WORLD HEALTH ORGANIZATION
COLLABORATING CENTRE FOR
PRIMARY HEALTH CARE

NIVEL

nederlands instituut
voor onderzoek van de
eerstelijnsgezondheidszorg

postbus 1568
3500 bn utrecht
telefoon: 030 319946
telefax: 030 319290

bezoekersadres
drieharingstraat 6
utrecht

netherlands
institute of
primary health care

p.o.box 1568
3500 bn utrecht
the netherlands

telephone number
. . - 3130319946
telefax number
. . - 3130319290

visitorsaddress
drieharingstraat 6
utrecht

date
Utrecht, 23 December 1989
reference
ROS/WB/MvG

A CHECKLIST OF PARAMETERS ON COMMUNITY INVOLVEMENT IN HEALTH IN THE NETHERLANDS

Expert comments on the WHO working paper
(consultation meeting, Antwerp 15-16 December 1988)

Authors: W.G.W. Boerma
J. Dronkers

NIVEL Foundation
UTRECHT, THE NETHERLANDS

CONTENT

1. INTRODUCTION

This report contains information on the suitability of a provisional checklist on community involvement in health in the Netherlands. This task resulted from a WHO consultation meeting on 15 and 16 December 1988 in Antwerp, Belgium.
The information has been based on expressions and comments of a number of experts in different sectors of this field. These experts have all been interviewed in December 1989. Prior to the interview they received information about the study and a copy of the checklist as provided by the Belgian researchers.
All interviews have been tape-recorded and later on worked up and summarized by the authors.

List of referents:
Mr. G. Plessius, Ministery of Health (WVC), Rijswijk.
Ms. M. Schrijver, Association of Dutch Municipalities (VNG), The Hague.
Mr. S. Bless, Primary Care Facilities Almere (EVA)/National Association of Health Centres (LVG), Utrecht.
Mr. P. Vos, National Council of Public Health section Mental Health Care, Zoetermeer.
Mr. H. van der Wilk, National Platform of Patients/Consumers (LPCP), Utrecht.
Ms. P. van Lin, Provincial Health Inspectorate, Maastricht
Mr. J. Collaris, Association of Dutch Sick Funds (VNZ), Zeist.
Mr. P. Groenewegen, Netherlands Institute of Primary Health Care (NIVEL), Utrecht
Mr. W. Boerma, Netherlands Institute of Primary Health Care (NIVEL), Utrecht.

2. GENERAL COMMENTS OF REFERENTS ON THE CHECKLIST

Before dealing with the individual questions referents made general remarks on the prevailing checklist. In this section we will summarize these comments for each of them.

Mr. G. Plessius (Ministery of Health)
Especially for international comparison this list should be accompanied by a glossary of definitions of concepts. For example: what are 'formal mechanisms', 'NGOs', what are standards for 'officially recognized' etc. etc. Apart from these problems the list is applicable in the Dutch context. Because of its degree of complexity respondents of the checklist should be selected carefully. Not all patient representatives will be able to understand and answer all items.
Missing in this checklist are items on resources available for patient participation (possibly compared to total amount of health care expenditures).
This checklist will not contribute to the development of new ideas about Community Involvement in Health. It is not inspiring.

Ms. M. Schrijver (Association of Dutch Municipalities; VNG)
In general it is a useful instrument. The threefold subdivison (input-process-output) is workable. Most of the items can be answered in the Dutch context. May be it is a problem that in this early stage of development of the checklist the instrument is too sophisticated. It may be more fruitful to start with a more general list facilitating international comparison. Ms. Schrijver does not have the impression that important things are missing in the checklist.

Mr. S. Bless (Projectmanager in the Almere experiment/Chairman of the National Association of Health Centres)
Several concepts have to be more clearly defined. To assure a reliable international comparison interviewers have to be thouroughly trained (for instance in a special meeting of at least one week). Per item of the list perfect agreement has to be established.
This list is a reflection of a certain ideology about the way people express their needs. A more market oriented perspective gives a totally different way of expression: one should not look at representation but at preferences in the use of facilities.
Missing in this list in a measure of professional development in quality assurance (for instance interprofessional review) as a condition facilitating community involvement and community control.
Another addition might be that community involvement may not be limited to official (elected) representatives but also by people 'posted' in boards and councils.
This list does not cover aspects of patient participation like self-help groups, volunteer work, information meetings and -bulletins. By these activities representatives intermediate between professionals and patients. It is doubtful whether this checklist gives a reliable impression of the complex Dutch health system. Even within the patient movement there are enormous differences in goals, interests, continuity and scope.
Distribution of this questionnaire should be preceded by collection of basic data on health care systems in the countries studied.

Mr. P. Vos (National Council of Public Health, section Mental Health Care)
This is a global and theoretical checklist. It is useful to give examples to clarify the questions and to make subdivision in levels (local - regional - province - insurance bodies - patient groups). Respondents should be carefully

selected because of the difficulty of completing the list. Missing are questions about continuity in representation. The better patients are organized the more continuity is guaranteed. Availability of resources may improve this.

Mr. W. Boerma (Netherlands Institute of Primary Health Care, NIVEL)
This checklist is only partly workable in the Dutch context. It is strongly focused on formal aspects of patient/consumer participation, and therefore rather limited in its significance.
Questions are too global as a result of an effort to construct just one checklist for a variety of health care systems. Questions are hard to apply to one specific country. This will result in a lot of subjective interpretation of questions which damages comparison between countries as well as within countries over time.
All questions asking for numbers or amounts therefore produce unreliable information.
Good questions are sometimes hard to answer because of unavailability of the information or availability only after extensive studies.
Although one checklist for all countries appears to be unfeasible it will not be necessary to develop one list per country; there will be sufficient improvement if two lists will be developed, one for National Health Systems and one for pluralistic systems. Anyhow there has to be started with a short description of the health system in a country (planning, financing etc.).

Mr. H. van der Wilk (National Platform of Patients/Consumers)
It is preferable to start collecting in interviews general information on elements of community involvement in health outside the well known structures of political parties. By this information the context of the items in the checklist should be determined.
The checklist does unsufficiently justice to the special character of the Dutch system. Role of patient organizations should be more stressed.

Mr. J. Collaris (Association of Dutch Sick Funds)
Measuring of community involvement in health is a difficult task. Preceeding description of health care systems may be helpful. Community involvement is different in prevention, cure and care sector. International comparison may be troublesome because of different structures in the European countries.
Only after a description of health systems Community Involvement can be assessed for each level: cure - care - prevention - financing - political etc.
Development of indicators is related to conceptual problems: they are intermediate between theoretical background and observable facts. If the checklist is abundant it will of course always be possible to find a few appropriate items in it. But this approach will certainly obstruct the use for international comparison.
A problem in answering the questions is a lack of representativeness of the patient organizations. There are even conflicts of interest between them. Lack of representativeness also goes for official bodies and councils: often patient-members are appointed by recommendation and recruited from a small number of people.

Ms. P. van Lin (Provincial Health Inspectorate)
The checklist does not reflect enough the government's responsability in the field of CIH. Government should create conditions for the development of CIH.
Community involvement should be broken down to: possibility to influence care - to influence the professions - to influence planning - to influence financing and politics.
The checklist should be understandable for non-professionals.

There is no attention in the checklist for what government really has done on CIH since the Alma Ata Declaration (information about what has been achieved can be found in legislation, regulations, green papers etc.). This has to be collected first.
This factual information is a prerequisite for evaluation and comparison.
If the checklist is ordered in a functional way, parts of it may be easily answered by governmental bodies, institutional and ambulatory care bodies, financial bodies, professional organizations and patient organizations. In this way factual information may be easily collected.
Counterpart of CIH promotion is the consciousness-raising of health care consumers. This is still poorly developed.

Mr. P. Groenewegen (Netherlands Institute of Primary Health Care, NIVEL)
The checklist is workable for countries with a WHO organization model like Scandinavia, United Kingdom, South- and East-European countries where there is a National Health Service or some kind of socialized health system. In the Netherlands however (like in Belgium, France, Germany, Austria and Switzerland) this is not the case. Thus a different approach of the assessment of CIH should be chosen.
First of all a description per country has to be made containing information about the existence of a district level. If this is not the case other relevant levels have to be chosen that are most appropriate to gather this information on CIH. Not until than, questions can be made about these specified levels. It is an illusion to try to make one checklist for both groups of countries mentioned.
A major reason why CIH in the Netherlands is not well developed is that primary care is not organized at district level. There are (or were) some opportunities for participation. In community nursing associations there used to be ample opportunity to exert influence. Restructuring in community nursing however has strongly diminished this opportunity. And also the Health Care Facilities Act in which a district level and community involvement was foreseen is about to be withdrawn.
Only in the sector of community-based prevention, which has been organized by local or regional authorities, the population can formally exert some influence by their representatives in the local council. Since formal opportunities for CIH in the Netherlands are scarce it might be good to add some items in the checklist on volunteer work. Especially in a pluralistic and little organized health system as in the Netherlands these may play important roles.
Reality in pluralistic systems is very diverse. The professional perspective differs a lot from the perspectives of financers or community nursing associations etcetera. Besides people tend to see reality normative. During 15 years the Dutch health care system has generally been described as an echelonized system. Nowadays, after a memorandum of a governmental expert committee all descriptions tend to see a lot of market elements. But actually nothing has been changed in the structure in this period. In short, answers are dependent on the position of the respondent and the current tendency in health care policy.

3. COMMENTS PER ITEM

In this chapter comments of consultants are described per item of the checklist. Since three referents only made general remarks on the checklist this overview has been based on information of the six remaining interviewees. These are indicated by their initials.

1. Communication:
1.1. INPUT

(a) - Existence of formal mechanisms for expression of demands and needs concerning health care services; concerning health issues related to social and physical environment.

GP: 'Formal mechanisms' should be defined. Answerable when indicated which level is meant. For instance this question may be applied to sick funds, hospitals but also national or regional level.

MS: At this time not answerable for the Netherlands. These items had better been asked under 'representativeness' (section 2 in the checklist). The concept of expression of demands and needs is no longer useful in this country. One should look at representation of community groups (like patient representatives in boards of health care institutions and insurance bodies).

SB: Answerable.

PV: Too global question and 'demands and needs' should be defined.

WB: Answerable.

HvdW: Item is too general; should be more specified.

(b) - Existence of formal mechanisms for expression of complaints concerning quality of health care.

GP: Answerable. Level should be specified: local, regional, national, individual. In the Netherlands district level is unknown.

MS: Answerable.

SB: Answerable.

PV: Answerable.

WB: Answerable.

HvdW: Answerable.

(c) - Existence of officially recognized health committees at district level; municipal level; health care service level; other ...

GP: Answerable. Real health committees do not exist at district level in the Netherlands. At local level there are committees on the regulation of General Practitioners' establishment and in local hospitals there are formal links to the authorities.

MS: Not appropriate in the Netherlands.

SB: We do not know health committees. Besides: 'officially recognized' should be defined, and by whom is it recognized. Patient participation at local level does exist and is stimulated by the government.

PV: Health committees do not exist. In absence of districts a choice has to be made of the most appropriate level in certain cases. There is no one best level. It depends on which sector of health care is considered.

WB: Not appropriate for the Netherlands. In general: better description of terms is needed.

HvdW: Terminology is not appropriate in the Dutch situation.

(d) - Number of NGOs/of community associations dealing solely/amongst others with health issues at district level.

GP: Answerable if concerning commissions of Provincial Councils involved in planning of facilities.

MS: Answerable. Patient associations exist at regional level where there is no administrative structure.

SB: What is meant by NGO? In the Netherlands most institutions in health care are private.

PV: 'Community association' is not clear.

WB: This question is too non-specific. Besides working areas in the health system are generally poorly attuned in the Netherlands. Asking for numbers of NGOs is useless: are they large or small, active or not.

HvdW: Answerable if restriction to district level may be neglected.

(e) - Possibility or not to identify easily the relevant partners for communication on district health issues, in particular:
- Existence or not of a formal health district; criteria for formal or informal population boundaries
- Existence or not of district health authorities or of district authorities dealing with health issues amongst others and influencing health related issues at district and/or local level.

GP: Answerable although not appropriate to Dutch context.

MS: Answerable but terminology should be adapted. The most important thing is the possibility given to patients by financers and other health care bodies to influence deliberations at district or local leel.

SB: Uniformity of boundaries in health care is still a problem. District Health Authorities are non existent in this country.

PV: hardly answerable because of lot of overlap in working areas.

WB: Good question but it should be the first question of the checklist. Formal or informal population boundaries have to be properly defined.

HvdW: Not appropriate in the Dutch context.

(f) - Degree of decentralization of decision making to the district level: types of decisions in health related matters to be taken at district, regional, national level.

GP: Answerable although only a limited proportion of decision-making has been decentralized in the field of planning.

MS: Answerable.

SB: Answerable. This question countains a lot of different levels.

PV: Unclear question. The concept of decentralization is sometimes interpreted as the movement from public to private and sometimes as the process of shifting power from central to regional to local level.

WB: Answerable but should also be one of the initial questons. Questions (e) and (f) together describe the Dutch context.

HvdW: Answerable.

(g) - Areas in which CIH is officially recognized at district and/or local level: environmental issues, ethical issues, health care system (resource allocation, manpower issues ...).

GP: Answerable if 'district' is read as 'province'.

MS: Answerable.

SB: Answerable.

PV: What has to be considered as CIH in this country. Who is going to answer this question. Who is the representative of the patient's interest.

WB: This question belongs to the general description of the system.

HvdW: Answerable and relevant.

(h) - Skills of community and representatives to negociate, to communicate.

GP: Hazy question. What is meant by 'skills'.

MS: Answerable.

SB: Answerable. There are training programmes to promote expertise.

PV: Answerable but not easy.

WB: Vague question. Shouldn't 'skills' be read as 'tools'?

HvdW: Incomprehensible question.

1.2. PROCESS

(a) - Actual modes of expression of satisfaction and dissatisfaction with the health system (use of services, mass media, direct negociation ...);

GP: Answerable.

MS: Answerable.

SB: Answerable. This question is too broad; has to be specified to prevent incomparable answers.

PV: Answerable.

WB: Answerable. Question should be specified because answers provide inside information from a variety of perspectives.

HvdW: Answerable and interesting.

(b) - Number and content of interventions in the health field from district or local political representaves.

GP: Difficult question. Nobody knows. Almost not feasible to quantify. Probably gives unimportant answers.

MS: Answerable if the concept 'intervention' is broadly interpreted. The question should be illustrated by some examples.

SB: Content of interventions can be listed as well as numbers globally but one should keep in mind that it covers only a part of the health care system.

PV: Hazy question.

WB: What is meant by interventions? Without good definitions it is useless to ask for numbers.

HvdW: Answerable if more adapted to the Dutch context.

(c) - Number of press conferences on district health issues by NGOs / by community associations.

GP: See comment on question 1.2 B

MS: Answerable.

SB: Good idea. These things are not customary in this country. This question reflects a totally different way of thinking.

PV: Answerable but not sure whether a number can be given.

WB: Interesting question but nobody knows.

HvdW: No relevant question in this country.

(d) - Type of demands of NGOs / by community associations in health field.

GP: Answerable. Gives to global answers.

MS: Dim question. Too comprehensive.

SB: 'NGOs' and 'community associations' should be well-defined and limited to patient associations.

PV: Answerable.

WB: Terms have to be clarified; question vague and too broad.

HvdW: Answerable.

(e) - Type of issues on which disagreements arise between community representatives and authorities.

GP: See comment on question 1.2 B.

MS: Good measure.

SB: Community representatives and authorities have to be defined in more detail.

PV: Answerable. To get reliable information this question should be answered by different persons in different places. Existing disagreements are related to the political conditions.

WB: Community representatives: does it mean those elected?

HvdW: Answerable.

(f) - Presence or not of community representatives at public discussions around controversial issues (or only authorities and professionals).

GP: What is meant and on which level?

MS: Answerable and measurable.

SB: May provide very divers answers.

PV: In the Netherlands health insurance (public as well as private) is non-governmental. So this question has to be split up for possibilities in insurance system on the one hand and those in administration on the other hand.

WB: Too crude question. Cannot be answered by yes or no. Public debates usually do not take place once-only at one place. Unworldly question.

HvdW: Interesting and answerable question.

(g) - Actual expression of community representatives in negociation and/or communication bodies (who speaks, what content?).

GP: Answerable when 'community representatives' is read as the public forum. Should be better described.

MS: Workable if specified to the changing conditions in Dutch health care from a planning system with opportunities of participation to a more market oriented system based on free negotiations.

SB: Vague. Kind of expression very dependent on who speaks.

PV: Vague but answerable.

WB: Answerable if 'community representatives' has been reformulated and broader defined. For example members of patient councils in health centres should be covered by this concept.

HvdW: Answerable.

(h) - Community and/or its representatives: initiating or reacting to authorities?

GP: Answerable. They are initiating as well as reacting to authorities.

MS: These characteristics may be too subtle.

SB: Answerable. Mostly there will be a mixture of initiating and reacting.

PV: Answerable. It is a personal judgement if something is called initiating or reacting.

WB: Very global question.

HvdW: Answerable. What is meant by 'representatives': elected representatives or also members of NGOs and other patient groups.

(i) - Type of issues discussed in health committees.

GP: Unanswerable in the Dutch context.

MS: Good question.

SB: Possible to answer if 'health committees' is read as National Council of Public Health. For other bodies difficult to answere.

PV: If properly answered 1.2 (h) and (j) are redundant.

WB: Very global question.

HvdW: What is health committee?

(j) - Intensity of work of health committees.

GP: Unanswerable.

MS: Obvious question.

SB: See comment on 1.2 (i).

PV: Hazy issue.

WB: Unanswerable. What would be the value of answers.

HvdW: Same comment as 1.2 (i).

2. Representativeness

2.1. INPUT

(a) - Degree of social stratification of the community and diversity of group-specific value-systems and of group-specific health needs (socio-economic groups, categories such as handicapped, elderly ...).

GP: Answerable.

MS: Obvious question.

SB: Answerable. A lot of information is available on this issue.

PV: Difficult question. Seems to refer to a total sociological frame of concepts.

WB: Too global and comprehensive question. If not tailored the answer will be a broad sociological discourse.

HvdW: This question is platitudinous.

(b) - Official mechanisms for selecting community representatives (elected or appointed, by whom ...).

GP: Answerable if 'official mechanisms' are better defined.

MS: Obvious question.

SB: Answerable ('there are no').

PV: Answerable.

WB: This question does not seem to be limited to health care. Is that correct?

HvdW: Answerable.

(c) - Existence of official mechanisms for information / for consultation of community representatives?

GP: Answerable. Not very relevant for the Netherlands.

MS: Answerable.

SB: Answerable ('there are no').

PV: Answerable.

WB: Good question.

HvdW: Answerable.

(d) - Existence of official areas of accountability of representatives; to whom.

GP: Not very clear. What are 'official areas'?

MS: Answerable.

SB: Answerable.

PV: Answerable.

WB: What are 'official areas'. For certain subsystems and with a little good will it may be answerable.

HvdW: Not very appropriate in the Dutch context.

(e) - Availability of resources for communication (information, consultation ...) between representatives and community; source; amount.

GP: Good and clear question.

MW: Answerable.

SB: Answerable although not without difficulty. Great differences exist between one situation and another.

PV: Answerable.

WB: Answerable but a huge effort.

HvdW: Answerable but not a very significant question.

2.2. PROCESS

(a) - Personal characteristics of representatives (social class, age, sex) as compared with distribution within community.

GP: Answerable.

MS: Obvious question.

SB: Answerable but it is a survey on its own. People are not part of one committee but are organized in a variety of local and regional associations.

PV: Answerable and interesting.

WB: Answerable. Information available on members of health centres patient groups.

HvdW: Clear question; answerable.

(b) - Representatives: following or leading public opinion?

GP: Answerable but not very useful because the answer will be 'both'.

MS: Answerable.

SB: Following or leading related to (very different) personel characteristics.

PV: Everything is countable. Reliability can be questioned.

WB: Personal interpretation of the respondent; not reliable.

HvdW: Relevant question.

(c) - Representatives backed by an organization?

GP: Has to be specified: in which way, why and with what result.

MS: Answerable.

SB: Answerable.

PV: Answerable.

WB: Answerable.

HvdW: Answerable.

(d) - Methods, frequency and content of communication between representatives and community?

GP: Answerable if 'community' is better defined.

MS: Answerable.

SB: Answerable but needs keen observations.

PV: Answerable.

WB: Answerable but difficult to obtain accuracy.

HvdW: Is measurable.

(e) - Management of conflicts of interests between subgroups of community.

GP: Difficult question. Is there any management of conflicts in the Netherlands at this level.

MS: Answerable.

SB: Not yet applicable in the Netherlands.

PV: Difficult question.

WB: Answerable.

HvdW: Good question. Nobody will be willing to give an honest answer because it is a strategic question.

(f) - Degree of professionalism of representatives?

GP: Answers show great variation in degrees of professionalism.

MS: Good question.

SB: Good question.

PV: Good question. Does sustaining also belong to it (material/financial)?

WB: Answerable. What is 'professionalism'.

HvdW: Good question.

3. Information

3.1. INPUT

(a) - Existence or not of legislation concerning the rights of the community to be informed.

GP: Question is clear when community means municipality.

MS: Good question; can be answered at all levels.

SB: Answerable.

PV: Answerable.

WB: Answerable.

HvdW: Answerable.

(b) - Existence of training-programmes for community to ask for information, to interpret information, to ask questions, to make objections?

GP: Answerable.

MS: Answerable, especially at local level.

SB: Answerable.

PV: Answerable but material and moral support is more important.

WB: Answerable.

HvdW: Answerable. Questions should also be asked to estimate needs for such training programmes.

(c) - Existence of public resources for training community members?

GP: Answerable.

MS: Distinction should be made between levels on which resources are available. Another distinction is between the responsibility for the general policy and responsibility for the elaboration of it.

SB: Answerable.

PV: Answerable.

WB: Answerable.

HvdW: Answerable.

(d) - Existence of training programmes for professionals to give proper information to the community?

GP: Answerable.

MS: Answerable.

SB: Answerable but not too relevant.

WB: Answerable.

HvdW: Can be asked. Good question although actually strange that special training programmes are necessary for these elementary tools.

3.2. PROCESS

(a) - Proportion of professionals trained in giving proper information.

GP: Is professionals equivalent to care provider?

MS: Answerable.

SB: Answerable, but content of 'proper information' has to be well defined.

PV: Answerable but this formulation does not indicate which level is meant.

WB: Answerable. Information given to whom? (also to individual patients?)

HvdW: No relevant question for us.

(b) - Number and type of requests from community (to whom) for information on health issues.

GP: Difficult to quantify.

MS: Answerable.

SB: Difficult to answer. There is no one way in which information is gathered in the Netherlands.

PV: Hazy question.

WB: Unclear what kind of requests are meant and difficult to quantify.

HvdW: Infinite question; should be rubricated.

(c) - Information given to community: giving more than one solution?

GP: Answerable.

MS: Answerable.

SB: Answerable.

PV: Answerable.

WB: Useless; too broad question.

HvdW: Not understandable.

(d) - Degree to which lay knowledge is taken into consideration.

GP: Clear question. Answerable.

SB: Answerable.

PV: Answerable.

WB: Not very useful; subjective answer.

HvdW: Expression 'lay knowledge' suggest incapability and lack of knowledge. Better to use the expression 'knowledge by experience'.

4. Decision making

4.1. INPUT

(a) - Existence or not of official declaration at national level that communities should be involved in decisions related to the health system, at district level in particular.

GP: Clear question; answerable.

MS: Answerable.

SB: What is meant by 'communities' in this question.

PV: Vague question. Answers more declarations of intent than facts.

WB: Answerable, but what is meant by 'official declaration'?

HvdW: Answerable. Is this question only referring to laws or also to other policy expressions (white papers etcetera).

(b) - Existence or not of official mechanisms on how communities should be involved in decisions related to the health system.

GP: Answerable.

MS: Answerable.

SB: Answerable.

PV: These types of questions should be answered by lawyers. To the answer a list of laws and regulations might be added.

WB: Answerable.

HvdW: Not applicable (typical WHO question).

(c) - Official rights of community representatives: to be informed; to be consulted; to negociate; to participate in decision-making; veto-right ...

GP: Clear question; answerable.

MS: Answerable. These should also be a question about existing general rights which are not assigned to specific groups.

SB: Answerable.

PV: Answerable.

WB: Answerable but very global question.

HvdW: Answerable. These rights can be found in several laws not yet existing or already withdrawn and in vague conditions of admission.

(d) - Official position of representatives (minority, majority?)

GP: Answerable.

MS: Answerable and a good question for international comparison.

SB: Answerable.

PV: Levels, sectors and places have to be specified to prevent an insignificant answer. In mental health care, for instance, patients do have a lot more influence than else in health care.

WB: Answerable.

HvdW: Good question (representatives are always a minority).

(e) - Tradition of Community Involvement in other fields than health.

GP: Answerable

MS: Answerable

SB: Only answerable if boundaries of 'other fields' have been determined.

PV: Difficult to answer for those working in health care in absence of sufficient knowledge about another sector.

WB: Answerable.

HvdW: Answerable but not relevant for relations in Dutch health care.

(f) - Degree of social legitimacy of lay assessment of health care quality (cfr Godbout 1981).

GP: Difficult question. What is 'social legitimacy' and to whom will this question be asked?

MS: Answerable

SB: May be answered. Non-professionals have a limited say in service aspects of health care. Real quality of care however is the exclusive domain of professionals.

PV: Answerable.

WB: What is 'social legitimacy'. How can 'degree' be established. In a broad sense this question is answerable.

HvdW: Objections against expression 'lay assessment'. Apart from that it is a good question. This subject starts developing in the Netherlands.

(g) - Ideology of CIH: who wants CIH and why? Attitudes of professionals, authorities, communities towards the desirability of CIH.

GP: Answerable.

MS: Answerable.

PV: Answerable, but there is a lot of interpretation in it.

WB: Answerable. Question should be placed earlier in the list.

HvdW: Question should be more directed towards clarification of ideology.

4.2. PROCESS

(a) - Management of conflicts of interest between professionals and community.

GP: Difficult to get unambiguous answers.

MS: Answerable.

SB: Answerable.

PV: Time consuming question.

WB: Answerable.

HvdW: Answerable.

(b) - Management of conflicts of interests between authorities and community?

GP: See comment on 4.2 (a).

MS: Answerable.

SB: Answerable.

PV: See comment on 4.2 (a).

WB: Answerable.

HvdW: Answerable.

(c) - Type of experts' interventions in front of technically inappropriate decisions.

GP: See comment on 4.2 (a). Unclear question: what is meant?

MS: Not understandable. Are those interventions made by community representatives?

SB: Not understandable. Are disciplinary committees or courts of justice meant in this question?

PV: Answerable but produces extensive answers because various levels have to be taken into account.

WB: What is meant by 'in front of technically inappropriate decisions'. Which experts are meant. An airy-fairy question.

HvdW: No clear question. Technology will more and more get a referee function in decision making.

4.3. OUTPUT

(a) - Proportion of resources allocated with control of community.

GP: Answerable.

MS: Answerable.

SB: Answerable.

PV: Vague formulation.

WB: Vague question. Poorly defined: allocated for what, which resources, which level? If better specified answerable.

HvdW: Answerable.

(b) - Ethical issues for which policy has been changed under influence of public debates.

GP: Hard to answer.

MS: Useful question.

SB: Answerable.

PV: Does not ask for facts but produces opinions.

WB: Answerable.

HvdW: Answerable.

(c) - Number of demands satisfied/unsatisfied by authorities.

GP: Unclear. Whose demands?

MS: Useful question.

SB: Unclear formulation. If this is a continuation of question 4.3 (b) it is possible to give an answer. Probably numbers are not countable.

PV: Hazy question. Interesting if related to question 4.2 (c).

WB: Crudely formulated question: satisfied versus unsatisfied; which authorities are meant, what kind of demands?

HvdW: May be answerable by other people.

4. SOME CONCLUSIONS

A recurrent comment of the interviewees is the advice to start with a general description of the health system per country. From this information the checklist should be derived. They expect that this approach most probably will lead to the development of more than one checklist: at least one for countries with a National Health Services (-like) health structure and another one for countries with pluralistic systems. These two lists may of course have some overlap.

If we limit ourselves to pluralistic health systems it is quite relevant to distinguish different levels of participation or involvement and to describe them. One should try to have separate informants per level; it is useless to ask people information about other sectors than the one they are involved in. It may be a good thing to collect data from a system of informants, each contributing partly to the checklist. Reliability may also gain by using several informants per country.

In general our referents express a need for more definition of concepts. These should also be clarified by using examples. If questions are too broad, respondents will try to apply to a known situation to be able to answer. By this uncontrolled interpretation it will be no longer valid to compare items. An answer based, for instance, on a small local patient group is incomparable to an answer based on patient representatives in a national council.

Composition of the checklist should take into account the amount of work needed to answer questions. If an item is answerable this does not mean that the information needed is easy available. Demands of the checklist and resources at respondent's disposal should be in balance. Especially collection of quantitative data may be time-consuming and expensive.

The checklist seems to reflect an implicit ideology: community involvement in health can best be achieved by means of formal representation. Other ways may however be imagined. In a market oriented context, for instance, consumers may exert their influence by changing preferences in their use of facilities.

Some respondents may be hampered by the fact that the checklist is not in their native language.

We do not have the impression that our referents have been inspired by the checklist to develop new ideas or activities in the field of community involvement in health.

We have got some suggestions for new items in the checklist.
It may be useful to pay attention to the development of professional standards related to quality of care, since community/patients may use these standards to assess and promote quality of care from their point of view.
Information should be gathered on subsidies and other forms of support on behalf of patients organizations and volunteer work.