



VALIDATING A SATISFACTION QUESTIONNAIRE USING MULTIPLE APPROACHES: A CASE STUDY

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Abstract—We examined the validity of a questionnaire designed to measure the satisfaction of users of health services, using multiple tests of construct validity. Members of 2 health insurance plans in Geneva (Switzerland) answered a mailed questionnaire in 1992 ($n = 1007$) and 1993 ($n = 1424$). Response rates were 82%, participants were 18–44 years old in 1992. The questionnaire included 22 questions on satisfaction with medical care received during the past 12 months. Most items were adapted from the *Patient Satisfaction Questionnaire*. Four dimensions of satisfaction were measured: satisfaction with physician services (8 items), communication (8 items), access (4 items) and insurance services (2 items). Reliability (Cronbach's α) was satisfactory for the 2 former dimensions ($\alpha = 0.81$ and 0.82 respectively), but lower than desired for the 2 latter ($\alpha = 0.63$ and 0.49 respectively). Participants who gave positive open-ended comments had satisfaction scores 0.7–1.2 standard deviation units higher than participants who gave negative comments. Satisfaction scores were weakly correlated with satisfaction with private life, which indicates that the instrument did not simply measure a general tendency to be satisfied. Participants who said that care received in 1993 was worse than care received in 1992 (retrospective assessment) experienced a decrease in satisfaction scores between 1992 and 1993 (prospective assessment). Most validation procedures provided independent but partial evidence for the validity of the instrument. Triangulation of several validation methods, as illustrated in this paper, may greatly improve the understanding of an instrument's properties. © 1997 Elsevier Science Ltd

Key words—patient satisfaction, questionnaire, validation, quality of medical care

INTRODUCTION

In an increasingly competitive medical marketplace, the assessment of consumer satisfaction can be crucial to health care and health insurance providers. The lack of valid instruments is a common problem when assessing consumer satisfaction, in particular in non-English speaking countries. When, in 1992, we proceeded to evaluate a managed care plan recently created in Geneva, Switzerland, we found no validated patient satisfaction questionnaire in French. We decided to translate some items of one of the most frequently cited instruments, the *Patient Satisfaction Questionnaire* (PSQ: Ware *et al.*, 1983). We needed an instrument able to measure several dimensions of satisfaction and to detect satisfaction changes over time. The question addressed in this paper is that of the validity of this partial French-language adaptation of the PSQ.

Optimally, several validation procedures should be performed to establish the validity of a survey instrument (Kerlinger, 1973). The underlying concept is that of triangulation, i.e. the use of several complementary methods to address the same research question (Greene and McClintock, 1985). In a situation where no standard validation method exists, the use of several tests, however imperfect each may be, provides the most accurate assessment of the instrument's properties.

A first criterion is content validity, meaning that the survey instrument makes sense and reflects appropriately the domain under investigation. Second, construct validation can be used to test whether the questionnaire performs as predicted by the theory. To establish the construct validity of a satisfaction questionnaire, a series of hypotheses are formulated about the characteristics of the questionnaire. Satisfaction is assumed to be measured correctly if the hypotheses are supported by data. In this paper, we tested a series of hypotheses about the internal structure of our survey instrument, about its association with other variables and about its capacity to measure satisfaction changes over time.

METHODS

Study setting and participants

Data were used from a study conducted in Geneva, in 1992–93, to assess satisfaction among insureds of the first managed care plan created in the French-speaking part of Switzerland. Two mechanisms were used to manage care in this new plan. First, access to specialised care was controlled by general practitioners (gatekeepers) who worked at a local clinic. Second, a global budget was established on a capitation basis. Usually in Switzerland,

access to specialists is unrestricted and no global budget is imposed by insurance plans. In 1992, all members of the University health insurance plan were automatically switched to the managed care plan. The evaluation study analyzed the impact of this transformation on costs and on the satisfaction of insureds (Perneger *et al.*, 1996). A cohort of University plan members was compared to a cohort of insureds continuously covered by indemnity insurance. Eligible enrollees had been members of their respective insurance plan for 1 year or more, lived in Geneva, were 18–44 years old in 1992 and read enough French to fill a self-administered mailed questionnaire. Participants were selected at random from insurance company rolls. Respondents included 1007 persons who answered the baseline survey (1992, participation 82%) and 1424 persons who answered the follow-up survey (1993, participation 83%); 791 persons responded to both surveys.

Measurement of satisfaction

The instrument included 20 items taken from the PSQ, selected to fit the needs of the study of health insurance plans. Two additional items were formulated by ourselves. All items referred to health care and insurance services received in the past 12 months. Each item was followed by 5 response options, from “strongly agree” to “strongly disagree”. Factor analysis of the 22 items yielded 4 principal components which explained 50% of total variance (Table 1). Four satisfaction scores were computed, labeled “physician services” (8 items),

“communication” (8 items), “access to care” (4 items), and “insurance services” (2 items). In addition, we computed a score for “health care” using the 20 items excluding “insurance services”. For each score, corresponding item responses were averaged (after inversion of negatively formulated items) and re-expressed on a scale between 0 (lowest possible satisfaction) and 100 (highest). Scores were declared missing if more than half of corresponding items had missing responses.

Two criteria were used to attribute each item to one of the scores: loadings from factor analysis and content validity. Items that loaded on only one factor were attributed to that factor. Items that loaded on 2 factors, with a difference <0.2 between the loadings on the first and second factor, were attributed to one of these 2 factors according to their content. This choice was made to retain a maximum of respondent input, while preserving the content validity and interpretability of satisfaction scores. Using this procedure, 3 out of 22 items (Nos 13, 19 and 20, Table 1) were not attributed to the factor on which their loading was the highest.

In addition to closed-format questions, respondents were invited to give open-ended comments. Comments were coded as positive or negative in each of three categories: health care in general, physician services and access to health services.

Translation and adaptation of the original instrument

The translation was conducted in 3 steps (Perneger *et al.*, 1995a). Initially, 3 independent translations were obtained: one by a professional

Table 1. Factor loadings and dimensions to which the items were ascribed

N ^c	Item content (abbreviated)	Factor loadings, after Varimax rotation			
		Factor 1 “Physician”	Factor 2 “Communication”	Factor 3 “Access”	Factor 4 “Insurance services”
1	I'm very satisfied with medical care	0.72	0.23	0.09	-0.02
2	Doctors are very careful	0.72	0.31	0.02	0.09
3	Doctor's office has everything needed	0.65	-0.03	0.22	0.10
4	Doctors keep me from worrying	0.60	0.32	-0.01	-0.09
5	Doctors always treat me with respect	0.56	0.33	0.23	-0.10
6	Medical care I received could be better	0.52	0.33	0.34	0.14
7	I see the same doctor every time	0.44	0.21	0.17	-0.11
8	Doctors call a specialist if necessary	0.43	0.35	-0.24	-0.03
9	Doctors do not give me explanations	0.23	0.71	0.16	0.02
10	Advice about ways to avoid illness	0.04	0.70	0.09	0.00
11	Doctors miss important information	0.26	0.53	0.32	0.10
12	Problems I've had in the past are ignored	0.24	0.53	0.34	0.04
13	Doctors tell me what to expect	0.54	0.51	0.08	-0.06
14	Advice for a healthier lifestyle ^a	0.24	0.50	-0.07	-0.20
15	Explanations if x-rays are ordered	0.17	0.50	0.42	0.12
16	Doctors aren't thorough enough	0.15	0.47	0.24	0.15
17	It is hard to get an appointment right away	0.20	0.10	0.72	-0.04
18	Waiting time at doctor's office	0.08	0.24	0.61	0.13
19	Medical services are conveniently located	0.57	-0.16	0.39	0.00
20	I can find help if I have a medical question	0.50	0.28	0.35	-0.03
21	Insurance should pay more	0.09	-0.01	0.00	0.82
22	My insurance premiums are too high ^a	-0.11	0.01	0.08	0.75
	Percentage of total variance explained by each factor	31.7	7.1	6.0	4.9

^aNot PSQ items.

The hypothesized dimensions were: Global satisfaction (items 1 and 6); Physician-technical (items 2, 3, 8 and 16); Physician-interpersonal (items 4 and 5); Physician-continuity (items 7 and 12); Physician-communication (items 9, 11, 13, 15); Physician-prevention (items 10 and 14); Access to health services (items 17–20) and Health insurance (items 21 and 22).

translator of medical texts, another by a translator at the World Health Organization (WHO) headquarters, and the last by the authors. PSQ items were reformulated as to apply to care received personally by the respondent. On the basis of these translations, a preliminary version of the questionnaire was developed in presence of 2 experts at the WHO (the head of French-English translation services and a bilingual specialist in survey methods). Finally, the preliminary version was iteratively field-tested in a sample of 50 respondents.

Other variables

Four questions addressed satisfaction with life in general (work, social activities, private life, finances), using the same response format. At follow-up only, respondents were asked whether the care they received in the past year was better or worse than the care received previously, and whether they preferred managed care or unrestricted indemnity insurance. Respondents also provided their age, sex, country of birth, years of education, and income category. Baseline respondents were also followed up to termination of their insurance contract.

Instrument characteristics

The proportion of missing responses reflects the acceptability of each item. We estimated the overall proportion of missing data and identified variables associated with missing responses.

Cronbach's coefficient α was used to assess the internal consistency of the scales, for each independent dimension of satisfaction (Cronbach, 1951). For group comparisons, coefficients $\alpha > 0.7$ are usually considered satisfactory (Nunnally and Bernstein, 1994).

Validation procedures

(1) *Factor analysis.* Factor analysis of the 22 items was used to identify independent dimensions of satisfaction. Principal components (eigenvalue > 1) were rotated using the Varimax procedure. The larger follow-up sample was used for this analysis ($n = 1424$). Principal components were then compared with dimensions of satisfaction that had been postulated *a priori*.

(2) *Open-ended comments.* We hypothesized that satisfaction scores would be highest for respondents who provided positive comments, lowest for participants who provided negative comments and intermediate for participants who gave no comments or mixed comments (i.e. both positive and negative). This analysis was conducted separately for scores and comments on health care in general, on physician services, and on access to health services.

(3) *Plan member retention.* We hypothesized that dissatisfaction with health insurance services would predict future termination of the insurance contract (Marquis *et al.*, 1983; Senf and Weiss, 1991; Ware

and Davies, 1983). Baseline satisfaction scores were divided into quartiles, which were then compared with respect to time until termination of contract, using Kaplan-Meier methods and logrank tests (Clayton and Hills, 1993). This analysis excluded persons who were automatically transferred into the managed care plan at baseline, since their change of insurance plan was not motivated by dissatisfaction (Etter *et al.*, 1995; Perneger *et al.*, 1995b). Participants in this analysis were the 344 persons continuously insured under indemnity insurance, for whom satisfaction scores at baseline and follow-up and duration of membership could be computed.

(4) *Transfer to managed care.* Some participants ($n = 421$) were transferred from unrestricted indemnity insurance to a managed care plan in which primary care was delivered at a single location and access to specialists was controlled by gatekeepers. In compensation, premiums were lower and copayments were abolished in this plan. We hypothesized that in these participants, satisfaction with access to care would decrease, but satisfaction with insurance services would increase.

(5) *Discriminant validity.* A good instrument should be able to discriminate between several aspects of satisfaction, i.e. measure satisfaction with medical care or insurance services, and not a general tendency to be satisfied. Therefore, we hypothesized that correlations between satisfaction with health care, with insurance services and with life in general would be weak.

(6) *Changes over time.* Participants who took part in both surveys provided both a prospective assessment of changes in satisfaction (scores in 1992 and 1993), and a retrospective assessment (in 1993). We hypothesized that the prospective and retrospective assessments would be correlated. This analysis was performed on the 583 persons for whom satisfaction scores could be computed at baseline and follow-up, and who gave a retrospective assessment of change.

(7) *Preference for managed care or indemnity insurance.* Participants were asked to express their preference for (A) an indemnity health insurance system with unrestricted access to providers, or (B) a managed care system with gatekeeper-controlled access to specialized care but lower premiums. We hypothesized that among participants who were transferred from system A to system B, preference for A would be associated with a decrease in satisfaction, and preference for B with an increase in satisfaction.

RESULTS

Sample characteristics

On average, participants to the 1993 survey were 31 years old ($SD = 5.8$), 47% were men, 40% were university students, and 63% were born in countries

Table 2. Mean satisfaction scores (SD) according to type of open-ended comments, among 1424 participants in a health care satisfaction survey

	Dimension-specific comments			P-value ^a
	Positive only	None or mixed	Negative only	
Satisfaction with..				
Health care	71 (15)	66 (14)	54 (15)	<0.001
Physician services	71 (15)	69 (15)	52 (16)	<0.001
Access to care	70 (16)	64 (19)	56 (18)	<0.001

^aP-value based on test for linear trend.

other than Switzerland. The average number of school years was 16.2 (SD = 4.9).

Instrument properties

In the follow-up survey (1993), the proportion of missing responses per item varied between 23% and 25% for all respondents, between 12% and 15% among participants who reported at least one health care visit in the past year, and between 7% and 8% for participants who reported more than 5 visits. Multivariate logistic regression analysis indicated that the risk of having a missing score for the "health care" dimension was increased in persons with less than 9 years of education (relative risk 2.3, $P = 0.01$), and in persons who were born in countries other than Switzerland (relative risk 2.2, $P = 0.001$). Age, sex and income were not independently associated with the risk of having a missing score.

Internal consistency (Cronbach α) coefficients were satisfactory for scales measuring satisfaction with health care (0.89), physician services (0.81), and communication (0.82), but lower than desired for access to care (0.63) and insurance services (0.49).

Validation procedures

(1) *Factor analysis.* The dimensions of satisfaction identified by factor analysis approached, but did not match, dimensions postulated a priori (Table 1). While we hypothesized 8 distinct dimensions, only 4 principal components were found. After taking into account the reduced number of dimensions, 15 of 22 items (68%) were attributed by factor analysis to the dimension that we hypothesized a priori.

(2) *Open-ended comments.* Respondents who gave only positive comments on health care had higher scores for satisfaction with health care than persons who wrote only negative comments, or who wrote no comments or mixed comments (Table 2). The same was true of the relationship between comments and scores of satisfaction with physician services and access to care. The differences between persons who wrote positive and negative comments ranged from 0.7 to 1.2 standard deviation in the corresponding scores.

(3) *Plan member retention.* Participants who were most satisfied (highest quartile) with their insurance plan in 1992 were more likely to be still enrolled at the end of 1994 (89.5%) than persons who were least satisfied (lowest quartile: 83.7%; logrank $P = 0.33$; see Fig. 1).

(4) *Impact of change in health insurance system.* Insurees who were transferred into a managed care plan gave lower scores for satisfaction with access to care at follow-up than at baseline (2.0 points on a 0-100 scale), while respondents who retained indemnity coverage gave higher scores (+2.8 points, between-group difference: $P = 0.03$). In contrast, satisfaction with insurance services increased in the former group (+2.6 points) and decreased in the latter (4.9 points, $P = 0.006$).

(5) *Discriminant validity.* Correlations between the 3 satisfaction scores related to health care were moderate to high, while correlations of these scores with satisfaction with health insurance or with private life were weak and generally negative (Table 3).

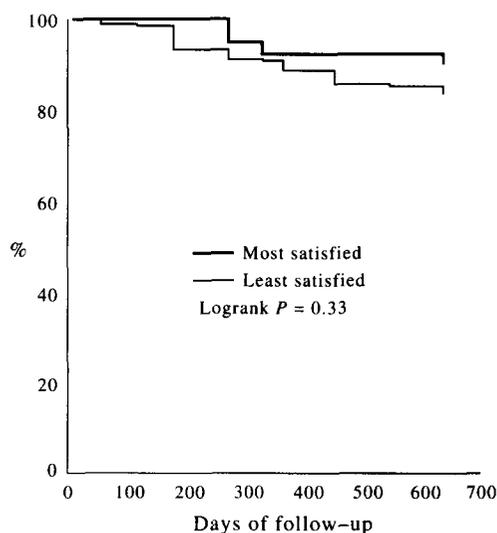


Fig. 1. Proportion of persons still enrolled in the health insurance plan, according to level of satisfaction towards health insurance measured at baseline, among 344 members of an indemnity insurance plan.

Table 3. Assessment of discriminant validity: correlations (Pearson) between satisfaction scores, among 1424 participants in health care satisfaction survey

	Access	Physician	Communication	Insurance services
Physician	0.57*			
Communication	0.55*	0.70*		
Insurance services	0.10*	0.00	0.03	
Life in general	-0.20*	-0.23*	-0.19*	-0.05

* $P \leq 0.001$.

(6) *Retrospective and prospective assessment of change.* At follow-up, persons who rated the medical care they received in the past year as "a lot better" than care received previously had experienced an increase of 8.9 points on the "health care" scale (0.6 SD) while those who rated recent care as "a lot worse" had experienced a decrease of 24.9 points (-1.6 SD). Retrospective and prospective assessments of change in satisfaction were related in a gradual manner (Fig. 2). Between-group differences were highly statistically significant (Anova $P < 0.001$).

(7) *Preference for managed care or indemnity insurance.* Satisfaction with health care increased slightly between 1992 and 1993 (+0.9 points, $P = 0.71$) among persons who were transferred into a managed care plan and who expressed a strong preference for managed care, and decreased (-1.9 points, $P = 0.36$) among those who strongly preferred indemnity insurance.

DISCUSSION

This paper reports on the validation of a questionnaire designed to measure the satisfaction with health care received in the past year, using a triangulation of several methods. This approach proved useful: each validation procedure provided

independent but partial evidence for the validity of the instrument. No single procedure gave overwhelming and indisputable proof of validity. It is the addition of several pieces of evidence that leads us to believe that the instrument under consideration measures to a large extent what it is intended to measure.

Before addressing the issue of validity, we examined the instrument's acceptability in the intended population, and its reliability. Persons who received no health care in the past year were likely not to respond to satisfaction items, which can be interpreted as an argument for content validity of the questionnaire. Despite the fact that simple language was used, the least educated respondents and persons whose mother tongue was probably not French had more difficulty in filling the questionnaire than the more educated and those born in Switzerland. This result stresses the importance of clear and unequivocal wording of survey items.

As expected, internal consistency coefficients were higher for longer scales than for scales consisting of only 2 or 4 items. Internal consistency coefficients for the "access" and "insurance services" scales may have seriously underestimated scale reliability, because individual items tapped very distinct aspects of the underlying dimensions. The correlation between the 2 items measuring insurance ser-



Fig. 2. Opinion on change in quality of care between 1992 and 1993, and difference in satisfaction scores measured in 1992 and in 1993, among 583 persons who participated in both surveys. Box-plots indicate the median (central bar), the 25th and 75th percentiles (edges of the box) and the maximum and minimum values (lateral "whiskers").

vices (i.e. premiums and insurance coverage) was low ($r = 0.33$), which explains why the internal consistency coefficient for this scale was low. Similarly, items measuring access to care explored components of access that may vary independently, so that a high level of correlation among them was unlikely. Consequently, the internal consistency coefficient of this scale remained fairly low (Nunnally and Bernstein, 1994). A test-retest procedure would provide a more accurate estimation of reliability. If test-retest reliability proved insufficient, addition of items to the shortest scales could correct the problem.

Factor analysis produced 4 independent dimensions of patient satisfaction, which was less than expected. Several aspects of medical care that we attempted to measure independently (technical aspects of care, relational aspects, etc.) were collapsed into a single factor. This means either that participants were unable to distinguish between these aspects of care, or that these aspects did not vary independently in the study sample. Even if the first hypothesis is true, it may still be useful to include a wide array of items when evaluating medical aspects of care, to maintain good content validity of the instrument. It seems appropriate that physician-patient communication remained as an independent dimension in patients' evaluations, as patients are in a good position to judge specifically this aspect of care. Assuming only 4 dimensions of satisfaction, the factor analysis yielded results that were relatively close to our hypotheses: 15 out of 22 items were attributed to the hypothesized dimension. To verify if this result is robust, similar analyses should be conducted in other populations.

These analyses provide encouraging but partial evidence for the validity of our French-language patient and insurée satisfaction questionnaire. Validation by means of external variables was generally consistent with our hypotheses, but differences were sometimes smaller than expected. Open-ended comments supported satisfaction scores based on closed-format items. Two of our *a priori* hypotheses were not confirmed by the data. No statistically significant relationship was observed between baseline satisfaction with insurance services and plan member retention. The association between preference for a given health insurance system and the changes in satisfaction scores after transfer into the managed care plan was also non-significant.

The best arguments for the validity of the questionnaire are supplied by a strong evidence for discriminant validity (the instrument is specific for health care and does not measure some general tendency to satisfaction), and by the good correlation between prospective and retrospective assessments of change in satisfaction. The latter result suggests that the instrument is able to detect changes over time. This is an important property for a satisfac-

tion instrument used in a study of the impact of a transformation in health insurance systems.

Construct validation confronts the researcher with the difficulty that while it is fairly easy to hypothesize the direction of an association between satisfaction and another variable, specifying the expected strength of the association is far more difficult (Kerlinger, 1973). One reason is sketchiness of theory (Carr-Hill, 1992; Williams, 1994), another is lack of information about the reliability of measurements involved in testing the hypothesis. A single construct validation test can hardly be accepted as a demonstration of validity. Triangulation of several methods, as illustrated in this paper, may greatly improve the understanding of an instrument's properties.

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APPENDIX

French-language User Of Health Services Satisfaction Questionnaire "Médecin"

1. Je suis très satisfait des soins médicaux que j'ai reçus.
2. Les médecins font très attention à tout vérifier quand ils m'examinent.
3. Le cabinet de mon médecin dispose de tout ce qu'il faut pour fournir des soins complets.
4. Les médecins font toujours de leur mieux pour me rassurer.
5. Les médecins me traitent toujours avec respect.
6. Certains aspects des soins médicaux que je reçois pourraient être meilleurs.
7. Je vois le même médecin presque chaque fois que je vais me faire soigner.
8. Quand les médecins ne sont pas sûrs de ce que j'ai, ils font toujours appel à un spécialiste.

"Communication"

9. Les médecins ne me donnent pas de conseils sur les moyens d'éviter les maladies et les accidents.
10. Les médecins ne m'expliquent presque jamais mes problèmes médicaux.

11. Quelquefois les médecins laissent passer des informations importantes que je leur donne.

12. Quand je consulte pour un nouveau problème de santé, on ne tient aucun compte des problèmes médicaux que j'ai eus par le passé.

13. Les médecins m'expliquent toujours ce à quoi je dois m'attendre durant le traitement.

14. Les médecins m'encouragent à prendre des habitudes plus saines.

15. Les médecins m'expliquent rarement pourquoi ils demandent des analyses et des radiographies.

16. Les médecins ne sont pas aussi minutieux qu'ils devraient l'être.

"Accès"

17. Il m'est difficile d'obtenir tout de suite un rendez-vous chez le médecin.

18. D'habitude, on me fait attendre longtemps chez le médecin.

19. Les lieux où j'ai reçu des soins sont très commodes d'accès.

20. Quand j'ai besoin d'un renseignement médical, je peux atteindre sans difficulté une personne qui peut m'aider.

"Assurance"

21. Mon assurance-maladie devrait couvrir davantage de dépenses qu'elle ne le fait.

22. Les primes de mon assurance-maladie sont trop élevées.