Program Evaluation And Health Policy: Nix, Knack And Nexus

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RÉSUMÉ

Les résultats des évaluations programmatiques dans le domaine des services de santé sont souvent ignorés ou sous utilisés par ceux qui sont en mesure de prendre des décisions. Ce papier soulève et examine ces questions. Il est suggéré que si les évaluateurs veulent contribuer à l'évolution des programmes de santé ou à la politique des services de lat santé, ils devront prendre une ligne de compte des raisons pour lesquelles il y a une lacune ou une sous utilisation de ces évaluations. De plus, ils devront prendre des mesures appropriées pour ainsi modifier leurs évaluations.

ABSTRACT

Results of program evaluations in the health field are often ignored or under utilized by health policy decision-makers and by program managers. The paper discusses several reasons for this phenomenon. It is suggested that if program evaluators are to make a positive contribution to changing the design and operation of health programs and the nature and specifics of health policies, they must be cognizant of the reasons for the lack of use of program evaluations to date and be willing to modify their program evaluations accordingly.

Introduction

The relationship between the evaluation of health programs and health policy, program or organizational change is anything but straightforward. Evaluation studies directed at assessing the efficacy or effectiveness of services and the efficiency of health care delivery systems are neither necessary nor sufficient for effecting changes in health care system that may have been the focus of the evaluation. Governments and health care organizations often make changes to existing health policies and program without any or sometimes on the basis of the most casual or superficial "evaluation" study. Equally disappointing is the all too common observation that the results and recommendations of evaluation studies do not lead to any significant transformation in the health policies and programs that were the subject of the evaluations. Program managers and policy makers frequently and quite deliberately neglect or ignore evaluative analyses. Benign neglect is not the worse fate of program evaluation studies. More distressing is the not uncommon occurrence of policy or program changes that are clearly contraindicated by the evaluation studies. For example, the development of the nurse practitioner training program and the incorporation of nurse practitioners in the health care delivery system were evaluated to be effective, efficient and acceptable to the public but rather than expand the training and use

of nurse practitioners the training program was eliminated. Such perverse policy or program decisions are often used by health care professionals as proof of the futility and uselessness of program evaluations. The disconcerting refrain "it makes no difference" can be heard at virtually every conference or colloquium on the need and value of program evaluation or on health policy.

The resignation implicit in the argument above is unwarranted and in any case counterproductive. There are examples of policy or program evaluations that have led to the desired policy or program changes. The recently enacted Canada Health Act is one such example. The suggestion that there is no (nix) relationship between program evaluation and health policy is demonstrably false. Nevertheless, it must be acknowledged that many of the findings of program evaluations are not utilized by program managers or policy makers. In order to reduce this "utility gap", program evaluators must meet two major challenges. First, they must examine and understand better the nexus between program evaluation and health policy making. Second, they need to develop and cultivate the knack for first framing and then undertaking the evaluation study in a manner that will compel, as much as possible, the attention and action on the part of policy makers, program managers and other parties materially concerned with the policies and programs under consideration. Central to both challenges is an understanding of why there is at present such a tenuous and uncertain relationship between program evaluation and changes in health policies and programs.

Factors which Limit the Utilization of Evaluation Studies

There are many constraints and factors which singly or in combination limit the utility of evaluation results in the health sector. In what follows the most important of these are discussed. No attempt is made to gauge their relative importance since empirical analyses of this matter are woefully lacking in Canada.

Timeliness of Program Evaluation

The lack of timeliness is frequently cited as an important factor in the insufficient use of evaluation studies (Rossi, Freeman and Wright, 1979; Davis and Salisin, 1975). "In fact, it is the rare author writing on the problems of the uses of evaluation who does not mention timing of the results as a critical problem issue" (Veney and Kaluzny, 1984: 16). For program evaluation to be useful, the results must be made available when they are required. Even the most scientific and systematic program evaluation studies have been ignored because the policy planning cycle had moved forward or the political-bureaucratic scene had changed in ways to make the evaluation irrelevant. Evaluation studies of long duration, and therefore very costly as well, are at a greater risk of being untimely. An example is the well-designed experimental study by the Rand Corporation begun in 1972 to assess the effect of various types of health insurance coverage on the use of services (Newhouse, 1974). The numerous results to date from this experimental study are interesting and do have policy significance and there

are more studies expected (Lohr et al, 1986). But the issue of national health insurance has become virtually irrelevant in the U.S.A. While it could reemerge as a vital political issue in the future, the experimental study conducted in the 1970s may well be considered too dated to be of much value. To be sure, the academic evaluation of the Rand study is of considerable value and use even if its impact on health policy may be minor. This leads to the next factor that explains why program evaluation results are often not used for policy or program planning purposes.

Academic Orientation of Program Evaluators

Program evaluators typically come out of the academic research tradition. Upon the completion of their study, they do not seek to be involved in the sponsoring organization's decision-making conflicts. While this is more true of academics and consultants, it is also generally true of program evaluators in government departments and health care organizations. Indeed, the academic orientation quite often leads evaluators to stop short of drawing conclusions and making recommendations most pertinent to program and policy reform. But the belief that "the facts speak for themselves" is generally not warranted in program evaluation studies. The abdication of the task (if not responsiblity) to draw policy or program implications from evaluation studies by those most intimately knowledgeable and informed about the strengths and weaknesses of the analyses often means that nobody does it, or does it well. The culture of non-involvement is further aided and abetted by the esteem in which evaluators are held by their professional colleagues if they manage to publish their results in a "respectable professional journal". While this is valuable, it is often regarded as the ultimate purpose of program evaluation studies by regrettably too many evaluators rather than just one aspect or purpose of a larger and more challenging endeavour. Sadly, when the results of studies do not speak for themselves as is usually the case, there is even a greater reluctance on the part of evaluators to become embroiled in policy and program reform (Weiss, 1974).

While the inattention and even perversion of program evaluation is not a thing of the past, presently greater attention is being focused on how to apply and implement the results of evaluation studies. There is a greater recognition of the sociopolitical processes involved in the implementation of scientific findings. Evaluators are increasingly cognizant of the need to interact with the service-providing organization or program and policy decision-makers at various stages in the evaluation process.

One of the major barriers to the implementation of the results of program evaluations arises from a lack of communications between the evaluator-researchers and program managers or policy makers. Policy makers are often accused of being unaware of the relevant research, whilst evaluators are often said to be unaware of and unconcerned with the policy makers' problems. The mutual accusation is hardly conducive for the effective conduct of program evaluation and the utilization of the resulting findings. Care should be taken, however, to avoid premature involvement to avoid the risk of compromising the credibility of the evaluative research.

Mispecified or Unrecognized Program or Policy Objectives

Program manager and policy makers often do not see the results of program evaluation as relevant to their decision-making needs. Perhaps the most serious manifestation of irrelevance is the not uncommon problem of misspecifying the objective(s) of health policies or programs. The frustrating but inevitable consequence of this problem is that program evaluators often solve the wrong problem, however sophisticated or correct their methods might have been for the program evaluation.

Another serious problem is that program evaluation is often conducted without due attention to outcomes and effects of health program on policies that are less intended or recognized. The narrowness of focus in many program evaluations leads to the charge of incompleteness and irrelevance and thus limit their application to decision-making. Program evaluations can not, of course, provide all the answers, but the two deficiences described above should be avoided if evaluators wish to have some impact on policy or program reform.

Limitations of Evaluation Techniques and Methods

The techniques and methods employed in evaluating health programs and policies are subject to numerous difficulties and reservations (Borus, 1982). There is a large and growing literature on the problems and shortcomings of randomized clinical trials, cost-benefit analysis, cost-effectiveness analysis, cost-utility analysis, risk-benefit analysis and so on (Feeny, 1986) but a discussion of these is avoided here for reasons of space. Suffice it to say, many of the difficulties pertain to the measurement of benefits and, though less commonly, to costs as well. Also, program evaluation typically derive aggregate and average results rather than marginal ones. But it is the latter type of results that are most relevant and useful for health policy and program reform. Another serious shortcoming of program evaluation studies in the health field is the lack of information on analyses about the distribution of burdens and benefits of existing or proposed health care programs and policies. Since distributional considerations are often critically important to the very raison d'être of many health programs and policies this deficiency in program evaluation is a major reason why studies can quite rightly be discounted if not ignored by decision-makers.

A major earlier review of how well program evaluation was conducted in the health field led to the conclusion that there was "a striking difference between the high quality and sophistication of the theoretical papers in this field and the lower quality research emerging from actual studies of programs. Many of the evaluations reported in the literature suffer, unfortunately, from a variety of shortcomings which reflect either lack of awareness of relevant conceptual and methodological principles or an inability to apply them properly" (Schulberg et al, 1969: 20). A review a decade later by the same authors led them to conclude that there was an improvement in the quality of the evaluative studies. Although the methodological sophistication and the quality of evaluation studies have risen markedly in

the recent past "they still constitute more an art than a science in program evaluation" (Schulberg et al, 1979: 23).

Organizational Resistance to Change

Organizations tend to prefer the *status quo* unless it is seriously threatening or politically risky. Reform and revisions in health programs and policies usually cause changes in the relationships between the funders, clients, other community organizations and pressure groups. New practices or changes in existing policies may not fit in with prevailing socio-political values.

Organizations, as do individuals, have ideological commitments. Results which threaten its basic allegiences are likely to be ignored, and rationalizations and excuses are hardly difficult to find. Criticism of the methodology is an easy and thus increasingly common counterattack against unfavourable or disagreeable program evaluations. These observations suggest that program evaluators must pay due attention to the feasibility and acceptability of the results of their evaluation studies. Just how this might be done and what it means in practical terms will, however, depend on individual studies and cases.

The Reliance on Ordinary Knowledge

Program evaluation is but one method among several that is used for health and social policy planning. A significant portion of decision-making in health and social policy depends on what Lindblom and Cohen (1979) call "ordinary knowledge", social learning, experience and interactive problem solving. Ordinary knowledge refers to program managers' and policy makers' knowledge and understanding that does not owe its origin, degree of truth status, verification or currency to a distinctive social or analytical inquiry but to common sense, casual empiricism or thoughtful speculation. These alternative decision-making methods often means that a formal program evaluation is not required. More pertinent to our discussion is that they can sometimes override the implications and results of program evaluations and thus account, in part, for the observed underutilization of the program evaluation studies.

The Complexities of Politics and Values

The nature and design of many health programs are determined to a great extent by political processes. Thus their survival and transformation will depend as much on political considerations as the results derived from program evaluations. Attached to health programs are the ideological commitments of political parties, expectations of the public, career of administrators, jobs of program staff and the economic welfare of providers. "In this environment it is naive to assume that the criterion by which program decisions are made is technical rationality based on some clear and rigorous evaluation process" (Veney and Kaluzny, 1984: 21).

It is the importance of the political phenomena that leads many evaluators to doubt the practical utility of program evaluations. Repeated failure to affect health policy or program moves evaluators from doubt to despair. But there is no way of avoiding the issue. If evaluators wish to be effective they will have to at least develop a reasonable understanding of the political currents surrounding their evaluation studies. This is an indispensable minimum requirement. Indeed, as suggested earlier, much more may be required including the involvement of the evaluator in the drawing of policy or program implications of the evaluation findings and perhaps even in their implementations.

Program evaluation is inescapably a political process. This is implicit in the very fact that some programs are evaluated and others are not. It is commonly observed that evaluations are often launched when programs are already or about to be in political difficulty. Also, programs that have particulary powerful constituencies are considerably less likely to undergo an evaluation than those that benefit politically weak or marginal groups.

Policy analysis is inescapably value-laden, particularly in the ways policy problems are identified and conceptualized (Rein, 1983). Relative perspectives are an inextricable feature of social scientific knowledge. The evaluator of health programs is especially likely to be affected by values stemming from societal philosophies and organizational priorities. More generally, program evaluation is likely to be influenced by four classes of values: personal ones of the evaluator(s); the values of the host institution or organization; those of the fiscal sponsor (if different from the host institution) and those of the subjects or beneficiaries of the program being studied (Vallance, 1972). It is unlikely that the four sets of values will be congruent. Indeed, in some instances there will be variations within each of the classes described above. It is difficult, if not impossible, for the evaluator to take account of all of them, let alone reconcile the divergent values in a program evaluation.

In the light of the foregoing the conclusion that some program evaluation experts have arrived at is hardly surprising. It is that "when decisions are primarily technical or economic, the evaluator can expect to have some impact on the results. When the rationality is essentially legal, social, or political, the evaluator should not ignore the effort but should not be overly optimistic about the probable results of his work" (Veney and Kaluzny, 1984: 27-28).

Concluding Remarks

While program evaluation can not be the object of grandiose hopes, it need not be the object of doleful disappointments. The many lessons learnt from past experience should prove advantageous to present and future undertakings.

There is one idea that may prove to be of the great value to program evaluators in the health fields. Schulberg and Baker (1979) have suggested that what is needed are program evaluators who could function as "R and D" specialists. They point out that in many fields such as engineering, pharmaceuticals and manufacturing there are experts who perform a crucially important bridging function between research and its application. The idea

is by no means novel. May and Cohen (1975) earlier described the characteristics and functions of a "health care engineer" who would translate research results into policy or program change, and define problems of clinical practice so as to provoke and initiate the pertinent research. Such "middle men" dispersed in the health fields offer valuable opportunities to induce policy and program change, which is the ultimate utility of the findings of program evaluations.

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