
Conceptual and Methodological Issues in Measuring Patient Satisfaction : Concepts and Dimensions of Measuring Patient Satisfaction with Health Care

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Interest in and research on patient satisfaction with health care have proliferated in the last two decades. However, much research has not seriously considered the complexity of the concept. As a result, there is no generally accepted conceptual framework with which measurement of patient satisfaction can be made. This paper identifies and examines some of the conceptual and methodological issues in the measurement of patient satisfaction.

Two theoretical models of satisfaction were specifically examined in terms of their conceptual clarity and methodological adequacy. Expectation theory conceptualizes satisfaction as the perception of outcome of care in relation to the extent to which it has met the patients' expectation. A distinction between ideal and practical expectation on the part of patients should be made in developing the concept of expectation. Attitude theory posits that satisfaction is the patients' affective evaluation of medical care they received. This theory might be applied to measure general degree of satisfaction (an overall assessment of physicians and medical care delivered). Common ground underpinning the models of satisfaction has been suggested. In so doing, the changing nature of a variety of characteristics pertaining to the provider and consumer of medical care has been stressed.

The problem of inadequate conceptual clarity of patient satisfaction is partly derived from the multidimensionality of the objects against which an evaluation of consumers of medical services is made. Korsch's dichotomy of expressive and instrumental dimensions correspond to Hulka's dimensions of physicians' personal quality and relationship to patients, and the technical components of physician care. Roghmann's typology of general and specific dimensions is limited to the patient having regular source of care. This paper examined one of the widely accepted models of patient satisfaction dimensions suggested by Ware and his associates. Several changes of dimensions have been recommended in accordance with conceptual clarity and methodological soundness.

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I. Introduction

Health care professionals have devoted considerable attention to measuring patient satisfaction in recent years. This attention can be attributed to several reasons. First, the rise of consumerism calls for a more stringent evaluation of consumer-defined health care services when the patient can be characterized as a consumer of a service, health care (Doering, 1983). In the evaluation of health care, patient satisfaction has been regarded as one important indicator of the quality of care. Donabedian (1966) maintains that patient satisfaction is an ultimate outcome in evaluating quality of medical care. Secondly, patient satisfaction has significant implications for health care providers since it can predict patients' continued use of services (Mechanic, 1976) and the extent of cooperation and compliance of the patients with physicians' directions (Korsch, et al., 1968). Especially for the physicians, patient satisfaction has its impact on patient recall (Brody, 1980) and adherence to therapeutic recommendations (Francis, et al, 1969; DiMatteo, et al., 1980; Bartlett, et al., 1984) and dissatisfaction with care lead to increased doctor-shopping (Kasteler, et al., 1976; DeMatteo, et al., 1979) and malpractice litigation (Vaccarino, 1977). Finally, for the health care planner or administrator, the measurement of patient satisfaction may provide an important indicator of which aspects of a service need to be changed to improve patient response.

Despite the increased attention paid to patient

satisfaction with health and medical services, much research on patient satisfaction has not seriously considered the complexity of the concept. In a review of literature in 1974, Lebow (1974) found little consensus regarding either the meaning or measurement of patient satisfaction. Luft (1981) argues that since the measurement of satisfaction involves consumer's feelings about various aspects of medical care, there is no generally accepted conceptual framework for evaluating satisfaction. As a result, there has been little clarification of the meanings of the term either to researchers who employ it or to respondents who report it (Locker & Dunt, 1978). The problem of inadequate conceptual clarification is partly derived from the multidimensionality of patient satisfaction. Since each patient is asked to report satisfaction on different aspects of health care, the specific dimension against which measurement can be made must be clearly determined. In addition to the conceptual problems, almost every study on patient satisfaction uses slightly different methods of gathering and interpreting data. It makes any attempt to compare across the studies very difficult. Therefore, it is of paramount importance to discuss and clarify both the conceptual and methodological issues involved in the measurement of patient satisfaction.

The major purpose of this paper is to identify and examine some of the conceptual and methodological issues in the measurement of patient satisfaction. It will require our theory-building efforts emphasizing the clarification of theoretical constructs and the evaluation of the

state of the art in measuring satisfaction focusing on the reliability and validity of measures. This paper is limited to identify and discuss conceptual and dimensional issues in measuring patient satisfaction.

II. Theoretical and Conceptual Issues in Measuring Patient Satisfaction

A. Conceptual Issues in the Determinants of Patient Satisfaction

One of the fundamental needs in measuring patient satisfaction is to clarify the nature of patient satisfaction. Conceptualizing patient satisfaction requires an investigation of theoretical constructs employed in its measurement. However, it is rare to find the concept of satisfaction explicitly defined in the literature, and its meaning is often left to the reader to derive. In this regard, we might ask a series of questions: What does the term really mean? Does the concept of satisfaction carry the same set of attributes to researchers and to the respondents who report it? What aspects of health care do patients consider important to their overall judgment of being satisfied? These questions cannot be fully addressed without a thorough consideration of the theoretical constructs used in the studies of patient satisfaction.

1) Expectation Model

Several researchers have observed that the most frequently used theoretical construct in the measurement of patient satisfaction is the concept of expectation. Stimson and Webb

(1975) have suggested that satisfaction can be modeled as the perception of the outcome of care in relation to the extent to which it has met the patients' expectation. Tessler and Mechanic(1975) support this definition in their study on the relations between patients' expressed satisfaction and their readiness to seek care. Other health care studies on patient satisfaction have implicitly used fulfillment theory (Linder-Pelz, 1982). According to Lawler (1971) who reviewed many studies on satisfaction including job satisfaction, the fulfillment theory includes several variables. The theory basically involves the difference between what occurred and what should have/was expected/was desired to occur. Thus, in addition to expectation, such variables as entitlement and desirability must be considered in the measurement of satisfaction. For example, patients might report being satisfied when they felt that a service actually delivered, fulfilled not only what they had expected but also what they had desired and what they believed they were entitled to receive. Some have suggested that increasing the congruence between patient desire for specific interventions and the interventions they actually receive might result in increased patient satisfaction with their physician (Uhlmann, et al., 1984;Eisenthal, et al., 1979).

Even though studies on patient satisfaction rely heavily on the construct of expectation, there are significant problems in utilizing this concept of expectation. First of all, it is such a crude concept that it might not reflect the true feelings of satisfaction. A model of satisfaction

should also recognize that there are different levels of expectation for different patients. Freidson(1961) has drawn a distinction between ideal and practical expectation. Whereas the former can be defined as the preferred outcomes deriving from a patient's evaluation of his problem and goal in seeking medical care, the latter designates anticipated outcomes stemming from an individual's own experience, the reported experience of others, or knowledge from other sources. Therefore, it is necessary to distinguish between patients' ideal, or preferred expectations and practical, or anticipated expectations that are learned from experience.

A number of researchers have reported that patients with previous hospital experience are more willing to be hospitalized than patients being admitted for the first time(Houston & Pasanen, 1972;Fleming, 1981;Nelson-Wernick, et al., 1981). This finding suggests that patients may replace ideal expectations with practical expectations through their accumulated experience, and thus become more satisfied.

Another crucial problem in the use of the concept of expectation is that the relation between expectation and satisfaction is not always clear and direct(Locker & Dunt, 1978). For example, in a study of consumer satisfaction with the social work department, Mckay and his colleagues (1973) found that 80% of those whose expectations for service were fulfilled were satisfied, but 50% of those whose expectations were not fulfilled were also satisfied. Freidson's distinction between ideal and practical expectation might provide a good explanation for these ap-

parently contradictory results. However, the situation also illustrates another dimension of patient's expectations : variance in the amount of services or outcome expected.

Discrepancy theory as another model of satisfaction deals with the issue of variance in the amount of expectation. Instead of the fulfillment theory's simple comparison between expectation and outcomes, discrepancy theory takes into account the amount of expectation in the first place. Discrepancy theory posits that satisfaction is the perceived but not necessarily actual discrepancy between what the individual desires /expects and what occurs(Lawler, 1971). Thus, discrepancy theory provides a measure of the extent of satisfaction by means of the patients' perception of the amount of difference between their expectations and the results.

2) Attitude Model

Recognizing the inadequacy of current theoretical formulations of expectation, we need to find other conceptual frameworks. Another important theoretical underpinning on which other determinants of patient satisfaction can be identified, is attitude theory. While the proponents of fulfillment and discrepancy theory emphasize the relationship between perception and expectation as the crucial factor affecting satisfaction, attitude theorists argue that satisfaction is determined largely by the patients' affective and value-laden beliefs and cognitive evaluation of care. Distinguishing attitude from perception, Fishbein and Ajen(1975) define attitude as a general evaluation of favorableness or unfavorableness toward an object in question.

According to this definition, the expression of satisfaction or dissatisfaction with care is identical to the expression of the attitude of patients about their care. Ware and his associates(1978) supported this conceptualization of satisfaction by pointing out that even in studies that do not explicitly study patient satisfaction—but rather attitudes or perception—the common feature was that researchers were in effect seeking peoples' evaluation or affective response to care.

Because attitude theory has been developed by social psychologists whose main interest was in the study on job or work satisfaction, empirical evidence that supports the appropriateness of the theoretical constructs tends to rely heavily on the studies on job satisfaction. Consequently, health professionals might be skeptical about the cross application of attitude theory to a variety of situations including doctor–patient and hospital relation. Yet, research findings in the measurement of patient satisfaction are a mixed blessing. On the positive side, the study of Ware and his associates(1978) confirmed that the measures of belief and evaluation correlated significantly with direct measures of patient satisfaction. However, in her theory–testing research on satisfaction, Linder–Pelz(1982) found that the value–laden attitude had little relationship to satisfaction rating. It can be suggested that attitude theory can be applied to measure an overall assessment degree of satisfaction since it denotes the patients' evaluation of favorableness toward the care they received.

3) Common Ground

Investigation into the social psychological de-

terminants of patient satisfaction is not an easy task. Especially in theory–testing research, it is almost imperative that the set of hypotheses to be tested should be congruent with theoretical premises and operationalization of measures should be sound enough to be exempt from serious methodological flaws. But both Ware and Linder–Pelz's studies have several limitations in terms of sampling biases, the reliability of measurement scales, and operationalization of measure to test each hypothesis. Therefore, it would be premature to conclude at this point that one theory explains patient satisfaction better than the other. More research need to be done in order to have a sound knowledge base of the measures and modelings of patient satisfaction.

Implicit in the above discussion on the theoretical constructs of patient satisfaction is the recognition that satisfaction can be represented by patients' relatively subjective judgment of health care. That is, both expectations and attitudes of patients can vary according to either each individual's own perception of care or his or her preference for the care. Making comparison and acknowledging discrepancy more or less involves patients' individual judgements no matter what criteria they use. In this regard, characteristics of patients such as sociodemographic variables and health status should be considered as an important determinant in measuring patient satisfaction. It also should be recognized that as expectation and/or attitudes change, the level of satisfaction can change. The change of satisfaction may arise from changes introduced by either the patient or pro-

vider since patient satisfaction is a function not only of their altered expectations but also of changes in provider behavior, e. g. to provide reduced quality of care. In summary, considering the dynamic, interactional, and judgmental nature of patient satisfaction, the diverse theoretical perspectives are not mutually exclusive, but mutually compensatory relations.

B. Dimensions of Patient Satisfaction

Patients hold expectations and attitudes about different aspects of health care. Accordingly, studies on patient satisfaction have been directed at a variety of different dimensions of health care. Early concern with patient satisfaction centered on issues of quality of care and delivery of services (Zastrowny, et al., 1983). For example, Koos (1954), one of the earliest researchers of patient satisfaction found that the most frequent reasons for dissatisfaction are ineffectiveness of treatment, unnecessary X-ray or treatment procedures, high cost, and lack of physician interest and concern. In fact, the interaction between health care providers and patients has received a great attention by many scholars because the manner in which services are provided is often more important for affecting satisfaction than the nature of the services themselves. For example, among the studies focusing on the patient-provider interaction, Larsen and Rootman's study (1976) demonstrated that patient satisfaction with medical care depends on the quantity of doctor-patient communication. But still others have emphasized the importance of structural characteristics of serv-

ice providers such as accessibility of care, convenience of location, and physical environment (Lebow, 1975; Tessler & Mechanic, 1975).

The wide and sometimes conflicting studies of satisfaction can be attributed partly to the differences in situations and patient preferences for seeking and delivering health care, and partly to the different approaches to measuring patient satisfaction. For example, in a study of pediatric care, the people who report satisfaction are almost always the parents of children. The parents might weight their satisfaction more heavily on the interaction between themselves and doctors than the actual treatment given to their children. In this case, the questions about quality of care focused on the child would not be appropriate measures of satisfaction. In support of this phenomena, Mechanic (1964) found that the major reason for mothers to be dissatisfied with pediatricians and change the doctors was the doctors' lack of interest, care, and motivation rather than their medical qualifications. On the other hand, studies have found that patients who had been hospitalized and gone through intensive treatment were more likely to evaluate their feelings about medical care in terms of technical quality of care. Doering (1983) maintained that for hospitalized patients, nursing care was the most influential factor in determining the patients' overall judgment on satisfaction. Another example is Snider's (1980) study of factors influencing older persons' satisfaction with medical care. He found that physician's attitudinal aspects regarding the doctor-patient communication proc-

ess were more strongly associated with patient satisfaction than other factors measuring access or continuity of care.

Many researchers have used a variety of different approaches in measuring patient satisfaction. One approach is to ask about patients' feelings with respect to a single aspect of health care and then generalize these reported feelings to form overall measures of satisfaction. Another approach has used questions about more than one aspect of care and compared them to determine important dimensions of satisfaction. In both cases, the major dimensions are predetermined and dictated by the interest of researchers. And what researchers consider important dimensions might not congruent with what patients think crucial in determining satisfaction.

Other studies have used open-ended interviews to allow respondents to elaborate on specific aspects of satisfaction. This might be the best way to probe some unidentified aspects of satisfaction. Yet, this approach leaves us with an unorganized and fragmented array of different aspects of satisfaction. Therefore, the major issues in determining dimensions of patient satisfaction are to clarify some important dimensions of satisfaction from the review of literature and construct empirically valid and reliable conceptual frameworks incorporating the various aspects of satisfaction.

Despite the complexity of dimensions of patient satisfaction, several scholars have attempted to clarify the various dimensions of satisfaction and suggested relatively important aspects

of satisfaction. Korsch and his colleagues(1968) provided evidence for two important dimensions of satisfaction—an expressive and an instrumental dimensions using physician-patient communication data in outpatient pediatric services. In addition, Hulka and her associates(1970) suggested three distinct domains of satisfaction : the professional and technical competence of physicians, their personal quality and relationship to patients, and the accessibility of care. Also, Roghmann and his associates(1979) distinguished a general satisfaction dimension, which is an assessment of physician and the medical care delivered, from a specific satisfaction dimension, which is assessed by patients' past experience with regular sources of medical care.

In evaluating these classification systems, we can observe that even though those authors used different terms in their typologies, some elements of the major dimensions have similar meanings. Korsch's dichotomy of expressive and instrumental dimensions correspond to Hulka's dimensions of physicians' personal quality and relationship to patients and the technical components of physician care in that both schemes involve both art and technical components of medical service delivery to a certain extent. But the dimension of accessibility which reflects the structural characteristics of health care has been added in Hulka's scheme. And it should be noted that the dichotomy suggested by Korsch is severely limited to the interactional aspects of physician-patient relationships.

The distinction between general and specific

dimensions in the Roghmann's typology might be useful in classifying diverse aspects of satisfaction, but his scheme can be criticized in that the specific dimensions need not be necessarily limited to the patients' past experience with regular sources of care. Although Hulka's typology captured many important dimensions that various researchers have used to measure satisfaction. But it has been criticized for its validity. Stamps and Finkelstein(1981) provide evidence that attempts to operationalize Hulka's three conceptual dimensions of satisfaction do not necessarily cluster empirically along such subdimensions.

Given the significant problems of a limited numbers of dimensions and lacking empirical support for some of the important dimensions, several researchers have tried to construct a model including broad and valid dimensions of patient satisfaction by developing indices based on theory, empirical evidence, and accepted social science procedures. Among the models of patient satisfaction dimensions, the work of Ware and his associates(1975) has been widely accepted because it is the most comprehensive classification system and includes extensive validity and reliability tests(Luft, 1981). After carefully reviewing patient satisfaction literature published up until 1975, these authors identified ten separate dimensions of patient satisfaction : accessibility/convenience, availability of resources, continuity of care, finance, outcome of care, humanness, information gathering, information giving, pleasantness of surroundings, quality/competence. In their later

study(1978), the ten dimensions were reduced to eight major dimensions with some changes of labeling and reorganization of several dimensions. These eight dimensions includes art of care, technical quality of care, accessibility/convenience, finance, physical environment, availability, continuity, and efficacy/outcome of care.

10 Dimensions	8 Dimensions
1. Accessibility/Convenience	1. Accessibility/Convenience
2. Availability	2. Availability
3. Continuity of Care	3. Continuity of Care
4. Finance	4. Finance
5. Efficacy/Outcome of Care	5. Efficacy/Outcome of Care
6. Pleasantness of Surroundings	6. Physical Environment
7. Quality/Competence	7. Technical Quality of Care
8. Humanness	8. Art of Care
9. Information Gathering	
10. Information Giving	

Figure : 1. Change from 10 Dimensions to 8 Dimensions of Measuring Patient Satisfaction

In developing the taxonomy of eight major dimensions of patient satisfaction. Ware and his colleagues assumed that characteristics of health care providers and services within each major dimension are logically and empirically interrelated but that the major dimensions are not redundant. Based on these assumptions they developed multiple test instruments to investigate the associations of specific elements within each dimension and the differences among dimensions. Several studies(Ware, et al., 1975; Aday & Anderson, 1975;Ware et al., 1984)

supported the basic assumptions of homogeneity within each dimension and heterogeneity among dimensions. However, there are several conceptual flaws in the construction of the major dimensions and methodological weaknesses in the test of the assumptions.

First, Ware and his associates defined the dimension of technical quality of care as the competence of providers and their adherence to high standards of diagnosis and treatment. In addition to the structural components of health care providers such as experience and training of physicians, the definition also includes process characteristics of health care providers involving accuracy, thoroughness, avoiding mistakes in the treatment and diagnosis. What is obvious about the definition is the collection of compounding elements of the structure and process measures of quality of care. It is generally recognized that structure, process, and outcome are three relatively independent measures of quality (Brook, et al., 1973). In this regard, a question might arise that how the measure of patient satisfaction with respect to quality of care can violate the longstanding and clearly distinguished three major ways of measuring quality of care. Given the fact that they deal with the outcome of care as a separated dimension, it is more appropriate to divide the two aspects of measuring quality of care—structure and process—and treat them separately. Thus, certain attempts must be made to isolate structure, process, and outcomes of the providers' characteristics and to see how they differentially affect the patients' perception of care.

Another conceptual problem in constructing the eight dimensions of satisfaction involves the importance of information transfer between doctor and patient. It is not clear whether the two dimensions of information gathering and giving which existed in the previous ten dimensions have been absorbed into the dimensions of art of care or elsewhere. Despite the paramount importance of the information transfer in terms of clinical treatment and interpersonal relationships between doctor and patient, the dimension has not explicitly considered as a separate dimension. Luft (1981) argues that two crucial activities having significant implications for patient satisfaction are the physician's obtaining information from the patient and providing adequate information to the patient about his or her condition. In addition, the investigation of Ware and his associates' specific contents of measurement for the construct reveals that there are several items in their questionnaires dealing with the dimension of information transfer. But it is still not clear whether the items are supposed to measure the dimension of art of care or technical quality of care because the exchange of information can be used for the purpose of either clinical decision making of physician or establishing good physician-patient relationships.

Finally, it should be noted that the construct of availability of services seems to be completely at odds with the basic assumption about characteristics of providers. In fact, the ways they define and actually measure the availability dimension are designed to represent patients' per-

ception and attitudes about the availability of medical resources in a certain community rather than the characteristics of providers. The question about whether there enough physicians, nurses, and other providers and such facilities as clinics and hospitals in the areas does not represent the characteristics of providers or services, but only reflects certain community characteristics in terms of the pool of health care resources. Therefore, the construct of the availability of services has not been validated by adequate operationalization of measures in testing their major dimensions. In fact, studies concerned with the dimension of availability of services are very few. Considering the weakness of the dimension, the dimension of availability of services might not be included in the major dimensions of patient satisfaction.

The current status of the dimensions of patient satisfaction can be contrasted with that of the measures of quality of care. The latter draws upon widely accepted distinctions among structure, process, and outcome measures. But the former has no generally accepted conceptual frameworks. Consequently, any attempt to combine and distinguish a variety of satisfaction dimensions might be fruitless because each can be considered as a separate dimension. However, the value of our efforts can be salvaged by our invincible commitment to construct a more meaningful taxonomy of satisfac-

tion dimensions through rigorous investigation of the existing knowledge base of social science.

III. Summary and Future Research Direction

Patients' satisfaction with medical care is receiving more attention from health care professionals because it is an important indicator of the quality of care and of which aspects of a service need to be changed to improve patient response. Although research on patient satisfaction has proliferated, the complexity of the concept has not been seriously examined. This paper focused on identifying and examining some of conceptual and methodological issues in measuring patient satisfaction. Two theoretical models of satisfaction and several conceptualizations of dimensions of satisfaction were thoroughly examined. Several recommendations have been suggested for the purpose of clarifying the conceptual and methodological problem identified in those models and conceptualizations. Future research on patient satisfaction should address the issue of developing a sound conceptual framework with which measurement of patient satisfaction can be made. Efforts should be undertaken to perform a systematic testing of the validity and reliability of the satisfaction measures.

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보건의료 서비스에 대한 환자의 만족도 측정에 관한 이론적·방법론적인 고찰

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보건의료 서비스에 대한 환자의 만족도 측정이 관심의 대상이 되고, 중요한 의미를 갖는 것은 다음과 같은 세가지 측면에서 그 이유를 찾을 수 있다. 첫째, 오늘날 의료서비스의 소비자들인 환자는 보건의료 서비스에 대한 보다 엄격한 질적 평가를 요구하고 있으므로 의료소비자에 의한 평가로서 환자의 만족도는 그에 관한 중대한 자료를 제공한다. 둘째, 의료서비스의 제공자인 의사나 병원은 환자의 만족도를 측정함으로써 의사나 병원의 의료서비스 제공에 관한 환자의 호응도와 협력의 정도와 지속적인 의료서비스에 관한 수요예측이 가능해진다. 그리고 보건행정가 또는 기획자는 환자의 만족도를 측정하여 분석함으로써 보건의료 자원 및 조직뿐만 아니라 서비스 전달방법 등의 제반사항을 개선 또는 변화시키는 근거를 마련할 수 있다. 환자의 만족도 측정은 그 중요성에도 불구하고 이론적으로나 방법론적으로 여러가지 문제점을 내포하고 있다. 이 논문의 목적은 환자의 만족도 측정에 관한 개념적 혹은 방법론적인 문제를 밝혀서 통합적인 이론적 모형개발을 위한 시론으로 전개된 것이다.

만족도 측정에 관한 결정요인으로 두가지 이론이 검토되었는데 그중 하나는 기대이론이다. 기대이론은 환자가 받은 의료서비스 결과가 그

환자의 기대수준에 어느정도 부합되는가의 여부에 관한 환자의 인식이 만족이라고 관념화한다. 변형된 충족이론은 기대의 개념을 보다 확대하여 최상의 질적 서비스까지 기대하는 것으로 개념화되어 있다. 기대란 개념은 충분히 정제되지 않았기 때문에 환자들의 제각기 다른 기대수준에 따라 만족도는 천차만별할 수 있다. 여기서 이상적인 기대와 현실적인 기대의 구별이 필요하다. 그리고 여러가지 조사연구에서 의료서비스에 대한 환자의 기대가 충족되었다고 반드시 만족한다는 연구결과가 나타나지 않는 것이 기대이론의 결함으로 지적된다. 만족도 측정에 관한 또다른 이론적 구성은 태도이론이다. 태도이론은 환자의 만족도를 환자가 의료서비스에 대한 환자의 인지적, 정서적인 요소가 첨가된 판단이라 관념화한다. 따라서 만족 또는 불만은 환자가 의료서비스란 대상에 대한 자신의 태도를 나타낸다. 태도이론에서는 일관된 연구결과에 뒷받침이 약한 것이 흠으로 지적된다. 여하튼 환자의 만족도는 환자의 의료서비스에 대한 주관적인 판단과 선호의 표시를 내포하고 있다는 점에서 환자의 개인적인 변수는 만족도의 결정에 중대한 영향을 준다. 위에서 제시된 두가지 이론에 대한 검증은 주된 목적으로 한 조사연구들에서 표본추출과 척

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도의 조작화 및 신뢰도에 여러가지 문제점이 노출되므로 이론적 체계를 구축하기 위한 진지한 작업이 중요하다.

환자는 보건의료 서비스의 특징에 대하여 기대와 태도를 갖고 있다는 의미에서 환자 만족도의 측정에서 보건의료 서비스의 다양한 차원이 분명히 제시되어야 한다. 여러 학자들이 제각기 중요한 차원을 열거했지만 가장 보편적으로 이용되고 그 범위에 있어서 다양한 차원들을 포괄적으로 수용한 하나의 모형을 검토해보았다. 그 모형에 의하면, 환자의 만족도 측정의 대상이 되는 중요한 8차원으로는 보건의료 서비스에 대한 접근성, 이용가능성, 지속성과

의료서비스의 결과, 의사의 치료 및 처방의 수준, 의사의 환자에 대한 인간적 기술, 병원의 물리적 환경, 의료비 등이 있다. 그중 4가지 차원에 대한 비평이 있었으며, 개념적으로나 방법론적으로 건설한 차원의 재구성이 요청되었다. 끝으로 이 논문은 다음 두가지 중요한 시사점을 발견하고, 향후 연구의 방향을 제시하였다. 환자의 보건의료 서비스에 대한 만족도의 측정은 우선 만족도에 영향을 주는 환자의 개인적인 요인에 관한 연구의 필요성과 만족도 측정의 대상이 되는 구체적인 차원의 설정이 개념적 또는 방법론적으로 그 타당성이 입증될 수 있도록 연구의 초점이 모아져야 한다.