as far as possible, and procedures established to assess performance and to provide that those responsible at all levels will be accountable for their performances. Unless this is done no one can justly be regarded as responsible and no one can fairly be called to account for failure or poor performance.<sup>5</sup>

Parliament is the body responsible for ensuring that public servants are accountable for their actions and that Ministers retain their level of accountability to Parliament and people. Clarification of procedures and reallocation, or addition, of resources will be needed from time to time to enable the concept of accountability to retain its meaning. There is increasing doubt about the ability of Parliament to bring to account Ministers and public servants.

The principle of accountability applies also to non-government organisations. To enable our democratic system to function in a responsible manner, all bodies that accept money from governments or from public appeals must honour a social obligation to be accountable to the public and to accept responsibility for what they do.

The health and welfare sector is currently consuming about 38 per cent of total Commonwealth outlay, and consumed about 16 per cent of gross domestic product in 1976-77 (see Table 1.1, page 9). It is therefore particularly important that this sector be accountable. The economic aspect is only one parameter. Evaluation should take place even where it may have little significance in terms of money goals or GDP.

At present, accountability in the health and welfare fields is largely confined to the narrow process of proving that funds have not been misappropriated. There have also been some one-off, ad hoc evaluation studies. Organisations must demonstrate to governments and to the public that they provide efficient and effective services. Effectiveness can be assessed adequately only by stating outcome objectives clearly and determining whether those objectives are being achieved.

Accountability is sometimes rejected by health and welfare workers because its application is believed to be rigid and confining in a field that attempts to serve a multitude of human reactions and feelings. However, we share the belief that, in dealing with human beings, it should be possible for accountability to be freeing and facilitative rather than restrictive.<sup>6</sup>

### **Inadequacies in the health and welfare system**

An attitude of complacency about health and welfare services in Australia must not be allowed to develop. It must not be assumed that these services are 'doing good' and that evaluation is therefore unnecessary. Descriptions of the state of the health and welfare system given in some recent reports show that it is far from perfect and that there is cause for concern about some services. For example, the Royal Commission on Australian Government Administration commented:

Despite well intended and intensive efforts, there is a lack of coherence in policy making and planning for health and welfare services in Australia, within and among the levels of government and the private sector.<sup>7</sup>

The Task Force on Co-ordination in Welfare and Health stated:

... we have found evidence of a degree of overlap, duplication, proliferation and excessive administration with regard to Commonwealth programs.<sup>8</sup>

Comments about service delivery were made by the Commission of Inquiry into Poverty when discussing concern about the rationalising of health services:

. . . concern . . . arises from the difficulty of integrating emerging or re-emerging concepts with practice, the manifest inability of services to deal effectively with current health problems, the result of disorganised incremental planning and the rising costs of curative care.<sup>9</sup>

Dr Lois Bryson, in a paper prepared for this Committee, reviewed the major reports in which client interactions with welfare agencies have been studied, and concluded:

What comes through loud and clear from this data on the negative aspects of welfare services is that many clients are not being well served. Even if services have been improved in the few years since most of these studies were reported it seems there was such a distance to go that it is unlikely that the problems will have been eliminated.<sup>10</sup>

Although this Committee did not specifically investigate the state of the health and welfare system, we did gain some general impressions and were appalled at the failure of most health and welfare services to state their objectives and at their lack of concern about effectiveness. Our observations and the criticisms cited above all illustrate clearly the need for ongoing evaluation of services.

### Expenditure on health and welfare

Estimates of total annual expenditure on health and welfare services in Australia are given in Table 1.1, which is derived from the tables in Appendix 1.

*Table 1.1* Estimates of government and private expenditures on health, and of government expenditures on social security and welfare, Australia

(Expressed in millions of dollars and as a percentage of the total outlay by each government sector for all its purposes.)

Government and private expenditures on health																
	1970-71		1971-72		1972-73		1973-74		1974-75		1975-76		1976-77		1977-78 <sup>(P)</sup>	
	\$m	%	\$m	%	\$m	%	\$m	%	\$m	%	\$m	%	\$m	%	\$m	%
Commonwealth	559	7.2	685	7.9	781	8.0	939	7.9	1 276	7.4	2 943	13.7	2 537	10.5	2 693	10.0
State	513	10.5	590	10.4	677	10.7	920	12.2	1 415	13.2	2 164	16.6	2 549	17.0		
Local	17	2.2	20	2.3	23	2.4	28	2.5	34	2.2	42	2.3	46	2.3 <sup>(P)</sup>		
State & Cwlth other	3		5													
Private	1 256		1 460		1 628		1 837		2 322		2 567		3 130			
Less																
Cash benefits	410		508		581		659		817		1 369		1 140			
Cwlth Govt grants	18		18		21		52		108		1 083		853			
Other	3		5		5		5		14		29		36			
Total Health	1 917		2 229		2 502		3 008		4 108		5 235		6 233 <sup>(P)</sup>			
Per cent gross domestic product	5.8		6.0		6.0		5.9		6.8		7.3		7.6 <sup>(P)</sup>			

Government expenditures on social security and welfare

	1970-71		1971-72		1972-73		1973-74		1974-75		1975-76		1976-77		1977-78 <sup>(P)</sup>	
	\$m	%	\$m	%	\$m	%	\$m	%	\$m	%	\$m	%	\$m	%	\$m	%
Commonwealth	1 377	17.7	1 594	18.5	2 101	21.6	2 489	20.9	3 654	21.0	4 914	22.9	6 352	26.4	7 404	27.5
State	66	1.3	95	1.7	122	1.9	128	1.7	171	1.6	215	1.7	260	1.7		
Local	4	0.6	5	0.6	6	0.6	10	0.9	14	0.9	20	1.1	24	1.2 <sup>(P)</sup>		
Less																
Cwlth Govt grants	10		43		126		30		69		80		37			
Total government social security & welfare	1 437		1 651		2 103		2 597		3 770		5 069		6 599 <sup>(P)</sup>			
Per cent gross domestic product	4.3		4.5		5.0		5.1		6.2		7.1		8.0 <sup>(P)</sup>			

Government expenditures on health, social security and welfare and private expenditure on health

Commonwealth	1 936	24.9	2 279	26.4	2 882	29.6	3 428	28.8	4 930	28.4	7 857	36.6	8 889	36.9	10 097	37.5
State	579	11.8	685	12.1	799	12.6	1 048	13.9	1 586	14.8	2 379	18.3	2 809	18.7		
Local	21	2.8	25	2.9	29	3.0	38	3.4	48	3.1	62	3.4	70	3.5 <sup>(P)</sup>		
State & Cwlth other	3		5													
Private health	1 256		1 460		1 628		1 837		2 322		2 567		3 130			
Less																
Health cash benefits	410		508		581		659		817		1 369		1 140			
Cwlth Govt grants	28		61		147		82		177		1 163		890			
Other	3		5		5		5		14		29		36			
Total government health, social security and welfare, and private health	3 354		3 880		4 605		5 605		7 878		10 304		12 832 <sup>(P)</sup>			
Per cent gross domestic product	10.1		10.5		11.0		11.0		13.0		14.4		15.6 <sup>(P)</sup>			

<sup>(P)</sup> = Provisional.

Source: Appendix I shows how these figures were derived and gives a complete list of the sources.

This table must be regarded as presenting very conservative estimates of expenditure on health, social security and welfare, because it is impossible to obtain figures for the following categories:

1. expenditure on welfare in the private sector;
2. expenditure which may reasonably be considered to be welfare expenditure, though not included in welfare statistics—for example, housing outlays;
3. transfer payments from State to local governments;
4. transfer payments from local to State governments;
5. untied grants from all levels of government which have been used for health and welfare purposes.

Payments in the last three categories will not affect the total estimates for health, social security and welfare but they will cause an underestimate of the outlay of the government sector from which they come.

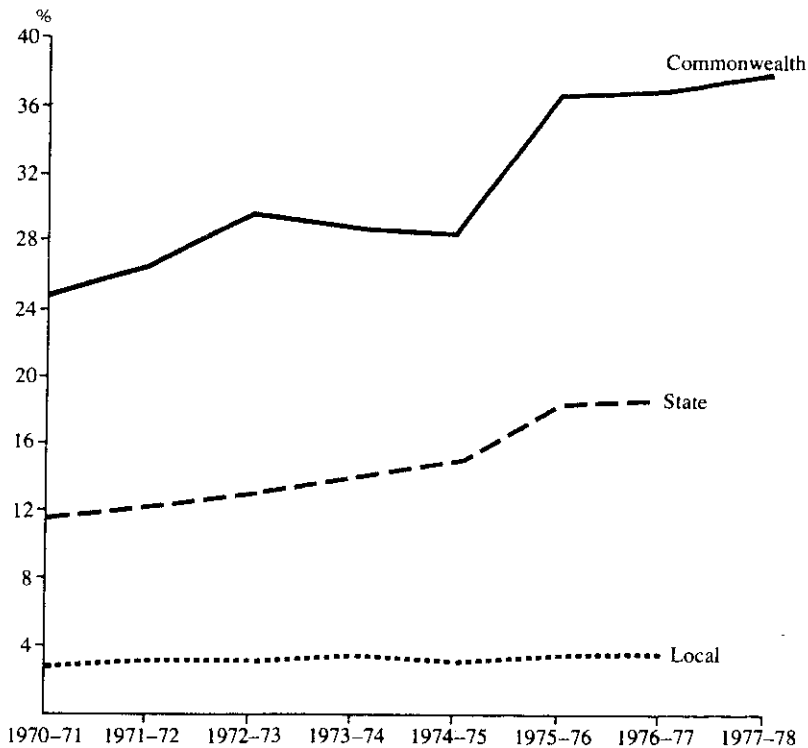
Furthermore, there are available almost no data on the extent to which industry, union, co-operative or other associations contribute to the meeting of welfare needs.

Table 1.1 shows expenditure, at all levels of government, on health, social security and welfare as defined by the Australian Bureau of Statistics.<sup>11</sup> For the private sector, health expenditure only is shown, as welfare figures are not available for this sector. For 1976-77—the last financial year for which most figures are available—total expenditure on health and welfare is estimated at almost \$13 000m. This represents almost 16 per cent of gross domestic product. Altogether, 81.7 per cent of government expenditure on health, social security and welfare was met by the Federal Government. State government expenditure, excluding Federal grants, represented 17.6 per cent and local government expenditure 0.7 per cent. Of all health expenditure in 1976-77, the Federal Government contributed 40.7 per cent. Excluding grants from the Federal Government, the States contributed 27.3 per cent. The local government share was 0.7 per cent. Excluding cash benefits to individuals, and other transfers from governments, the private sector accounted for 31.3 per cent. The Federal Government contributed 96.3 per cent of total government expenditure on social security and welfare. Excluding grants from the Federal Government, the States contributed 3.4 per cent. Local government accounted for 0.3 per cent.

These figures establish the necessity for significant Federal and State government roles in evaluation activity.

The Federal Government's expenditure on health, social security and welfare rose steadily from more than \$1900m, or almost 25 per cent of its total outlay, in 1970-71 to more than \$10 000m, or about 38 per cent of its total expenditures, in 1977-78 (see Table 1.1 and Figure 1.1).

*Figure 1.1 Commonwealth, State and local government expenditures on health, social security and welfare as a percentage of the total outlay by each government sector for all its purposes, Australia*



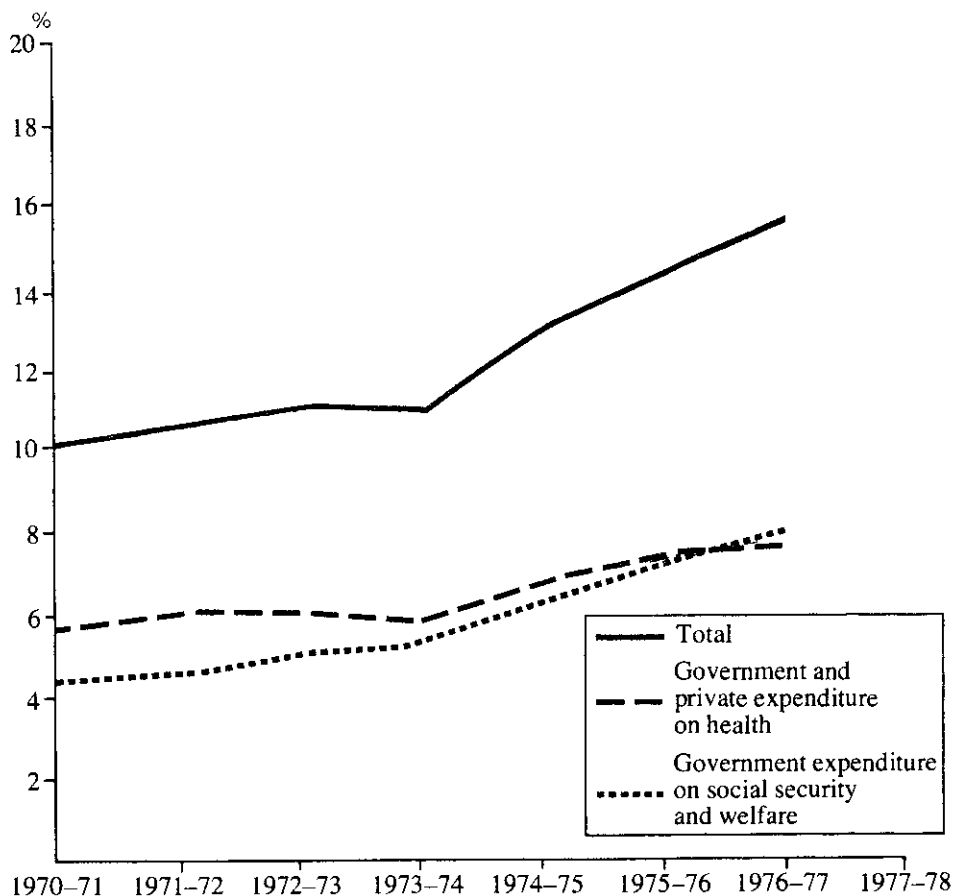
Source: Australian Bureau of Statistics (see Appendix 1)

It is estimated that the cost to the Federal Government in 1978-79 will be some \$10 928m—again about 38 per cent of Commonwealth outlays. Compared with other estimated Federal outlays for 1978-79, social security and welfare (\$8015m) and health (\$2913m) rank first and second, above defence (\$2501m), education (\$2498m), general public services (\$1927m) and economic services (\$1753m).<sup>12</sup>

Health, social security and welfare outlays by the States rose from 11.8 per cent of their total expenditures in 1970-71 to 18.7 per cent in 1976-77. Local government expenditure on health, social security and welfare has remained fairly constant at about 2.5 per cent of total outlays (see Table 1.1 and Figure 1.1).

Trends in expenditures on health and on social security and welfare as percentages of GDP are shown in Figure 1.2. Expenditure on health rose from 5.8 per cent of GDP in 1970-71 to 7.6% in 1976-77, and social security and welfare expenditures from 4.3 per cent to 8 per cent. Total expenditure on health, social security and welfare increased from 10.1 per cent of GDP to 15.6 per cent over the period.

Figure 1.2 Government and private expenditures on health, and government expenditure on social security and welfare, as a percentage of gross domestic product, Australia



Source: Australian Bureau of Statistics (see Appendix 1)

While the Committee would like to have made some international comparisons, there appears to be no basis of comparability. This matter has been considered by a Working Party of the Economic Policy Committee of the Organisation for Economic Co-operation and Development. This Working Party published figures on health and income maintenance programs for various countries but expressed caution about the validity of comparing the figures. In reference to the published health figures, it said that 'the cross-country comparisons . . . often rest on shaky foundations'.<sup>13</sup> In regard to the published income maintenance figures, the Working Party commented:

The complexity of countries' programs in this field, the variety of objectives to which they are aimed, and the role of other public programs and policies in pursuit of these objectives, is so great that the statistical comparability of the data presented in this report, even if it were perfect, would not be enough to engender clear-cut conclusions about the role and the efficiency of income maintenance in achieving its aims.<sup>14</sup>

For all these reasons, we have chosen not to proceed further with an analysis of such figures as OECD has produced.

A recent survey, from which came a report entitled *National Health Account—A Study*, was conducted jointly by the Commonwealth Department of Health, the Australian Bureau of Statistics and W. D. Scott and Co. Pty Ltd to determine health costs for the financial years 1974–75, 1975–76 and 1976–77. The methodology used was different from that employed by the Australian Bureau of Statistics, which records public expenditure made as cash payments but does not record the cost of the services provided. Table 1.2 shows the difference between figures for total health expenditure obtained by each methodology. It will be noted that estimates derived from the National Health Account study are larger than ABS figures, and more accurate as they are based on service costs.

Table 1.2 Estimates of total health expenditure, Australia

	1974–75	1975–76	1976–77
	\$m	\$m	\$m
National Health Account Study figures:			
Expenditure . . . . .	4158	5680	6474
Per cent of gross domestic product . . . . .	6.86	7.97	7.87
ABS figures:			
Expenditure . . . . .	4108	5235	6233
Per cent of gross domestic product . . . . .	6.78	7.34	7.58
Difference:			
Expenditure . . . . .	50	445	241
Per cent of gross domestic product . . . . .	0.08	0.63	0.29

Source: National Health Account—A Study (Canberra, 1978) and Table 1.1.

Though the ABS figures do not have the same accuracy as the National Health Account study figures, they do give a reliable picture of trends and the order of magnitude of expenditures.

Unfortunately, there is no comparable study for welfare and it is therefore not possible to make a better assessment of total health and welfare expenditure. The fact that accurate and complete figures cannot be obtained for health and welfare points clearly to the need for more resources to be applied to the collection of data in these fields. A full discussion on data appears in Chapter 7.

From all of this emerges the fact that expenditure on health and welfare is large and increasing. Evaluation of that expenditure is therefore vital.



## **Benefits of evaluation**

### *Decision-making process*

The principal value of evaluation is that it improves the decision-making process by providing a rational base from which judgments may be made. At present, many decisions at government level are made on an arbitrary and ad hoc basis and are not capable of analysis and rational justification. Mr J. Urbano, Chief Psychologist of the former Department of Employment and Industrial Relations, has commented:

Decisions about developing and implementing social action programs have generally not been made on the basis of empirical results but rather on the basis of what is thought (or hoped) will happen.<sup>15</sup>

This has occurred either because such empirical results as have been available were obtained from ad hoc, one-off evaluation reports which are inadequate for formulating decisions (see Chapter 2) or, more commonly, because the necessary empirical results have not been available.

Evaluation also improves the decision-making process by enabling governments to assess:

1. the need for new services;
2. the performance and impact of their own programs;
3. the performance and impact of non-government services that receive government money;
4. alternative ways of achieving a desired result;
5. the likely impact of proposed programs.

Evaluation would also enable Commonwealth and State Parliaments to endorse or challenge government initiatives on a rational basis, thereby improving the standard of national debate and raising levels of understanding.

The decision-making process at service levels also is improved by evaluation. If all health and welfare workers carefully study their own service evaluations and the evaluation reports of related services, they will be able better to assess:

1. the need for a particular type of service;
2. the impact of their services on the community;
3. their own performance;
4. alternative ways of achieving their aims.

Evaluation by service organisations would benefit them by providing rational arguments for use in submissions seeking government funds. By outlining the results of their own evaluation studies, organisations would be able to give more force to their submissions.

### *Alternative health and welfare solutions*

Evaluation is often a very important form of social research. Alternative remedial or helping programs will often be suggested by the examination of program deficiencies or of needs not met by current programs. Evaluation activity can help practitioners to avoid the trap of defending a program primarily because no other action has suggested itself.

Evaluation, as well as being a critical process, can be a creative process leading to the discovery of need and unmet need and to the predication of alternative objectives and actions.

### *Cost benefit of evaluation*

Despite recent evaluation activity in Australia, determination of the cost benefit of evaluation is still largely impossible. However, one study in the United States of America assessed the cost benefit of applied social research by comparing the social benefit of programs having an investment in applied social research averaging about 1 per cent of program cost with the social deficit that would have resulted without such investment. In this study, applied social research was regarded as a process of considering needs and demands, reporting the findings to government and assessing the social programs devised.<sup>16</sup> This is, in fact, a fair statement of the meaning of evaluation.

In the eleven years from 1965 to 1975 inclusive, the United States Federal Government spent approximately US\$7400m on applied social research related in some way to US\$1 000 000m worth of social programs.<sup>17</sup> With high investment in applied social research, the programs surveyed produced a net social benefit of about \$700 000m. Without applied social research, the same programs would have produced a net social deficit of about \$200 000m. It was concluded, therefore, that the total benefit of applied social research was about \$900 000m. As its cost was some \$7400m, the ratio of benefit to cost was well over 100:1.<sup>18</sup> This is an impressive demonstration of cost benefit, and a compelling reason why evaluation should be an integral part of programs.

### **Consequences of not evaluating**

#### *Indiscriminate cuts in funds*

It is obvious that the proportion of government expenditure devoted to health and welfare services cannot continue to rise constantly and steeply as shown in Table 1.1 and Figure 1.1. For some health and welfare areas, the share of expenditure will continue to increase; for others, therefore, the share will have to be reduced. While indiscriminate cutbacks might occur in any program, those programs that can demonstrate objectively some benefits for society may better resist the cost-cutting process.

#### *Continuance of the present ad hoc decision-making process*

Without evaluation, the present situation of ad hoc decision making at the government level will probably continue to bedevil health and welfare services. Bad decisions made at this level not only are wasteful but also may be harmful, because in practice a decision to spend in one area is a decision not to spend in another. Without careful and continual demonstration of the level and extent of unmet need, areas needing investment in essential services not presently provided may remain unidentified. Lack of evaluation prevents governments from recognising their mistakes and also allows them to cover up for bad decisions.

#### *Perpetuation of the present inadequate health and welfare system*

Without evaluation, there is no way of knowing who gets what from any program or whether the benefit of a program is equitably or efficiently distributed; consequently, inadequacies and inequalities in the health and welfare system will be perpetuated. Services will continue to overlap, resources that could be used more productively will be wasted, possibilities for alternative solutions will be overlooked and indiscriminate public funding of inefficient and ineffective services will continue. The most articulate bidders will continue to obtain the greatest share of resources. Improvements in services will be difficult to achieve internally, because there will be no way of knowing where inadequacies exist.

In order to achieve a more equitable, efficient, effective and accountable health and welfare system, all providers of services have a responsibility to conduct ongoing evaluation.

### Summary and conclusions

All health and welfare providers should conduct ongoing evaluation in order to fulfil their responsibility to be accountable for the services that they provide. Only then can the health and welfare system operate in a rational manner. Evaluation improves the decision-making process, both at the program-planning level and in the agencies, and enables all services to operate more efficiently and effectively. It also provides rational arguments to enable organisations to strengthen their bids for funds and resources. The consequences of not evaluating include indiscriminate policy decisions and inability to plan rationally for the development of the health and welfare system.

The essential prerequisites for evaluation—that is, the determination of needs, the setting of goals and objectives, the establishment of standards and the collection of appropriate data—are at present given low priority. The current level of activity relating to them is totally inadequate for ongoing evaluation.

The evidence shows that too little ongoing evaluation is being conducted. Most of the evaluation that is undertaken consists of one-off, ad hoc studies which are inadequate for effective decision making. It is imperative that proper evaluation occur in order to provide information essential to the proper planning of the health and welfare system and to the efficient and effective operation of agencies.

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14. Organisation for Economic Co-operation and Development, *Public Expenditure on Income Maintenance Programmes* (Studies in Resource Allocation, No. 3) (Paris, 1976), p. 17.
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## PART TWO

### EVALUATION IN THE AUSTRALIAN CONTEXT

Evaluation has never played an important part in the operation of the health and welfare system in Australia. Before 1973 there was an almost complete absence of formal evaluation. There had been a few inquiries into various aspects of the health and welfare system, but these could not be considered as adequate evaluation exercises. In recent years there has been a movement toward conducting large-scale inquiries (Toose, Henderson, Bailey—see Table 2.1, page 27), but these have been one-off, ad hoc studies rather than ongoing evaluation activity.

Our evidence, taken at numerous public hearings, has indicated a general and encouraging desire on the part of those engaged in health and welfare services to do more to measure and assess the efficacy and efficiency of their services. Some service departments have recently established evaluation sections, and evaluation seminar activity has increased markedly of late. In the non-government sector, the development of skills, and the arranging of seminars, related to evaluation in health and welfare, and the production of evaluation material, have become noticeable. Unfortunately, officials in the Departments of the Treasury and Finance who are engaged in the development of broad economic policy have shown much more interest in evaluation limited to budgetary and audit functions than in evaluation concerned with the effectiveness of the budgetary allocations under their control.

Overall, we conclude that evaluation activity in Australia remains inadequate in amount and deficient in quality.

## History of evaluation in Australia

The first section of this chapter traces the history of evaluation from 1901 to 1972 and shows that there was almost no formal evaluation during this time. The next section, entitled 'Evaluation Activity from 1973 to mid 1978', describes activity from 1973, when evaluation began to occur. It shows that such evaluation as there has been has consisted of one-off, ad hoc studies which are not adequate for decision making.

### EVALUATION ACTIVITY FROM 1901 TO 1972

The need for systematic planning and evaluation was apparent early in this century. The Commonwealth Department of Health Annual Report 1970-71 states:

. . . when the Maternity Allowance Act was introduced in 1912, people soon began to ask if the \$1 million spent annually under the scheme could not be better spent in improving the health of mothers and reducing the risks of child-birth. It was evident that the benefits of the Maternity Allowance Act were not improving the maternal mortality rate.<sup>1</sup>

However, before 1970 there was very little systematic planning or evaluation in Australia.

The Committee considers that the main prerequisites for systematic planning and evaluation are:

1. determination of needs;
2. delineation of goals and objectives for programs and groups of programs;
3. delineation of criteria or standards for evaluating progress toward those objectives and for assessing the competing claims of proposed programs;
4. development of a data base for providing measures of those criteria, through a process of monitoring the programs;
5. application or appropriate use of findings.

When social welfare programs were being formulated and implemented before 1970, one or two of these prerequisites were observed sometimes but seldom all five together. The following accounts illustrate this.

#### Commonwealth Department of Health

Dr J. H. L. Cumpston, the first Director-General of the Commonwealth Department of Health, stated:

. . . the proper objective of governmental (health) administration was . . . nothing less than positive health, freedom from all illness and disability for every individual human unit in the community.<sup>2</sup>

Although unattainable, this is an example of a government stating a broad strategic goal. It is notable, however, that no periodic evaluation was made so as to determine whether this goal was being achieved. In fact, no real assessment of the general health of the population has ever been made. The morbidity figures collected by the Department were—and still are—inadequate.

### **Nutrition survey**

The most notable attempt to assess need during the period under review was a three-year survey conducted by the Advisory Council on Nutrition.<sup>3</sup> Six reports were written, the final one being presented in 1939.

The method used by the Council to measure nutrition was to ask a representative sample of the population in each capital city to keep a record of what was consumed in the home. The length of time that the records were kept varied from one month to one year. Altogether, 1789 households were included in the sample. The survey depended on the co-operation of families, and for this reason the sample may not have been truly representative.

This survey provided a data base which enabled the Council to outline what it perceived as needs. Its recommendations were designed to satisfy those needs. Some of the recommendations were implemented but no follow-up survey was conducted to assess the effects on the level of nutrition in the community. In the 1970s, Australia still lacks a declared government policy on, and goals for, the nutrition of its population.

### **Report on unemployment insurance in Australia**

A report by Mr Godfrey Ince, Chief Insurance Officer of the British Ministry of Labour, which outlined proposals for an unemployment insurance scheme, was presented to the Commonwealth Government in 1937.<sup>4</sup> Mr Ince had no precise knowledge of the need that existed. He commented: 'Satisfactory statistics as to the volume and extent of unemployment in Australia are not available . . .'.<sup>5</sup> His report did, however, contain stated objectives for the proposed unemployment insurance scheme. The stated outcome goal was 'to enable a workman to tide over spells of unemployment due to trade fluctuations and to maintain himself and his family until he again obtains work'.<sup>6</sup>

The report also stated process goals:

The three main general principles to be followed are:

- (1) That the scheme should cover as large a number of persons as possible exposed to the risk of unemployment.
- (2) That on the occurrence of unemployment persons should have a right to receive payments in return for contributions paid.
- (3) That the contributions and benefits should be so adjusted that income is sufficient to meet expenditure, including administrative expenses.<sup>7</sup>

However, the scheme was never introduced.

### **Joint Committee on Social Security**

The Joint Committee on Social Security was appointed by the Commonwealth Parliament on 3 July 1941 'to inquire into and, from time to time, report upon ways and means of improving social and living conditions in Australia and of rectifying anomalies in existing legislation'.<sup>8</sup> The Committee sat from 1941 to 1946 and during that time presented nine interim reports on the following aspects of social security and welfare:

1. Social security planning and legislation.<sup>9</sup>
2. Unemployment and war emergency.<sup>10</sup>
3. Consolidation of social legislation and post-war employment.<sup>11</sup>
4. Housing in Australia.<sup>12</sup>
5. Reconstruction planning.<sup>13</sup>

6. Comprehensive health scheme.<sup>14</sup>
7. Commonwealth hospital scheme, hospitalisation: consolidation of social legislation.<sup>15</sup>
8. A comprehensive health scheme.<sup>16</sup>
9. National fitness.<sup>17</sup>

The first interim report related to social security planning and legislation, and demonstrated the Committee's awareness of the need to plan and assess the effects of social welfare services, as the following passages show:

The Committee is of the opinion that the time has arrived for the working out of a comprehensive plan of social development, so that all future social services can be introduced as part of a pre-determined plan which will cater for the most urgent needs first. Such a plan would enable us to introduce new services as national income expands or administrative techniques improve.<sup>18</sup>

\* \* \*

The attention of the Committee has been directed to our lack of knowledge of the effects of existing social legislation, Commonwealth and State, and the absence of facilities for research into social problems. It is certainly anomalous that despite, for example, the existence of a provision in the Commonwealth Child Endowment Act requiring that the endowment payments shall be applied for the maintenance, training and advancement of the child, the Department of Social Services, which has contingent responsibility to see that the moneys are so applied, has inadequate means of investigating the general social effects of the scheme, or of discovering how it should be altered or supplemented so as to obtain the desired results.<sup>19</sup>

One of the recommendations made by the Committee was:

That the Social Services Department be extended to include—

Facilities for research into social problems and the investigation and study of the effects of existing social legislation.<sup>20</sup>

If this recommendation had been implemented, there would have been an excellent beginning for evaluation in Australia. Unfortunately, it was not implemented for at least thirty years.

### **Report on the Australian Soldiers' Repatriation Act**

In 1943, a document entitled *First and Second Reports of the Committee of Senators and Members of the House of Representatives Appointed to Inquire into and Report on the Australian Soldiers' Repatriation Act* was presented to the Commonwealth Parliament. The Committee's terms of reference were:

To inquire into and report upon the general question of the Australian Soldiers' Repatriation Act and the amendments, if any, which the Committee recommends as desirable, in the light of the conditions caused by the present war.<sup>21</sup>

The terms of reference and the title of the report suggest that this was an evaluation study. However, when the methods employed are compared with what are now considered to be proper evaluation procedures (discussed in Chapter 8), the report is seen to be inadequate as an evaluation exercise. It was almost purely descriptive, outlining the provisions that existed and making recommendations on how these should be changed. The Committee did not have any means of determining needs; nor were there any stated goals that would have assisted the members in formulating their recommendations. They based their decisions on what they considered to be 'fair'. These comments imply no criticism of the Committee. In the circumstances, the recommendations could have been formulated in no other way.

### **Public health campaigns**

The two major public health campaigns conducted by the Commonwealth Department of Health against tuberculosis and poliomyelitis might be seen as having been adequately evaluated at the outcome level.

The need for action against tuberculosis was demonstrated by the number of deaths from the disease—25 per 100 000 of the population in 1949.<sup>22</sup> A national campaign 'to eradicate the disease' began in 1950.<sup>23</sup> Its success was measured by the progressive decline in the incidence of the disease—to 11 deaths per 100 000 in 1953 and to fewer than 2 per 100 000 in 1969.<sup>24</sup>

The need for action against poliomyelitis was illustrated by the notification of 4700 cases in 1951. Mass vaccination campaigns, using Salk vaccine, began in 1956. Sabin oral vaccine has been available since 1966. Success can be judged by the fact that only one case was notified in 1970.<sup>25</sup>

The evaluation of these campaigns was not conducted in a formal manner and there was no attempt to assess the impact of other factors on the overall decrease in the incidence of these diseases. However, sufficient data were available to allow a simple evaluation of these campaigns—a fact which should not be ignored.

### **Report on mental health facilities and needs of Australia**

In 1955 Dr Alan Stoller presented to the Commonwealth Minister for Health a report entitled *Mental Health Facilities and Needs of Australia*.<sup>26</sup> The report equated the size of the mental health problem with the number of people under care,<sup>27</sup> and the recommendations were framed accordingly. The study could be described as an attempt to evaluate the structure of existing mental health institutions. However, in this light, it was not an adequate evaluation study.

There were no stated goals and standards for mental health institutions. For each institution, existing facilities were described, staff-to-patient ratios were given and qualifications of staff were discussed. Judgments were made, but in the absence of stated objectives and standards these were very subjective. They were based on comparisons with other interstate and overseas institutions that the author had inspected.

### **Commonwealth Committee of Enquiry into Health Insurance**

Before 1970 the best evaluation document was the report of the Commonwealth Committee of Enquiry into Health Insurance which was presented in March 1969 by Mr Justice J. A. Nimmo as Chairman.<sup>28</sup>

The Committee's terms of reference included structure, process and outcome considerations. Although the report does not set out precisely the objectives of the Health Insurance Scheme in terms of structure, process and outcome goals, reference to these goals is made either directly or by implication, and judgments are made by taking these objectives into account. The data needed to measure the effects of the Scheme were obtained by calling for submissions and taking public evidence.

This document is far from ideal as an evaluation report. However, considering that evaluation was not widely discussed and understood at that time, the inquiry was certainly a step forward.

## **EVALUATION ACTIVITY FROM 1973 TO MID 1978**

This section of the chapter gives a brief account of the kinds of evaluation activity undertaken in Australia from the beginning of 1973 to mid 1978. It is a summary,



slightly modified, of a paper entitled 'Recent Evaluation Activity in Australia' prepared for the Committee by Paul F. Gross in July 1978. Because of an absence of data on internal evaluations in the non-government sector, the section concentrates on the evaluation of health and welfare projects and programs financed, administered or staffed by public sector agencies. As a historical account, it deals only with the salient features of the most significant of the evaluations during the period.

This review is not made project by project, since no useful purpose is served by identifying specific problems with specific studies made over the period.

### **Seven groups of evaluators**

The evaluation activities discussed fall into seven broad categories:

1. those conducted under the auspices of the Commonwealth Parliament;
2. those initiated by Commonwealth central management agencies, such as the Treasury, the Department of Finance, the Auditor-General's Office and the Public Service Board;
3. those initiated within Commonwealth departments and statutory authorities;
4. those initiated by commissions or committees of review or inquiry;
5. those initiated by State or local government authorities;
6. those initiated by voluntary agencies;
7. those initiated by independent academic researchers.

In general, the activities reviewed were brought about by concern in one of four major areas:

1. Assessment of the *community's need* for a new service or a modification of existing services.
2. The *structure* of an existing department, project or program—for example, how it was organised, financed, staffed or legislated for.
3. The *process* of delivering an existing service—for example, how and by whom the client or patient was initially contacted; what type of service was given; what happened to the client or patient on discharge or on ceasing contact with the service; what administrative, budgetary and financial control processes were used in relation to admission or entry, servicing, charging or follow-up of the client or patient.
4. The *outcome* of an existing or alternative service—for example, whether the service was, or was likely to be, effective in changing the health, dependency or needs status of the client; whether it did so, or was likely to do so, in a cost-efficient or cost-effective manner; whether the service was, or was likely to be, acceptable to both client and provider.

Studies in each category are summarised in Table 2.1 at the end of the chapter. In our text, for the sake of brevity, we have in many instances identified a study by using the name of the person who directed it. The formal title may be ascertained by reference to this table.

### **Adequacy of past evaluations**

Many of the evaluation exercises in this period had non-specific objectives which allowed considerable overlap in the reports presented. The criteria used to evaluate needs, structure, process and outcome were in some instances limited.

There are no universally agreed criteria for deciding whether one evaluation is more useful than another, but it is convenient to review these past evaluation studies under the following broad headings:

1. objectives and purposes;
2. comprehensiveness;
3. relevance to major policy issues.

#### *Objectives and purposes of past evaluations*

Table 2.1 suggests that a significant proportion of these evaluations focused on structure and process evaluation. In general, the bulk of the effort has been directed at:

1. The adequacy of administrative structures for health and welfare services—for example, the Royal Commission on Australian Government Administration (RCAGA) and the Bland, Bailey and Toose inquiries.
2. Program overlap in the health and welfare areas—for example, RCAGA Health-Welfare Task Force, and the Bailey and Holmes inquiries.
3. The adequacy and cost efficiency of existing programs—for example, the review of anti-poverty programs by the Henderson inquiry; the Galbally report; and the Medibank Review Committees.
4. Evaluations of the need for radical changes in income security or social welfare services delivery—for example the Asprey, Woodhouse, Hancock and Henderson reports and the report of the Family Services Committee.

#### *Comprehensiveness of past evaluations*

In the main, the evaluations summarised in Table 2.1 have been concerned with evaluation criteria such as:

1. efficiency of performance in the use of financial and human resources;
2. adequacy of the level of service or benefit to the client;
3. acceptability of the program or service to consumers, providers and politicians;
4. whether or not there are organisational overlaps in service provision.

It seems fair to say that very few of these evaluations enable us to answer crucial questions such as:

1. whether existing programs are responding to objectively determined social needs;
2. whether existing programs are meeting a social need in an effective manner;
3. whether existing programs are cost effective in achieving their outcome or whether there are more efficient ways of obtaining the same outcome.

#### *Relevance of past evaluations to major policy issues*

Apart from these fundamental questions of evaluation objectives and comprehensiveness of evaluation criteria, the relevance of much of the past evaluation activity to the policy maker, both in Parliament and in government agencies, may also have been diminished by a number of factors, including:

1. whether the evaluation answered the important questions being raised by the major policy makers;

2. the timing of the evaluation activity in the ongoing development of policies or programs;
3. the location, organisation and staffing of the evaluation activity;
4. the appropriateness of the data available to answer the type of evaluation question being posed;
5. the methods of presentation and dissemination of the evaluation reports;
6. the extent to which the results of any one evaluation activity are systematically reviewed, within a continuous process of evaluation, by Parliament and its committees, within Commonwealth and State government agencies, and within the non-government sector.

#### ANSWERING IMPORTANT QUESTIONS ASKED BY THE POLICY MAKERS

With few exceptions—for example, the Borrie report of 1978 and the RCAGA Health-Welfare Task Force—the evaluations listed in Table 2.1 have rarely canvassed the implications of a rapidly changing demography and unstable economic conditions for future policy relating to health and welfare services. In other words, the evaluations have not been future oriented.

Very few have clearly identified who is receiving what from the major social welfare programs. Few, if any, have given either a coherent or a complete picture of the effectiveness of expenditures on existing health and social welfare programs in terms of improving health, alleviating temporary distress or reducing welfare dependency; or of their cost effectiveness in terms of achieving their intended effects with the most efficient use of resources.

#### TIMING OF THE EVALUATION STUDY

A second issue of relevance is whether the duration of the evaluation and the timing of the report affect the implementation of any evaluation report. Many of the reports listed in Table 2.1 are from inquiries that stretched over years of evaluative research—for example, the Henderson and Toose inquiries and RCAGA. Others were produced in a short period of intensive effort—for example, the review of the community health program by the Hospitals and Health Services Commission in 1976 and the evaluation of relative costs of health centres in the Australian Capital Territory.

More to the point, because of differences in the times of initiation and reporting, many of the inquiries overlapped in their final recommendations—for example, the Asprey, Hancock, Henderson and Woodhouse inquiries—and someone else must subsequently sort out the consequences.

#### LOCATION, ORGANISATION AND STAFFING OF THE EVALUATION ACTIVITY

The evaluations reviewed have been instigated by different authorities. Very few of them have been initiated as part of the program management activities of government departments. Exceptions are the studies by the Health Commission of New South Wales in the South-East Region and in the Sutherland area. However, it is conceivable that much intramural evaluation never comes into public view and that Table 2.1 may be incomplete in this respect. It is unclear whether the method of implementation, be it by royal commission, a national inquiry, a government agency, an independent researcher or a parliamentary committee, is an important determinant of whether an evaluation report is acted on.

#### APPROPRIATENESS OF AVAILABLE DATA TO THE EVALUATION QUESTION POSED

It is a sad fact that many of the reports listed in Table 2.1 start their analysis with reservations about the adequacy of the data available to answer the evaluation question being posed. These reservations are the most conspicuous common feature of nearly

all the reports listed. Some action has been taken recently to repair some of the gaps in data in the health and social welfare areas. For example, the National Committee on Health and Vital Statistics has now been formed and the recent Scott study of health statistics by a team of public servants and a private consulting firm has produced a consolidated picture of statistics on health expenditures in the last three or four years. Some evaluation studies have been initiated in hospitals, health centres and community health projects in most States, and the results will probably be available by 1980. The new Social Welfare Policy Secretariat has already commenced the creation of a data base in the broader area of social welfare expenditures, with an initial focus on expenditures in 1977-78 and 1978-79.

#### METHODS OF PRESENTATION AND DISSEMINATION OF EVALUATION REPORTS

Most of the reports reviewed average 100 to 200 pages of fairly solid text and tables. It is a moot point whether the findings of a detailed national inquiry can be condensed into a few summary pages that would be digestible by the least enthusiastic reader. It is less moot whether the results of other types of evaluation can be better presented to readers who have little time to read long, convoluted reports. It is apparent also that there is a need for some central information service to disseminate reports on ongoing and completed evaluations so that overlaps in the funding of evaluative research are minimised.

Very few of the projects included in Table 2.1 can be seen to involve duplicate research. The central concerns in the various evaluations are sufficiently diverse for the duplication to be minimal in all areas, except for the recent spurt of evaluations of the performance of government agencies involved in the health and welfare areas—for example, the RCAGA Health-Welfare Task Force and the Bland, Holmes and Bailey inquiries. Even in the areas of income maintenance traversed by the Asprey, Henderson, Woodhouse and Hancock inquiries, there is minimal overlap. Indeed, the resulting reports suffer from the common limitation that the data then available were not adequate to identify who gets what from the relevant social welfare programs, such as those concerned with welfare benefits, compensation and superannuation, and the relevant tax expenditure programs.

#### SYSTEMATIC OVERSIGHT BY PARLIAMENT

To date, there has been little overt attempt to:

1. systematically review the major public sector programs in the health and social welfare areas;
2. systematically follow up the reports of past evaluations and inquiries to ensure that some action was taken, by appropriate agencies, to justify the large expenditures involved in national inquiries;
3. identify the state of the art and the adequacy of the different types of evaluation and audit in use by modern governments;
4. identify future evaluation capacities that the Parliament may need to develop in order to ensure accountability for expenditures.

It seems doubtful that systematic evaluation of public sector programs would occur in the absence of a continuous program of oversight and review by Parliament, its committees and various Commonwealth government agencies. The requirements of such a program of oversight and review are discussed in Chapter 3.

Table 2.1 Summary of evaluation activities from 1973 to mid 1978, Australia

<i>Type of evaluation</i>	<i>Major focus of evaluation</i>	<i>Evaluation</i>	<i>Report produced</i>
1. Need for a new service	Health/welfare status of population in a specific region	N.S.W. Health Commission studies in South-East Region, and in Sutherland area of Sydney	HC of N.S.W. 1977 (seven volumes)
2. Structure and/or process of an existing service	(2.1) Specific inquiries into performance of government department(s) involved in health and welfare	<ol style="list-style-type: none"> <li>1. Health-Welfare Task Force, Royal Commission on Australian Government Administration, 1975</li> <li>2. Royal Commission on Australian Government Administration, 1974-76</li> <li>3. Independent Inquiry into the Repatriation System, 1971-75 (Toose)</li> <li>4. Administrative Review Committee 1976 (Bland)</li> <li>5. Task Force on Co-ordination in Welfare and Health, 1976 (Bailey)</li> <li>6. Committee of Review, School of Public Health and Tropical Medicine, University of Sydney, 1974-75 (Hospitals and Health Services Commission)</li> <li>7. Review of the Delivery of Services Financed by the Department of Aboriginal Affairs (Hay)</li> <li>8. Review of health financial statistics, 1978</li> <li>9. Review of Post-arrival Programs and Services to Migrants, 1978 (Galbally)</li> </ol>	<p>AGPS, 1975</p> <p>AGPS, 1976</p> <p>AGPS, June 1975 (vols 1-2)</p> <p>Not available</p> <p>AGPS, 1977, 1978 (vols 1-2)</p> <p>HHSC, 1975</p> <p>AGPS, 1976</p> <p>AGPS, 1978 (<i>National Health Account—A Study</i>)</p> <p>AGPS, 1978</p>
	(2.2) Studies of voluntary agencies	<ol style="list-style-type: none"> <li>1. Voluntary Agencies and Government Financing (Social Welfare Commission)</li> <li>2. St Vincent's Hospital, Sydney—evaluation of efficacy of family planning services in a large sample of NFP clinics across Australia, 1975-78</li> </ol>	<p>SWC, 1976</p> <p>Johnson et al., 1978 (report to Commonwealth Department of Health)</p>
	(2.3) Specific inquiries into programs affecting human development, income security or economic opportunity	<ol style="list-style-type: none"> <li>1. National Committee of Inquiry into Compensation and Rehabilitation in Australia (Woodhouse)</li> <li>2. National Superannuation Committee of Inquiry, 1973-76 (Hancock)</li> <li>3. Commission of Inquiry into Poverty (Henderson)</li> <li>4. Taxation Review Committee (Asprey)</li> </ol>	<p>AGPS, 1974 (vols 1-2)</p> <p>AGPS, June 1974 (Interim Report); April 1976 (Final Report, Part One); March 1977 (Final Report, Part Two)</p> <p>AGPS, 1974-77</p> <p>AGPS, Jan. 1975 (Full Report)</p>

<i>Type of evaluation</i>	<i>Major focus of evaluation</i>	<i>Evaluation</i>	<i>Report produced</i>
		5. Report on the Australian Assistance Plan (Social Welfare Commission)	SWC, 1976
		6. A Medical Rehabilitation Program for Australia (Hospitals and Health Services Commission)	HHSC, 1973
		7. Hospitals in Australia (Hospitals and Health Services Commission)	HHSC, 1974
		8. Review of Community Health Program (Hospitals and Health Services Commission)	HHSC, 1976
		9. Family Services Committee (Social Welfare Commission)	FSC, 1978 (2 vols)
		10. Report on Housing (Priorities Review Staff)	PRS, 1975
		11. Report on Early Childhood Services (Priorities Review Staff)	PRS, 1974
		12. Committee on Care of the Aged and the Infirm (Holmes)	AGPS, 1977
		13. Income Security Review, 1975-78	Unpublished reports
		14. Medibank Review Committees (1976, 1977, 1978)	Unpublished reports
		15. Miscellaneous studies of usage of community health centres in N.S.W., Victoria, Tasmania, South Australia	Various project reports
		16. National Population Inquiry (Borrie)	AGPS, 1978 ( <i>Population and Australia: Recent Demographic Trends and their Implications</i> , Supplementary Report)
	(2.4) Ongoing audit/review activities of Parliament or independent statutory authorities	1. House of Representatives Standing Committee on Expenditure 2. Joint Committee of Public Accounts 3. Senate Standing Committee on Social Welfare (the current inquiry) 4. Auditor-General's Annual Report to Parliament 5. Public Service Board—efficiency audit activities under section 17 of the <i>Public Service Act</i> 1922 6. Forward estimates Budget review process 7. Review of Community Health Program by back-benchers committee, 1976	

<i>Type of evaluation</i>	<i>Major focus of evaluation</i>	<i>Evaluation</i>	<i>Report produced</i>
3. <i>Outcome</i> of an existing service	(3.1) Effectiveness of an existing program/project/service in achieving its specific objectives	1. Royal Commission on Australian Government Administration—reviews of counter services in Department of Social Security, 1975	AGPS, 1976 (RCAGA Report—Appendix, vol. two)
		2. Commission of Inquiry into Poverty ( <b>Henderson</b> )—various reports on migrants, low-income housing, health care	AGPS, various years
		3. Before-and-after study of impact of a health centre on health in a community, Inala, Brisbane	Ongoing
		4. Study of efficiency and effectiveness of obstetric care in a large teaching hospital (Brisbane, Sydney, Adelaide)	Gordon et al., 1978 (on two Brisbane hospitals); HHSC, 1977 (report by T. Kiiver on one Sydney hospital); (ongoing study, with 1978 progress report to HHSC, in Adelaide hospital)
	(3.2) Cost effectiveness of an existing program/project/service in meeting its specific objectives	1. Studies of relative costs of health centres in the Australian Capital Territory (treating specific conditions)	Ongoing; final report, 1978
		(3.3) Acceptability of an existing program/project/service to consumer-client or to provider	1. Royal Commission on Australian Government Administration, research project into problems of client access to personal services in Australian Taxation Office, Department of Social Security, Australian Housing Corporation and Australian Legal Aid Office
2. RCAGA pilot project development and evaluation of NOW project, Melbourne	AGPS, 1976 (RCAGA Report—Appendix 2.F, pp. 371-424)		
4. Likely <i>outcome</i> of an alternative service	(4.1) Likely costs and acceptance of alternative systems of health care	1. Evaluation of feasibility of a Prepaid Health Plan in South Australia	Progress report to Hospitals and Health Services Commission, 1977

AGPS = Australian Government Publishing Service.

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## **Current models of evaluation within parliamentary and government processes**

The aim of this chapter is to explore the use of evaluation by decision makers in the Commonwealth Parliament and Government. The Committee recognises that all Parliaments have a role in evaluation, but in this report discussion on the parliamentary role is confined to the Commonwealth Parliament. This chapter outlines the stated and perceived functions of relevant parliamentary and government bodies, and postulates functions that will be facilitated by the use of evaluation data, and some functions that may need to be modified to aid evaluation.

### **Role of Parliament in evaluation**

One of the primary functions of Parliament is 'to call to account those who do govern'.<sup>1</sup> Evaluation provides members with the basic data for their endeavours to ensure accountability.

Parliament has a dual role in evaluation. In the larger sense, it evaluates in the construction, amendment and criticism of Bills and budgets, and its developing committee system has undertaken, and is undertaking, evaluation of government activities at all levels. Parliament also has a role in translating evaluations into decisions—for example, in determining, as a result of demonstrated deficiencies or strengths, whether a program should be modified, terminated or boosted. Parliament should play an important part in ensuring that evaluation is conducted adequately. As was noted in Chapter 2 (see page 26), it seems doubtful that public sector programs will be systematically evaluated in the absence of a continuous program of oversight and review by Parliament and some Commonwealth agencies.

Some parliamentary committees are in fact evaluators in specific areas. They have been established for various reasons but principally because Parliament has specific interest in efficiency or effectiveness in particular areas or because the processes of Parliament as a whole can cope with certain functions only by delegating some work to committees. Committees could, given the opportunity and information, be important as program evaluators. In this context, their principal role is in the translation of inputs, including evaluation, into proposals.

Parliament has a fairly extensive system of committees. Some with interests in the health and welfare fields are:

1. House of Representatives Standing Committee on Expenditure
2. Joint Committee of Public Accounts
3. Parliamentary Standing Committee on Public Works
4. Senate Legislative and General Purpose Standing Committees:
  - (a) Standing Committee on Finance and Government Operations
  - (b) Standing Committee on Social Welfare
5. Senate Estimates Committees
6. House of Representatives Standing Committee on Aboriginal Affairs

The following sections note the stated powers and functions of each Committee, as well as each Committee's view of its own role. An assessment of the possibilities for evaluation within the work of each Committee is made also.

### *House of Representatives Standing Committee on Expenditure*

Paragraph 1 of the resolution of appointment of this Committee states:

That a Standing Committee be appointed to:

- (a) consider any papers on public expenditure presented to this House and such of the estimates as it sees fit to examine;
- (b) consider how, if at all, policies implied in the figures of expenditure and in the estimates may be carried out more economically;
- (c) examine the relationship between the costs and benefits of implementing government programs;
- (d) inquire into and report on any question in connection with public expenditure which is referred to it by this House.<sup>2</sup>

We note the emphasis placed on efficiency.

Established in April 1976, the Committee, in a report presented in October 1977, outlined what it saw as its functions:

After more than a year's experience it is possible to distinguish three broad types of functions, namely:

- examination and evaluation of the processes used in the planning, management and control of expenditure
- evaluation of programs to find out, among other things, whether there are alternative ways of attaining policy objectives more efficiently or at lower cost
- examination of programs and activities to find out if they are being administered with economy and efficiency.<sup>3</sup>

We have been informed that the work of the Standing Committee on Expenditure 'to date has been concerned more with evaluation of programs than examination of economy and efficiency or scrutiny of overall management and control of expenditure'.<sup>4</sup> Evaluation reports of the programs it has to examine would give it much of the information needed in its inquiries.

### *Joint Committee of Public Accounts*

The functions of the Joint Committee of Public Accounts are stated in section 8 of the *Public Accounts Committee Act 1951*:

The duties of the Committee are—

- (a) to examine the accounts of the receipts and expenditure of the Commonwealth and each statement and report transmitted to the Houses of the Parliament by the Auditor-General in pursuance of sub-section (1) of section fifty-three of the *Audit Act 1901–1950*;
- (b) to report to both Houses of the Parliament, with such comment as it thinks fit, any items or matters in those accounts, statements and reports, or any circumstances connected with them, to which the Committee is of the opinion that the attention of the Parliament should be directed;
- (c) to report to both Houses of the Parliament any alteration which the Committee thinks desirable in the form of the public accounts or in the method of keeping them, or in the mode of receipt, control, issue or payment of public moneys; and
- (d) to inquire into any question in connexion with the public accounts which is referred to it by either House of the Parliament, and to report to that House upon that question, and include such other duties as are assigned to the Committee by Joint Standing Orders approved by both Houses of the Parliament.

The Committee itself believes that its functions go beyond examining the accounts of departments. Mr R. Cleaver, a former Chairman, saw the role of the Committee as being primarily in the area of efficiency audit. In 1964 he said:

The Public Accounts Committee really operates in the field of an efficiency audit which means that it asks departmental officers appearing before it very much more difficult questions than it would if it confined itself solely to the accounts and Votes of the departments.<sup>5</sup>

The Auditor-General is now also taking on an efficiency audit role (see page 42). Though the Public Accounts Committee plays a valid watchdog role, its membership and staff resources do not allow it to carry out systematic evaluation in other than restricted areas of government administration. However, given that certain evaluation procedures were to be mandatory, the Committee would be important in ensuring that those procedures were carried out.

### *Parliamentary Standing Committee on Public Works*

The functions of the Public Works Committee are stated in section 17 of the *Public Works Committee Act 1969*:

- (1.) The Committee shall, as expeditiously as is practicable—
  - (a) consider each public work that is referred to it in accordance with this Act; and
  - (b) make a report to both Houses of the Parliament concerning the expedience of carrying out the work and concerning any other matters related to the work in respect of which the Committee thinks it desirable that the views of the Committee should be reported to those Houses,

and, for those purposes, shall do such things and make such inquiries as it thinks necessary.

- (2.) The Committee may, in its report on a public work, recommend any alterations to the proposals for the work that, in its opinion, are necessary or desirable to ensure that the most effective use is made of the moneys to be expended on the work.

- (3.) In considering and reporting on a public work, the Committee shall have regard to—
  - (a) the stated purpose of the work and its suitability for that purpose;
  - (b) the necessity for, or the advisability of, carrying out the work;
  - (c) the most effective use that can be made, in the carrying out of the work, of the moneys to be expended on the work;
  - (d) where the work purports to be of a revenue-producing character, the amount of revenue that it may reasonably be expected to produce; and
  - (e) the present and prospective public value of the work.

The provisions contained in paragraphs (a), (b) and (c) of sub-section (3.) are notable for their relevance and specific application to evaluation.

In a letter to our Committee, the Chairman of the Public Works Committee stated that 'the basic rationale behind our inquiries is for the Committee to be satisfied that there is a need for a particular proposal to proceed'.<sup>6</sup> The examination of evaluation reports would enable the Public Works Committee to have the benefit of an objective process for the assessment of need in determining the adequacy of existing facilities and, therefore, the utility of a new works project. A more objective assessment of whether the proposed project was the most appropriate means of satisfying the need would thus be possible.

### *Senate Legislative and General Purpose Standing Committees*

The powers of all Senate Legislative and General Purpose Standing Committees are set out in paragraph (2.) of Senate Standing Order 36AA:

The Standing Committees appointed pursuant to paragraph (1.) shall be empowered to inquire into and report upon such matters as are referred to them by the Senate, including any Bills, Estimates or Statements of Expenditure, messages, petitions, inquiries or papers . . .

This means that, with the Senate's concurrence, and given adequate resources, committees could evaluate services or examine health and welfare evaluation reports and make recommendations thereon. Indeed, by reference from the Senate, committees have from time to time been required to evaluate various services including, for example, repatriation and the Australian Trade Commissioner Service. Two committees are particularly relevant to health and welfare services: the Standing Committee on Finance and Government Operations and the Standing Committee on Social Welfare.

#### SENATE STANDING COMMITTEE ON FINANCE AND GOVERNMENT OPERATIONS

The Senate Standing Committee on Finance and Government Operations outlined its perception of its role in a progress report presented on 14 September 1977:

We see great responsibility on this Committee to enhance the scrutiny by the Senate of public expenditure. In this context we envisage scrutiny of the reasons and methods of expenditure as well as the amount.<sup>7</sup>

If it is the intention of the Committee to scrutinise all public expenditure rather than just selected parts, it will inevitably involve itself in health and welfare matters. Evaluation reports would provide basic data for this function.

#### SENATE STANDING COMMITTEE ON SOCIAL WELFARE

This Committee believes that, as part of its oversight of health and welfare matters referred to it by the Senate from time to time, it has a potential role to play in the examination of health and welfare evaluation reports and in ensuring that adequate evaluations are carried out. Most program evaluations require substantial resources and expertise. They are therefore more properly carried out by the Administration itself or by appropriate consultants. This Committee's proper role is, rather, to encourage the performance of effective evaluation and the exploration and understanding of the implications of such activity.

#### *Senate Estimates Committees*

Under the provisions of Senate Standing Order 36AB, Estimates Committees—at present six in number unless otherwise ordered—are appointed at the commencement of each Parliament to consider the annual Estimates and the Additional Estimates. The annual Estimates and the Additional Estimates are then referred to these Committees by resolution of the Senate at the appropriate time. It is customary on each occasion for the resolution to fix a date by which the reports must be presented.<sup>8</sup> If adequate staff were provided for these Committees, they could have a definite role in examining evaluation studies and questioning departments about expenditure on programs, or parts of programs, in the light of the information provided by such studies. This would increase the influence of Estimates Committees enormously and would encourage the Executive and departmental officials to adopt evaluation as part of their decision-making processes.

However, efficiency of these Committees is limited at present by the rigid form of the Estimates. (See pages 43 to 46 for a more complete discussion on budget preparation as an evaluation mechanism.)

#### *House of Representatives Standing Committee on Aboriginal Affairs*

This Committee is appointed to inquire into, take evidence and report on:

- (a) the present circumstances of Aboriginal and Torres Strait Island people and the effect of policies and programs on them, and

- (b) such other matters relating to the Aboriginal and Torres Strait Island people as are referred to it by—
  - (i) resolution of the House, or
  - (ii) the Minister for Aboriginal Affairs.<sup>9</sup>

The Committee has presented reports on a number of matters, including conditions of the Yirrkala people, the Special Work Projects Scheme to provide employment and on-the-job training for Aboriginals, and alcohol problems of Aboriginals.<sup>10</sup> In the main, its reports have assessed needs, though the second report cited is in fact an evaluation.

### **Evaluation in the legislative process**

The examination of Bills in Parliament itself involves the use of evaluative data and, indeed, may of itself be an evaluation process. The introduction of a Bill into Parliament ostensibly denotes an action with an objective based on some assessment of needs, and may have been preceded by a course of action which has been the subject of an evaluation. Members are then required to convert evaluative data and reports into decisions.

However, at present, members often have to rely on insufficient and inadequate information produced by the Administration or on information hurriedly prepared by a research assistant or the Parliamentary Library. Furthermore, whatever evaluation is undertaken in Parliament ends when a measure is passed. Existing legislation is not normally subjected to ongoing parliamentary scrutiny, though an Act may undergo further evaluation if it has specific provisions requiring periodic amendment—for example, when the amount of a levy or subvention prescribed in that Act is to be changed—or if amendments for other purposes are being considered.

### *Sunset legislation*

Sunset legislation is a relatively new reform being developed in the United States of America. It is designed to increase the level of legislative control of public sector activities. Basically, the sunset concept is that agencies and programs periodically terminate and resume only after an evaluation and a legislative vote to re-establish them.

This can be brought about in two ways. Firstly, all new legislation establishing a program may stipulate a termination date (hence 'sunset') which will take effect unless the legislature takes positive action to continue the program. Secondly, an amending Act may specify a termination date, or various termination dates, for previously established programs authorised by a principal Act.

To date, proposals have involved reviewing programs every five to ten years. Consideration is given to the proper balance in the intervals between reviews to ensure that they are neither too short for a review to be effective nor so long as to allow problems to become entrenched. One criticism has been that program managers will spend their pre-review year justifying their performance or even artificially bolstering it.

At the end of 1978, some twenty-seven States had adopted some form of sunset legislation<sup>11</sup> and President Carter was supporting a draft Bill approved by the United States Senate in 1977 which sought to limit the life of most federal programs to five years, subject to review by House of Representatives and Senate committees which would be able to recommend reconstitution.<sup>12</sup> This Bill also provided for zero-base budgeting arrangements.

The review processes available to the congressional committees under the terms of the Bill are described as follows:

- The bill groups all federal programs by function and, with limited exemptions, sets a phased five-year schedule for the review of each function. For example, the functions included in the first year's review are national defense, recreational resources, farm income stabilization, disaster relief and insurance, health research and education and veterans housing.
- New budget authority for programs scheduled for review in a particular year would not be permitted until the House and Senate committees with legislative jurisdiction over the programs conduct their sunset review, or, in the language of the bill, a "*systematic evaluation . . . to determine if the merits of the program justify its continuation rather than termination*" or *its continuation at a different spending level. The review would include an assessment of whether the original program objectives have been achieved* [our italics]. If the House or Senate were unhappy with the thoroughness of a committee's review, it could reject the recommendation and send it back for more study.
- Before new budget authority could be granted, the authorizing committees would have to report to Congress on their reviews, including assessments of the consequences of eliminating programs or consolidating them with other programs and projections of the anticipated needs of the programs and when they might fulfill their objectives.
- If a program has not been reauthorized by the scheduled time, one-fifth of the Members of either chamber could file a bill that would receive expedited consideration to keep the program alive for one year. According to a Muskie aide, an extension resolution could be passed in subsequent years, but, as a practical matter, a program probably would not be extended indefinitely under this procedure. "From a practical standpoint, if the sunset review cannot pass in a year or two, that probably would mean there is not enough congressional or public support for the program," said James H. Davidson, counsel to the Senate Governmental Affairs Subcommittee on Intergovernmental Relations.<sup>13</sup>

The concept of sunset legislation has its basis in the same factors that have given rise to our report, namely the problems of regulatory failure and the inadequacy of legislative oversight caused by the increasing complexity of government (see Chapter 1). The practice of incremental budgeting—that is, examining only additions to the previous year's budget rather than the entire budget for each program—is often cited as a major reason for the adoption of sunset legislation. Further, by shifting the burden of proof from those who would terminate a program to those who would continue it, the advocates of sunset legislation hope to provide greater incentive for improved performance by individual programs.

Some sunset laws, such as the United States draft Bill discussed above, provide for programs with similar purposes to terminate at the same time. This requirement facilitates examination of the questions of goal duplication and of conflicting or contradictory goals. Sunset legislation need not be a case of 'to be, or not to be'. The process could end with a whole series of recommendations, ranging from 'improve please' to 'amalgamate or transfer functions' to 'abolish'.

Sunset legislation has also had some useful side effects such as revealing additional budgetary information. In Alabama, for example, US\$30 000 per annum was being spent on the development of a river bordering on Alabama, Florida and Georgia. A sunset review revealed that Georgia was not financing the development at all and Florida was spending money to stop it.<sup>14</sup>

In practice, sunset legislation has not, as yet, shown itself to be a potent legislative tool. In Colorado, in the first operative year of the statute, thirteen agencies were liable to be terminated unless they were saved by the legislature. Three boards regulating boxing, sanitariums and shorthand reporters were eliminated and agencies licensing barbers and beauticians were combined. Decisions on the most powerful agencies up for review were delayed for a year because lawmakers said they did not have time to study them fully.<sup>15</sup>

These events illustrate one of the major problems with sunset legislation: far from decreasing legislative and administrative workloads, it actually increases the number of decisions to be made. United States experience is particularly germane in this regard, as the responsibilities for review rest largely with extensively developed committee systems which are liberally staffed and powerful. Senator Harrison A. Williams has estimated that staff requirements for the full implementation of the review responsibilities of his Labor and Public Welfare Committee would cost an additional US\$1 million annually.<sup>16</sup>

Sunset legislation, therefore, costs money, and may be cost ineffective if implemented indiscriminately. Colorado, for example, found that the review of the first thirteen agencies cost some \$212 000—almost twenty times the \$11 000 saving achieved by approved cutbacks.<sup>17</sup> While cost cutting could be a worthwhile spin-off, sunset legislation per se is not a cost-cutting measure. It is a device designed to make government more efficient and accountable to the legislature. United States experience has shown that very few bureaucracies have, within themselves, the staff resources to enable them to prepare meaningful evaluation.

For sunset legislation to work, substantial changes in the priorities of legislators are required. Much time and effort will be involved in absorbing and understanding the contents of evaluative reports. It has been suggested that, to overcome this problem, legislators should make some kind of choice as to which programs should be examined in detail. This approach, however, would rob sunset legislation of one of its strongest features: its essential neutrality, accompanied by greater freedom from the politicking that would be involved in choosing some agencies or services and not others.

There has been similar criticism of a further suggestion made to avoid an immediate overload of bureaucratic and legislative resources. Since there may be a necessary learning process for both bureaucrats and legislators involved in the implementation of sunset legislation, some of the proponents have suggested that the sunset mechanism be phased in over several years. Such flexibility for the relief of workload is, however, open to manipulation—for example, by those who might use it to further a particular ideological stance.

Sunset legislation could also lose its credibility should it prove to be no more than another process sanctioning the status quo. Unless there is modified or terminated at least one program with a clientele that is strong politically, numerically or by reason of its security and permanence, it will soon seem to all that only vulnerable or inconsequential programs are likely to be threatened.

Sunset legislation cannot be a simple 'live-or-die' process. For example, neither the age pension nor quarantine procedures can really be threatened with termination, but the enabling legislation for each can be modified to take account of changes in need and of demonstrated inadequacies or loopholes. Sunset legislation must not be allowed to become just another paper requirement for bureaucracies. Its effectiveness hinges on the application of vigorous, appropriate evaluation. A number of objections to sunset legislation have been raised. While they do not detract from its usefulness, they do raise a number of issues that have to be taken into account in the implementation of sunset provisions.

Charges and criticisms that have been made include the following, which were made by Alan Rosenthal, of Rutgers University, at a sunset law conference in the United States in April 1977:

Sunset, Rosenthal charged, ignores recent advances in program evaluation by state legislatures, and instead substitutes a 'black-and-white, live-or-die, justify-your-damned-existence' approach.

'Not all programs or agencies need review, especially on a set schedule. Why review an agency if it's working okay? Legislators should choose—exercise judgment and discretion,' Rosenthal said.

'Bureaucracies will become disillusioned by the amount of paperwork engendered,' Rosenthal charged. 'Sunset will prove to be little more than a symbolic gesture to the public, reassuring them the legislature is at work even if it isn't. When the initial glow of congratulation wears off, the scene will be covered with litter—data and paper piled on high.'

The easiest alternatives to sunset, Rosenthal said, are to strengthen current legislative oversight and 'not to enact unneeded new programs'.<sup>18</sup>

Though evaluation may provide the rationale for termination, and sunset legislation the opportunity, termination may be difficult to achieve. Each program has its own body of support, and the general desire for more efficient, accountable government which gives rise to sunset legislation is likely to falter when a specific program is in question. A particularly apt Australian example of the faltering of this desire was the unsuccessful attempt—not in itself a sunset proposal—in 1976 to terminate the funeral benefit.

There is some precedent for sunset-type provisions in Australian Federal legislation. For example, the Darwin Reconstruction Act 1975, which provided for the establishment of the Darwin Reconstruction Commission, provided also that the Commission wind up its affairs after five years. In fact, the Commission was wound up by proclamation on 31 December 1977.

The Senate Standing Committee on Finance and Government Operations has said that it may in future recommend that an authority automatically terminate after a period unless specific reauthorising legislation is enacted. That Committee has also urged that the sunset concept become an integral feature of the creation of new authorities.<sup>19</sup>

Finally, the impediments to general evaluation apply equally to sunset legislation. Principally, these are lack of clear program objectives; of effective determination of need; of data; of evaluative skills; and of adequate tools for judging, say, the effect of a new health regulation on morbidity.

However, in summary, one can draw some conclusions from the foregoing pages. Sunset legislation could be one means of facilitating the use of evaluation in the decision-making processes of the legislature. Sunset legislation could provide a real incentive for program managers to examine their programs and for legislators to become fully involved in a process that is central to efficient, effective and accountable government. Care would be needed to ensure that an inordinate amount of time was not absorbed in the legislative process. The very real advantage of sunset legislation, however, is that legislators will at regular intervals become involved with the efficacy of programs.

### **Future use of evaluation in Parliament**

The parliamentary committee system and the legislative process itself have positive roles to play in facilitating adequate evaluation and scrutinising reports on the evaluation of health and welfare services. They must also translate the flow of data into decisions. At present, there is little systematic work done in the area by the Parliament or its committees.

Writing about parliamentary oversight of public sector expenditure, Paul F. Gross stated that, to mid 1978, there had been very little attempt to review major public health and welfare programs, to follow up past costly evaluations or inquiries, to identify the adequacy of the different types of evaluation in use by governments or to identify the evaluation capacities that Parliament may need to ensure accountability.



Preliminary studies by the Social Welfare Policy Secretariat have identified at least ninety programs providing income benefits or subsidies, nearly seventy service programs offering benefits in kind, by way of health, housing, food and community services, and nearly thirty programs that enhance economic opportunity by means of education and training.<sup>20</sup>

Because of the substantial amount of work involved in ensuring adequate oversight of government programs, it will be necessary for Parliament to make a definite commitment and to ensure that adequate evaluation is carried out and that the results are integrated with the decision-making process. It will not be sufficient for Parliament or its committees to review a few selected programs on an ad hoc basis. At the same time, neither Parliament nor its committees would have time or resources to undertake evaluation studies themselves. Evaluation must be an administrative responsibility. However, all reports on evaluation studies should be tabled and printed as parliamentary papers and be referred to appropriate committees of both Houses for consideration. The committees would then be able to examine them and report back, making such recommendations as they might see fit. The additional workload might well require a review of committee resources.

In the final analysis, Parliament must examine its own procedures to ascertain whether they need to be changed or extended to facilitate the use of evaluation reports.

### **Centralised control and evaluation in the Commonwealth Public Service**

The Department of the Treasury, the Department of Finance, the Department of the Prime Minister and Cabinet, the Public Service Board and the Auditor-General all have roles in centralised control and evaluation in the Commonwealth Public Service. The Social Welfare Policy Secretariat is a new body whose work could have a significant evaluation component.

#### *Department of the Treasury and Department of Finance*

The Treasury advises the Government in the areas of economic, fiscal and monetary policy. Within this broad role, it undertakes:

- . . . a continuous assessment of current and future economic conditions and provides advice on appropriate policies including:

- budgetary policy—matters relating to expenditure, revenue and deficit/surplus and means of achieving overall budgetary objectives;

- monetary policy—matters relating to the control of the money supply, official interest rates etc;

- taxation policy—matters relating to the structure and level of taxation in relation both to budgetary needs and general economic effects;

- incomes and prices matters—providing advice on trends in income and price levels and on wages policy; and

- matters relating to economic development, growth and resource allocation and policies towards industry.<sup>21</sup>

This charter clearly gives Treasury a prominent role in central economic planning and evaluation. This role requires that it possess an understanding of the goals that governments wish to achieve, including health and welfare goals.<sup>22</sup> Clearly, this function and Treasury's historical role involve it to some degree in planning and evaluation at the service level, including giving advice as to appropriateness or effectiveness of individual programs, though this is nominally more the role of the Department of Finance. In this context, the following passages from evidence given to the House of

Representatives Standing Committee on Expenditure on behalf of Treasury are of interest:

**Mr HURFORD**—Who would make the decision that it is a joint responsibility? Suppose, for instance, it first came under notice to you that Finance should be involved, or it first came under notice to Finance that you should be involved. What are the processes?

**Sir Frederick Wheeler**—Common sense—I am not meaning to be flippant as I say that. We have not endeavoured to draw up a rule book which lays down what is of interest to Finance, what is of interest to Treasury, which is the primary interest, which is the minor interest. We just do not operate by a rule book.<sup>23</sup>

**Mr HURFORD**—Would you yourselves stimulate any questioning of the existence of some programs? Only in an informal way you might raise the question in the Treasurer's mind and then the rest of the running would have to be in his hands. Is that so?

**Sir Frederick Wheeler**—Both in the pre-split and in the post-split situation, if we feel that there is a question mark on a program which ought to receive ministerial attention, we do raise it, and of course so does Finance in particular raise it. Now what happens thereafter depends on what the Treasurer thinks and decides after he has considered the points put to him. If he decides the queries are worth sending on to Cabinet, well then he sends them on to Cabinet in the form of a Cabinet submission.<sup>24</sup>

While it may be a secondary role, this must involve Treasury in questions of need. Treasury—quite erroneously, in the Committee's view—saw this as being almost solely a political matter<sup>25</sup>, with perhaps some technical data input.<sup>26</sup> To the greatest extent possible, need should be measured objectively (see Chapter 4). The Committee is concerned that, because of a lack of statements of need (see page 56), Treasury is forced to make subjective recommendations to governments. Recommendations on program funding must have better bases than accumulated experience and subjective judgment.

The broad functions of the Department of Finance are stated in these terms:

The Department of Finance examines, reviews and evaluates governmental expenditure proposals and programs and collects and analyses forward estimates of expenditure and administers the Public Account.<sup>27</sup>

This Department certainly has a role in the evaluation and planning of health and welfare services. That role, of necessity, requires mainly a broad-brush approach, as the vast range of government expenditure virtually precludes detailed evaluations. When the Department does on occasion become involved in detailed evaluations, these are ad hoc.<sup>28</sup>

The broad-brush, ad hoc approach gives the Committee cause for concern, particularly because the bases necessary for proper and effective evaluation require definition and measurement, and goal statements are generally obtuse, unreliable or non-existent.<sup>29</sup> A lack of reliable parameters and resources for evaluation appears to force a process that is ad hoc in the sense that only programs facing a political or financial crisis are evaluated, and broad-brush in that the central departments such as Finance and Treasury are forced to make arbitrary value judgments based largely on information from numerous departments. The Committee notes that a large part of the information comes from those under scrutiny. There is some need to examine this situation.

Neither Department possesses the necessary resources or the will to send officers into departments to gather detailed data and undertake a precise evaluation. Both are forced to rely on whatever information other departments possess and see fit to pass on to them. The position of the Department of Finance is indicated in the following passage from evidence given by Mr R. W. Cole, its then Secretary:

**CHAIRMAN**— . . . . In fact you are a client for the information which other departments possess.

**Mr Cole**—Yes.

**CHAIRMAN**—The question then comes back to your perception of the quality of information which other departments possess.

**Mr Cole**—Frequently in these two areas and others there is not the ideal amount of information on which to base a decision. Probably that is more the case in these areas than most others. We have to do the best we can with what we have, but in many of these areas information is very hard to come by.<sup>30</sup>

In making bids for finance, departments rely on parliamentary, ministerial or administrative initiatives in setting objectives and standards. As a result, the quality of information going to central departments is poor and gives rise to hurried de facto or tacit evaluations.

### *Department of the Prime Minister and Cabinet*

The functions of the Department of the Prime Minister and Cabinet are stated in these terms:

Policy advising for the Prime Minister; secretariat services to Cabinet and its Committees; co-ordination of government administration; policy and program development and evaluation; relations and communications with the State Governments; Government ceremonial and hospitality.<sup>31</sup>

The evaluation role is new and is still being developed, and as yet has no clear definition. While the Department has stated that it does not intend to carry out evaluation itself<sup>32</sup>, there were, on the other hand, in late 1978, some indications that it will at least take a very central role in the selection of programs to be evaluated, as well as in the evaluations.

It must be noted that this is a very important Department in a position of great power. It has built up an extensive organisation to provide advice to the Prime Minister on budget proposals, program changes, new programs and a whole range of other activities. In the absence of clear definitions of goals, need and standards, and without program evaluation, that advice depends on a number of undefined value positions and tacit evaluations.

### *Public Service Board*

The Public Service Board's role is stated as follows:

As the central personnel authority for the Australian Public Service, the Public Service Board is responsible for ensuring the development of broadly common standards of pay, job classification, organisation, recruitment, staffing and terms and conditions of employment in the Service, and for devising means of effecting economies and promoting efficiency in the management and working of departments.<sup>33</sup>

While the Board may not have specific responsibility for evaluating individual programs, it does have a vital structural and procedural role to play. However, the Board, because of its functions in relation to efficiency and economy, tends to concentrate on staffing structures, classifications and job qualifications, though the provision of staff from what may be regarded as a fixed pool implies evaluation of performance.

The Board is involved in a very important part of the evaluation process, but it, like Treasury and the Department of Finance, relies heavily on departmental, ministerial and parliamentary initiatives for the provision of data, operational objectives and evaluation standards. Nevertheless, the Board appears to be moving in a very useful direction with its present emphasis on defining programs for forward staff estimates.

### *Auditor-General*

The Auditor-General is required by law to:

- (a) certify that amounts notified to him on instruments signed by the Minister for Finance are lawfully available for expenditure. When executed by the Governor-General such instruments, known as Governor-General's Warrants, become the authority to draw the amounts so notified from the Commonwealth Public Account;
- (b) examine the books and accounts relating to the collection and expenditure of the public moneys of the Commonwealth and to the custody and control of public stores;
- (c) deal, in the manner provided by the Act, with any irregularities that he may discover; and
- (d) report to the Parliament on the Minister for Finance's Statement of Receipts and Expenditure and on such other matters as he thinks desirable.<sup>34</sup>

The Auditor-General, therefore, has a very specific role in the evaluation of the efficiency of public organisations. The *Audit Amendment Act 1979*, which came into operation on 7 March 1979, also empowers him to undertake efficiency audits. A representative of the Auditor-General's Office indicated the approach that will be adopted:

#### Efficiency Audit Approach

Efficiency may be regarded as occupying the centre of a spectrum bounded at the 'upper' or strategic level by what is termed 'effectiveness', which is a measure, not always quantifiable, of how closely government objectives are being achieved and at the 'lower' or transaction level by compliance which is essentially concerned with the administration of funds appropriated or collected by the Government and its agencies.<sup>35</sup>

This new power could lead to a true evaluation function. However, it, too, would appear to rely on certain departmental, ministerial or parliamentary objectives. Its efficacy will have to be examined after the two-year trial period proposed.

### *Social Welfare Policy Secretariat*

On 19 December 1977, the Prime Minister announced the establishment of the Social Welfare Policy Secretariat, which is to work through a committee of Permanent Heads to the Social Welfare Policy Committee of Cabinet. The Permanent Heads Committee on Social Welfare, to which the Secretariat reports, is composed of the Permanent Heads of the Departments of the Prime Minister and Cabinet, Finance, Health, and Social Security.

The Secretariat is responsible to the Permanent Heads Committee for the provision of advice on, and the integrated development of plans, policies and programs in the broad fields of health and welfare. It will:

Provide, or ensure the provision of support to the Social Welfare Policy Committee of Cabinet on matters in the broad field of health and welfare.

Assist the Permanent Heads Committee on Social Welfare to carry out its functions, including those of any sub-committee it might establish.

Ensure the co-ordinated development and review of health and welfare policy and ensure that appropriate research activities are directed to these ends.<sup>36</sup>

The practical requirements of these functions are still being assessed. However, there is a danger that the capacity of the Secretariat to deal with matters of substance could be reduced by the referral of trivial issues for its attention.

The Secretariat could have any number of important roles with regard to evaluation. Some of the possibilities suggest themselves as having high priority. For example, the Secretariat could:

1. assess the usefulness of our report for development of the evaluation function;

2. act as a consultant on evaluation procedures;
3. play an active role in delineating the policy implications of evaluation reports.

*Government budget process as an evaluation mechanism*

Such evaluation as is carried out at present is largely based on the need for continued funding. This is true for both government and non-government sectors. Central to this is the process surrounding the construction and negotiation of the annual budget. Neither the Federal budget nor the budgets of State governments, however, appear to be appropriate vehicles for evaluation. Indeed, they may require changes to facilitate evaluation exercises which are carried out separately from the budget process.

A budget is a developed response to the historical role of stewardship, and is designed to guard against careless, ill-informed or malevolent administrators. In the last forty years, budgets have also become major tools of economic policy. The primary developments in budget processes and presentation are those that have dealt with the macro-economic functions of budgets.

CENTRAL PROBLEMS

The Commonwealth budget is at present not a managers' budget: it is not geared for decision making at lower levels of planning. It is this aspect of the budget that concerns the Committee.

The budget, in its present form, cannot be an evaluation tool. While centralised evaluations can be carried out, on budgetary pretexts, by the Department of Finance and the Department of the Prime Minister and Cabinet, the limited resources of these Departments prevent systematic, continuing evaluations. The budget is brought down in a rigid line format which, while adequately identifying expenditure on items such as wages, stationery etc., does not allow an accurate assessment of the costs of particular programs or goal-attaining activities.

In Australia, the budget process is incremental; that is to say, the budget makers base their decisions about funding largely on criteria derived from previous levels of expenditure. Approximately 95 per cent of spending each year is related to existing programs.<sup>37</sup> As one writer has stated:

Because most of the budget is a product of previous decisions, the largest determining factor of the size and content of this year's budget is last year's budget. The budget is thus like an iceberg: By far the largest part of it is below the surface, outside the control of anyone. Long-ranging commitments have been made; this year's share is included as part of the annual budget. There are mandatory programs, such as veterans' pensions, whose expenses must be met. Powerful political support makes the inclusion of other activities inevitable. Budgeting, therefore, is incremental, not comprehensive . . . [Those] who make the budget are concerned with relatively small increments to an existing base.<sup>38</sup>

This situation has a number of implications:

1. Previous levels of expenditure are mostly taken for granted.
2. As budget preparation is carried out by large numbers of people and organisations possessed of incomplete information and drawn together by a central financial authority, it is a highly approximate activity, and an error of only 1 per cent represents, in the Commonwealth budget, for example, more than \$200m.
3. Official budgeting is an activity in which decisions are largely fair and appropriate rather than optimal.<sup>39</sup>

No country has yet moved far beyond incrementalism<sup>40</sup>, but the possibility of doing so is a challenge that needs to be taken up.

One new element that has been added to assist in planning is the forward estimate. It has, however, been described as a 'departmental wishing list'<sup>41</sup> and is consequently of little relevance to succeeding budgets.

#### SOME ATTEMPTED SOLUTIONS

Following the presentation of a White Paper in 1970, the British Government set up a system within the Civil Service, based on the Public Expenditure Review Committee and the Central Policy Review Staff, to undertake analysis and review of nominated programs. Under this scheme, the British Treasury tries to get departments to nominate selected programs for review. It aims at getting departments thinking about goals, origins and cost of policies. At present, the scheme is only a limited attempt to analyse some substantial expenditure 'just to see what happens'. As yet, it appears to have made no contribution to policy making.<sup>42</sup>

This approach formed the basis of the recommendations made by the Royal Commission on Australian Government Administration for the assumption of program review functions by the Department of the Prime Minister and Cabinet.<sup>43</sup> Though this development is useful, unless that Department is given extremely large resources its role can be only superficial or fragmentary.

Another approach uses zero base budgeting (ZBB). This is a managerial technique which requires that each agency or department justify every dollar of the budget allocation it seeks, as opposed to the incremental technique. One writer has described it in these terms:

ZBB focuses its activities on answering two basic questions (Phyrr [sic], 1977, p. 1): (a) Are the current activities efficient and effective? and (b) Should current activities be eliminated or reduced to fund higher priority new programs or to reduce the current budget?<sup>44</sup>

ZBB requires that each agency evaluate and review all programs and activities through four basic steps:

1. identification of decision packages, with defined objectives;
2. analysis of decision packages to allow ranking and evaluation by the establishment of a minimum budget level with possible add-ons to improve performance;
3. ranking of priorities for programs, their add-ons and alternative programs;
4. preparation of a detailed operating budget.<sup>45</sup>

The purpose is to allow for the elimination of low priority programs, for the shifting of resources to provide increased funding for high impact programs, and for the assessment of the benefits to be derived by retaining programs.<sup>46</sup> By analysing what would happen if programs were reduced to bare bones levels, these procedures provide opportunities for efficiency and effectiveness to be improved.

ZBB provides improved management information. Further, because it involves staff at the lowest levels, it gives employees a sense of participation in the budgetary process.<sup>47</sup> However, this Committee is not convinced that employees will have a significant role. ZBB has, on the other hand, raised problems of its own:

1. It requires much time, money and paperwork—too much, some contend.
2. Particularly in large organisations with disparate segments, the normal budget review process can entail thousands of decision packages. It is precisely for the reduction of the immense task of making so many decisions that the incremental budgeting method is used.

3. Data collection within an organisation may have to be modified to ensure collection in the appropriate decision package format.
4. The decision package ranking approach may become ineffective if the decision packages themselves have to be altered as funding levels change.<sup>48</sup>
5. Major efforts are required to educate lawmakers and bureaucrats in the technique.
6. Decision packages can be padded in anticipation of cuts.
7. Historical cost and performance data which are needed for decision packages are often not available.
8. Ranking can be manipulated by placing popular items lower than items less likely to receive funding.<sup>49</sup>

The whole concept has been criticised as the introduction of another technique to replace management by objectives, which had replaced the planning-programming-budgeting approach. The latest concept is alleged to differ only in degree from both its predecessors.<sup>50</sup>

The adoption of zero base budgeting is dependent on:

- (a) development of and adherence to a set of objectives for use in decision making;
- (b) the ability to develop meaningful objective criteria to incorporate in decision packages;
- (c) the collection of appropriate data; and
- (d) the ability to train administrators to think in non-traditional ways so that they will use the collected data to develop these packages.<sup>51</sup>

If these conditions are not fulfilled, ZBB will fail and thereby create more problems than exist with traditional budgeting, for ZBB is, at least in the short term, a cost-creating activity. Therefore, its implications should be fully explored before it is adopted.

ZBB does, however, provide opportunities for the decision-making process to offer for consideration alternatives and their implications; it also ensures that decision making is a more open and visible process. The need to present decision packages would ensure more evaluation than is carried out at present.

The Senate Estimates Committees are limited by the rigid form of the Estimates. Proposed expenditures are presented in a manner that takes little account of program costs and provides no specific information about the cost of a particular program. Program costs can be spread across a large number of line items with no information provided to show what fraction of the line item should be attributed to a particular program. It may even be impossible to tell how many line items are relevant to a particular program.

The form of the Estimates must be recast or extended so as to make clear what is spent to attain a particular goal. The cost of specific programs must be clearly stated in a form that shows current and capital costs and apportions on an appropriate basis costs such as rent and salaries.

Though the current form of the Commonwealth budget does not allow individual programs to be distinguished, it now appears that the program concept is to be used increasingly. Evaluation presupposes the recognition of discrete activities aimed at achieving a stated goal. Indeed, much of our report rests on the program concept. A program-based budget is more concerned with outputs than is a line-based budget. The Public Service Board, in its manpower estimations, already uses the program concept.

While we do not suggest that an entirely new budget framework be adopted, it is clear that, if the efficacy of government activities is to be established, the concept of goal-attaining program activity needs to be clarified and made part of the budgetary process. This step would also substantially increase budgetary information to Parliament and enhance parliamentary control over the budget.

### *Centralised evaluation functions*

Particularly in the last decade, the Commonwealth Parliament has undertaken limited experimentation with its forms and procedures to increase its effectiveness. It is now time for Parliament once again to look critically at stratagems that can improve its effectiveness in ensuring the accountability of agencies and departments.

One requirement is the establishment of appropriate Commonwealth administrative procedures for the assessment of progress toward stated goals. Central control authorities will have to perform new tasks in overseeing the evaluation function and these will enhance existing functions, particularly those related to co-ordination and control. Parliament will have to adopt new procedures to cope with a greater flow of more appropriate data, and members will require some education in the uses to which evaluation results may be put.

The Federal Administration appears to be well served by centralised overseer agencies. The Departments of the Prime Minister and Cabinet, Treasury and Finance, and the Public Service Board all fill this role. The Auditor-General also is involved in central oversight, and this will be particularly so with his new functions in efficiency auditing. The resources presently available to these authorities do not permit them to undertake systematic, comprehensive evaluation: they must rely on information supplied by authorities responsible for programs. In practice, then, the situation might be described, in computer jargon, as one of 'garbage in, garbage out'.

It is clear to this Committee that the evaluation process ought to be the responsibility of the department providing a program or service, perhaps with access to specialised units in the Commonwealth Public Service to which it can turn for help with specific evaluation exercises. Centralised authorities should have the task of examining such evaluations with a view to ensuring that they are adequately carried out and that there is an analysis of the overall policy ramifications.

While evaluation is probably always a threatening activity, it is less so when it becomes a matter of responsibility, and perhaps pride, for those who actually run the particular program. This also is in line with the recommendations of the Royal Commission on Australian Government Administration, which encourage some devolution of central responsibility.

Centralised, systematic evaluation, either through the budget process, or as a new central function, is neither practical nor possible. It is not practical, because it does not sufficiently involve the operative staff, and thus is ineffective and more intrusive and threatening than necessary. It is not possible, because the resources that would be required would be vast and remote from the sources of data.

The stewardship and economic roles of a budget are vital, but the problems of management and effective utilisation of vast public resources demand that the budget process take on a further role for which it has much potential. Federal and State budget formats must be developed in a way that will allow budget information to be used as a management tool. A budget must clearly show how much money is being spent towards the achievement of particular stated goals.



## Recommendations

Specifically in relation to budgeting, the Committee recommends:

1. That the Departments of Social Security and Health define their activities in program terms and apportion costs, including departmental overheads, accordingly.
2. That functional categories in the Commonwealth budget be further broken down to identify spending on individual government programs and to enable the cost of each program to be seen.
3. That the House of Representatives Standing Committee on Expenditure be invited to formulate proposals for changes or additions necessary for the Commonwealth budget to become a management tool more appropriate to monitoring of the attainment of policy goals.
4. That a Commonwealth department or a particular program be chosen for a trial of zero base budgeting, the trial to be fully costed and publicly documented.

On the more general issues, the Committee recommends:

1. That the Commonwealth Government ensure that all health and welfare evaluation reports presented by or to it be tabled and printed as parliamentary papers, and that State Governments be encouraged to do the same.
2. That evaluation reports tabled in the Commonwealth Parliament be referred to relevant committees of both Houses of the Parliament.
3. That a committee of the Parliament be asked to investigate the possible use of sunset provisions in legislation.
4. That the Department of the Prime Minister and Cabinet be charged with the responsibility for ensuring that adequate program evaluation is carried out by all Commonwealth authorities, and that it certify annually that the results of such evaluations have been properly reported to the Parliament.
5. That freedom of information legislation, when enacted, provide for access to all evaluation information, with adequate safeguards for the privacy of individuals.

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## PART THREE

### **THE PROCESS OF EVALUATION, AND ITS COMPONENTS**

The process of evaluation has four prerequisites: the formulation of statements of *need*; the formulation of statements of strategic *goals* and specific *objectives*; the formulation of statements of *standards*, or criteria, for evaluating progress toward those objectives; and the development of a *data* base. These prerequisites improve objectivity in the evaluation process. Without them, assessment is based almost solely on the values and perceptions of the evaluator. This type of assessment is of very limited use for decision making.

These four prerequisites are important not only to evaluation but also to the effective functioning of the health and welfare system. They allow the system to operate in a logical manner. Without them, the system muddles along, reacting when specific pressure is applied, but often without any rational direction or purpose. After these prerequisites have been satisfied, it is possible to choose an appropriate model of evaluation for the program under review and to assess what has been achieved.

Evaluation activity in Australia is, in the main, inadequate in amount and quality, especially in respect of establishing these four prerequisites.

## Chapter 4

# Need

This chapter is about need: what it is; how one measures it; how it is or is not measured in Australia; and its importance in an equitable and rational health and welfare system. The chapter contains criticisms of some official and professional attitudes to the measurement of need in Australia. It also assesses the implications of these attitudes for health and welfare programs, their funding and their evaluation.

### Concept of need as part of the evaluation process

Need can be defined as *a situation that is judged to require a response*.<sup>1</sup> The response can lead to the provision of cash or services. It is the assessment of need that gives the goal-setting process its rationality, for goal setting without a measure for the assessment of need is dependent on the values and prejudices of those setting the goals.

The Australian public has only a poor perception of problems existing in the health and welfare areas. It has unsympathetic attitudes to many people and groups in need and there is no general agreement about program appropriateness or standards. Perhaps worst of all, the public does not comprehend how much it does not know.

Nevertheless, society has expectations that its health and welfare systems should achieve certain desirable goals, even though these goals may not always be stated with any clarity or precision. The development of a concept of need allows goals to be stated clearly and more precisely. To the extent that an understanding of need underpins the development and introduction of policy, a system will be rational and, we believe, probably more equitable and more efficient. Many systems have developed otherwise, using expressed demand, political expediency and general feelings of goodwill to determine how and to what end resources should be shared. These systems are generally less efficient, less equitable and less comprehensive than they should be.

Australia has an indifferent record in setting goals based on demonstrated need. However, there have been many successful initiatives, perhaps the result of serendipity or expediency rather than of rationality.

### Concept of demand

Some difficulties arise in isolating what properly constitutes need. For a start, there is a question about who should make the assessment. There is also the related issue of whether need and demand are separate, identical or related parts of the same expression of deprivation.

If need refers to a situation requiring a response, demand, by contrast, refers to what and how much consumers want. Demand is subjective and is determined by cultural expectations as well as by more objective measures. Many calls for service in the Australian scene are demands rather than expressions of need—a difference of some significance.

Economists regard demand as a central component of economic market models that determines the efficient allocation of resources in the market. Economic demand is an expression of how much of a particular service a consumer will want at a particular price; so price becomes a regulator of demand. The health and welfare market,

however, has some features that make the market model unacceptable as an a priori method of allocating resources.

Firstly, our society is coming to regard some benefits and services in the health and welfare area as rights. In this situation, demand is inadequate to ensure provision or adequacy, not least because demand may become increasingly divorced from ability to pay. Society may in fact determine that the achievement of health and welfare goals should not be related at all to economic factors. Secondly, increasing government subvention in the health and welfare areas has reduced the significance of price as a measure of the cost of supplying a service and as a regulator of demand. Thirdly, demand may come more from involved professionals than from clients or patients. Fourthly, need may be inversely related to ability to pay. Fifthly, demands from one source may be in conflict with the demands of other consumers of benefits or services. Sixthly, the classic market model assumes perfect knowledge by consumers; and we know that such knowledge is not always possessed by our health and welfare consumers.

We can reject, then, any simple market model for the allocation of health and welfare resources. Demand remains, however, and is difficult to assess as a legitimate expression of need. To the extent to which compassion must be extended to inarticulate groups unable to express demand, to the extent that demand is often political rather than rational, and to the extent that it may be inappropriately arbitrary, it is not an adequate or reliable measure of need.

Mr I. Yates, Secretary-General of the Australian Council of Social Service Inc., questioned on need and demand, said:

Those various sorts of representations—publicity and so on, all the things to which we have referred—are demands. They may represent very real need but they are not in themselves an accurate barometer of need. They may, in a particular issue, represent very real needs, pressing needs, and clearly in a lot of cases do so, but they are not, I think, a systematic way of approaching [the measurement of need].<sup>2</sup>

Dr R. Douglas, Senior Lecturer in the Department of Community Medicine, University of Adelaide, qualified this view somewhat when he said:

. . . I talked about the rather thin grey line that I believe separates the concepts of need and demand. I am sure you will receive testimonies from those who say there is a vast distinction between the two. In my view the best judge of need is not an outside professional but the individual himself . . . in the final analysis, use of health services comes about when an individual decides that he needs to see somebody about his problem, and that I believe is where our definition of need should begin, with the individual's perception of his problem . . . I know some will argue that if we concentrate in this way we will simply be opening the door to a flood of impossible demands from the public which bear no relationship to what medical science can provide nor to professionally defined need. I would answer that some of the most impossible and inappropriate demands on the health purse are directly attributable to the mistaken idea that professionals are the best judge of need.<sup>3</sup>

Because of the economic connotations of the concept of demand, it seems preferable not to use the term at all. A more precise expression in the context of this report would be 'expressed need'. Its use also has the advantage of not implying any value judgment.

Expressed need is often vociferous but is not always appropriate. It may identify only one manifestation of a problem and miss the central issue; it may identify only some potential clients; it may ignore services available; and it may be articulated ineffectively owing to lack of skills or resources, or of will, power or capacity to bargain and communicate with responsible authority. Further, many expressed needs are

immediate, fragmented and short term; and, since health and welfare services are planned ahead, requirements have to be anticipated.

The problem of not being able to clarify needs in their proper context is not confined to individual or group expressions of need. Lack of knowledge and lack of data are problems at the upper levels of planning. Resources are limited and choices have to be made on the basis of technical assessments. These assessments are modified by community and cultural considerations. For example, the Aboriginal health program for the treatment and prevention of trachoma would hardly have resulted solely from expressions of need voiced by a predominantly urban white community, as that community was not sufficiently aware of the prevalence or severity of the disease among Aborigines.

### **Concept of need**

We believe that need is, or could be, measurable. Many measures are already available and more may yet be required. Two recent reports dealing with need that has been measured objectively are *Families and Social Services in Australia*<sup>4</sup> and the First Main Report of the Commission of Inquiry into Poverty (**Henderson**).<sup>5</sup> To generate a response, need should really exist and its existence should be objectively demonstrable.

Four types of need have been described by Bradshaw, namely normative need, comparative need, felt need and expressed need.<sup>6</sup> *Normative* need is what the expert or professional defines as a need in any given situation. A minimum standard of provision or performance is laid down. This involves a value judgment and may need careful justification. *Comparative* need is a measure of need found by studying the characteristics of different groups, usually comparing those in receipt of a service with those not in receipt of it. *Felt* need is equated with want. It may be felt, but he who feels it may not be able, or have the will, to express it. It is limited by the capacity and perception of the individual, depending, for example, on whether he knows that a service is available, or whether he is reluctant to confess a loss of independence. *Expressed* need flows from felt need when, by political or other action, demand for a service is articulated.

Thus our concept of social need has four categories. This scheme of classification allows a more precise and systematic view of need and a more rational set of judgments in the making of policy than does the use of a global concept.

### **Importance of measuring need**

New initiatives in health and welfare should respond to some need. Where choices between competing claims have to be made, the extent of need should be one critical factor in these judgments.

The establishment of need provides the best rationale and basis for policy development. It is essential to the proper planning and delivery of appropriate services. Where need has not been measured, a new program either will be a stab in the dark, of greater or lesser appropriateness, or will be a response to the expressed needs of a particular interest group.

Precise measurement of the need to be satisfied is an essential prerequisite for the evaluation of a program or policy outcome. The extent to which need is satisfied provides the most rational basis for judging the effectiveness of a program.

The identification of need should be a crucial element in the provision of human services. Major E. Dawkins, of the Salvation Army, gave a clear example of what basic data can reveal when attempts are made to use them:

Out of the report on homeless persons in Newcastle came the fact that 32 per cent of the persons who arrive on the homeless persons scene ultimately, leave home before they are 15 years. Now our experience is that we do not see those people until they are in their late twenties. The question then arises of where they are. What should we be doing for them? How can we get to them? I cannot answer that directly, but because of my association with the Youth Counselling Service and the personnel of that service I know that they are out on the street and where those kids are. I have a fair idea that they would be able to come up with some substantial information that may help us to quantify this problem . . . .'

The identifying of need must be an active process; it cannot occur passively. Need will in all probability exist in an objective sense for some time before it is recognised. For example, while the high rate of Aboriginal infant mortality was recognised only in recent years, it clearly has existed for some time. Organisations must be continually feeling the community pulse and seeking those changes in community indicators that may reveal need. Current efforts at organising services in terms of client groups or geographic needs offer hope for responding more appropriately.

A process that actively pursues need will also endeavour to anticipate needs in accordance with structural changes in the community.

Unmet need also should be measured and assessed regularly to identify areas not being adequately covered by programs. The concept of unmet need is an aid to evaluation of the performance of different programs. Measures of need and unmet need are more than morbidity, mortality and poverty statistics; they include the whole range of measures of social disability, of measures of typical symptoms presented, and of measures of factors such as positive mental health and acceptable quality of life.

The process of measuring need must take account of all the types of need—normative, comparative, felt and expressed. Clients must be involved in the process. Need provides the basic reason for each program; and the public which is to be served, and which pays the bill, should know the rationale and be able to have an input in the consequent setting of priorities. Identification of need, then, must be a public process. Feedback is crucial. The public should have an untrammelled right to this information from public and private sources.

Mr P. Jenkins, First Assistant Secretary in the Community Division of the former Department of Environment, Housing and Community Development, identified the gathering of basic data as the first step in the process of determining need:

Right at the very beginning I said you have to know what questions you want to ask. If you do know those reasonably well and you do know what questions you need to ask, then you can define what information you need to answer those questions. I suppose this principle can go through the programs and the acts of government, which will say 'We have to review these things and we have to look at expenditure on our programs et cetera every year, and therefore we need a minimum of a certain amount of information so we can answer the questions dealing with those programs'.<sup>5</sup>

This issue is discussed more fully in Chapter 7.

### **Measurement of current need in Australia**

Most witnesses considered that little or no measurement of need is regularly undertaken, even though the process was recognised by all as being important. One witness took the view that need could be assessed politically. The political definition of need was enunciated by Mr P. J. Lanigan, Director-General of the Commonwealth Department of Social Security, who placed heavy reliance on felt and expressed needs as the measure of need:



At the administrative level perhaps the most significant factor of all in establishing an awareness of need is the continual flow of representations to the Minister through the ordinary democratic process and through the processes of the Parliament.

Not representations alone, but the Minister's own political involvement in the Minister's party; the Opposition's involvement; the bringing together of ideas in the form of a parliament; the enormous flow of representations which come into this Department in particular every week on every conceivable aspect of welfare needs. It is not so much the particular letter but the general trend of letters which gradually impresses upon members and political parties a fairly significant awareness of what is going on.

I am speaking about welfare in the broader sense. I would, of course, accept that all of the national statistics, all the important indicators of how the economy is progressing and all facets of the economy, are an equally important input—both to the Government and to the administrators and to the newspapers of course.<sup>9</sup>

This was reinforced in the answer to a further question:

**Chairman**— . . . How do you adjudicate between competing claims? Or how do you determine that social claims, however loudly they are expressed, are in fact correct? And so on and so on. Do you do this routinely? You have said that you can do it.

**Mr Lanigan**—Surely it must be essentially a political judgment in most cases. We can input some part of the answer but I suggest, with respect, that it tends to be a ministerial and Cabinet decision as to what needs we respect and what needs we do not.<sup>10</sup>

Mr Lanigan was supported by Mr A. S. Colliver, First Assistant Director-General in the Social Welfare Division of his Department, who said:

In dealing with this question of need, as Mr Lanigan has said, there does emerge a general social consensus from various groups which then become recognised as a general social need. You do get competing demands from various groups but from that there does come eventually an awareness—a consensus—that there is a particular social need in the community.<sup>11</sup>

One could be excused for concluding that, at the highest administrative levels, the Department of Social Security, unlike other departments, uses expressed need as its most significant indicator of deprivation. We reject this approach as irrational, inefficient and inequitable, and record our disappointment at the Director-General's apparently inadequate understanding of the limitations of demand as an index of need. By way of contrast, attention is directed to evidence given on behalf of the then Department of Environment, Housing and Community Development. Mr R. B. Lansdown, its Secretary, was questioned on this same matter:

**Chairman**—If we agree that levels of need are not sufficiently appreciated at the moment, do you think in what is a political process that we should set out to measure and know need, do you think it is only possible to take the intensity of criticism or critical letters to government as a measure of need, or do you think in fact that we need some objective measurements?

**Mr Lansdown**—We believe you need some objective measurements. I do not discount at all the correspondence. That is like the daily feel one gets for what the program is doing, but I do not see that as an effective substitute for effective evaluation.<sup>12</sup>

Many Australian initiatives have been a response to expressed need rather than measured need. To this extent, they have ignored the inarticulate or powerless who have not known how to express their needs effectively. The response has been political rather than equitable.

The needs of the inarticulate go unexpressed and are, by definition, almost unknown unless some action is taken to establish them. Further, expressed demand is

often related tactically to whatever is most likely to attract funding. Organisations tend to seek what is available rather than what is needed. For example, Mrs A. Gorman, Executive Director of the Family and Children's Services Agency in the New South Wales Department of Youth and Community Services, told the Committee:

The submissions we get indicate that people tend to ask for services which they know they will get funding for. Until recently they knew they could get funding for pre-schools for long day care and they put in a submission which reflected that. We have gone back to some of the areas and said to the people: 'You have put in a submission asking for certain things but is that really what you want?' They have said: 'We did not know there were any other options'. That is one of the problems in assessing need. People know that there are certain things on the shelf and they say: 'We will take one of those because the Government will fund that and it is better than nothing at all'.<sup>13</sup>

Success in this kind of political process stems largely from knowing where resources lie and how to gain access to them. It has very little to do with the level of need in the community. Such a process largely ensures that resources will go to the aspirant with the loudest voice.

Expressed need, then, is one tool to be used in understanding and identifying need. Inadequate on its own, it is disastrous if used as the sole measure of need. We therefore reject in emphatic terms the thrust of Mr Lanigan's evidence in this area.

#### *Ad hoc measurement of need*

Such measurements of need as are made in Australia are, typically, ad hoc and 'one off'. Few continuing processes for the assessment of need have existed. Some notable examples of the measurement of need are the Nutrition Survey (see page 20), the Commission of Inquiry into Poverty, the Social Indicators Program of the South Australian Department for Community Welfare, a number of studies by the Health Commission of New South Wales, and needs measurement undertaken by the Brotherhood of St Laurence as part of its normal program assessment.<sup>14</sup>

Mr P. Allen, Acting Executive Director of the Victorian Council of Social Service, told us that 'there is certainly no continuous monitoring of the need'.<sup>15</sup> The occasional exercises in the measurement of need are much less than parts of a planned, continuous program. We need longitudinal information about changing levels of need, and the capacity to integrate different sets of figures.

Mr Allen also observed:

There is a lack of social research and social experimentation in Australia but there was a period, during the time of the poverty inquiry, when Australia expended an enormous amount of money on social research and social experimentation. Very little appears to be undertaken at present. Much of the valuable work of the poverty inquiry in setting up frameworks within which information could be gathered over time appears to be progressively being lost to those involved in social service planning and delivery through the unwillingness or other difficulties involved in keeping that information up to date and in performing replication studies in other parts of Australia. An example is the research that was done into social indicators by Vinson and Homel. That research should be replicated in other parts of Australia but there is certainly not the money and perhaps not the interest to replicate that in an attempt to build up a much more useful set of indicators which social service planners may be able to use in order to develop services more likely to respond to needs, to be targeted more accurately to those who are in need.<sup>16</sup>

In this area, as in many others, the adequacy of present information and research has been called seriously into question in this inquiry. The deficiencies need better recognition at the higher administrative and planning levels to enable us to develop and deploy adequate resources.

### *Needs not known*

A current running through evidence before the Committee was that very little was known of health and welfare needs in the community. For example, in respect of the handicapped—an area in which some agreement on needs is more readily possible than in others—data are worse than poor. A representative of the Department of Social Security told the Committee:

To be absolutely frank it seems to me that you are addressing yourself to one of the key issues which the National Advisory Council for the Handicapped keeps stressing in its annual reports: that, quite apart from all the points which Mrs Coleman and Mr Colliver and others have made about the difficulties of interpreting data, there is not even sufficient basic data.<sup>17</sup>

Certainly, there is no register of the number of handicapped<sup>18</sup> and there has been no lack of calls for such data.<sup>19</sup> Even a proper research basis for data collection appears to be lacking. This view was echoed throughout the inquiry.<sup>20</sup> It appears also that, no matter how one defines voluntary agencies, we do not know how many there are.<sup>21</sup> One group which claimed to have a knowledge of the level of needs in the community had had to rely on the extrapolation of overseas figures.<sup>22</sup> Other witnesses made it clear to the Committee that, while some numbers were known, they were based on cases that became known only when situations degenerated to crisis point,<sup>23</sup> as, for example, when children appeared in the courts. The level of unmet need is probably even less comprehended than the level of actual need.<sup>24</sup>

A number of witnesses acknowledged that we do have some knowledge of need, but qualified their view in one of two ways. Some said that we do not know enough—for example, in the area of housing;<sup>25</sup> others added that, in many instances, the existing structures do not effectively integrate what we do know into policy making or into modifications to existing patterns of service delivery.<sup>26</sup>

The issues relating to use and derivation of data on need are discussed more fully in Chapter 7.

### *Developments*

The Committee gained the impression that a large amount of data is collected but not collated or used by agencies owing to lack of time, staff and expertise. Some degree of reliance on anecdotal information was noted.<sup>27</sup> There is also a lack of information about the number and range of non-government agencies in Australia, but some efforts to rectify this situation are now being made.<sup>28</sup>

There are a number of useful developments related to the assessment of community needs. The fact that people lament the lack of information about need reflects a desire for the information. Welfare organisations are becoming more aware of the data required to predict needs and measure responses and are examining their own data-generating capabilities.<sup>29</sup>

Government departments are developing means of reducing the information gap with respect to need. This was noted particularly in evidence given by the Department of Veterans' Affairs,<sup>30</sup> the Commonwealth Department of Health,<sup>31</sup> the Health Commission of New South Wales and the Department of Youth and Community Services in that State,<sup>32</sup> the Brotherhood of St Laurence,<sup>33</sup> and the Smith Family.<sup>34</sup> These efforts

need general encouragement and also specific support by way of funding and the dissemination of information.

Active searching for needs rather than waiting for them to declare themselves is now beginning to occur.<sup>35</sup> This new approach includes some basic efforts in the use of social indicators (see pages 88–9).

On a somewhat hopeful note, it is clear that some, albeit very few, organisations are able to 'plug in' to the system and are beginning to have a very good idea of the needs to which they must respond. Examples that have come to the Committee's notice are the Brotherhood of St Laurence, the Sydney City Mission and the Hunter Region Health Services in New South Wales. Their success demonstrates the possibilities for successful use of the concept of need as a rationale for action.

### *Problems with the measurement of need*

The political process used now to allocate priorities in health and welfare favours the articulate, the powerful and the attractive, in the battle for resources. Many groups that do well in this situation will not readily relinquish their privileged access to the process. Nor will they easily agree to higher priorities being given to others on the basis of some objective measurement—especially if this is seen as anonymous and impersonal. It will require toughmindedness to insist that information derived from surveys of need be used to change priorities.

Further, organisations' priorities are altered by the demands made on them. The Rev. C. Miller, Director of the Department of Community Service, Baptist Union of Queensland, said: 'I do not think we are really assessing their needs; we are being, not exactly manipulated by our waiting list, but pushed'.<sup>36</sup>

The identification of need entails dangers and political costs. Some needs that may be identified may be ones with which the available resources cannot cope or for which the appropriate strategies are not known. Some needs may fall outside the prevailing value system.

The identification process will itself use resources. The Committee was not able to make a judgment about the level of cost involved. Indeed, such a judgment presupposes a number of decisions as to the extent and rigour of the process. Furthermore, it is difficult to ascertain what uncollated or unused information on need exists in the community. In any judgment of costs, however, one must balance against the cost of the identification process the increasing number of official inquiries that investigate needs, such as the Commission of Inquiry into Poverty and the Review of the Commonwealth Employment Service.<sup>37</sup> With an adequate identification process, the requirement for these one-off, costly inquiries would be much less. The cost could also be reduced if such a process were made part of the normal administrative procedures for evaluation. It is felt, however, that the resultant increase in accountability (see Chapter 1) would offset and justify even a relatively high level of cost.

A major problem in the identification of need is the lack of basic data. New data collections and new methods of collection may be necessary. There must also be better co-ordination of agencies on a national and local level to allow for the use of what could be a large amount of uncollated and unrelated information. Though problems of methodology and privacy will arise, we believe that they are not insurmountable.

Priorities will still remain the principal problem. After needs have been identified, someone has to make the final decision on which needs are to have priority. In a properly ordered system, the decision makers will not have to determine priorities by relying on the number and strength of expressions of need, the volume of mail to an

office, or bald guesswork. They will have at their command data that will enable decisions to be made on a rational basis, perhaps systematically, and above all according to visible criteria.

Further, one cannot argue that demonstration of need removes from the situation the values of the professional. The values of professional and politician are involved in the process of defining needs to be measured, in setting priorities between different areas requiring measurement and in methods used to identify need. These values must be recognised and stated.

## **Recommendations**

### **The Committee recommends:**

- 1. That all levels of government make a commitment to identify and declare the state of need and of unmet need in Australian health and welfare, and to assess these factors continually.**
- 2. That the Social Welfare Policy Secretariat, in co-operation with the non-government health and welfare sector, formulate and publish basic minimum data requirements for the assessment of levels of need in health and welfare services.**
- 3. That instrumentalities with programs designed to answer need be responsible for the collection, updating and dissemination of appropriate statistics relevant to measuring levels of need.**
- 4. That the non-government welfare sector be given specific grants for the collection and publication of data already collected by agencies with programs designed to answer need.**
- 5. That funding proposals by government departments and by non-government agencies receiving government funds be required to identify need in an approved, objective fashion and that independently funded bodies be encouraged to do the same.**
- 6. That:**
  - (a) all collected data on need be published, irrespective of their quality; and**
  - (b) lists of what data are available be published also.**
- 7. That legislation establishing new programs within government authorities include a requirement that measures of unmet and satisfied need be detailed in the annual reports of the relevant authority.**
- 8. That non-government agencies receiving government funds be required to furnish publicly, at specified intervals, measures of unmet and satisfied need.**
- 9. That independently funded bodies be encouraged to make statements of unmet and satisfied need in their annual reports.**

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## Goals and objectives

This chapter shows why it is important that goals and objectives be set in all health and welfare programs, describes their importance for planning and co-ordination at the government level and for the guidance of service organisations, and illustrates why they are necessary for evaluation. A description of the current unsatisfactory situation regarding the setting of goals and objectives in the community is given, followed by a discussion about the resources that may be required to improve this situation.

### Definitions

For the purposes of this report, goals are defined as *broad statements of intent*. Objectives are *statements of specific intent that describe target groups or desired achievable results within specified time frames*.<sup>1</sup>

Objectives can be divided into three separate categories: *structure, process* and *outcome*. Mr J. Martins, Acting Director of the Policy Analysis and Special Projects Unit of the Health Commission of New South Wales, has described each of these categories for health services. Similar considerations apply to welfare services. The descriptions given by Mr Martins are:

The structure—

or the setting in which people and the health services provided exist, with:

- (i) Physical structures, facilities and equipment.
- (ii) General organisational features.
- (iii) Administrative organisation.
- (iv) Staff organisation.
- (v) Finance, costs and related aspects of organisation.
- (vi) Geographic factors.

The process—

or the way in which people receive the services provided, with given characteristics of use of the service provided including:

- (i) Extent to which screening and case-finding activities are carried out.
- (ii) Diagnostic activities.
- (iii) Treatment.
- (iv) Consultation and referral.
- (v) Co-ordination and continuity of care.
- (vi) Staff turnover.
- (vii) Staff absenteeism.
- (viii) Use of health services by providers.
- (ix) Client complaints.
- (x) Compliance or non-compliance with health and illness management program.
- (xi) Knowledge about health and illness in general, and any current illness in particular.
- (xii) Changes in knowledge or behaviour expected after prior exposure to medical care.
- (xiii) Volume of care provided.

The outcomes—

or the measurement of the ultimate result of the interaction between people and the services being provided expressed in terms of:

- (i) Health outcomes, including changes in morbidity and mortality in general, and in relation to specific groups of people and diseases, life expectancy and restoration of physical and social functioning.
- (ii) Satisfaction of the clients and providers with the structures, process and health outcomes.<sup>2</sup>

Outcome objectives are the most important consideration. Process and structure objectives outline what should happen and the conditions needed to enable the outcome objectives to be achieved to the fullest possible extent. All objectives should be clearly defined and measurable.

### **Importance of setting goals and objectives**

Goals and objectives need to be set for three main reasons:

1. to assist in the general planning and co-ordination of the health and welfare system;
2. to provide guide-lines for health and welfare workers at the service level;
3. to make adequate evaluation possible, by enabling decisions to be made about what to monitor, and by serving as a reference point to permit a judgment about the success or failure of what has been attempted.

### **Goals and objectives to assist in planning of services at government level**

The setting of goals and objectives would provide a rationale for the planning and co-ordination of services at government level. Clear statements of intent by both government and services would enable planners to determine the relevance of service objectives to government goals and give the process of resource allocation a rational direction. Without such goals and objectives, planning becomes completely reactive,<sup>3</sup> with resources being allocated in a piecemeal, non-directed fashion.

Goals and objectives enhance the co-ordination of services by enabling planners to identify and quantify the resources available in a particular location to meet a specific need. New services may then be located where there are deficiencies and where they will not overlap with existing services. For example, several services may have facilities to meet the needs of migrants but, unless each sets and announces objectives directed to helping migrants, planners may be unaware that proposed services will overlap.

### **Goals and objectives to serve as guide-lines at service level**

Government goals function as guide-lines for services by providing an outside reference point for the establishment of service objectives. Without such goals, services may not know the roles that they are expected to fulfil in the total complex of the health and welfare system. In such a circumstance, it may be impossible for them to state clear objectives.

At the service level, there is a belief that bureaucratic decisions about funding are sometimes arbitrary.<sup>4</sup> The existence of government goals makes it more difficult for funds to be suddenly withdrawn without any rational reason. The measure of security thus given to health and welfare workers enhances the quality of their work. The existence of government goals also provides services with a rationale on which submissions for funds may be based.



Objectives in services function as guide-lines for health and welfare workers. They give direction to daily activities and enable rational decisions about the allocation of resources to be made. They are essential for the efficient and effective operation of every health and welfare service.

One witness felt that there was a specific disadvantage in setting objectives for the guidance of agencies. He stated his support for setting objectives but added that they may have constricting effects on service delivery.<sup>5</sup> However, this might not be a problem if multiple objectives were set. These should be stated in order of priority and constantly reviewed and adapted in the light of changing need, knowledge and political pressures. This matter is discussed later in the chapter.

### **Importance of objectives to evaluation**

Objectives are essential to evaluation because they enable decisions to be made about the type of data to be collected. For example, if reduction of the incidence of trachoma in the Aboriginal population by half within two years is set as an objective, data identifying the results achieved by treatment programs become essential.

Objectives also serve as reference points to enable judgments to be made about the success or failure of what has been attempted. Without them, it is impossible to gauge whether any advancement has been made.

Not all witnesses agreed on the value of stated goals and objectives for evaluation. Mr M. Chadwick, Chief Executive Officer of the Royal Tasmanian Society for the Blind and Deaf, stated that it was possible to evaluate without clearly identified goals. When asked whether success or failure could be judged without the setting of goals, he added that it was possible to identify it by the service delivery to the client and the client's response to that service delivery.<sup>6</sup> Service delivery and the client's response should play an important part in evaluation. However, they are really only measures for use in the assessment of process, and very little else. Of themselves, therefore, they are not sufficient for the assessment of the total service.

Mr D. Oakley, Director of the Victorian Children's Aid Society, said that stated goals were of crucial importance<sup>7</sup> but added that an experienced person could evaluate without goals and objectives 'on the basis of his experience, knowledge and general intuition'.<sup>8</sup> The Committee does not agree with this view. While experience and intuition may be valuable in assessing the efficiency, or process, of an organisation, they cannot assess effectiveness. An overall assessment of the effectiveness of a service must be made against stated goals. Further, assessment 'on the basis of . . . experience, knowledge and general intuition' in fact calls on a set of assumed professional values and goals.

Mr P. Jenkins, First Assistant Secretary in the Community Division of the then Department of Environment, Housing and Community Development, said that he thought goals were necessary but expressed some reservations about limiting the evaluation to the stated objectives alone, because often programs have unforeseen effects which may be missed if goals and objectives are the only considerations.<sup>9</sup> A similar point was made by Mr W. Bruen, Acting Assistant Director-General, Health Service Research and Planning Branch No. 1, Commonwealth Department of Health, who has until recently directed the Evaluation Section within that Department.<sup>10</sup>

The Committee appreciates the argument put forward by these two witnesses. While evaluation should be concerned primarily with measuring against stated objectives, unpredicted results should be watched for and considered in the overall evaluation report.

Mr P. J. Lanigan, Director-General of the Department of Social Security, thought that it was sufficient to evaluate against very broad, non-specific goals:

I believe that having regard to our datum point which is the legislation itself and the general consensus, although a tacit consensus, in the community of what the legislation is aiming at, there is sufficient conception of what the Act is trying to do which can be evaluated from the point of view of whether we are doing it efficiently and effectively or whether we are doing things at greater expense than we need to accept.

As long as we do not try to be too specific in defining our objectives we can assume broad, underlying objectives of the legislation, and we can evaluate by reference to them.<sup>11</sup>

The Committee disagrees with this view for three main reasons. Firstly, if objectives are too broad, and are not stated, it is almost impossible to decide what is to be monitored; hence, adequate evaluation cannot take place. Secondly, there is no reference point against which a judgment of success or failure can be made. Thirdly, 'tacit consensus' is not as prevalent as Mr Lanigan supposed. He gave us an example of it as the general understanding in the community of what the pension legislation is doing. He believed this understanding was extensive.<sup>12</sup> However, when the Committee asked a number of witnesses what the goals of the age pension were, the most definite replies elicited were to the effect that the pension was for income maintenance and/or the maintenance of a decent standard of living.<sup>13</sup> The Committee believes that it would be almost impossible to conduct an adequate evaluation against these goals. Several witnesses experienced in administration and cost transfer programs said that they had no idea of the goals of the age pension legislation.<sup>14</sup>

### **Flexible goals and objectives**

To enable a service to remain flexible, it is important that multiple objectives be set. They permit a compromise between many possible views of the functions of a particular service and enable the service to be made more comprehensive. These multiple objectives should be listed in order of priority.

Changes in need in the community, changes in political policies and advances in knowledge should be constantly monitored by all health and welfare services. Objectives should be updated continually in the light of these changes.

### **Current situation regarding goals and objectives in Australia**

#### *General impressions of goal setting in Australia*

The health and welfare sector, both government and non-government, has a number of subliminal goals. It hopes to meet and satisfy needs by providing or improving access to equitable, effective and efficient services. As a contribution to the national political debate, it states propositions and makes policy offers as a basis for response by the political process. It is concerned with other less generally identified aims. It provides employment for a significant percentage of the workforce. This sector also offers prestige, and access to power and self-esteem. The non-government health and welfare organisations also have an important consumer advocacy role and provide much of the informed criticism of the activities of the government health and welfare sector.

However, the Committee believes that the setting of goals and objectives in Australia has not developed sufficiently. Our view was supported by Mr R. B. Lansdown, Secretary of the then Department of Environment, Housing and Community Development, who has been in a position to observe the overall situation.<sup>15</sup> However, there has been some encouraging progress toward the setting of goals and

objectives on an adequate scale. Dr B. Hennessy, First Assistant Director-General in the Policy and Planning Division of the Commonwealth Department of Health, told the Committee that goals and objectives were just beginning to be set but were yet too vague.<sup>16</sup> Mr Bruen, speaking of the efforts of the Department's Evaluation Section to encourage health services to set objectives, said: ' . . . we rarely get to the stage beyond where broad aims are set'.<sup>17</sup>

Many of the witnesses who appeared before the Committee said that the organisations that they represented did have objectives.<sup>18</sup> However, most of the objectives stated in response to questioning were so broad as to be not useful for evaluation<sup>19</sup> or were merely implicit.<sup>20</sup> Some were stated in broad terms of seeking to provide a service.<sup>21</sup>

The first report of the Task Force on Co-ordination in Welfare and Health attempted to identify objectives of various government programs.<sup>22</sup> However, many of the objectives identified were process objectives, and vague, unmeasurable outcome objectives, such as those of the Institute of Family Studies:

The Institute is to conduct research into factors affecting marital and family stability in Australia with the object of promoting and protecting the family and to advise and assist the Attorney-General in the making of grants and their employment.<sup>23</sup>

The objective of 'promoting and protecting the family' is certainly not an adequate outcome objective that could be used for evaluation.

Another example of lack of appropriate standards was given during a meeting of Senate Estimates Committee D in April 1977. Dr N. A. Elvin, Superintendent of Woden Valley Hospital in the Australian Capital Territory, was asked by Senator Peter Baume to state the objectives of the hospital. The substance of the reply was that the hospital exists to heal the sick.<sup>24</sup> This is not an operational objective that could be used for evaluation.

### *Goal setting in the government sector*

The importance attached to the setting of goals and objectives varies markedly between Commonwealth departments. The then Department of Environment, Housing and Community Development was aware of the need to set goals and objectives, and stated in its submission that one matter which must be central to the evaluation process is:

- the examination of program goals, including the original formal goals, informal goals which have developed in practice over time, and possible future goals.<sup>25</sup>

In contrast, the Department of Social Security attaches little importance to the stating of clearly defined goals. As quoted earlier, it holds a view that broad underlying objectives are sufficient for evaluation.<sup>26</sup> As already stated, the Committee disagrees with this view.

The declared attitudes of some State Governments have impressed us. Concerning the importance of establishing goals and objectives, Dr H. Gwynne, Senior Medical Officer, Division of Health Services Research, Health Commission of New South Wales, told the Committee:

I think high priority should be given to try to build into our organisations some program of evaluation whereby they can evaluate their own activities, set objectives, define their targets, set standards and define procedures that will maintain the quality of services. They can identify the target of population, find out whether they are reaching it and can set budget limits.<sup>27</sup>

The South Australian Government, for example, has taken action to incorporate stated goals in legislation. Section 7 of the Community Welfare Act, 1972 contains the following provisions:

Without limiting in any way the operation of this Act, it is declared that the objectives of the Minister and the Department, in the administration of this Act, include the following—

- (a) to promote the well-being of the community by assisting individuals, families and sections of the community to overcome social problems with which they are confronted and to promote the effective use of human resources and the full realization of human potentialities;
- (b) to promote the welfare of the family as the basis of community welfare, to reduce the incidence of disruption of family relationships and to mitigate the effects of such disruption where it occurs;
- (c) to assist voluntary agencies engaged in the provision of services designed to promote the well-being of the community;
- (d) to collaborate with other Departments of Government whose activities directly affect the health or well-being of the community;
- (e) to establish, promote and co-ordinate services and facilities within the community designed to advance the well-being of children and young persons;
- (f) to collaborate with agencies engaged in the provision of assistance to those in need or distress and to promote rationalization and co-ordination of the assistance provided for those persons;
- (g) to promote research into problems of community welfare and to promote education and training in matters of community welfare;
- (h) to promote generally an interest in community welfare.

While this is a very broad statement of goals, it does at least give those administering the Act some idea of what they are trying to achieve. The Committee believes that this practice of identifying goals in health and welfare legislation should be adopted by all governments.

A number of witnesses were asked whether they were aware of any government goals. Almost all replied that they were not.<sup>28</sup> One reason for this could be that goals that are set in the government sector are not communicated to other sectors. However, the Committee believes that the main reason for this lack of knowledge is that there have been very few instances in which adequate goals have been established at government level. This view was enunciated by several witnesses who worked at program level.<sup>29</sup>

It should be noted that the need for setting objectives for health and welfare programs at the federal level was emphasised in 1975 by the Royal Commission on Australian Government Administration:

We need to increase the extent to which Parliament is asked to legislate the goals and purposes of such programs, the guidelines within which they should be implemented, and the processes of evaluation and review.<sup>30</sup>

It appears that very little has been done by the Federal Government to satisfy this need.

#### *Resources available for the setting of goals and objectives*

At least two government instrumentalities offer practical assistance in setting goals and objectives. The Policy and Planning Division of the Commonwealth Department of Health publishes an occasional monograph series of papers in the general field of

health care delivery research, planning and evaluation.\* The first paper in the series was produced in April 1978. It discusses evaluation against established goals and objectives; and one section deals with the aims of services and discusses the types of objectives that could be adopted in health care organisations.<sup>31</sup>

Within the Policy and Planning Division is the Evaluation Section, one of the stated functions of which is 'to provide advice and assistance to health service projects seeking to evaluate their services'.<sup>32</sup> The Section could provide invaluable advice, and we hope that health service organisations will be prepared to consult it when attempting to set goals and objectives.

The Health Commission of New South Wales also provides resources to assist agencies in setting goals and objectives. It has produced a 'Community Health' series of six booklets which set out seven broad goals for community health services that reflect the policies of the Commission. Under these seven goals, the series outlines objectives and strategies that health workers and planners might use to achieve their goals. Four organisational objectives are proposed: (a) services; (b) programs and facilities; (c) area responsibility; and (d) management.<sup>33</sup> These are concerned mainly with structure and process objectives. When asked by the Committee why there was not a fifth category dealing with effectiveness (or outcome) of services, Dr Gwynne replied:

I think that effectiveness is a very difficult issue to get at. I said earlier that the only absolutely conclusive way of getting effectiveness is by some sort of randomised controlled trial of about two to five years. We are talking about an expensive process.<sup>34</sup>

The Committee does not accept this statement as necessarily true of all evaluations of effectiveness. Other more simple, relatively inexpensive methods of determining effectiveness are available. The setting of outcome objectives is an essential part of evaluation and the Committee urges the Health Commission of New South Wales to provide agencies with additional guide-lines for the setting of such objectives.

### Summary and conclusions

It is important to set goals and objectives for three main reasons:

1. to assist in the general planning and co-ordination of the health and welfare system;
2. to provide guide-lines for health and welfare workers at the service level;
3. to make adequate evaluation possible, by enabling decisions to be made about what to monitor, and by serving as a reference point to permit a judgment about the success or failure of what has been attempted.

At present, the extent of the setting of goals and objectives in the community is inadequate for the purposes of either planning or evaluation. There are almost no government goals in health and welfare, and very few departments state adequate objectives either for sections within departments or for programs that they operate. Nor, for most non-government organisations and the programs that they administer, are there precise operational objectives. When objectives do exist at the service level, they are usually either implicit or so broad as to be incapable of being used for evaluation purposes.

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\* The Department invites anyone wishing to receive these papers to contact the Assistant Director, Regional Planning and Resource Allocation Section, Policy and Planning Division, Department of Health, P.O. Box 100, Woden, A.C.T.

## Recommendations

### The Committee recommends:

1. That the Commonwealth and each State Government, in association with the non-government sector and consumers, declare in writing, clearly and publicly, (a) broad strategic goals for its health and welfare programs, and (b) precise and testable objectives for each program in which it is involved, either directly or as a funding authority; and that, in the Commonwealth sphere, the Social Welfare Policy Secretariat, if necessary, be charged with the planning, oversight and implementation of these proposals.
2. That all governments state clearly, in relevant legislation, their goals for health and welfare initiatives.

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## Standards

The aim of this chapter is to illustrate the importance of standards and to describe their present status in the community. It shows why standards are necessary for the efficient operation of the health and welfare system. It also shows why standards are important to evaluation. A description of the standards that do exist, and of the type of standards that are required, is given with related recommendations.

### Definition of standards

The Concise Oxford Dictionary defines 'standards' as *weight or measure to which others conform or by which the accuracy or quality of others is judged . . . thing serving as basis of comparison*.<sup>1</sup> It is the concept of standards being a measure of quality, amount, accessibility or relevance that the Committee has adopted. There are two broad categories of standards: **provision standards** and **performance standards**.

**Provision standards** may be divided into distribution standards and structural standards. *Distribution standards* refer to the number of facilities in proportion to the size of a demographic group: for example, x hospital beds per y people over age 60, or x child-minding centres for y children aged from 1 to 5 years. *Structural standards* refer to numbers and types of facilities or staff that should be available within a service: for example, x basins for y children, or one supervisor to z children.

**Performance standards** refer to desirable patterns of care or practice: for example, workers should be empathetic in their interaction with clients. Avedis Donabedian has identified two types of performance standards and has described how each is derived. *Normative standards* are derived, in principle, from:

the sources that legitimately set the standards of knowledge and practice in the dominant medical care system. In practice, they are set by standard textbooks or publications, panels of physicians, highly qualified practitioners who serve as judges or a research staff in consultation with qualified practitioners. Normative standards can be put very high and represent the 'best' medical care that can be provided, or they can be set at a more modest level signifying 'acceptable' or 'adequate' care. In any event, their distinctive characteristic is that they stem from a body of legitimate knowledge and values rather than from specific examples of actual practice. As such, they depend for their validity on the extent of agreement concerning facts and values within the profession or, at least, among its leadership.<sup>2</sup>

*Empirical standards* are derived from:

patterns of care observed in actual practice. The standards consist of the practice of an institution accepted as a leader in the field, or of averages and ranges obtained from information about practice in a large number of institutions.<sup>3</sup>

Standards not only are important in the process of evaluation, but also are essential to the general operation of the health and welfare system.

### Importance of standards to the health and welfare system

Standards play a vital role in the day-to-day running of a service by providing a rationale for decisions. The Victorian Council of Social Service supported this view in a submission to the Committee:

. . . the principal purpose of standards is to reduce the uncertainty in the decision-making process. When an individual, groups of individuals, or an organisation (i.e. a



decision-making entity) makes a decision about the allocation of resources in its environment which will eventually affect the welfare of itself and others, then standards help to ensure that these effects will be acceptable to the decision maker. As such, standards aid in the routinisation of the process of decision making by providing an external decision rule which will help guide one portion of the decision-making process along an acceptable path.<sup>4</sup>

Standards also guide the individual health and welfare worker and make more possible inter-agency comparison and co-operation. The lack of broad-ranging consultation between services in Australia<sup>5</sup> means that it is very easy for workers to become 'lost in their own little world'. They accept the norms of their own service and may lose sight of their intended role in the total system. If standards were set, these workers would have some reference point in the outside world by which they could assess their own performance and would be able to communicate more easily and co-operate with other similar services.

Clients also benefit from defined standards which provide them with information about their welfare rights. If expectations about rights are not realised in a particular agency, clients can submit a valid complaint using the defined standards as a basis. They can also 'shop around' for an agency that meets the standards. These opportunities could improve the chance that the client will receive satisfactory service.

At the same time, the availability of standards could improve the quality of the health and welfare system by placing pressure on agencies to conform to the standards if they wished to avoid losing their clients and possibly their funding.

One of the most serious consequences of a lack of stated standards is a wide variation in the quality of services provided. Mrs A. Gorman, Executive Director of the Family and Children's Services Agency in the New South Wales Department of Youth and Community Services, illustrated this point when she told the Committee that the standards of institutions for children across Australia vary from Dickensian to excellent.<sup>6</sup> She elaborated by saying:

... there is a tremendous unevenness in the quality of care. Let us take children's homes as an example. We have done some work on this. Some children's homes have a custodial relationship with the children. They feed and clothe them but nothing else. No effort seems to be made to run a program of activity for the children. The homes have small staff numbers and the quality of the staff is also low in that the staff has had no training and does not have too much time for the children. The staff get cranky and might be authoritarian.<sup>7</sup>

A consequence of a lack of provision standards is inadequate capacity to plan at program level. Without such standards, there is no rationale for deciding the type and location of services or the facilities to be contained within them. This view was supported by Mr Maurice Benfredj, Director/Social Planner of the Western Adelaide Regional Council for Social Development:

The absence of such standards leads to ad hoc planning, and thus to the overlap of services in some areas and the complete absence of services in other areas.<sup>8</sup>

At agency level, the absence of provision standards also creates problems. When making submissions to governments for funds, agencies without set structural standards have no rational base from which they can state their case for improved or expanded facilities. They do not know whether the facilities that they have are above or below the norm. Without distribution standards, they can have little idea of where their agency should be located to serve most effectively; that is, they do not know whether there are too many or too few of a type of service in any particular area.

### **Importance of standards to evaluation**

Goals and objectives are essential to evaluation (see Chapter 5). Without standards, it is difficult to set realistic goals and objectives. If agencies do not know the norm for particular services, it is difficult for them to set objectives achievable in their own environment.

In evaluation activity, a set of standards is needed:

1. to specify the dimensions that are to be considered;
2. to provide a measure against which assessment can be made.

Standards therefore make evaluation reports more objective and comparable.

### **Standards used to specify the dimensions of evaluation**

There is a wide range in the quality of services in Australia and, without a statement of standards, internal evaluations conducted by any government department or non-government agency will depend on the norms of the evaluator. The set of criteria adopted for evaluation in one service may be totally different from criteria in another, and any assessment of their relative worth may be impossible. For example, if there is no standard requiring that nursing home staff be empathetic and kind in their approach to patients, a nursing home that does not include this concept of kindly attitude in its criteria may be unaware that its operation is not optimal. Furthermore, without this standard being set, there is no rationale for anyone to tell an evaluator of the particular nursing home that this dimension should be included.

### **Standards used as a measure for assessment**

Simple specific standards such as x beds per y people over age 60 can be used alone to serve as a measure in assessing achievement. However, broader standards may need to be broken into several simpler criteria to enable the assessment to be made. For example, one of the ethical standards set by the Australian Medical Association is: 'A doctor should be ever striving in the interests of his patients to improve his knowledge and skill'.<sup>9</sup> From this standard, criteria such as numbers of journals read per week or post-graduate courses undertaken may be specified, and these would enable the performance of a doctor to be measured more objectively and accurately.

### **Current situation in standard setting in Australia**

The current situation regarding standard setting in Australia is unsatisfactory. In both government and non-government services, there is a lack of precisely defined standards for the efficient operation of the health and welfare system and for its adequate evaluation. Our view was supported by several witnesses who work at the planning levels of the health and welfare system. Ms E. Cox, Director of the Council of Social Service of New South Wales, told the Committee: 'I think one of the problems with the welfare section, generally is that there has been very little investment in standard setting'.<sup>10</sup> Mr Maurice Benfredj observed:

The more difficult aspect of the evaluation of health and welfare services is that of qualitative standards. The basic problem here is, in our opinion, that there are no adequately defined standards in existence.<sup>11</sup>

Mr P. Allen, Acting Executive Director, Victorian Council of Social Service, said:

We made a serious attempt in our study within Victoria to identify standards which we could use to assess the efficiency and effectiveness of existing service provisions, and we were unable to do so.<sup>12</sup>

Our view was further supported by several other witnesses from the non-government sector,<sup>13</sup> and by a social worker in hospital practice.<sup>14</sup>

However, our evidence did reveal that there has been an increasing amount of standard setting in Australia. One notable set of performance and structural standards is the *Accreditation Guide for Australian Hospitals and Extended Care Facilities*<sup>15</sup> issued by the Australian Council on Hospital Standards. This is a comprehensive guide about staffing arrangements, facilities that should be provided, and procedures to be followed in hospitals and extended care facilities. The stated purpose of the publication is 'to provide standards of comparison for hospital professionals intent on improving patient care in the facilities in which they give service'.<sup>16</sup>

There are also specifications set out in various Acts controlling health and welfare professionals, for example, the New South Wales Medical Practitioners Act, 1970. However, the provisions contained in these Acts are very limited in their purview, pertaining mainly to qualifications, and they provide no real guide-lines for the professional in his day-to-day activities.

Some professional organisations have established their own standards in the form of a code of ethics. The Australian Medical Association, for example, has produced a booklet<sup>17</sup> which outlines the traditional standards for doctors. These are derived from statements in the Hippocratic Oath, the Declaration of Geneva and the International Code of Medical Ethics, as well as from additional statements of policy definitions and rules developed over the years.<sup>18</sup> The statements of standards cover the doctor's interaction with the patient, the practice, his colleagues, other professions, commercial undertakings, the general public and the media. The stated purpose of the publication is:

. . . to serve as a guide to members of the profession in maintaining a high standard of ethical conduct, and as a basis for answering many of the problems which confront them in their relationship with one another, with their patients, and with the community as a whole.<sup>19</sup>

The Australian Physiotherapy Association has also published a booklet outlining basic ethical principles, rules of ethical conduct, ethical guide-lines on private practice, advertising and research involving human subjects.

State Governments have formulated minimum standards for some services. For example, the Queensland Children's Services (Day Care Centres) Regulations of 1973 set out minimum standards on building requirements, furniture and equipment, health, hygiene and safety, staffing and number of children. Most standards are concerned with facilities and staff numbers. These standards are set in terms of the *minimum* level that is acceptable to government. There is a lack of standards concerned with the *desirable* number of facilities for each service. Standards relating to desirable numbers would be a better guide for agencies in formulating objectives and making submissions to governments than would minimal standards.

Additionally, there is a reference to performance, in Regulation 36:

(3) Each member of the staff employed on the premises of a day care centre shall be a person who—

- (a) is sympathetic to the welfare of children;
- (b) has adequate knowledge, understanding and experience to recognize and meet the needs of children and the ability to superintend children;
- (c) is of suitable age, health and personality to carry out his respective duties;
- (d) is a person of good character and repute.

The Western Australian Government has developed some distribution standards. In that State, the Health Services Executive is responsible for the review of distribution standards. It receives or has received, recommendations from State committees and from national bodies such as the National Health and Medical Research Council, the former Hospitals and Health Services Commission, and the Hospital and Allied Services Advisory Council. The opinions of international and other State bodies are also taken into consideration. On several occasions, the State Health Services Executive, through the Minister, has contracted consultants to advise on particular matters of standards and distribution.<sup>20</sup>

Examples of the distribution standards operating in Western Australia are:

*Hospitals.*

*Bed Provision Rates.*

*Acute Hospital Beds:* 5 beds/'000 Weighted Population

3.5 Beds/'000 General

0.5 Beds/'000 Obstetric

0.5 Beds/'000 Psychiatric

0.5 Beds/'000 Super Specialty

When planning for small areas these rates are modified to take account of the Demographic Structure of the population under consideration. Allowance also must be made for Aborigines.

*Doctors.*

Approximately 1 doctor/700 population

*Dentists.*

1 Dentist/2000 population

*Nurses:* 1/200 population.

*Physiotherapists.*

Metropolitan area—1 Physiotherapist/5000 population

Rural—general—1 Physiotherapist/10 000 population

—specific—variable between.<sup>21</sup>

While these standards, on number of facilities in proportion to population, are certainly a step forward, it would be more useful to planners if demographic variables were taken into account. Facilities should be expressed, for example, in number per thousand children aged from 1 to 5 or people over age 60. This would ensure that services were placed in optimal locations where they would be most relevant to the surrounding population. There should also be distribution standards relating to accessibility in terms of time or distance travelled for urban dwellers; for example, people should not have to travel more than x miles to reach a hospital.

### **Summary and conclusions**

Standards are important to the efficient operation of the overall health and welfare system, to the efficient operation of agencies and to evaluation.

Standards facilitate the efficient operation of the health and welfare system by encouraging a relatively uniform quality of services throughout the country, and by facilitating rational decisions about location, type of service and required facilities.

At the agency level, standards assist in the efficient operation of services by providing a rationale on which submissions for increased facilities can be based and assessed; by providing a rationale for day-to-day decision making; by providing a reference point for comparisons with the outside world so that individual professional workers can make some assessments of their own performance; and by making more

possible inter-agency comparison and co-operation. Clients also benefit from the information about welfare rights that is provided by defined standards.

Standards are important for the purposes of evaluation, because they enable more precise and relevant objectives to be set; they specify the dimensions that are to be considered; they enable evaluation reports to become more comparable one with another; and they provide measures against which assessment may be made.

The evidence presented to us indicates that the extent of standard setting and articulation in the community is insufficient for the efficient operation of the health and welfare system and for its adequate evaluation.

We acknowledge that the task of setting standards is not easy. At times it is even difficult for those providing a service to achieve a consensus on the major dimensions for the operation and evaluation of a service. However, the Committee believes that the existence of standards is so important that a determined effort must be made to set adequate standards.

## Recommendations

### The Committee recommends:

- 1. That all professional groups develop and disseminate comprehensive standards of performance for the guidance of their members and for the protection and information of clients.**
- 2. That the Social Welfare Policy Secretariat be instructed to develop a co-operative strategy which will ensure that appropriate standards are progressively developed in Australian health and welfare services before 1981 and that mechanisms are established for regular review and updating of these standards.**
- 3. That the Commonwealth and each State Government set and disseminate appropriate, comprehensive structure and distribution standards for health and welfare services under its control.**

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## Data

The collection of data is important and is inadequately carried out in Australia.<sup>1</sup>

The Bright report on health services in South Australia pointed up a lack of data for tactical and strategic planning.<sup>2</sup> The Syme-Townsend report on hospital and health services in Victoria noted that the lack of data in the health field 'came as a surprise to us', to the extent that the terms of reference for the inquiry were rendered incapable of a firm answer.<sup>3</sup> The Health-Welfare Task Force of the Royal Commission on Australian Government Administration commented: 'The lack of comprehensive social indices or statistics is another obvious gap which contributes to policy making shortcomings'.<sup>4</sup> The **Bailey** Task Force on Co-ordination in Welfare and Health found that it was extremely difficult to obtain an estimate of the extent of government support of non-government organisations, and to get information about the kind of service to which this support was given.<sup>5</sup>

The Centre for Social Welfare Studies at the Kuring-gai College of Advanced Education found that data on the amount of monetary resources devoted to welfare services in the community had not been collected. Indeed, no one had attempted to collect it.<sup>6</sup> The **Henderson** Commission of Inquiry into Poverty was forced to collect its own statistics. Though the collection of those statistics inspired the ill-fated household income and expenditure survey of the Australian Bureau of Statistics, such data collections have never been repeated since 1975-76.<sup>7</sup>

The Social Welfare Commission and the Hospitals and Health Services Commission, until disbanded, both played important roles in pointing to data deficiencies and in generating some data.

The lack of satisfactory goal statements for health and welfare has been a limiting factor in the development of an adequate data base, simply because it is unclear what we need to measure. As the incidence and amount of rational planning and evaluation of health and welfare services increase, and as organisations intensify their efforts at critical evaluation, the need for data will increase and the types of data required will be better comprehended. However, unless there is established a minimum data threshold that will support effective planning and evaluation, these activities will inevitably become largely subjective and fail to provide an impetus for further data collection.

### Need for data

The primary functions of a system of health and welfare statistics can be summarised as follows:

1. to indicate the health and welfare status of a population;
2. to point to needs for programs of health and welfare promotion and control;
3. to make possible evaluation of the success and adequacy of such health and welfare measures as are instituted as a result of the determination of needs;
4. to serve basic health and welfare research requirements.<sup>8</sup>

Researchers, practitioners, professionals and inquirers need more data than exist at the moment. Clearly, there are insufficient basic health and welfare data when we do not possess precise basic information on, for example:

1. the structure of our community in terms of its social condition, and income levels;
2. the incidence and pattern of illness;
3. the nature of the health and welfare services that exist in the community;
4. the effects of our expenditure on health and welfare;
5. the kinds of non-government services that receive government subsidies;
6. the proportion of government resources going to health and welfare.

It is not quite clear, however, what kinds of data should have priority. Data collection can be costly and can impose a heavy burden on both providers and recipients.

Data overload can be a significant problem. If too much information is generated, recipients may have many more data than they want, need or are able to digest. For example, decision makers can be swamped or 'snowed' to the extent that relevant data are ignored or not comprehended.<sup>9</sup>

Providers of information also can suffer from overload. Feedback to them is important, for they must be able to see the relevance of data and be assured of the effectiveness of data in order to justify the cost entailed and the time absorbed in providing them. In fact, the burden imposed, especially on clients of services, by the requirement that large numbers of questions be answered in the quest for data is now becoming a community issue.<sup>10</sup> One witness described the importance of feedback to those who provide basic information:

. . . Australia to date has seen the Commonwealth, and to a lesser extent the State governments, as the major collectors of information about existing service provisions. They use this information for their own decision-making purposes with little or no feedback to the people they collected the information from. The result is that information that might often be extremely useful to a non-government agency in improving its own service provision is unavailable to it, although the organisation has co-operated with the Commonwealth or State government in providing the information. The result is that there is some hesitancy, on the part of non-government agencies in particular, in getting involved in just another data gathering exercise. There is quite a lot of evidence that the importance of routine and systematic feedback to people who are providing information, to assist them in any decision making that they might be involved in, increases the likelihood not only that they will go on providing the information you require but that they will be receptive to expanding the range of information that they are prepared to collect in the future. I can give an example from this emergency relief study that I referred to before. A common reaction among many of the emergency relief providing agencies in Victoria was that we have done it all before about four or five times.<sup>11</sup>

When data collection proposals are put forward, it must be made clear to all concerned what purposes the data will serve. It may be that there will still be too great a burden on some of those concerned; so decisions will have to be made as to which data are most useful.

Priorities and goals for data collection must be established on a rational basis. One writer has made the following pertinent comment:

Measurement . . . is not an end in itself. Its scientific worth can be appreciated only in a situation in which we ask what ends measurement is intended to serve . . . what functions it performs in inquiry.<sup>12</sup>

The requirements and techniques of data collection will evolve as rational planning and evaluation increasingly become part of Australian health and welfare services. Governments must assist in the articulation of data requirements and priorities



and then use their considerable data resources to co-ordinate and produce the appropriate statistics. This Committee is not convinced that the Australian Bureau of Statistics is as active as it should be in the process of discovering data requirements.

### **Locked-in data**

For one reason or another, a considerable amount of the data collected now is locked in at some point. An example of the difficulty in ascertaining the size of the potential client population was given to the Committee by an organisation working with paraplegics and quadriplegics, which asserted that it was not able to receive aggregate information known to be in the possession of a hospital.<sup>13</sup> Clearly, this and similar information is vital to agencies in the planning of their services and, in aggregate form, should be available. The Committee is concerned that such examples of inability to obtain existing, recorded data may not be isolated.

The social welfare system, at both Commonwealth and State levels, holds a vast amount of information which, since it is made inaccessible to the agencies that need it, may be regarded for practical purposes as non-existent. Possible reasons for the non-dissemination of such data include recalcitrance, low priority, a need to process data further before their release, and lack of resources, as well as inability to use the system on the part of those who require the information.

Data may be locked in because of lack of co-ordination. Organisations may simply be unaware of the data collections of other organisations in their own or related fields.

Organisations may also fail to perceive information that does exist. Data may be produced but some organisations may not be aware of them or know how to obtain them. Further, surrogate information may be available but organisations may not be aware of its usefulness to them.

The resources issue may be viewed from two perspectives: on the one hand, the retrieval of existing information would involve additional cost; on the other hand, the cost of retrieving existing data would be lower than that of generating a whole new system of data collection. Financial arrangements may need to be made to provide for the charging of such cost to the client or a particular fund.

While confidentiality is necessary to protect individuals from disclosure of traceable information, it would never be a valid reason for withholding the dissemination of aggregate figures.

After supplying returns and answering requests for information for some time and receiving no feedback, many organisations feel that a great amount of information is locked in. If information is not seen to be used, those who have provided it may feel that their efforts have been wasted. One witness commented:

I have sympathy with that view. If information is not going to be used, I doubt whether it should be collected. I think there is sometimes a lack of understanding as to what use that information is being put. There is no effort to say: 'This is what we are trying to do.' I think that at times one does find some resistance to this type of exercise. I think it could be overcome by a bit of dialogue between the provider of the information and the user of the information.<sup>14</sup>

The problem could also be overcome by providing a right to disclosure of all factual and survey data, and thereby unlocking information.

When the final text of this report was settled early in 1979, the Federal Parliament had before it the Freedom of Information Bill 1978, the purpose of which is 'to give members of the public rights of access to official documents of the Government of the Commonwealth and of its agencies'. This measure will have dual importance to both those who pay for and those who benefit from health and welfare programs. On the one hand, it should allow the release of information needed for the making of sound

judgments about the effectiveness of health and welfare expenditure; and, on the other hand, it should protect those who give private information to public organisations. It would appear that our record in protecting privacy is much better than our record in ensuring access to useful information.

### **Types of data needed**

This Committee has no desire to dictate what data are required, but we feel constrained to mention some needs and some gaps in the current data situation that have come to our attention.

There is need for a whole range of basic data<sup>15</sup>, including information about the community's social and economic structure and the basic social problems from which it suffers. Particularly, there is need for improved and wider information on the community's health status. The Committee notes some excellent work which is being done in this area and which requires continued funding and support.<sup>16</sup>

It was put to the Committee that more comprehensive epidemiological data are needed.<sup>17</sup> At present, the collection of epidemiological data consists mainly of keeping information on communicable diseases. Very little effort can be spared for the measurement of other forms of morbidity. Western Australia is in fact the only State that has a comprehensive collection of data on hospital morbidity, though New South Wales will have a comprehensive collection system by 1979.<sup>18</sup>

Information collected from organisations that do measure data is mostly restricted to head counts<sup>19</sup>, and data on effectiveness are rare to non-existent. This was noted also in a report prepared by Professor Gerald Caiden for the Task Force on Efficiency established by the Royal Commission on Australian Government Administration.<sup>20</sup> Ms Julia Hayes, Executive Director of the Council of Social Service of the Australian Capital Territory, told the Committee:

I think people have been saying in the welfare area for as many years as I can remember that there are plenty of services there but nobody knows where they are and nobody knows just how relevant they are to a particular need.<sup>21</sup>

A representative of the Commonwealth Department of Health, while asserting that the situation was improving, said: 'I certainly agree with you that the lack of national data systems is a hindrance as far as the Commonwealth is concerned'.<sup>22</sup> This witness went on to give examples of gaps in health insurance and finance data and hospital utilisation and morbidity data.<sup>23</sup> We do not even know the number of handicapped people, let alone have any idea of their degree of handicap. The Health-Welfare Task Force of the Royal Commission on Australian Government Administration 'could discover no data which provided a reasonable picture of the activities of religious, charitable, voluntary and community organisations in Australia'.<sup>24</sup> Data on the income and the welfare status of minority groups also are poor.<sup>25</sup>

It is clear that there is a general lack of basic data and that some kinds of data, in particular, are required. It is clear also that better definition of data requirements is needed and, more particularly, that proper priorities for data collection ought to be set. For example, Mr R. W. Cole, then Secretary of the Department of Finance, said: 'We do not have a good understanding in Australia of income distribution for a start'.<sup>26</sup>

A Treasury witness told the Committee:

There is a great deal of information on the tax system in relation to incomes and their distribution. There are various qualifications that one can make to that but by and large we have a system which enables the pretty ready provision of fairly detailed information.<sup>27</sup>

Australia needs data to facilitate planning. Data should monitor current policy operations. The collection and analysis of statistics should, where appropriate, anticipate changes in policy and provide data relevant to expected policy developments.<sup>28</sup>

Also clear is the need for close Commonwealth–State co-ordination. Commenting on the present situation, Mr P. Allen, Acting Executive Director of the Victorian Council of Social Service, said:

Speaking from the Victorian experience, one of the most important aspects of improving our data collection is to do it co-operatively. One of the serious inadequacies with the limited data collecting we do now is that everyone seems to collect the same data in different ways. In many cases that is just because, for example, the State and Commonwealth governments and the non-government sectors do not sit down and agree on a standard format for collecting data. Each have their own responsibilities or decisions for which they require information. They proceed almost in isolation from each other to collect broadly similar data.<sup>29</sup>

Government and non-government organisations engaged in the health and welfare fields have further basic tasks with regard to data. Ms Eva Cox, Director of the Council of Social Service of New South Wales, commented:

I would maintain that a very large number of welfare organisations are not even at the point that they know what they are doing. Their basic record keeping, their basic information systems, are non-existent. I think this also comes partly from the way that they are funded in terms of the fact that they do tend to be funded on head counting of clients. As far as I know no funding organisation—and I think this applies probably even at the government level—has an efficient system here. The setting up of efficient record and information systems is very often a very low priority. There is a lot of talk about bureaucracy, but very often government departments literally cannot answer a question on how many people are receiving certain types of services. It is all on paper; they have massive amounts of paper work. But to answer that question they would have to go through forty-five filing cabinets to find the information. If organisations were funded on the basis, and planned on the basis, that they did set up a good information system for their own use—which would obviously then provide good information for other people's uses—I think we would start getting to the point where people would see that the setting up of a good information system had value for them. In essence a lot of welfare organisations do not see the importance of it.<sup>30</sup>

### **Positive developments**

A number of encouraging developments in the government and non-government health and welfare sectors have come to the Committee's notice. Among these are the following:

1. A standard method of recording hospital statistics has been developed.<sup>31</sup>
2. The Commonwealth Social Welfare Policy Secretariat holds promise for the initiation of priority setting for data collection on a wider and more rational basis.
3. Some government organisations, such as the Health Commission of New South Wales and the Commonwealth Department of Veterans' Affairs, are developing useful data systems.<sup>32</sup>
4. Some efforts are being made to map non-government welfare services.<sup>33</sup>
5. A program of health surveys is being carried out in various parts of Australia with a view to developing a national health data base.<sup>34</sup> An example is the health care survey in the Gosford–Wyong and Illawarra regions of New South Wales made in 1975.<sup>35</sup> The value of these surveys should be enhanced when they become a continuing process.

6. The National Working Party on Welfare Statistics is working toward the collection of national data on family and children's services.<sup>36</sup>
7. The National Committee on Health and Vital Statistics has formed working parties to report on statistics in six subject areas:
  - (a) hospital usage;
  - (b) perinatal events;
  - (c) human resources (manpower);
  - (d) physical resources;
  - (e) financial matters;
  - (f) health status.<sup>37</sup>
8. A general increase in the demand for health and welfare statistics is evident.<sup>38</sup> For example, the first issue of the *Social Indicators*<sup>39</sup> booklet produced by the Australian Bureau of Statistics was rapidly sold out.

While these developments do not fill the data gaps—and some are only developments in prospect—they do demonstrate a number of positive efforts that will provide valuable planning and evaluation information.

### Social indicators

National account<sup>40</sup> product figures are currently the only available datum that can be used as an overall indicator of social well-being. They have, however, many limitations—principally for what they do not measure. Two main lines of thought have evolved:

1. The social indicator movement, which emphasises more the multidimensional aspects of welfare.<sup>41</sup>
2. The extension of national accounts to incorporate phenomena such as social malfunction and disamenity. The Australian Bureau of Statistics explains national accounting in these terms:

National accounting aims at providing a systematic summary of the transactions taking place in the economy, especially of those that relate to the production and use of goods and services, and to transfers of income or capital between sectors of the economy.<sup>42</sup>

We would favour the first of these alternatives. The extension of national accounts would place too much reliance on monetary measures and would tend to retard, if not stop, the collection of quantitative or qualitative data.

The social indicator movement has ranged widely in the search for indicators of well-being. The term 'social indicator' is probably best understood in a negative sense—that is, as being any indicator that could not be described as economic—for example health, housing, crime, culture, social status. However, even this statement needs qualification. While the search for additional indicators has been largely in the area defined above as social, economic factors are often added to indexes of well-being to give a complete picture.

Social indicators have been developed to circumvent a situation in which data that are easy to identify and collect—predominantly economic data expressed in monetary terms—drive out of circulation qualitative information of greater significance. Further, it is also easier to ask social data questions that are easily quantified: how much, and how many? This tends to retard the circulation of qualitative information about more subjective factors that may be more important in people's lives, such as dignity, uneasiness, satisfaction. We must not fail to endeavour to measure such factors, particularly as some are measurable and others have useful surrogate measures.<sup>43</sup>

The Committee does not neglect to acknowledge the real difficulties in measuring such factors.

The most useful definition is that social indicators are those statistics which:

1. Are components in the model of how our society works; thus, for any particular social condition, a social indicator involves some judgment of the social processes involved.
2. Can be collected and accumulated over a period to allow for comparison between years and trends over the years.
3. Can bring together information from all parts of the country and from all levels of society; for example, how many people are presenting for emergency cash at all branches of welfare agencies. Further, it should be possible to break down aggregate figures to indicate the situation for particular groups of people or for particular geographic areas. For example, it is useful to know the national incidence of a disease, but it is even more useful to know that it occurs mostly in a particular geographic area.<sup>44</sup>
4. Are aggregated to fit into a structure deliberately designed so that they are related to each other. For example, it would be useful to know the crime level; however, it would be even more useful to know whether crime at that level was concentrated in a particular geographic area and whether it coincided with other factors such as unemployment or lack of transport.<sup>45</sup>

A social indicator 'indicates' in that it:

... is a direct measure of welfare—that is, of direct normative interest. It must, like figures on per capita income, be subject to the interpretation that, if it changes in the 'right' direction, while other things remain equal, things have gotten better, or people are 'better off'. Thus statistics on the number of doctors or policemen could not be social indicators, whereas figures on health or crime rates could be ... A social indicator, in short, must be among other things a measure of the condition of a society or the 'quality of life' within it.<sup>46</sup>

The figures referred to in this passage are not purely descriptive as are social statistics. Social indicators are closely related to the goals of a society and particularly those articulated as national policy.<sup>47</sup> To the extent that the nation can state its goals more clearly, more accurate and more useful social indicators can be developed.

There are some complex, unresolved issues about what constitutes a social indicator and about the ways in which the structure of society and the distribution of power define what can be measured.<sup>48</sup> The value positions that people hold determine which statistics are collected. The debate on these issues is continuing.

### *Role of social indicators*

The purpose of social indicators is to provide information required for rational decisions on social policy. To do this, social indicators should measure the state of a health and welfare system, and identify the need for, and gauge the effectiveness of, health and welfare programs.

Social indicators are important to policy in many ways. They can:

1. aid in the establishment of appropriate outcome goals;
2. monitor the effectiveness of programs;
3. aid in the assigning of social value to different program outputs;
4. increase the level of rationality in individual decisions;

5. increase the rationality of collective decisions by helping co-ordination and avoiding conflicting decisions;
6. aid in the provision of a set of social goals;
7. continually bring attention to society's goals;
8. aid in the relative valuation of economic and social policies;
9. fill the gap produced by our present lack of qualitative social information.

### *Problems*

The Organisation for Economic Co-operation and Development has sought a consensus on social concerns and has undertaken to measure them, where possible, in a very extensive project to develop social indicators.

The OECD project is by far the most extensive yet mounted, and it has highlighted the real difficulties in producing social indicators.

The basic cause of the problems is the lack of a theory that can show the relationships between certain factors or events in our society. This situation may be contrasted with the narrower area of economics. Since Keynes expounded his theories in the 1930s, economists have been able to identify crucial factors, such as consumption, investment, income and gross national product levels, for statisticians to measure. The measurements have allowed economists to postulate the interrelationships between these measures and the consequences of changes in them.

The lack of such a theory for society as a whole, among other factors, has convinced most that an aggregate measure of well-being is not possible and, indeed, might have no informative value were it available. The proposition, then, is that a series of indicators for each area of social concern is needed. With these available, it would be possible to overcome some of the conceptual problems.<sup>49</sup>

However, the major obstacle is, and remains, a lack of collectable statistics. For the fifty-two indicators that the OECD wished to collect, it was found that major modifications of statistical data were required for approximately one-quarter, sufficient data existed for another quarter and the remaining half were areas of new data collection.<sup>50</sup>

The gap between the theoretical ideal and what has so far been achieved is enormous. Firstly, there is some disagreement about what social progress is. Secondly, the means of measuring it are not altogether clear. Thirdly, there are problems of aggregation and disaggregation. Fourthly, some factors are impossible or prohibitively costly to quantify. Nevertheless, social indicators promise to be a valuable tool for social analysts and decision makers.

### *Social indicators in Australia*

In 1976, the Australian Bureau of Statistics began publishing periodically a book titled *Social Indicators*. It is an amalgam of statistics produced by the Bureau which may well be used as social indicators. Its production is to be applauded and its sales clearly indicate its perceived usefulness. However, as Owens comments:

. . . it has to be pointed out that the statistics contained in social reports and compendiums, however useful they may be in documenting specific aspects of national life, do not satisfy even the loosest definition of social indicators.<sup>51</sup>

The more precise mapping of needs among regions and groups in society made possible by the use of social indicators would improve the decision making of bodies such as the Schools Commission and the various health commissions, and of welfare bodies, by enabling them to meet the needs of particular regions or social groups

more effectively.<sup>52</sup> Further, social indicators could map changes in sociocultural conditions and thus aid in the discovery of new strategies for health and welfare expenditure.

Vinson and Homel undertook to report to the Department of Social Security on indicators of community well-being. On the basis of their contention that 'an enormous amount of social data is generated in the process of institutional book-keeping', they attempted to collate information to demonstrate the geographic distribution of individual and social problems in our society.<sup>53</sup> They used, as social indicators, statistics that were available but rarely compared—among many others, for example, the incidence of infectious hepatitis, a mortality ratio, court appearances, 'child care/protection orders' and intelligence assessments. Vinson and Homel concluded that the major achievements of their research had been to demonstrate:

- (i) marked differences in the overall vulnerability of different localities throughout New South Wales and
- (ii) the fact that those differences can be expressed in terms of indicator scores which invite social action tailored to the particular needs of regions.<sup>54</sup>

In 1974, the South Australian Department for Community Welfare commissioned consultants to prepare a study of the feasibility of a set of social indicators in South Australia. From pilot indicators in two areas, it was concluded that a system was feasible.<sup>55</sup> In a co-operative effort involving government and non-government organisations, over 270 data items were canvassed, and approximately 200 were finally used in eleven established categories such as need for educational services (0-17 years) or need for community development (all ages).<sup>56</sup> Examples of data in the latter category are appearances before juvenile aid panels, males and females widowed, and sales of dwellings.<sup>57</sup> Weights were given to all these data, which were then converted to a rate and standardised.

After the first indicator had been produced, the following conclusions were reported:

. . . after two years of careful and painstaking effort, a functioning and comprehensive social indicator system has been established in this State. In addition, the Department has established detailed and extensive data collection systems and a distribution network which will be an invaluable resource to all involved in welfare and related fields in this State.<sup>58</sup>

The Vinson and Homel study and work by the South Australian Department for Community Welfare must be seen as milestones in activity of this kind in Australia. Work on human reactions to social change must now follow.

Social indicators would use much of the data that we collect now, whether monetary, quantitative or qualitative. Social indicators, however, would endeavour to put sets of data into a structure of some coherence. The present system of data collection needs refining and extending. Further, a set of social indicators would give new meaning to some statistics already collected, produce a whole range of new measures of performance, and provide data required for rational policy formulation.

A Commonwealth interdepartmental committee on social indicators was established in 1973 to investigate the possibility of a social indicator statistical collection, but met only twice before it 'died away of a natural process'.<sup>59</sup> This lack of commitment must not continue.

The task of developing appropriate social indicators will be a continuing one, with no expectations of spectacular or immediate success. A wholehearted program must be pursued.

**The Committee therefore recommends:**

- 1. That the Australian Bureau of Statistics be directed to accord an immediate high priority to the development of a continuing set of social indicators in conjunction with State authorities and the non-government health and welfare sector.**
- 2. That a Green Paper be produced to establish what criteria should be set for social indicators, and the measures of these criteria that could be developed.**
- 3. That the Commonwealth Government support and encourage research into the development of social indicators, including those dealing with human reactions to identified sociocultural changes.**

### **Problems of cost, resources and priorities**

Until very recently there was a widespread belief that health services provided by professionals, including doctors, physiotherapists and others, must be effective simply because they are provided.<sup>60</sup> This view is changing and with the change has come the realisation that we need to place a higher priority on measuring and recording progress toward objectives. While we do on the whole possess adequate methodology for monitoring progress toward health and welfare objectives,<sup>61</sup> some areas still require additional resources to make possible further definition.<sup>62</sup> There are, of course, administrative problems with statistical collection in our federal system, but these are not insurmountable.

Currently, resources for the preparation of health and welfare statistics are limited. The Australian Bureau of Statistics told the Committee: 'Our resources are so limited at the moment that we cannot even cover the basic core adequately'.<sup>63</sup> This matter is discussed at page 91.

It must be noted that production of health and welfare data can have high costs in terms of money and expertise.<sup>64</sup> It could, in fact, be almost in the 'bottomless pit' category. But this is no reason to avoid the task. Two important points are: firstly, we require the establishment of priorities and needs for data collection; secondly, Australia, while making some efforts, lags behind comparable countries and needs to do more (see pages 59 and 92).

Officers of the Demographic and Social Branch of the Australian Bureau of Statistics were asked about the resources that the Branch would require to enable it to collect all the data that might be required for purposes such as those that we have just discussed. The response was:

The Australian Statistician does appreciate this. He has been extremely helpful to us in our expansion process. In the current staff ceilings we have had a modest increase; other areas of the Bureau have had actual cuts. We did not suffer that kind of indignity. But when you compare it with some of the overseas statistical organisations like Canada you could double or treble it and still have work to do. On whether it is desirable to do that quickly or slowly—there are other constraining factors outside the Statistician's Office.<sup>65</sup>

There have already been some curiously inappropriate decisions concerning vital health and welfare planning data. There was a government decision not to produce some data from the 1976 census and to delay producing other census data, thus rendering some quite useless. For example, a two-year delay in the production of information needed for planning services for pre-school children makes pointless the expenditure incurred in the production of such data and also makes the planning process dependent on out-of-date and possibly inaccurate information. Some census data will actually be produced as long as four years after collection.



Census data are used as bench-marks for many other data collections. Therefore we have particular concerns about completeness of the census data and their early presentation. In many fields, data are now either not available at all or are based on out-of-date figures; validity suffers accordingly. The census is our only national data base and the decision to restrict production of census data was very unfortunate. They must be produced in full and in the least time possible.

The Committee also notes that the Bureau no longer undertakes the household income and expenditure survey. The last collection for this survey was in 1975–76. It provided valuable social planning information and, in fact, was the only effort at continuing any statistical work of the Henderson poverty inquiry. This Committee is convinced that the cost of not collecting such a valuable planning tool was inadequately investigated.

The lack of adequate health and welfare data has been a matter of concern for many years now and it is disappointing that positive developments appear to have been so few. There is sometimes said to be too much talk and too little action.<sup>66</sup> More resources must be devoted to expanding data collections if we are to improve the degree of accountability in the human services area and ensure that intervention produces benefits in welfare and health. More resources must be devoted to production and dissemination of health and welfare data.

While the Australian Bureau of Statistics is the major collector of statistics for the health and welfare system, it devotes an inappropriately small amount of its budget to the production of these data. Full-time officers employed in areas relating solely to expenditure that is classified in the categories 'social' and 'social surveys and indicators' in the ABS Annual Report represent less than 4 per cent of total staff.<sup>67</sup> Estimated direct expenditure in the same categories amounted to 6.5 per cent of total expenditure,<sup>68</sup> compared with the 37 per cent of total Commonwealth budget outlays that health and welfare services command.

The vast preponderance of ABS statistics result from the development of Keynesian and neo-Keynesian models and reflect the greater pressure put on the Bureau for the production of economic statistics. While this development may have been understandable at one time, it is now totally inappropriate that such meagre attention is paid to measuring the impact of 37 per cent, or \$11 000m, of Commonwealth expenditure. Health and welfare organisations at all levels should be making bids and pressing the Bureau for an increased volume of health and welfare statistics.

The *Census and Statistics Act 1905* and the *Australian Bureau of Statistics Act 1975* set out the responsibilities of the Australian Bureau of Statistics (see Appendix 2). The Bureau has functions in producing 'vital social statistics', in co-ordinating statistics for State and Federal Governments, and in ensuring 'the maximum possible utilisation for statistical purposes, of information, and means of collection of information, available to official bodies'.<sup>69</sup> The legislation certainly permits the Bureau to expand into the health and welfare fields. We believe that there is an additional obligation on the Bureau to unlock the useful data presently collected by government organisations but not aggregated, analysed or disseminated. The Bureau also has the potential for a consultancy role in aiding government organisations to produce statistics, and those organisations should take advantage of that potential.

Organisations at all levels should make known to governments and the Bureau the need for it to bring its great statistical expertise and experience to bear on the data gaps which currently exist and which impede rational planning and evaluation.

## Conclusions

Professor J. S. Western, of the University of Queensland, told the Committee:

I would like to start by simply making the point that Australia lags very far behind most of the developed world in health services research generally, and in the accumulation of basic data relating to the delivery of health care.

We do not have broad-scale age, specific morbidity and mortality rates over time. We do not have systematic data on social class differences with respect to morbidity and mortality, information that is available for a variety of other countries. We do not have the same sort of data for ethnic minority groups in any systematic way, although there is increasing data on Aboriginal groups. We do not have systematic data on groups in poverty, although the most recent Henderson report, of course, goes some way towards improving that situation.<sup>70</sup>

If it is considered desirable to have rational health and welfare planning and evaluation, more resources and effort must be directed to data production. While it is not clear exactly what data are required, two broad areas of need are recognisable.

Basic data are necessary. For example, as discussed in Chapter 1, we know only approximately how much governments spend on health and welfare. Exactly what the expenditure is devoted to is not clear. As Professor Western noted, there is a range of basic social data, such as statistics of morbidity, mortality and income distribution, which is not available.

The Commonwealth Government needs to take not only a co-ordinating role in the production of health and welfare statistics but also an active role in the discovery of priorities and demands for statistical collections. The Australian Bureau of Statistics should lead in this more active role of discovering what the market is demanding. The rapid selling out of the first issue of the ABS publication *Social Indicators* shows that there is a substantial demand for social statistics.

A further group of data dealing with outcome or effectiveness needs to be collected. This type of data measures what programs actually do. In this area, a substantial and active process of priority setting and definition is needed, together with some significant changes in administrative philosophy and practice. The Australian Bureau of Statistics, for example, has found little demand for outcome information. The reason given for this was:

I suspect that some people in policy areas—and I think they are pushed into this situation—feel that their statistical requirements are covered by getting good effort statistics. I do not think in Australia at the moment we are asking ourselves to justify our actions in terms of our outputs in the sense of quality and adequacy. That is a real problem. I do not think firstly it lies with the statistician to fix that. I think it lies with the decision and policy makers to understand that problem.<sup>71</sup>

Organisations, at all levels of government and in the non-government sector, should take advantage of the potential of the ABS as a body with substantial expertise in the production of statistics and also in advising on their production, and with wide knowledge of what statistics are already available both in the Bureau's collection and in collections made by other organisations.

More attention should be given to the long-range planning of data bases in such a way as to enable information to be drawn off quickly when needed for decision making.

We cannot continue to spend \$11 000m annually without any capacity to be specific about what it is meant to achieve and without being able to monitor its effects.

## Recommendations

The Committee recommends:

1. That the Commonwealth Government direct the Australian Bureau of Statistics to raise to an appropriate level the proportion of its budget spent specifically on health and welfare statistics.
2. That the Commonwealth and State Ministers responsible for health and social welfare direct the National Working Party on Welfare Statistics and the National Working Party on Health Statistics to produce within two years, in consultation with the non-government health and welfare sector, a list of priorities for the identification and collection of basic outcome data.
3. That the Social Welfare Policy Secretariat be required to report publicly, and within two years, on priorities for the identification and collection of health and welfare data.
4. That the non-government health and welfare sector be given grants to enable it to report on the data priorities of non-government health and welfare organisations.
5. That data obtained from any future census be fully processed and made available without delay, and that resources appropriate to this task be provided.

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## Models and prospects for future evaluation

Evaluation has a clear purpose: 'to provide evidence of the outcomes of programs so planners can make wise decisions about those programs in the future'.<sup>1</sup> Evaluation must always be carried out with the aim of providing decision makers with a rational basis for decisions.

All organisations undertake some appraisal of their activities. For some, it is a kind of subliminal activity—a process that goes on in the minds of some or all people in the organisation. At the other extreme, there is the rigorous scientific exercise which is required to satisfy the usual criteria of scientific experimentation. Between these two extremes are to be found many forms of evaluation activity.

The scientific method has an appeal because of its rigour and precision, but its transfer from the laboratory to the community is not easy. People do not follow physical laws like molecules; nor do they behave like rats in a cage! Moreover, the very length of time and the sustained effort involved in ensuring a correct scientific experimental method give rise to pressures for one-time, ad hoc efforts.

Evaluation of health and welfare activities cannot occur in the same 'scientific' sense as laboratory experiments, but some use can often be made of scientific principles in evaluation, especially if built in when new projects are being planned. For example, the use of the scientific method usually involves comparing a group which receives a program with a similar group which is carefully isolated from the effects of the program. However, it could be unethical and untenable to contemplate that any one section of the community should be denied the benefits of a particular program in order to provide a control group for the testing of results. The Committee therefore recognises that, in health and welfare, the use of the scientific experimental method might often be inconsistent with the principles of natural justice.

Other methods which are sometimes adopted use some of the techniques and rigour of the scientific method. For example, pre-program data may be compared with post-program data over a period to determine changes relative to populations not served by the program. While such methods are not truly scientific, they make some attempt to isolate program factors and may be described as quasi-experimental.

Non-experimental research permits two types of evaluation methodology<sup>2</sup>—comparison of the situation before a program with the situation after, and comparison of planned performance with actual performance. Such methods are easier and cheaper than the scientific methods outlined above. However, often they are not planned in advance. Therefore, appropriate data are not always collected, and changes in program participants caused by factors outside the program are not always adequately allowed for.

Evaluation must be tailored to produce appropriate information for decision making. It could, for example, be inappropriate in terms of resources and costs to undertake a rigorous scientific evaluation of a program costing \$5000 which could be evaluated with very simple criteria or with 'soft' data—that is, data that may not satisfy rigorous technical or theoretical criteria. Indeed, some programs are amenable to evaluation only by what may be described as 'soft' methods. It may cost too much to collect some data and in some instances the social theory or statistical techniques necessary for optimal evaluation may not exist.

Further, evaluation may not be a simple 'yes or no' exercise: it may indicate continuation of a program if certain changes are made. Where appropriate, evaluation should offer implications for future action. This is important not only to ensure that evaluation is relevant to decision making but also to reduce the level of any threat associated with evaluation. Evaluation should be not solely a matter of survival but also a matter of educating staff and improving service provision.

### **Some evaluation models**

A number of models for evaluation have been identified. Some are described below, though discussion is by no means exhaustive. All the models except one deal with outcome data and goal attainment, but each answers a different order of question to assist in the making of a different type of decision.

Each of the models is discussed as it might operate under perfect conditions. However, there are numerous versions of each which allow for particular aspects to be emphasised or to be given less emphasis in order to lessen cost, to take account of particular circumstances or to facilitate decision making.

#### *Evaluation without outcome goals*

While evaluation without goals may appear to be a logical impossibility, the phrase does describe a number of assessment methods that are used:

1. A program may be evaluated on efficiency criteria alone, solely to determine whether resources are being utilised in the most efficient, economic manner. Issues emphasised might include the determination of which ball-point pens are the cheapest, what are proper cash flows and whether they are being maintained or what checks are needed to ensure that there is no excess staff, rather than the determination, for example, of whether appropriately skilled workers are answering clients' needs. Such an assessment may, for example, fail to reveal that clients refrain from using the service as it is not appropriate or relevant or accessible.
2. A program may be evaluated purely on cost-benefit criteria.
3. A program may be evaluated in terms of the processes that go on within it: for example, is the counter service adequate and quick, and how long does it take an application for a cash benefit filled in at the counter to get to head office?
4. A program may also be structurally evaluated. For example, are staff appropriately organised, and is the service housed in an appropriate building?

Despite claims by organisations that they have to use these methods because they are not given statements of goals by policymakers, they are in fact using methods that do have unstated goals. These goals are nearly always least-cost or easier-to-do (process) goals, but they do entail the marshalling of organisational activities in a particular direction.

#### *Social experiment*

This involves the launching and testing of new programs, and is a forward-looking kind of evaluation. Its function is to inform policy makers of the viability and effectiveness of innovations before much time or money is committed. A social experiment has two basic features:

1. It is a true experiment, with random assignment of participants, with appropriate control conditions, and with before-and-after measurement.

2. The program is explicitly defined and firmly controlled to ensure that the prescribed principles and modes of operation are adhered to.<sup>3</sup>

A less costly variant is the experimental demonstration. In this, no control group is used, but control is exercised over input and process variables and these, together with output variables, are measured. At times, several variants of the same program are run to gauge the effects of variations in treatment.

Social experiments, however, have a number of drawbacks which, while not peculiar to this model, should be noted:

1. They can be costly.
2. Usually, only a few sites can be sampled.
3. Data showing effects on small scattered groups may not indicate outcomes that would result if areas were saturated.
4. Programs may fail, if not well handled, despite the use of correct techniques.
5. There are ethical problems in giving a group benefits for the purposes of a study only to remove them when the study has ended.
6. Long periods can elapse before results are available to decision makers.<sup>4</sup>

#### *Traditional evaluation activity*

This is a catch-all term to describe the methods mainly used until now in studying the effects of an ongoing program. It is essentially a before-and-after assessment of the extent to which goals are being achieved. The stimulus applied can often be imprecise and may change according to internal and external opportunities and constraints. However, traditional evaluation activity can provide good estimates of overall effectiveness. This evaluation model is often characterised by being a one-off type evaluation (see Chapter 2).

Four specific types of evaluation activity can be identified here:

1. *Project rating* relies on assessment of the relative effectiveness of different projects within an overall program. Prerequisites are definition and measurement of environmental variables and definition of short-term measures of output.
2. *Overall program impact evaluation* focuses on a program's effectiveness in reaching its objectives. Output variables need to be defined and appropriate measurement techniques established. Groups for comparison should also be delineated.
3. *Relative program effectiveness evaluation* places the emphasis on determining which alternative program techniques, strategies and methodologies are most effective. This type of evaluation depends on prior definition and measurement of the appropriate environmental, input, process and output variables.
4. *Project evaluation* measures managerial and operational efficiency of a project within a program, and depends on the measurement of key output variables, as well as on the use of appropriate comparison groups.<sup>5</sup>

#### *Accountability system*

In this model, evaluative data are built into an ongoing information system to meet continuing decision-making needs.<sup>6</sup> Most organisations already collect data, often in very large quantities, about clients, staff, finances and processes. Relatively simple measures of success can be devised and follow-up data collected on a systematic basis.



Accountability can have a number of meanings depending largely on how the data are specified. Data can be specified so as to:

1. designate staff members or units as accountable for their own performance;
2. measure goal achievement, and perhaps constraints on goal achievement;
3. demonstrate a program's accountability to those to whom it is responsible—for example, to the general public, to its own benefactors, to its clients, to other organisations which refer clients, or to several of these groups at once.<sup>7</sup>

If the last meaning of accountability is accepted, adequate mechanisms for the resolution of goal conflict have to be provided, as it is conceivable that the different groups may well demand that the program aim at different goals. Such conflict can be accommodated by the production of multidimensional information reflecting the different goals. Each group would then be able to judge efficacy within its own framework and decision makers would be able to make trade-offs between the differing criteria.

Relevant interest groups identify their criteria and define the necessary outcome data. The accountability system then permits periodic assessment of how well the program is doing from the standpoint of each interest group. Thus the accountability system must ascertain in advance the needs and priorities of intended users and groups to whom a program is held responsible. This allows for selection of the data that will be assessed and utilised.

With this model, care would have to be exercised to ensure that evaluation for its own sake did not assume greater importance than was accorded to the objectives of the activity being evaluated.

## **Conclusions**

None of the models discussed are mutually exclusive. They represent a scale of progressively increasing precision and complexity, and each is a higher development of those below it in the scale. The choice between models is not made simply by selecting the most precise or the most elaborate. The choice will depend on the types of decision that need to be made for the particular evaluation. For example, depending on the requirements that have to be met, a simple model might produce a satisfactory evaluation at lower cost than if an elaborate model were chosen.

There are large numbers of evaluation models and a variety of ways in which each of these can be used. Which model is appropriate and the way it should be used depend on the skills, understanding and competence of the officers involved, on the circumstances in which the evaluation is undertaken and on the type of information required.

Research into the further development and clarification of these models should be encouraged, as they provide the base from which we make decisions about the expenditure of vast amounts of money—decisions that affect the lives of a great many people.

## **Recommendations**

Resource material is needed to aid organisations wishing to carry out evaluation. **The Committee therefore recommends:**

1. **That the Social Welfare Policy Secretariat, either alone or after appropriate consultations, prepare a document, or a number of documents, outlining the methods available to organisations for the evaluation of their activities.**

**2. That the Departments of Health and Social Security provide a consultancy service, free of charge, to enable organisations receiving health and welfare grants from the Federal Government to evaluate their own activities.**

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## PART FOUR

# THE CHALLENGE OF EVALUATION FOR AUSTRALIA IN THE FUTURE

The task of evaluation will not be easy. There are many obstacles to surmount. Some of these are specific and may be overcome by direct action. They include lack of data, of standards and of national goals, and the unsatisfactory manner in which funds are allocated. The recommendations of this report are designed mainly to overcome these obstacles.

However, there are more nebulous obstacles which also hinder evaluation activity in Australia. These are concerned mainly with attitudes toward evaluation. It is perceived as threatening by many health and welfare organisations and is given low priority by almost all of them. We cannot make concrete recommendations designed to remove these obstacles. We can only urge all organisations to examine the benefits of evaluation and to make concerted efforts to conduct some form of evaluation within their own fields of responsibility.

This report acknowledges that worthwhile evaluation activity occurs in Australia. It also sets out the major deficiencies that have been found, and calls for remedial action.

## Constraints and opportunities

A central thesis of this report is that evaluation activity in Australia is inadequate in amount and inferior in quality. In this chapter, we explore some reasons why this situation exists, we describe some useful evaluation activities that have been or are being undertaken, and we offer some suggestions for the solution of problems.

Analysis of the reasons why evaluation activity in Australia is unsatisfactory is an important prerequisite for proposals for remedial action. Present evaluation in Australia is unsatisfactory for at least the following ten reasons:

1. Evaluation is threatening.
2. There is a lack of national goals.
3. Necessary data either do not exist or are not accessible.
4. There is a lack of defined standards.
5. The present funding mechanisms do not encourage evaluation.
6. The way in which Parliament functions does not encourage evaluation.
7. Evaluation requires considerable resources.
8. Evaluation has not been seen as necessary.
9. There is no tradition of evaluation in Australia.
10. Converting theory into practice has been difficult.

In the sections that follow, each of these factors is examined in detail.

### Evaluation is threatening

No one enjoys licence tests or examinations of one's professional competence, for the consequences of failure are distressing or costly. Each such examination is stressful and threatening because of consequences that could follow adverse findings. Evaluation of health and welfare activity is no different. It has threatening connotations for whoever is delivering or is responsible for the service or program being examined. It is as threatening for a government department to be assessed by the Auditor-General or the Public Service Board as it is for a non-government welfare agency to be evaluated or for a doctor to submit his activities to review by his peers.

Although government departments have little cause for concern about loss of resources as a consequence of evaluation, non-government organisations do have this fear, and it was a constant theme in the evidence given to the Committee. Primary concern related mostly to the likelihood of funding cuts if an organisation were shown to be ineffective. The Rev. I. Ellis, Director, St John's Homes for Boys and Girls, Melbourne, referred to fear of evaluation, and stated:

Primarily it is a fear about funding . . . in Victoria, because of the subsidy system, the voluntary homes are very heavily dependent upon government subsidies. Their very survival depends on the maintenance of their existing subsidy system. Any suggestion that Government might evaluate their program is very threatening indeed.<sup>1</sup>

The Australian Council of Social Service Inc. (ACOSS), in a paper submitted to the Committee, commented:

One other significant response to program evaluation which ACOSS has found it necessary to investigate can be described quite simply as *fear*. Fear, we have found, is very much at the basis of some agencies' resistance. Fear is a response which is usually evident when there is some present danger. In the case of welfare agencies responding to the possibility of program evaluation, fear is the response that is manifest when evaluation is seen to be linked to the cutting of program funds.<sup>2</sup>

The fate of the Good Neighbour Councils shows that there may be sound basis for this fear. The Galbally report on migrant services and programs reviewed the work of the Councils and recommended that 'funds previously allocated to the Good Neighbour Councils . . . be directed to other community programs over a two-year period'.<sup>3</sup>

However, in most cases, this fear is irrational. Evaluation is used primarily to improve programs, not to cause the withdrawal of funds. Our view is supported by ACOSS:

It must be recognised that fear is not necessarily, or always, a rational response. Program evaluation need not lead to fund cuts and welfare organisations, far from losing from the experience, may in fact stand to gain: for example, a better, more sound welfare program; a smoother, more efficient management system; a clearer, more appropriate set of goals.<sup>4</sup>

Organisations, including the larger ones, that do not rely on government funding might fear that public contributions to appeals could be reduced if evaluation were unfavourable. Pastor Bruce Price, Director of Communications, Victorian Conference, Seventh-day Adventist Church, pointed this out to the Committee when he said:

Large organisations have to watch their public image very jealously. They look upon each other as a threat because they are dependent on the public for moneys.<sup>5</sup>

Reduction or withdrawal of funds is not the only danger that is feared. Evaluation is also perceived as a threat to reputation and self-esteem. This threat is felt equally within government and non-government organisations. There is a great deal of suspicion that an evaluation study will be used to criticise the individual health or welfare worker. Mrs J. Moran, Member of the Executive of the Psychiatric Rehabilitation Association, Sydney, illustrated this point:

. . . they begin to see evaluation as a criticism. For instance, they know that they are striving to do their best but they know that possibly there are elements that they could do better. I believe the threat comes when they are possibly not willing to share those elements in which they feel they could do better.<sup>6</sup>

How should organisations respond to the threats inherent in evaluation activity? Unhelpful responses include refusing to allow external evaluation<sup>7</sup>, invalidation of evaluation reports<sup>8</sup> and failure of agency staffs to support internal assessment activity.<sup>9</sup> These responses to a perceived threat may be understandable, but they are certainly not acceptable. As discussed in Chapter 1, any service using public funds—that is, funds obtained either from government sources or from public appeals—has a social obligation to be accountable for those funds. Ongoing evaluation provides the only adequate means of ensuring accountability. Any attempt to evade evaluation, because the threat to ego or funds is perceived as being too great, shows a reluctance to be accountable.

A number of techniques that help to lessen the threat which evaluation poses were described to the Committee. Particular management techniques can be used to emphasise the benefits rather than the threats, and to make these benefits known to all who participate in or could be affected by the exercise. The purpose of an evaluation

study should always be fully explained in order to allay suspicion and minimise speculation. Mr G. Brewer, Senior Research Officer of the Brotherhood of St Laurence, explained the procedures that he used to alleviate anxiety about evaluation. Speaking of a particular service, he said:

. . . we have spent some time with the persons operating that service to explain the object of the research and the expectations we have of it. Also, we will engage with them in dialogue about the research design so that they may influence that. I think that is one way of alleviating the threat.<sup>10</sup>

In the final analysis, no procedure can completely eliminate the threats inherent in evaluation activity. One would be ill advised to assure an organisation that no threat will arise, because, as Mr I. McAulay, Deputy Director of the Department of Youth and Community Services in New South Wales, explained to the Committee:

. . . one might put in an evaluation saying that there is no function for that particular operation. If we say there is no threat, our credibility is threatened.<sup>11</sup>

### **Lack of national goals**

Australia has no adequate set of national health and welfare goals clearly stated and attracting broad support. There is an urgent need for government statements of policy on the elimination of malnutrition and hunger, on the provision of adequate housing, on minimum adequate income security, and on many other goals.

Such national goals, if articulated, would allow new and more predictable principles of funding and would also encourage the development of evaluation guidelines. They would also make consultation and co-operation between consumers and administrators easier, particularly in regard to programs in progress and agreements for new initiatives.

National goals are discussed more fully in Chapter 5.

### **Lack of data**

Necessary data for monitoring or assessment may not exist or may be unavailable—including, for example, data necessary to establish levels of unmet need, census data, social indicators or information specific to one organisation anxious to examine its own activities. A full discussion on need and data appears in Chapters 4 and 7.

### **Lack of standards**

The lack of standards for both provision and performance in the community inhibits the process of evaluation. A full discussion on the standards that are required and the resources that will be needed to set such standards is to be found in Chapter 6.

### **Present system of funding**

The present system of funding does nothing to encourage accountability. Funds are given to organisations, often without any clear statement of purpose and without any information about the efficacy of the services concerned. Records sufficient to show the Auditor-General that funds have not been misappropriated are generally all that is required.<sup>12</sup>

The submission presented to the Committee by the Department of Social Security in 1976 states:

The usual principle is that the national government subsidises the actual suppliers of assistance in kind for the provision of particular services. Most of these subsidy programs are formulated so that eligible organisations have a right to the particular subsidy which they

are in effect able to use as they wish. This lack of contractual arrangement between Department and recipient organisation means that the Department has only weak control over the effective use of departmental subsidies on such aspects as the quality of service or the geographical distribution of services. The absence of contractual arrangement also means that evaluation other than headcounts and basic physical standards is difficult, if not impossible.<sup>13</sup>

At a public hearing held in 1978, the Department claimed that this situation had changed. On that occasion, the Committee was told:

... there has been a greater movement towards expectations for agencies to provide a certain quality of service and also in the geographical distribution of those services.<sup>14</sup>

It is most unsatisfactory that departments have only weak control over the effective use of departmental subsidies.

### **Present functioning of Parliament**

Another reason for the lack of evaluation in the health and welfare sector is that Parliament does not operate always in a logical manner. It sometimes lacks information that is essential to enable it to respond sensitively to the problems of the health and welfare sector. It is not sufficiently energetic in publicising or setting out disadvantages suffered by susceptible groups. It has failed to learn from previous inquiries such as that which, in 1973, reported on a community health program for Australia<sup>15</sup> and those conducted by the Royal Commission on Australian Government Administration, Bailey and Holmes (see Table 2.1, pages 27-9). It too often ignores opportunities to consult with those likely to be affected by, or those likely to implement, programs. It has not yet solved the problems presented by a federal system of government. And it moves slowly to provide essential backup legislation (such as freedom of information legislation) needed to perform effective evaluation.

### **Resources required for evaluation**

The Committee was told that the process of evaluation is significantly inhibited by the fact that considerable resources are required. Several witnesses who worked at government level considered that most services had limited resources and that the directors of those services would be wary of investment in a process that promised them uncertain benefits.<sup>16</sup>

It is true that evaluation will consume resources. It is difficult to estimate the appropriate proportion of the total budget that should be allocated to it. One United States study suggested that a reasonable allocation is likely to range from 0.5 per cent to 2 per cent of the total program budget.<sup>17</sup> Someone must meet this cost. Therefore, the Committee commends to governments the proposal that funds to assist evaluation be included in funding for health and welfare projects.

Many organisations do not have staff with the skills necessary for evaluation studies. According to the Rev. J. Davoren, Secretary of the Australian Catholic Social Welfare Commission, it would be rare to find an administrator to whom such a task could be delegated.<sup>18</sup>

At present, some governments have, within departments, sections that advise organisations about evaluation methods—for example, the Evaluation Section within the Commonwealth Department of Health.

Evaluation is said by some to be not worth the resources that it consumes. Mr A. S. Colliver, First Assistant Director-General, Social Welfare Division, Department of Social Security, told the Committee that it was a matter of concern that the large numbers of small grants invested in evaluation over recent years had not been terribly

productive in improving the administration of social programs.<sup>19</sup> This concern is well founded. The present reliance largely on one-off, ad hoc evaluation studies (see Chapter 2) does not lead to cost-effective procedures. The Committee agrees with Mr A. Kelly, Executive Member of the Queensland Council of Social Service, who said that 'evaluation in the short, sharp burst . . . is really ineffective'.<sup>20</sup> However, there is evidence that, when evaluation is conducted properly, there are large cost benefits. For example, the ratio of benefit to cost for social research—equivalent to evaluation—in health and welfare programs in the United States was reckoned by one observer to be well over 100 : 1 (see page 14).

### **Evaluation has not been seen as necessary**

There is widespread feeling among health and welfare workers that evaluation is unnecessary. This feeling was described by several witnesses representing umbrella agencies. Ms Julia Hayes, Executive Director of the Council of Social Service of the Australian Capital Territory, told the Committee that well-established welfare organisations consider that, if they are delivering a service which is in demand and which appears to be satisfying its clients, there is really no need to enter into any detailed analysis of its effectiveness and accountability.<sup>21</sup> Ms E. Cox, Director of the Council of Social Service of New South Wales, felt that organisations perceived evaluation as 'a lot of bureaucratic mumbo jumbo'<sup>22</sup>, and Mr I. Yates, Secretary-General of the Australian Council of Social Service Inc., believed that many people saw evaluation as a 'frill'.<sup>23</sup>

Another reason why evaluation is given such low priority in the health and welfare field is that it is not a direct 'helping' activity. Mr Davoren stated that the responsibility for collecting data falls on the clerical staff, who cannot rely on the full cooperation of the staff actually delivering the service. He considered that this happens because the importance of the data-collecting activity is not appreciated and it is believed that the time of the service delivery staff should be utilised in 'helping'.<sup>24</sup>

What Mr Davoren describes is a very limited view. While 'helping' may be a satisfying activity for the health and welfare worker, it will waste resources unless the activity is effective. The only way to determine effectiveness is to evaluate. While the managers of health and welfare services continue to attach much importance to process and very little to outcome, they run the risk of using their resources in a non-directed, wasteful manner and achieving little.

### **No tradition of evaluation in Australia**

As there is no tradition of evaluation in Australia, there is some reluctance by both government and non-government health and welfare services to undertake a task that is new and relatively unproved. The Committee appreciates the trepidation felt when venturing into something new. However, we believe the benefits to be gained from evaluation are worth the effort.

### **Difficulties in converting theory into practice**

Another problem in evaluating health and welfare services arises in converting subjective concepts to operational terms. Mr Davoren states:

There are very few instruments for measuring the effectiveness of work done in the welfare field. It will be appreciated that welfare covers a very wide area of activity and is concerned with the well-being of particular members of society. What well-being means and how well it has been restored or achieved in a particular instance is very hard to measure and to express in quantitative terms.<sup>25</sup>



In the health area, similar problems are faced. Professor Stephen Leeder, Professor of Community Medicine at the University of Newcastle, has indicated the problem presented by the enormous number of criteria that exist in the health field:

—the quality of care provided in general practice with its rich variety of diagnostic and therapeutic challenges is comprised of hundreds, if not thousands, of little things within the doctor's personality, his knowledge and experience, his problem-solving skill, the characteristics of his receptionist, the personality and compliance of the patient, the surgery furnishings and the weather, to name but a few.<sup>26</sup>

With such a huge range of criteria to choose from, it is difficult to determine which most effectively measure progress toward the broad outcome goal of improved health.

The evaluation of health and welfare services can never be a purely objective exercise. The evaluator must be selective in what he looks at. He has to choose from a host of aspects of a service those which he can evaluate. Laurence Lynn, Jr, Assistant Secretary of Planning and Evaluation in the United States Federal Department of Health, Education, and Welfare, writes:

The choices . . . and values of the researcher often guide the decisions to at least some degree. Evaluation is much more of an art than a science, and the artist's soul may be as influential as his mind. To the extent that this is true, the evaluator becomes another special interest or advocate rather than a purveyor of objectively developed evidence and insights, and the credibility of his work can be challenged.<sup>27</sup>

Problems arise when organisations reject unfavourable evaluation studies because they believe—or wish to believe—that the researchers are biased.

Though problems arise in the search for appropriate measures for evaluation, they are not serious enough to serve as a valid reason for not evaluating. Our view is supported by Avedis Donabedian, a notable writer on evaluation methods, who states:

The search for perfection should not blind one to the fact that present techniques of evaluating quality, crude as they are, have revealed a range of quality from outstanding to deplorable. Tools are now available for making broad judgments of this kind with considerable assurance.<sup>28</sup>

Evaluation methods were examined in other respects in Chapter 8.

### **Positive developments in evaluation**

Notwithstanding the situation so far described in this report, some organisations have demonstrated a growing willingness and capacity to evaluate. Despite deficiencies in data, resources and skills, some organisations have been able to 'plug in' to what is available for service evaluation.

Most organisations undertake some level of appraisal of their various parts or functions. Most of these appraisals, though they may be valuable, would not constitute evaluation. They may involve no more than head counts, resource mapping or a range of non-specific activities that produce a feeling of worth simply because they have been undertaken, regardless of their outcomes.

Many organisations undertake establishment and methods surveys designed to ensure either that a staff position carries appropriate qualifications and duties or that forms are written up and communication facilities maintained efficiently. Organisations such as the public services have put substantial resources into this area. Though this does represent evaluation activity, evidence before the Committee indicates that its value as an evaluation mechanism is greatly limited by lack of standards and objectives (see pages 66–8 and 75–6).

It would certainly be true that the great majority of organisations exercise much care in overseeing their financial operations. Expenditures are often rigorously scrutinised. Much effort and, sometimes, considerable resources are applied to ensuring that financial accountability is of a high order. Governments may even audit non-government organisations. This is an important and necessary function but it may not constitute evaluation.

Many organisations, particularly those with professional staff, have, or are developing, organisational forms that allow for feedback from, or even participation by, staff at all levels. This can provide for very useful appraisals of an organisation's activities.

Some organisations, in the main those which receive substantial government funding or which have tight government regulation, are subject to inspection. Inspectors or social workers may visit such organisations to appraise the services that they provide. However, these visits are infrequent and rarely amount to anything more than a survey of relatively mechanical functions, structures and activities. This inspection function may even take the form of requiring organisations to supply returns of information to some central authority.

The need for more systematic evaluation of health and welfare services has been realised only recently. While there have been substantial developments, there is, as yet, no set body of concepts, methods or experience for organisations to draw upon. With this in mind, it is easy to understand that the development of evaluation in health and welfare programs is only in the pilot-experimental-educative phase. This phase is bringing to light a number of positive evaluative factors. These include:

1. the existence of some external evaluation activities;
2. an acceleration in the gathering of information, including data on resources and need;
3. increasing cognisance of the need to be responsive to clients;
4. peer review proposals;
5. increasing use of pilot and experimental programs.

The Australian Council of Social Service established an Evaluation and Accountability Task Force in March 1977. The general objective of the Task Force is 'to facilitate a commitment and ability on the part of the non-government welfare organisations to evaluate their social welfare programs'. It also has a number of more specific objectives, including consultation with organisations implementing evaluation, liaising with government on matters of evaluation, and publishing papers on evaluation and accountability. The Task Force had been involved in some fourteen 'low key consultations' to February 1979.<sup>29</sup>

There are a number of continuing evaluation activities which receive scant attention but which are vital to the status of health. These are the environmental monitoring activities. Various government authorities monitor water and air quality, radiation safety and control, housing quality, noise in industry, and various other environmental aspects. Programs enforcing standards in these areas are important preventive health measures, and continual monitoring of these programs is an important evaluative activity.

There are also evaluated services in the communicable diseases area—for example, the smallpox immunisation program. While not all programs are proved effective—for example, the incidence of venereal disease is increasing despite control measures—the impact of programs is being documented more fully and more effectively.

Until recently, we did not know what services were provided, let alone what were needed. Even now, this information is not complete, but basic information needed for evaluation is being gathered increasingly. The activities of the erstwhile Hospitals and Health Services Commission have given us some kind of inventory of health manpower and a first indication of available health facilities. State health commissions also are developing inventories of services. Councils of social service are endeavouring to document services in the non-government sector.<sup>30</sup> Individual organisations are collecting information on the scale and frequency of service provision. There is evidence (see Chapter 4) that numbers of organisations are endeavouring to come to grips with the task of identifying and measuring need. Some organisations are measuring service utilisation to obtain information that can be useful in a number of ways. These information processes are significant steps in the development of evaluation programs.

Some organisations are endeavouring to be more responsive to the people who receive service from them. The mid to late 1960s saw the 'participation ideology' gain popularity. In this approach, clients participate in the identifying of their own needs. Feedback from clients can then be used as one performance indicator.

Some organisations are also demonstrating efforts to be more responsive internally to external pressures to evaluate and be self-critical. Several years ago, the Federal Minister for Health announced that he would give the Australian Medical Association three years to make some moves toward peer review and would then judge whether or not they had been sufficient. There is now some evidence that the AMA is moving slowly in this direction in response to the pressures imposed on it by government.<sup>31</sup> On 9 February 1979, the Minister announced a Health Program Grant of \$50 000 to the Association to assist in establishing a Peer Review Resource Centre.<sup>32</sup> The centre will foster peer review initiatives by medical and other professions, health authorities and individual institutions. It will also provide training and advice and develop proposals for peer review in hospitals.

The Australian Council on Hospital Standards operates a hospital accreditation program, which is essentially a peer review system.<sup>33</sup> It should be acknowledged that in this case rewards are associated with accreditation.

The Australian Medical Association and the Australian Council on Hospital Standards, together with the Australian Hospital Association, have produced a useful publication, *Guidelines to Clinical Review*, to 'assist those who wish to formalise the peer review process in a way which is objective, non-threatening, easily administered and adaptable'.<sup>34</sup>

The use of demonstration or pilot projects is increasing,<sup>35</sup> and this also is encouraging. Such projects demonstrate growing acceptance of experimentation and assessment, and rejection of the concept of organisational self-perpetuation.

While the measures described above do not necessarily amount to vigorous evaluation, they do indicate some progress. They demonstrate that, given stimulus, opportunity and resources, some organisations have started to evaluate themselves by processes of both internal and external evaluation, and have gained satisfaction and reward from these processes. Pressure or the prospect of reward may have been used, but it is to be hoped that evaluation will come to be seen as an essential part of programs in health and welfare.

However, what is occurring at this stage is little more than an ideological, educational, experimental movement based on a search for adequate motivation and also adequate tools for evaluation.

Efforts to train professionals are also being made in order to provide the skills necessary for effective evaluation in the health and welfare fields. During 1978, seminars and conferences were held at the University of New South Wales, the Canberra College of Advanced Education and other institutions, and within the Commonwealth Public Service.

### Summary, conclusions and recommendations

The major factors that inhibit evaluation in Australia are:

1. perception of evaluation as a threat;
2. lack of national goals;
3. lack of data;
4. lack of defined standards;
5. the present inappropriate system of funding;
6. the present inappropriate functioning of Parliament;
7. the magnitude of the resources required for evaluation;
8. failure to see evaluation as being necessary;
9. lack of an evaluation tradition in Australia;
10. difficulties in converting theory into practice.

These obstacles to evaluation are not insurmountable. Program managers must accept that they have a social obligation to evaluate their services, even though the task may not be easy and the evaluation may seem threatening.

In spite of the difficulties that have appeared, there have been some positive developments in evaluation. Some level of appraisal—which may be valuable but which would not reach the level of evaluation—occurs in most organisations, and some have moved toward formal evaluation. Various government authorities monitor environmental and health situations. An increasing amount of data required for evaluation is being collected, and pilot programs in evaluation have been launched. Increasing emphasis is being placed on the training of professionals in the necessary evaluative skills.

The Committee concludes, however, that evaluation in Australia is still only in the initial stages and that more resources and effort must be devoted to the task. Therefore, in order to encourage evaluation activity, **we recommend:**

- 1. That, in future, Commonwealth funding for any health or welfare organisation be contingent on a written agreement by the organisation that it will conduct ongoing evaluation of a quality that is approved by both the organisation and the Government; and that State Governments be encouraged to follow a similar practice.**
- 2. That each State Government ensure that, within its Public Service, there is a section that will provide advice for organisations which wish to evaluate their own services.**

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## **Evaluation in the future— the pivotal activities**

### **Development of accountability criteria**

Evaluation of health and welfare programs is needed to give governments, organisations and the community appropriate information to judge the efficacy of expenditure amounting to some 16 per cent of gross domestic product. Without this evaluation, money may be spent over a long period with no evidence of either success or failure. Indeed, failure may be evident only after the precipitation of some major crisis. Moreover, the crisis may take some time to manifest itself.

The conclusions of many recent health and welfare reports reinforce this point. History has shown that evaluation in Australia has consisted of one-off, ad hoc studies inadequate for the purpose of aiding decision making.

The thrust of this report is to make recommendations that will provide for systematic evaluation relevant to decision making, and thereby facilitate an increase in the accountability for government activities that become ever larger, more complex and more numerous.

### **Developing forward-planning and evaluation capacity**

Governments need to improve their ability to anticipate social problems that may require specific governmental programs or services. We therefore make recommendations that will entail immediate consideration by governments of studies of likely future expenditures in health and welfare. These studies will in turn require identification of the extent of probable need and demand for health and welfare services.

We make further recommendations which endeavour to ensure that governments and organisations are required specifically to assess the impact of rapid social, economic and technological change on the need for particular programs or services. Such a requirement means that prior attention should be given to the adequacy of existing evaluation methodologies as they affect the assessment of need.

### **Establishment of social need**

To improve the nation's ability to discern the needs of the community, we make recommendations to provide for a consistent and concerted attempt to develop efficient, understandable indicators of social need that might help governments to:

1. evaluate whether, and to what extent, existing programs are meeting real needs;
2. evaluate the overall impact of existing social welfare programs;
3. effect a rational allocation of resources to other levels of government and to voluntary organisations.

The information base required to establish such needs is lacking, and its development is a neglected part of Australia's data collecting. Consequently, we make recommendations that allow for:

1. continuous monitoring of demonstrated needs;
2. searching for needs as yet undemonstrated;

3. the first steps toward the development of a set of indicators of the health and welfare status of the community.

First, however, we need to explore the issues relevant to getting better access to data that currently may be collected but not released for use. We need also to develop agreed priorities for the identification of basic data.

Society looks to government for active leadership in discovering who in the community is in need, what the nature of that need is, and how it may be satisfied. Need is disparate and changing and must be monitored continually.

### **Goal setting based on definition of need**

Goals based on the definition of need should be set for three main purposes:

1. to facilitate planning and co-ordination;
2. to provide guide-lines for workers at service level;
3. to make evaluation possible by enabling decisions to be made about what to monitor, and by serving as a reference point to permit a judgment of success or failure concerning what has been accomplished.

Goals should be flexible—and may be multiple—to account for changes in need and political perspectives and for advances in knowledge. Further, there are often hierarchies of goals which a single intervention may attempt to satisfy.

The Committee has recommended that all government and non-government health and welfare organisations state publicly, and in writing, both broad strategic goals and precise, testable objectives. Statements of this kind should also be included in legislation.

Statements of goals make programs and services more visible, more answerable and more accountable as it becomes clear what achievements are being pursued.

### **Standards in evaluation**

Standards are the yardstick of achievement. They supply the means for the setting of realistic goals; they specify the dimensions that are to be considered in the evaluation process; and they provide a measure against which assessment can be made.

Further, standards play a vital role in the day-to-day running of services by providing a rationale for decisions, by guiding the individual worker and by facilitating inter-service co-operation and comparison.

In the main, Australia lacks precisely defined standards, and all involved groups need to develop and disseminate comprehensive standards of performance to guide their members and to protect the public. Australia needs a strategy to ensure that appropriate standards are developed, disseminated, accepted and reviewed regularly to maintain their suitability and effectiveness. Governments need to play a central role in facilitating these processes.

### **National data base for evaluation**

Australia lacks basic health and welfare data. For organisations to be able to define and assess need accurately, and then make some judgment about the adequacy of their activities in satisfying need, certain data are required. Some data are now available but not all organisations are aware of them. Some are collected but not disseminated. However, many are not collected at all. We make recommendations for the establishment of priorities for the identification and collection of basic data, particularly outcome data. We also make recommendations that endeavour to gain the release of data currently 'locked in'.

Without the provision of appropriate data, evaluation can only perpetuate existing prejudice.

### **Priorities for program evaluation in health and welfare agencies**

While recognising that the state of the art in evaluation does not yet allow rapid development of evaluation effort, we consider that a systematic review of acceptable evaluation approaches is long overdue. For effective evaluation in Australia, we need to identify clearly those evaluation methodologies that even now are applicable within Commonwealth agencies—in evaluations by various parliamentary committees and by central management agencies such as the Auditor-General's Office, the Public Service Board and the Department of the Prime Minister and Cabinet.

Specifically, we need to:

1. take systematic inventory of what is going on;
2. identify what is known from past evaluations;
3. identify what gaps exist in both the knowledge and the data required to achieve *specific* evaluation objectives;
4. evaluate the appropriateness of specific systems of management review to the improvement of program performance in the health and social welfare areas;
5. identify particular inadequacies in existing information systems; especially, we should examine the issues relating to information derived from program management data but not currently available for use;
6. identify what levels of funding are required to plug the information gaps;
7. identify the extent of any gaps in evaluation skills in the Commonwealth Public Service and in non-government health and welfare organisations;
8. take immediate action to upgrade evaluation knowledge and skills through appropriate training programs and/or technical assistance;
9. ensure that evaluation information is made public and shared widely.

The results of studies addressing themselves to these issues must be capable of being understood by the consumer and must be applicable at all levels of organisation.

### **Priorities for program evaluation within management**

Not only must evaluation be carried out effectively; management must be capable of using the results.

Parliament has a role in managing vast health and welfare resources and has developed a number of mechanisms to serve it in this role. These include an extensive committee system. The parliamentary processes have a potential for both overlapping and leaving gaps and must be examined with a view to ensuring the adequacy of the Parliament's oversight capacity.

A number of critical issues must be examined:

1. the adequacy of Parliament's present capacities to acquire, produce, disseminate and use evaluation material;
2. the need for an alternative method of parliamentary oversight that will systematically review the development of programs and projects from start to finish; this should include the use of experimental techniques such as zero base budgeting and sunset legislation;
3. Parliament's relationships with organisations involved in the evaluation of different aspects of the effectiveness of health and welfare programs, including



the Department of the Prime Minister and Cabinet, the Department of Finance, the Treasury, the Auditor-General's Office, the Public Service Board, the Social Welfare Policy Secretariat, and other relevant individual departments and statutory authorities, as well as State and non-government organisations.

The Public Service has developed an extensive system of management hierarchies and techniques to cope with the immense problem of managing programs and services. A number of centralised overseer departments and authorities have developed a range of particular management functions. These central departments are important to the evaluation function now—and will remain so. They face significant problems in overseeing, or evaluating, an increasing range of government activities that become ever larger and more complex. Despite such central control, departments involved in the actual administration of programs have a large part to play in ensuring adequate evaluation.

The Public Service, then, must face a number of critical issues:

1. the quality and adequacy of the information flow to the central overseer departments;
2. the responsibility for ongoing evaluation in departments providing a program or service;
3. the role of central departments in ensuring adequate evaluation and in the interpretation of such evaluation;
4. the dissemination of designated information to the public;
5. the allocation of resources to evaluation activities;
6. new management techniques that may be required to facilitate evaluation and the use of evaluation results.

The management problems of the non-government health and welfare sector differ only in magnitude. No less than the public sector, non-government organisations need to examine their management capacities and techniques for undertaking evaluation and for incorporating evaluation results into organisational decision making.

Some critical issues that the non-government sector must face are:

1. the acquisition or diversion of resources for evaluation;
2. the setting of priorities between service delivery and evaluation;
3. the necessity for persuading workers and management of the need for appropriate evaluation;
4. the gaining of skills and knowledge necessary for evaluation;
5. the consolidation and accessibility of the considerable volume of data possessed by this sector;
6. the special problems of disseminating evaluation results and experience among the great variety of widely dispersed non-government organisations as well as among their often disparate sources of funds.

Parliament and management in all organisations in the health and welfare fields face the problems of developing appropriate skills for dealing with evaluation.

## **Conclusions**

Accountability is a central theme of this report. Those who spend such large amounts of money as are now spent on health and welfare must be accountable, particularly as the expenditure has such a direct impact on people's lives.

Evaluation also makes good sense in terms of social policy. It allows for clearer definition of need, discovery of new or changing needs and more precise direction of social policy.

Effective, ongoing evaluation is difficult to undertake, and also difficult to incorporate into decision making. Evaluation requires forward planning.

The Committee does not underplay these difficulties; it does not underplay the lack at times of appropriate techniques for effective evaluation; it does not underplay the lack of skills and the resultant need for training and education.

However, the task is necessary. We cannot afford to delay any longer. Parliamentarians, public servants, managers and workers in the field will all have to learn as evaluation proceeds.

We have not been at all prescriptive in our view of evaluation processes. We have only identified certain necessary steps. Each organisation will have to select the evaluation process most effective for its own objectives and environment.

Evaluation, however, does not necessarily ensure accountability. Accountability needs to be facilitated by adequate documentation and dissemination of information. Only in this manner can responsibility become visible as the basic tenets of rational, informed argument are provided.

PART FIVE  
**THE INQUIRY**

## **Background and conduct of the inquiry**

### **Terms of reference and initiation of the inquiry**

On 2 June 1976, the Senate agreed to a motion by Senator Peter Baume setting out the terms of reference which appear at the front of this report, on the reverse of the title page.

The inquiry was advertised in the national press on 9 June 1976, with advice that the Committee intended first to examine only points 1 and 2 of the terms of reference. The advertisements produced little response. Factors which contributed to this meagre and generally unproductive result were the breadth and complexity of the subject, lack of resources within some agencies for the preparation of submissions, and real fears by some about possible implications of the Committee's work.

In the initial stages, the Committee also wrote to a dozen Commonwealth Ministers seeking the assistance of Commonwealth authorities, to all State Premiers and to 229 non-government organisations, academics and individuals.

Ten out of fifteen Commonwealth authorities responded to invitations to present submissions, as did the New South Wales, Victorian, South Australian and Western Australian Governments. The Queensland and Tasmanian Governments provided no information, but assured us of their willingness to co-operate. The Tasmanian Government subsequently provided written material and offered witnesses if required.

After the Committee had decided to pursue points 3 and 4 of the terms of reference, an oral invitation to present a submission on these points was extended to representatives of the Department of Social Security at the public hearing held on 4 July 1978. This was followed by a further, written invitation on 11 September 1978. We believe that the functions of this Department are central to major concerns in the inquiry and regret that no submission on points 3 and 4 had been received by the time the final text of this report was settled early in 1979.

Of 218 non-government organisations invited to provide submissions, seventy-six responded. An additional twenty-seven organisations spontaneously forwarded material to us. Of eleven individuals approached, four responded, and another nine persons spontaneously provided information. A further nine submissions were received late in the inquiry.

We can only guess at the reasons why many of those to whom we wrote did not respond. In some instances, as we learned later, our letter had not been received; in others, pressure of work inhibited a response; in yet others, the reference was not considered to be relevant to the particular organisation.

Initially, there was considerable misunderstanding of our objectives and we noted a disposition on the part of some departments and organisations to treat the exercise as one emphasising a need for self-justification. The value of some early public hearings in three States was limited because organisations saw the visit of the Committee as an opportunity to display their activities rather than to address the issues raised by the reference.

### **Interruption of the inquiry**

After the initial processing and assessment of submissions, the Committee was able to conduct only a limited number of public hearings before interrupting work on the reference at the end of October 1976 to concentrate its full attention on completing an inquiry into the problem of drug use in Australia which had been initiated earlier and had then reached a crucial stage. The report on that inquiry, entitled *Drug Problems in Australia—an intoxicated society?*, was presented to the Senate on 25 October 1977. An election campaign for both Houses of the Parliament which followed in November of the same year caused some further postponement of Committee activity.

The earlier work done on the evaluation reference had demonstrated the need for a review of our strategy. In particular, the Committee had found in the community a belief that the real purpose of the inquiry was to examine and evaluate individually a vast array of health and welfare programs and services. But this was not the Committee's intention at all. We were trying to determine, and to understand, what evaluation activity was occurring; by what means it was being undertaken; the nature of the responses to it; and, ultimately, the requirements for ongoing evaluation as an integral feature of the development of health and welfare programs and services. To state our purposes succinctly, we were attempting to evaluate evaluation.

Following reconsideration of the program early in 1978, and bearing in mind particularly the delay of more than twelve months in progress with the reference, the Committee determined that, in the circumstances, all four points of the terms of reference should be considered together. Where appropriate, this decision and the resumption of work on the reference were notified to interested parties. The active phase of collecting evidence was then resumed.

### **Gathering of evidence**

Public hearings began in Adelaide on 28 September 1976 and continued in Perth, Brisbane, Rockhampton and Townsville over the next month. They resumed in 1978 on 4 July and concluded on 24 October. All these later hearings were held in Canberra. Altogether, 120 witnesses were heard at a total of twenty public hearings. Fifteen of these witnesses were representatives of organisations which had not responded to our original letter. We deliberately sought evidence from this group to satisfy ourselves that its views had been presented. In addition, 166 written submissions were received and considered, and a large volume of supporting material was gathered and studied.

### **Other activities**

Over the period of the inquiry, members and staff of the Committee were able to attend a number of seminars and conferences on various aspects of evaluation in health and welfare services. These helped to augment the background of theory necessary for the work of the Committee and were also in themselves indicative of the developing general interest and involvement in evaluation. Participation in these seminars and conferences enabled the Committee to derive considerable benefit from contacts with numerous academics and professional workers actively engaged in administrative and operational work in a wide range of programs and services.

When reviewing the program for the inquiry in the early part of 1978, the Committee was fortunate enough to be able to bring together a selected group of experts for special discussions designed to clarify some important issues that were central to our strategies and plans. These discussions were of signal value in helping us to determine the program for completion of the inquiry.

In May 1978, in a further attempt to make the best possible use of the available pool of expertise, the Committee commissioned a series of papers on particular aspects of evaluation activity. The experts who undertook to write for us on those topics included academics with both Australian and international expertise, and professional persons with active experience in programs and services in the health and welfare fields. Their skills and experience covered the provider, agency and client levels of participation. The four expert papers received have provided valuable information and insight. At the time of settling the final text of this report early in 1979, three further papers were expected. We intend to take the initiative of bringing all these papers together and publishing them later as volume two of this report for easier reference, as a contribution to the understanding of evaluation activity.

### **Expert adviser**

Because of the intricate and technical nature of the reference, the Committee found a need for expert assistance and advice. We were fortunate enough to be able to approach Professor Stephen R. Leeder, who had studied, and been engaged in, evaluation activity both in Australia and overseas. The Committee secured his services, temporarily and on a part-time basis, on 31 May 1977, and on 22 November of the same year his engagement was extended for the duration of the inquiry.

### **Acknowledgments**

The examination of this reference has presented an opportunity, for the first time, to attempt a national assessment of evaluation in health and welfare programs and services. The inquiry has been notable for the extensive range of activity and involvement at many levels. In such a broad and complex reference, the assistance of a great many persons and organisations has been indispensable. Firstly, we thank the witnesses for their contribution. Like ourselves, many found difficulty with an intricate subject having hidden and often unsuspected ramifications. The effective discharge of our responsibilities would have been impossible without the co-operation given to us by State Premiers and their departments, by many Commonwealth Ministers, departments and authorities, by voluntary agencies and by individual witnesses.

The Committee is particularly grateful for the assistance of Mr Colin Benjamin, Mrs Merle Hurcomb, Mr David Jones, Mrs Anne Kern and Mr Tony Wiseheart, who were members of the consultative group that helped us to clarify our task early in 1978. We are indebted also to the expert authors of the papers on special topics who responded to our call on them.

We would be remiss if we did not thank also the National Health and Medical Research Council for having made it possible, initially, for us to obtain the services of Professor Leeder, and the University of Newcastle for subsequently allowing him to continue his work for us. We were especially fortunate in receiving his help at a time when he and the University were heavily committed in the development of a new medical faculty. As our expert adviser through most of our inquiry, Professor Leeder has, with great dedication, contributed his skills for our benefit.

The Committee also places on record its deep appreciation of the work done by its dedicated secretariat. The Secretaries, originally Mr R. P. Joske, and later Mr R. G.

Thomson, Assistant Secretary, Mr K. L. Bone, and Research Officer, Mrs Patricia Mayberry, organised a large volume of material and produced excellent theoretical working papers on complex subjects. To Mrs D. Devir the Committee expresses its appreciation for her efficient stenographic and general office assistance.

A handwritten signature in black ink, appearing to read 'P. Baume', written in a cursive style.

PETER BAUME  
*Chairman*

The Senate  
Canberra  
May 1979

Appendix 1

**Estimates of government and private expenditures on health, and of government expenditures on social security and welfare, Australia—1970–71 to 1977–78**

The three tables in this appendix contain the detailed data from which Table 1.1 and Figures 1.1 and 1.2 (see pages 8, 10 and 11) were prepared. For sources, see note following Table 3.

These figures must be regarded as very conservative estimates of expenditure on health, social security and welfare because the figures for the following categories cannot be obtained:

- expenditure on welfare in the private sector;
- expenditure which may reasonably be considered to be welfare expenditure, though not included in welfare statistics—for example, housing outlays;
- transfer payments from States to local governments;
- transfer payments from local to State governments;
- untied grants from all levels of government which have been used for health or welfare purposes.

Furthermore, there are available almost no data on the extent to which industry, union, co-operative or other associations contribute to the meeting of welfare needs.

*Table 1 Estimates of Government and Private Expenditures on Health, Australia*  
\$ million

	1970-71	1971-72	1972-73	1973-74	1974-75	1975-76	1976-77	<sup>(p)</sup> 1977-78
<i>Commonwealth</i>								
Final consumption expenditure	115.7	137.7	156.8	205.6	302.9	416.2	463.5	503.6
Expenditure on new fixed assets	16.1	21.5	19.4	22.0	40.3	57.7	58.3	53.6
(a) Cash benefits to persons	409.5	508.1	581.3	659.0	817.0	1 369.4	1 140.4	1 010.6
(b) Grants to the States	17.8	18.0	21.0	51.8	108.0	1 082.9	852.8	1 107.2
(c) Other transfers to private sector	n.a.	n.a.	1	1	5.4	8.3	11.5	17.5
(d) Other outlay	n.a.	n.a.	1	n.a.	2.4	8.9	10.5	0.1
Total outlay on health	559.1	685.3	780.5	939.4	1 276.0	2 943.4	2 537.0	2 692.6
Per cent Commonwealth outlay, all purposes	7.2	7.9	8.0	7.9	7.4	13.7	10.5	10.0
<i>State</i>								
Final consumption expenditure	428.2	495.9	576.5	791.7	1 206.2	1 830.2	2 202.3	..
Expenditure on new fixed assets	85.2	93.6	97.5	123.9	202.9	321.1	332.8	..
Grants to local government	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
(e) Other transfers to private sector	n.a.	n.a.	4	4	4.7	10.2	11.8	n.a.
(f) Other outlay*	n.a.	n.a.	-1	n.a.	1.5	2	2.5	n.a.
Total	513.4	589.5	677.0	919.6	1 415.3	2 163.5	2 549.4	..
Per cent State outlay, all purposes	10.5	10.4	10.7	12.2	13.2	16.6	17.0	..
(g) Combined State & Commonwealth other transfers to private sector	2	3	..	..	..	..	..	..
(h) Combined State & Commonwealth other	1	2	..	..	..	..	..	..



	1970-71	1971-72	1972-73	1973-74	1974-75	1975-76	1976-77	(P)1977-78
<b>Local</b>								
Final consumption expenditure	15.9	19.2	22.8	26.6	32.6	40.0	(P)43.0	..
Expenditure on new fixed assets	0.6	0.7	0.5	0.9	1.1	2.4	(P)2.5	..
Transfers to the States	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	..
<b>Total</b>	16.5	19.9	23.3	27.5	33.7	42.4	(P)45.5	..
Per cent local government outlay, all purposes	2.2	2.3	2.4	2.5	2.2	2.3	(P)2.3	..
<b>TOTAL GOVERNMENT OUTLAY (excludes (b) )</b>								
	1 074.2	1 281.7	1 459.8	1 834.7	2 617.0	4 066.4	(P)4 279.1	..
Per cent government outlay, all purposes	10.2	10.7	10.9	11.3	11.5	14.8	(P)13.5	..
Per cent gross domestic product	3.3	3.5	3.5	3.6	4.3	5.7	(P)5.2	..
<b>Private</b>								
Final consumption expenditure	1 214	1 415	1 580	1 796	2 268	2 484	3 030	..
Expenditure on new fixed assets	42	45	48	41	54	83	100	..
<b>Total</b>	1 256	1 460	1 628	1 837	2 322	2 567	3 130	..
<b>TOTAL EXPENDITURE (excludes (a), (b), (c), (d), (e), (f), (g) and (h))</b>								
	1 917.7	2 228.6	2 501.5	3 007.7	4 108.0	5 234.6	(P)6 232.4	..
Per cent gross domestic product	5.8	6.0	6.0	5.9	6.8	7.3	(P)7.6	..

n.a. = Not available.

(P) = Provisional.

\* Cash benefits by the States are negligible.

**Table 2 Estimates of Government Expenditures on Social Security and Welfare, Australia**

\$ million

	1970-71	1971-72	1972-73	1973-74	1974-75	1975-76	1976-77	(P)1977-78
<b>Commonwealth</b>								
Final consumption expenditure	47.0	56.5	72.4	99.5	153.0	202.4	218.6	255.1
Expenditure on new fixed assets	6.2	2.6	2.5	10.7	8.7	12.9	8.5	6.6
Cash benefits to persons	1 294.9	1 471.1	1 870.0	2 316.4	3 354.9	4 506.6	6 031.9	7 031.1
(a) Grants to the States	9.7	42.7	126.4	29.5	68.6	79.6	37.0	45.7
Other transfers to private sector	18	19	29	31	68.1	108.6	55.0	63.9
Other outlay	1	2	1	2	0.5	4.2	1.4	1.4
<b>Total outlay on social security and welfare</b>	1 376.8	1 593.9	2 101.3	2 489.1	3 653.8	4 914.3	6 352.4	7 403.8
Per cent Commonwealth outlay, all purposes	17.7	18.5	21.6	20.9	21.0	22.9	26.4	27.5
<b>State</b>								
Final consumption expenditure	41.7	49.6	59.9	64.0	91.6	110.8	127.6	..
Expenditure on new fixed assets	3.8	6.2	6.0	8.1	8.3	8.8	11.6	..
Cash benefits to persons	19	37	54	52	67	88	115	..
Grants to local government	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.

	1970-71	1971-72	1972-73	1973-74	1974-75	1975-76	1976-77 <sup>(P)</sup>	1977-78
Other transfers to the private sector	1	2	2	3	3.5	6.7	4.7	..
Other outlay	..	..	..	1	0.5	0.8	0.6	..
Total	65.5	94.8	121.9	128.1	170.9	215.1	259.5	..
Per cent State outlay, all purposes	1.3	1.7	1.9	1.7	1.6	1.7	1.7	..
<i>Local</i>								
Final consumption expenditure	3.6	4.0	4.8	7.0	10.2	13.6	<sup>(P)</sup> 16.6	..
Expenditure on new fixed assets	0.8	1.0	0.8	2.6	3.8	6.1	<sup>(P)</sup> 7.0	..
Transfers to the States	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Other outlay	..	..	..	..	0.1	0.1	<sup>(P)</sup> 0.1	..
Total	4.4	5.0	5.6	9.6	14.1	19.8	<sup>(P)</sup> 23.7	..
Per cent local government outlay, all purposes	0.6	0.6	0.6	0.9	0.9	1.1	<sup>(P)</sup> 1.2	..
<b>TOTAL GOVERNMENT OUTLAY (excludes (a))</b>	1 437.0	1 651.0	2 102.4	2 597.3	3 770.2	5 069.6	<sup>(P)</sup> 6 598.6	..
Per cent government outlay, all purposes	13.6	13.7	15.7	16.0	16.5	18.4	<sup>(P)</sup> 20.8	..
Per cent gross domestic product	4.3	4.5	5.0	5.1	6.2	7.1	<sup>(P)</sup> 8.0	..

n.a. = Not available.

<sup>(P)</sup> = Provisional.

**Table 3 Estimates of Government and Private Expenditures on Health, and of Government Expenditures on Social Security and Welfare, Australia**

\$ million

	1970-71	1971-72	1972-73	1973-74	1974-75	1975-76	1976-77 <sup>(P)</sup>	1977-78
<i>Commonwealth</i>								
Final consumption expenditure	162.7	194.2	229.2	305.1	455.9	618.6	682.1	758.7
Expenditure on new fixed assets	22.3	24.1	21.9	32.7	49.0	70.6	66.8	60.2
(a) Cash benefits to persons	1 704.4	1 979.2	2 451.3	2 975.4	4 171.9	5 876.0	7 172.3	8 041.7
(b) Grants to the States	27.5	60.7	147.4	81.3	176.6	1 162.5	889.8	1 152.9
(c) Other transfers to private sector	18	19	30	32	73.5	116.9	66.5	81.4
(d) Other outlay	1	2	2	2	2.9	13.1	11.9	1.5
Total outlay on health, social security and welfare	1 935.9	2 279.2	2 881.8	3 428.5	4 929.8	7 857.7	8 889.4	10 096.4
Per cent Commonwealth outlay, all purposes	24.9	26.4	29.6	28.8	28.4	36.6	36.9	37.5
<i>State</i>								
Final consumption expenditure	469.9	545.5	636.4	855.7	1 297.8	1 941.0	2 329.9	..
Expenditure on new fixed assets	89.0	99.8	103.5	132.0	211.2	329.9	344.4	..
Cash benefits to persons (welfare)	19	37	54	52	67	88	115	..

	1970-71	1971-72	1972-73	1973-74	1974-75	1975-76	1976-77 <sup>(p)</sup>	1977-78
Grants to local government	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	..
(e) Other transfers to private sector	1	2	6	7	8.2	16.9	16.5	..
(f) Other outlay*	..	..	-1	1	2	2.8	3.1	..
<b>Total</b>	<b>578.9</b>	<b>684.3</b>	<b>798.9</b>	<b>1 047.7</b>	<b>1 586.2</b>	<b>2 378.6</b>	<b>2 808.9</b>	<b>..</b>
Per cent State outlay, all purposes	11.8	12.1	12.7	13.9	14.8	18.3	18.7	..
(g) Combined State & Commonwealth other transfers to private sector	2	3	..	..	..	..	..	..
(h) Combined State & Commonwealth other	1	2	..	..	..	..	..	..
<i>Local</i>								
Final consumption expenditure	19.5	23.2	27.6	33.6	42.8	53.6	<sup>(p)</sup> 59.6	..
Expenditure on new fixed assets	1.4	1.7	1.3	3.5	4.9	8.5	<sup>(p)</sup> 9.5	..
Transfers to the States	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	..
Other outlay	..	..	..	..	0.1	0.1	<sup>(p)</sup> 0.1	..
<b>Total</b>	<b>20.9</b>	<b>24.9</b>	<b>28.9</b>	<b>37.1</b>	<b>47.8</b>	<b>62.2</b>	<b><sup>(p)</sup>69.2</b>	<b>..</b>
Per cent local government outlay, all purposes	2.8	2.9	3.0	3.4	3.1	3.4	<sup>(p)</sup> 3.4	..
<b>TOTAL GOVERNMENT OUTLAY (excludes (b))</b>	<b>2 511.2</b>	<b>2 932.7</b>	<b>3 562.2</b>	<b>4 432.0</b>	<b>6 387.2</b>	<b>9 136.0</b>	<b><sup>(p)</sup>10 877.7</b>	<b>..</b>
Per cent government outlay, all purposes	23.8	24.4	26.6	27.3	28.0	33.2	<sup>(p)</sup> 34.2	..
Per cent gross domestic product	7.6	8.0	8.5	8.7	10.5	12.8	<sup>(p)</sup> 13.2	..
<i>Private Expenditure on Health</i>								
Final consumption expenditure	1 214	1 415	1 580	1 796	2 268	2 484	3 030	..
Expenditure on new fixed assets	42	45	48	41	54	83	100	..
<b>Total</b>	<b>1 256</b>	<b>1 460</b>	<b>1 628</b>	<b>1 837</b>	<b>2 322</b>	<b>2 567</b>	<b>3 130</b>	<b>..</b>
<b>TOTAL EXPENDITURE (excludes (b) and health component of (a), (c), (d), (e), (f), (g) and (h))</b>	<b>3 354.7</b>	<b>3 879.6</b>	<b>4 603.9</b>	<b>5 605.0</b>	<b>7 878.2</b>	<b>10 304.2</b>	<b><sup>(p)</sup>12 831.0</b>	<b>..</b>
Per cent gross domestic product	10.1	10.5	11.0	11.0	13.0	14.4	<sup>(p)</sup> 15.6	..

n.a. = Not available.

<sup>(p)</sup> = Provisional.

\* Cash benefits by the States for health purposes are negligible.

*Sources:* These figures were derived primarily from the following Australian Bureau of Statistics publications:

- *Social Indicators No. 2, 1978* (Catalogue No. 4101.0).
- *Public Authority Finance—Federal Authorities, 1974-75, 1975-76, 1976-77, 1977-78* (Catalogue No. 5502.0; previously Ref. S, 12).
- *Public Authority Finance—State and Local Authorities, 1975-76 and 1976-77* (Catalogue No. 5504.0).

- *Australian National Accounts—National Income and Expenditure, 1976–77* (Catalogue No. 5204.0).

Figures from 1974 to 1978 on final consumption expenditure, expenditure on new fixed assets, other transfers to the private sector, and other outlays for all levels of government were supplied by the ABS in an unpublished table.

Current figures and breakdowns between Commonwealth and State for some of the figures in *Social Indicators* were supplied privately by the Bureau.

*Appendix 2*

**Extracts from legislation prescribing responsibilities and functions of the Australian Bureau of Statistics**

**CENSUS AND STATISTICS ACT 1905**  
(as amended)

*Section 16:*

(1) The Statistician shall, subject to the regulations and the directions of the Minister, collect, at least annually, statistics in relation to all or any of the following matters:—

- (a) Population;
- (b) Vital, social, and industrial matters;
- (c) Employment and non-employment;
- (d) Imports and exports;
- (e) Inter-State trade;
- (f) Postal and telegraphic matters;
- (g) Factories, mines, and productive industries generally;
- (h) Agricultural, horticultural, viticultural, dairying, and pastoral industries;
- (i) Banking, insurance, and finance;
- (j) Railways, tramways, shipping, and transport;
- (k) Land tenure and occupancy; and
- (l) Any other prescribed matters.

(2) The Statistician shall collect such statistics as are necessary for the purposes of the compilation of statistics referred to in paragraph 20 (1) (a).

*Section 20:*

(1) The Statistician shall compile and tabulate—

- (a) statistics of the number of the people of each State as on the last day of March, June, September and December in each year; and
- (b) the statistics collected in pursuance of sub-section 16 (1),

and shall publish those statistics or abstracts thereof, as the Minister directs, with observations thereon.

\* \* \*

**AUSTRALIAN BUREAU OF STATISTICS ACT 1975**

*Section 6:*

(1) The functions of the Bureau are as follows:—

- (a) to constitute the central statistical authority for the Australian Government and, by arrangements with the Governments of the States, provide statistical services for those Governments;
- (b) to collect, compile, analyse and disseminate statistics and related information;
- (c) to ensure co-ordination of the operations of official bodies in the collection, compilation and dissemination of statistics and related information, with particular regard to—
  - (i) the avoidance of duplication in the collection by official bodies of information for statistical purposes;
  - (ii) the attainment of compatibility between, and the integration of, statistics compiled by official bodies; and

(iii) the maximum possible utilisation, for statistical purposes, of information, and means of collection of information, available to official bodies;

(d) to formulate, and ensure compliance with, standards for the carrying out by official bodies of operations for statistical purposes;

(e) to provide advice and assistance to official bodies in relation to statistics; and

(f) to provide liaison between Australia, on the one hand, and other countries and international organisations, on the other hand, in relation to statistical matters.

(2) For the purpose of the performance of its functions and for the purpose of co-ordinating statistical activities and securing the observance of statistical standards, the Bureau may collaborate with bodies, being Departments and authorities of the States, the Administrations and authorities of the external Territories and local governing bodies, in the collection, compilation, analysis and dissemination of statistics, including statistics obtained from the records of those bodies.

\* \* \*

*Appendix 3*

**Witnesses**

	<i>Submission No.</i>
Allen, Mr P. M., Acting Executive Director, <b>Victorian Council of Social Service</b>	127
Allen, Mr R. Q., Director of Professional Services, <b>Autistic Children's Association of New South Wales</b>	140
Back, Professor K., Vice-Chancellor, James Cook University of North Queensland	..
Bannerman, Mr C. E., Acting Assistant Commissioner, <b>Public Service Board, Canberra</b>	137
Bartlam, Mrs V. G., C/o Post Office, Bluff (associated with Fitzroy Interim Regional Council for Social Development, Rockhampton, Qld)	..
Benfredj, Mr M., Director/Social Planner, <b>Western Adelaide Regional Council for Social Development</b>	81
Benn, Mrs C., Associate Director (in charge of social issues and research), <b>Brotherhood of St Laurence, Fitzroy, Vic.</b>	..
Bennett, Mrs B. E., Family Welfare Officer, Salvation Army (associated with Northern [Qld] Regional Council for Social Development, Townsville)	..
Brewer, Mr G. F., Senior Research Officer, <b>Brotherhood of St Laurence, Fitzroy, Vic.</b>	..
Briggs, Mr A. W., Assistant Secretary, <b>Department of Finance, Canberra</b>	141
Brodribb, Mrs E. H., Welfare Officer, <b>Paraplegic and Quadriplegic Association of Victoria</b>	..
Brown, Mr R. L., Research Fellow, Department of Social Security (associated with Fitzroy Interim Regional Council for Social Development, Rockhampton, Qld)	..
Bruen, Mr W. J., Acting Assistant Director-General, Health Services Research and Planning Branch No. 1, <b>Commonwealth Department of Health, Canberra</b>	39
Bubner, Mr D., Community Worker, Community Media Association (associated with Western Adelaide Regional Council for Social Development)	..
Burgess, Mrs U. E., Marriage and Family Counsellor, <b>Life Line Centre, Sydney, N.S.W.</b>	..
Buttsworth, Mr I. R., Secretary, <b>National Committee on Health and Vital Statistics, Canberra</b>	136
Campbell, Mrs B. M., Welfare Officer, Senior Citizens Welfare Association (associated with Northern [Qld] Regional Council for Social Development, Townsville)	..
Carpenter, Mr R., Community Development Worker, Blackwater and District Social Development Committee, Blackwater (associated with Fitzroy Interim Regional Council for Social Development, Rockhampton, Qld)	..

Chadwick, Mr M. J., Chief Executive Officer, <b>Royal Tasmanian Society for the Blind and Deaf</b>	..
Coates, Mr D. A., Secretary, <b>Department of Public Health, W.A.</b>	17
Cole, Mr R. W., Secretary, <b>Department of Finance, Canberra</b>	141
Coleman, Mrs M. Y., Director, Office of Child Care, <b>Department of Social Security, Canberra</b>	117
Collingridge, Mr H. R. K., Administrator, <b>Crippled Children's Association of South Australia Incorporated</b>	48
Colliver, Mr A. S., First Assistant Director-General, Social Welfare Division, <b>Department of Social Security, Canberra</b>	117
Cooper, Mr E. J., Assistant Commissioner (Planning), <b>South Australian Health Commission</b>	100
Cox, Ms E. M., Director, <b>Council of Social Service of New South Wales</b>	55
Dawkins, Major E. J., Director, Senior Citizens and Homeless Persons Services, Territorial Social Services, <b>Salvation Army, Sydney</b>	..
Dewhurst, Mrs P. (associated with Western Adelaide Regional Council for Social Development)	..
Dibnah, Mr L., Community Development Officer, Bowen (associated with Northern [Qld] Regional Council for Social Development, Townsville)	..
Dixon, Ms J. (associated with Western Adelaide Regional Council for Social Development)	..
Donovan, Dr J. W., Chairman, <b>National Committee on Health and Vital Statistics, Canberra</b>	136
Dorgan, Mr D. J., Koongal (associated with Fitzroy Interim Regional Council for Social Development, Rockhampton, Qld)	..
Douglas, Dr R. M., Senior Lecturer, Department of Community Medicine, University of Adelaide	36
Duckett, Mr S. J., Chairman, Health Committee, <b>Council of Social Service of New South Wales</b>	55
Ellis, Rev. I. G., Director, <b>St John's Homes for Boys and Girls, Canterbury, Vic.</b>	6
Fitzherbert, Mrs M., Secretary, Mt Morgan Social Development Council (associated with Fitzroy Interim Regional Council for Social Development, Rockhampton, Qld)	..
Fleming, Dr K. J. A., Chief Director (Medical Services), <b>Department of Veterans' Affairs</b> (formerly Department of Repatriation), Canberra	116
Geddes, Brigadier J., O.B.E., Consultant, Territorial Social Services, <b>Salvation Army, Sydney</b>	..
George, Mr A. R., Former President, <b>Australian Association for the Mentally Retarded, Melbourne</b>	19
Giles, Mr M. D., Assistant Statistician, Demographic and Social Branch, <b>Australian Bureau of Statistics, Canberra</b>	..



Gillespie, Mrs C. D., Community Development Officer, Livingstone Social Development Council (associated with Fitzroy Interim Regional Council for Social Development, Rockhampton, Qld)	..
Giordano, Mr A., Australian Co-ordinator for the Italian National Association of Migrant Families (associated with Western Adelaide Regional Council for Social Development)	..
Gorman, Mrs A., Executive Director, Family and Children's Services Agency, <b>Department of Youth and Community Services, N.S.W.</b>	131
Gorman, Miss G. L., Townsville (associated with Northern [Qld] Regional Council for Social Development)	..
Gwynne, Dr H., Senior Medical Officer, Division of Health Services Research, <b>Health Commission of New South Wales</b>	131
Hall, Mr A. N., Acting Senior Social Planner, <b>Department for Community Welfare, S.A.</b>	100
Hall, Mr J. D., Acting First Assistant Director-General, Rehabilitation Policy and Services Division, <b>Department of Social Security, Canberra</b>	117
Harris, Mr C. E. M., Director (Regional Services) (Acting Deputy Director-General), <b>Department for Community Welfare, S.A.</b>	100
Harris, Mr W. J., First Assistant Secretary, Housing Division, <b>Department of Environment, Housing and Community Development, Canberra</b>	79
Harrison, the Rev. V. H., Past Chairman of the <b>South Australian Council on the Ageing</b> and President of the <b>Australian Council on the Ageing, Adelaide</b>	..
Hart, Mr E. T., Director, <b>Churches of Christ Social Service Committee, Brisbane</b>	50
Hayes, Ms J. D., Executive Director, <b>Council of Social Service of the Australian Capital Territory</b>	143
Heatley, Mrs J. M., Convenor, <b>Northern (Qld) Regional Council for Social Development, Townsville</b>	110
Hennessy, Dr B. L., First Assistant Director-General, Policy and Planning Division, <b>Commonwealth Department of Health, Canberra</b>	39
Hickey, the Rev. Father B. J., Director, <b>Catholic Family Welfare Bureau, Perth</b>	3
Higgins, Dr C. I., Assistant Secretary, Fiscal and Monetary Policy Branch, General Financial and Economic Policy Division, <b>Department of the Treasury, Canberra</b>	..
Hodges, Mr J. E., Director (Social Statistics), Demographic and Social Branch, <b>Australian Bureau of Statistics, Canberra</b>	..
Holman, Dr L. J., Director-General of Public Health, <b>Department of Public Health, W.A.</b>	17
Houston, Mrs J. M., Deputy Chief Social Worker, Social Work Department, <b>Sir Charles Gairdner Hospital, Perth</b>	130
Jenkins, Mr P. M., First Assistant Secretary, Community Division, <b>Department of Environment, Housing and Community Development, Canberra</b>	79

Joel, Mr G. R., Administrator, <b>Paraplegic and Quadriplegic Association of Victoria</b>	..
Johnson, the Rev. W. J., Director of the Moorfields Interim Committee for Adult Care, <b>Uniting Church in Australia (Victoria)</b>	20
Jones, Mr J. C. M., First Assistant Auditor-General, Head of Efficiency Audit Division, <b>Auditor-General's Office</b> , Canberra	144
Keeffe, Alderman S. D., Local Authority Representative, <b>Northern (Qld) Regional Council for Social Development</b> , Townsville	..
Kelly, Mr A. D., Executive Member, <b>Queensland Council of Social Service</b>	..
Kelly, Mr R. G., Deputy Chairman, <b>Repatriation Commission</b> , Canberra	116
Knack, Mr W. J., Community Development Officer, Charters Towers (associated with Northern [Qld] Regional Council for Social Development, Townsville)	..
Lanigan, Mr P. J., O.B.E., Director-General, <b>Department of Social Security</b> , Canberra	117
Lansdown, Mr R. B., Secretary, <b>Department of Environment, Housing and Community Development</b> , Canberra	79
Last, Dr P. M., Director, <b>State Health Resources Unit, S.A.</b>	100
Lauder, Mrs B., Collinsville Delegate, <b>Northern (Qld) Regional Council for Social Development</b> , Townsville	..
Leahy, Mrs D., Community Development Officer, Emerald District Social Development Council (associated with Fitzroy Interim Regional Council for Social Development, Rockhampton, Qld)	..
Luckens, Mr T. J., Administrator/Project Officer, <b>Western Adelaide Regional Council for Social Development</b>	81
Lugg, Dr M. M., Chief Health Statistician, <b>Department of Public Health, W.A.</b>	17
MacDonald, Miss J., Regional Development Officer, <b>Fitzroy Interim Regional Council for Social Development</b> , Rockhampton, Qld	107
Manning, Mr S. H., General Manager, Wesley Central Mission, <b>Life Line Centre</b> , Sydney	..
Marriner, Miss N. A., Member, Professional Services Board, <b>Australian Association of Speech and Hearing</b> , Perth	32
Martin, Mr (associated with Western Adelaide Regional Council for Social Development)	..
Martins, Mr J., Deputy Director, Division of Health Services Research, <b>Health Commission of New South Wales</b>	131
McAlister, Mr C. A., First Assistant Director-General, Development Division, <b>Department of Social Security</b> , Canberra	117
McAulay, Mr I. W., Deputy Director, <b>Department of Youth and Community Services, N.S.W.</b>	131
McGuire, Mr K., Executive Officer, <b>Australian Association for the Mentally Retarded</b> , Canberra	19

	<i>Submission No.</i>
McNulty, Dr J., Commissioner of Public Health and Medical Services, <b>Department of Public Health, W.A.</b>	17
Michell, Mr J. T., O.B.E., Executive Director, Spastic Welfare Association of Western Australia, and National Secretary, <b>Australian Cerebral Palsy Association</b> , Perth	..
Miller, the Rev. C. L., Director, Department of Community Service, <b>Baptist Union of Queensland</b>	145
Moran, Mrs J., Member of the Executive of the <b>Psychiatric Rehabilitation Association</b> , Sydney	30
Muir, Mr J. W., Acting First Assistant Commissioner (Treatment Services), <b>Department of Veterans' Affairs</b> (formerly Department of Repatriation), Canberra	116
Neely, Mr D., Manager, Welfare Services, <b>The Smith Family</b> , Sydney	..
Oakley, Mr D. M., Director, <b>Victorian Children's Aid Society</b>	..
Parkinson, Ms C., Program Co-ordinator, Non-government Welfare Sector, <b>Australian Council of Social Service Inc.</b> , Sydney	146
Payne, Father J. M., Chairman, Lower Burdekin Community Assistance Association, Ayr (associated with Northern [Qld] Regional Council for Social Development, Townsville)	..
Peel, Mrs G., President, <b>Queensland Council on the Ageing</b>	87
Pike, Mrs J. E., Secretary/Treasurer, Banana Shire Social Development Council, Biloela (associated with Fitzroy Interim Regional Council for Social Development, Rockhampton, Qld)	..
Price, Pastor E. B., Director of Communications, Victorian Conference, <b>Seventh-day Adventist Church</b>	..
Rackemann, Mr A. G., part-time Mt Morgan Community Development Officer, Mt Morgan Social Development Council, Mt Morgan (associated with Fitzroy Interim Regional Council for Social Development, Rockhampton, Qld)	..
Randell, Mrs V. M., Community Worker (CDO), Alpha-Jericho Social Development Committee, Jericho (associated with Fitzroy Interim Regional Council for Social Development, Rockhampton, Qld)	..
Roberson, Mr G. G., Member, <b>Northern (Qld) Regional Council for Social Development</b> , Townsville	..
Roberts, Dr W. D., Director-General of Medical Services, Medical Department, <b>Department of Public Health, W.A.</b>	17
Ross, Mr A. D., Chief Finance Officer, Taxation Policy Branch, General Financial and Economic Policy Division, <b>Department of the Treasury</b> , Canberra	..
Russell, Mr G. E., State President, <b>Society of St Vincent de Paul, W.A.</b>	..
Ryan, Mr P. S., State Secretary, <b>Retarded Children's Welfare Association of Tasmania</b>	..
Rye, Mr C. R., First Assistant Secretary, General Financial and Economic Policy Division, <b>Department of the Treasury</b> , Canberra	..

	<i>Submission No.</i>
Sanderson, the Rev. W. A., Director of Life Line, Townsville (associated with Northern [Qld] Regional Council for Social Development, Townsville)	..
Sharkey, Miss M., Chief Social Worker, Social Work Department, <b>Sir Charles Gairdner Hospital</b> , Perth	130
Shea, Dr B. J., Director-General Medical Services, <b>South Australian Hospitals Department</b>	100
Stephenson, Mrs M. O., Executive Officer, Council of Social Service of Western Australia Inc. (appeared as an individual)	43
Sutherland, Mr, Mayor, City of Woodville, S.A.	..
van der Est, Mrs L. W., Executive Committee Member, <b>Queensland Council on the Ageing</b>	87
Vern-Barnett, Dr A., M.B.E., National President, <b>Federation of Autistic Children's Associations of Australia</b> , and President, <b>Autistic Children's Association of New South Wales</b>	140
Ward, Mrs A., Representative, <b>Northern (Qld) Regional Council for Social Development</b> , Townsville	..
Wark, Mr J. M., First Assistant Secretary, <b>Department of Finance</b> , Canberra	141
Westaway, Mr D. L., Co-ordinator of Client Services, National Guide Dog and Mobility Training Centre, <b>Royal Guide Dogs for the Blind Associations of Australia</b> , Kew, Vic.	61
Western, Professor J. S., Department of Anthropology and Sociology, University of Queensland	40
Williams, Miss H. R., Assistant Secretary, <b>Department of Finance</b> , Canberra	141
Willmetts, Mr C. A., Regional Community Development Officer, <b>Northern (Qld) Regional Council for Social Development</b> , Townsville	..
Woodruff, Dr P. S., Director-General, <b>Department of Public Health</b> , S.A.	100
Woodward, Mr L. B., Acting Deputy Commissioner, <b>Public Service Board</b> , Canberra	137
Wryell, Mr M., Deputy Director-General, <b>Department of Social Security</b> , Canberra	117
Yates, Mr I. G., Secretary-General, <b>Australian Council of Social Service Inc.</b> , Sydney	146
Zubrick, Ms D. A., Member, Professional Services Board, <b>Australian Association of Speech and Hearing</b>	32

## Appendix 4

### Submissions

Apart from submissions received from witnesses, written submissions were presented by the following individuals and organisations:

	<i>Submission No.</i>
Aboriginal Affairs, Department of, Canberra	54
Aboriginal Legal Service of W.A. (Inc.), Perth	113
Advisory Committee on Needs of Disabled, Croydon, Vic.	77
Albury-Wodonga Development Corporation, Albury, N.S.W.	92
Albury Wodonga Regional Council for Social Development, Albury, N.S.W.	101
Alice Springs Interim Regional Council for Social Development, Alice Springs, N.T.	72
Anderson, Mr D. R., Black Rock, Vic.	138
Anglican Health and Welfare Services, Perth	15
ANZSERCH (Australian and New Zealand Society for Epidemiology and Research in Community Health), North Adelaide	123
Association for the Welfare of Children in Hospital, Parramatta, N.S.W.	114
Australian Association of Clinical Biochemists, Camperdown, N.S.W.	35
Australian Birthright Movement, Sydney	22
Australian Council for Rehabilitation of Disabled, Surry Hills, N.S.W.	97
Australian Council of Community Nursing, Highgate Hill, Qld	37
Australian Council of Employers' Federations, Hawthorn, Vic.	34
Australian Council of Trade Unions, Melbourne	23
Australian Council on Hospital Standards, St Leonards, N.S.W.	41
Australian Dental Association, North Sydney	73
Australian Federation of Adult Deaf Societies, Stanmore, N.S.W.	24
Australian Federation of Family Planning Associations, Redfern, N.S.W.	124
Australian Greek Welfare Society, Melbourne	2
Australian Hospital Association, St Leonards, N.S.W.	62
Australian Institute of Medical Technologists, Floreat Park, W.A.	85
Australian Medical Association, Glebe, N.S.W.	148
Australian Pensioners' Federation, Croydon Park, N.S.W.	58
Australian Physiotherapy Association (Federal Council), Caulfield, Vic.	51
Australian Red Cross Society, Melbourne	49
Barclay, Ms S. (jointly with Ms P. Sebastian), Melbourne	90
Barwon Regional Council for Social Development, Geelong, Vic.	69
Batzias, Ms D. (jointly with Ms E. Gawith, Mr N. Polites, Ms S. Verbickis and Ms B. Gayler), Richmond, Vic.	26
Bonney, Mr H. C., Caloundra, Qld	150
Broadmeadows, City of, Broadmeadows, Vic.	65

	<i>Submission No.</i>
Brunswick Community Health Service, Brunswick, Vic.	108
Capital Territory, Department of the, Canberra	45
Capital Territory Health Commission, Canberra	53
Citizens' Advice and Aid Bureaux (Victorian Association), Melbourne	88
Citizens Advice Bureau (Bundaberg), Bundaberg, Qld	133
Commissioner for Community Relations, Canberra	129
Darby, Dr D. N., School of Marketing, University of New South Wales	91
Darwin Regional Council for Social Development, Darwin, N.T.	56
Duff, Ms J. (jointly with Ms W. Jamieson), Melbourne	120
Dysart Action Committee, Dysart, Qld	84
East Burwood Counselling and Care Centre, East Burwood, Vic.	11
Educational Co-ordinating Committee for Handicapped Children, Melbourne	112
Ella Community Centre, Haberfield, N.S.W.	155
Evans, Sister Margaret, Nudgee, Qld	132
Family Planning Association of New South Wales, Chippendale	118
Fisher, Dr S., Gordon, N.S.W.	7
Foundation for Multi-Disciplinary Education in Community Health Inc., Adelaide	29
Fraenkel, Professor G. J., School of Medicine, Flinders Medical Centre, Bed- ford Park, S.A.	102
Gallagher, Mr M., Devonport, Tas.	25
Garrett, Mrs B. F., Adelaide	165
Gawith, Ms E. (jointly with Mr N. Polites, Ms S. Verbickis, Ms D. Batzias and Ms B. Gayler), Richmond, Vic.	26
Gayler, Ms B. (jointly with Ms E. Gawith, Mr N. Polites, Ms S. Verbickis and Ms D. Batzias), Richmond, Vic.	26
Goldfields Regional Social Development Board, Kalgoorlie, W.A.	52
Gray, Ms J., Beecroft, N.S.W.	121
Griffin, Mr L., Sydney	13
Gross, Mr P. F., Canberra	99
Gunnedah & District Council of Social Development, Gunnedah, N.S.W.	59
Hamilton, Mrs J., Warrnambool, Vic.	14
Hawthorn, City of, Hawthorn, Vic.	139
Health Advisory Committee to the Albury Wodonga Consultative Council, Albury, N.S.W.	67
Hetzel, Dr B. S., Adelaide	1
Hinchley, Dr P., Albany, W.A.	161
Jamieson, Ms W. (jointly with Ms J. Duff), Melbourne	120
Jorgensen, Dr D., Adelaide	57
Katherine Regional Council for Social Development, Katherine, N.T.	44

	<i>Submission No.</i>
Kealy, Mrs A. K., Coleraine, Vic.	94
Kirby, Mr P., Hobart	10
Kwinana, Shire of, Kwinana, W.A.	154
Launceston, City of, Launceston, Tas.	159
Ley, Mrs C. T., Wodonga, Vic.	68
Liveris, Mr M., Dean of Health Sciences, Western Australian Institute of Technology	95
Llewelyn-Davies Kinhill Pty Ltd, Sydney	80
Lower Great Southern Regional Council for Social Development, Albany, W.A.	8
Macdonald, Professor W. B., Professor of Child Health, The University of Western Australia	111
Mackay Regional Council for Social Development Limited, Mackay, Qld	115
Melbourne Family Care Organisation, Glen Waverley, Vic.	27
Milligan, Mrs N., Mawson, A.C.T.	142
Mentally Retarded Children's Society of South Australia Inc.	158
Mentally Retarded Children's Welfare Association, Chadstone, Vic.	160
Mornington Social Welfare Group, Mornington, Vic.	157
Mount Isa Welfare Council, Mount Isa, Qld	18
Murrell, Professor T. G. C., Department of Community Medicine, University of Adelaide	38
New England Regional Council for Social Development, Tamworth, N.S.W.	96
New South Wales Council for the Mentally Handicapped, Ryde, N.S.W.	28
North Richmond Family Care Centre, Richmond North, Vic.	76
North West and Western Tasmanian Regional Council for Social Development, Burnie, Tas.	109
North-West Regional Council for Social Development Ltd, Glenroy, Vic.	125
Northern Tasmanian Regional Council for Social Development, Launceston, Tas.	31
Northern Territory, Department of the, Darwin	60
Outer Western Regional Council for Social Development, Blacktown, N.S.W.	21
Pacy, Dr H., Tea Gardens, N.S.W.	93
Paraplegic and Quadriplegic Association of N.S.W., South Hurstville, N.S.W.	75
Pharmacy Guild of Australia, Deakin, A.C.T.	135
Polites, Mr N. (jointly with Ms E. Gawith, Ms S. Verbickis, Ms D. Batzias and Ms B. Gayler), Richmond, Vic.	26
Polkinghorne, Mrs N., Marion, S.A.	149
Practice Management Consultants Pty Ltd, Parkville, Vic.	106
Presbyterian Church of Australia (Social Service Department), Sydney	12

	<i>Submission No.</i>
Presbyterian Church of Victoria (Social Services Department), Melbourne	9
Queensland Association of Occupational Therapists, St Lucia, Qld	126
Rawson, Mr G., Lecturer, School of Health Administration, University of N.S.W.	163
Royal Australian College of General Practitioners, Sydney	122
Royal Dental Hospital of Melbourne, Melbourne, Vic.	83
Royal Flying Doctor Service of Australia, Sydney	63
Royal New South Wales Institute for Deaf and Blind Children, Sydney	86
Royal Victorian Institute for the Blind, Melbourne	61
St George Community Planning Committee for Aged and Disabled, Kingsgrove, N.S.W.	128
St Vincent de Paul Society, Sydney	74
Sebastian, Ms P. (jointly with Ms S. Barclay), Melbourne	90
Service to Youth Council Inc., Parkside, S.A.	82
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