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.

Chapter 1

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.[1]

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'.[2]

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'.[3]

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.[4]

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.[5]

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.[6]

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.[7]

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.[8]

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.[9]

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.[10]

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*(p)	
	$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*(p)		
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(p)			
Per cent gross domestic product	5.8		6.0		6.0		5.9		6.8		7.3		7.6(p)			

Government expenditures on social security and welfare

	1970–71		*1971–72*		*1972–73*		*1973–74*		*1974–75*		*1975–76*		*1976–77*		*1977–78*(p)	
	$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*(p)		
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(p)			
Per cent gross domestic product	4.3		4.5		5.0		5.1		6.2		7.1		8.0(p)			

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*(p)		
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(p)			
Per cent gross domestic product	10.1		10.5		11.0		11.0		13.0		14.4		15.6(p)			

(p) = Provisional.

Source: Appendix 1 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.

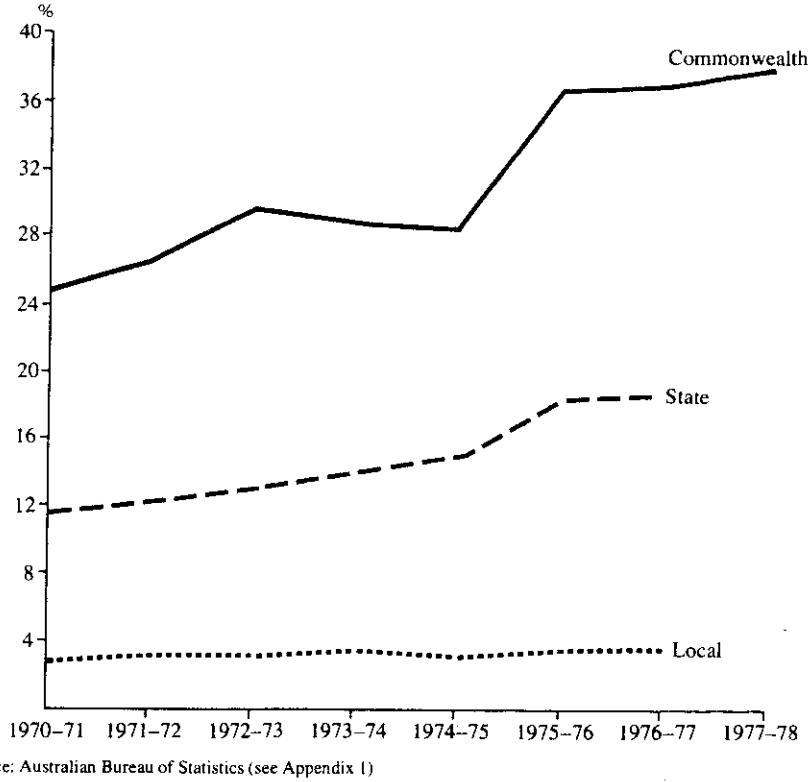
Furthermore, there are available almost no data on the extent to which industry, union, co-operative or other associations contribute to the meeting of welfare needs.

Table 1.1 shows expenditure, at all levels of government, on health, social security and welfare as defined by the Australian Bureau of Statistics.[11] 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**



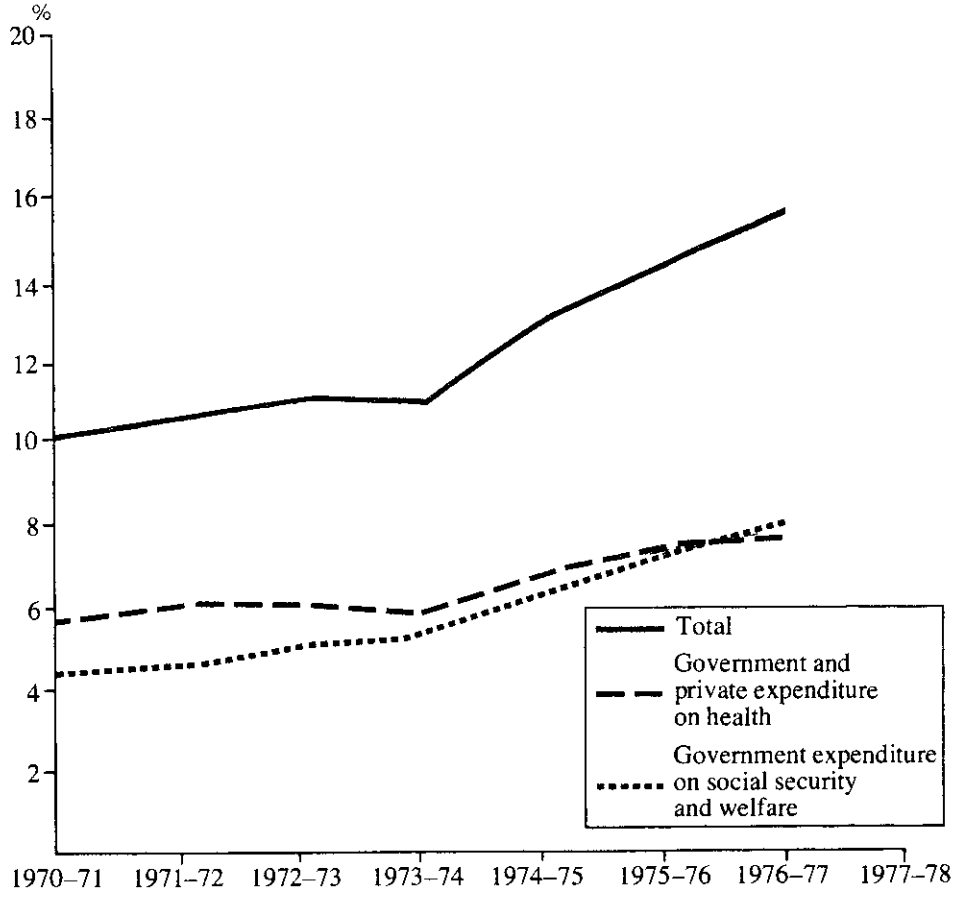
Source: Australian Bureau of Statistics (see Appendix 1)

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).[12]

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'.[13] 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.[14]

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.[15]

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.[16] 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.[17] 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.[18] 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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