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Consumer satisfaction with occupational health services: should it be measured?

J Verbeek, F van Dijk, K Räsänen, H Piirainen, E Kankaanpää, C Hulshof

Abstract

Objectives—To find answers in the literature to the questions if, why, and how consumer satisfaction with occupational health services (OHSs) should be measured.

Methods—Publications about the concept of consumer satisfaction with health care and surveys of consumer satisfaction with occupational health care were reviewed.

Results—For care providers, surveys of consumer satisfaction can be useful to improve quality or as indicators of non-compliant behaviour among patients. For clients, satisfaction surveys can be helpful for choosing between healthcare providers. Satisfaction is made up of an affective component of evaluation and a cognitive component of expectations. Also, in occupational health care, patient satisfaction is measured by dimensions such as the humanness and competence of the care provider similar to health care in general. However, there are dimensions that are specific to occupational health—such as the perceived independence of the physician, unclear reasons for visiting an OHS, and the perceived extent of knowledge of OHS professionals about the patient’s working conditions. Dimensions of client satisfaction are mostly similar to patient satisfaction but include more businesslike aspects. They are different for the two groups of client, employers and employees. To measure consumer satisfaction in occupational healthcare specific questionnaires must be constructed. To achieve the highest possible reader satisfaction guidelines are provided for construction of a questionnaire.

Conclusions—Consumer satisfaction is a complex theoretical concept, but it is relatively easy to measure in practice and can be a valuable tool for quality improvement. Consumers’ evaluations of occupational health services will become increasingly important due to changes in the organisation of occupational health care. Occupational healthcare providers are encouraged to measure the consumer satisfaction of their services.

Methods

We reviewed the literature on the concept of consumer satisfaction with health care and on surveys of satisfaction with occupational health care. The concept of consumer satisfaction was considered within the framework of the quality of occupational health care and with regard to different consumer roles in occupational health. Finally, guidelines were derived from the literature on how to construct a satisfaction questionnaire of your own.

Results

QUALITY OF OCCUPATIONAL HEALTH SERVICES

In recent decades increasing attention has been paid to the quality of health care in general. This quality framework has been applied to OHSs as well. Occupational health care can be regarded as a system with input at one end, processes in between, and health outcome at the other end. Improvement of health outcome could be an indicator of quality of an OHS. However, health outcome is often difficult to measure and influenced by many other variables that are beyond the control of the OHS. For example, the implementation of interventions to improve working conditions is reserved exclusively to the management of a company and is usually beyond the control of the OHS. This will
Consumer satisfaction with occupational health services

influence health outcome in different companies and OHSs, apart from the efforts of OHSs. Therefore, it can be more convenient to measure quality of processes instead of health outcome.

There are different methods for measuring and improving the quality of processes in occupational health services such as audit, certification, or quality handbooks. Measuring consumer satisfaction can also be a means to measure the quality of OHS processes. For health care in general, some authors argue that consumer satisfaction is not merely an indicator of quality of health care but that it is a desired outcome of care and therefore an essential part of its quality. Hulslof et al are of the opinion that patient satisfaction is an important measure of outcome. This means that satisfaction of consumers can be considered an important aspect of quality of OHSs. However, the collection of information on consumer satisfaction is not an end in itself.

Assessment of quality of care should have consequences, otherwise it would not be worth doing. Firstly, it is expected that consumer evaluations lead to improvement in the quality of care. Some authors very strongly argue that preferences of the patients should be used to develop new innovative health services. Assessing patient satisfaction is an at least one way to find out which services need improvement according to patients’ preferences. Furthermore, it seems logical that if consumer satisfaction is a desired outcome of care, a healthcare provider would put effort into increasing patient satisfaction. However, there seems to be no empirical evidence to date that such a mechanism exists in health care in general or in occupational health care. Nevertheless, it is a widely held belief that consumer reports lead to an improvement of the quality of health care. Moreover, data on consumer satisfaction are easy to gather compared with other information on quality of care. It is a simple way to monitor the performance of a health service at relatively low cost.

Secondly, patient satisfaction is used to evaluate the effectiveness of treatment. However, there is the possibility of a conflict between patient satisfaction and health related outcomes. Patients can be satisfied with a treatment that is not effective in terms of health outcome. This has been shown in studies on the effectiveness of treatment for low back pain and post-traumatic stress debriefing.

Thirdly, data on quality as reported by patients are used for decision making by consumers. In the United States, consumer assessments of so called health plans (an insurer and provider of health care) are collected and used for that purpose. Patient reports on aspects of health services provided by a health plan are successfully used to enable patients to make a choice between different health plans. This method of consumer reports has been used in occupational health in the Netherlands by the Trade Union Confederation, which rated the quality of OHSs with stars to make choosing between different OHSs easier for councils of workers. The rating is based on a quality assessment by councils. However, there is also some doubt about the importance of reports by patients in choosing between healthcare providers. There is evidence that people seem to rely more on information from friends or relatives when choosing a doctor or a health plan than on reports by patients.

Fourthly, consumer satisfaction can be regarded as an indicator or predictor of unwanted patient or client behaviour. Already some decades ago it was shown that dissatisfied patients do not keep their appointments and do not comply with their treatment or medication. Also they are more inclined to leave their practitioner and to change health plan.

WHO ARE CONSUMERS OF OHSs?
Occupational health services are positioned at the intersection of the healthcare system and the world of work. By contrast with patients in clinical practice who are the sole consumers of services, there are different types of consumers of occupational health care. In OHSs there are sick workers who come for treatment or advice on work related health problems. Also healthy workers visit OHSs for preventive services. With both, the occupational physician has a patient-doctor relation. Therefore, we would call both types of consumers “patients”, comparably with patients in clinical practice. It is likely that they will evaluate OHSs in a similar way as patients do in health care in general.

As well as the patients, we deal with managing directors, managers, heads of departments, supervisors, and personnel managers with whom we have a consultant type of relation. We advise them about organisational matters, improvement of working conditions, or reduction of sickness absence. We would call these consumers of our services clients rather than patients. It is likely that they will evaluate our services differently from patients. For example, business-like aspects—such as speed of services or reliability of the OHS as a company—will be more important than they are for patients.

Furthermore, we have to communicate with employers and employees (representatives) or works councils who pay for our services or who have a say in the contract between a company and an OHS. They are sometimes called the stakeholders of OHSs, but we prefer to call them clients as well. To them we have to be accountable for how well we have been doing in prevention and rehabilitation in their company. Interests of the different clients can be conflicting, with employees’ representatives usually being more interested in the improvement of working conditions and employers giving priority to the reduction of sickness absence or other forms of risk control.

Also, we have to deal with governmental or social security institutions, employer organisations, or trade unions that are usually also called stakeholders. Because they operate at a different level of society they will not be called clients, and we do not regard them as direct consumers of OHSs. However, their different roles also can be mixed.

This can lead to the complicated situation that we encounter a patient who is at the same time client of the OHS. Many occupational
physicians will recognise immediately the value of such a managing director who leaves our offices as a satisfied patient. So, answers from different types of consumers about their satisfaction with services originate from different interests and expectations.

WHAT IS CONSUMER SATISFACTION?
There is confusion about the concept of consumer satisfaction. Many theories have been put forward, especially on patient satisfaction, but none of them is supported by much evidence. Most authors agree that patient satisfaction is best defined as a patient’s evaluation of (aspects of) a healthcare service based on the fulfilment of their expectations. It is good to bear in mind that evaluation is in the affective domain and ascribes favourable or unfavourable feelings toward the object in question. Expectations are in the cognitive domain. This means that we hold certain beliefs about health care and the healthcare system, which from the basis of the relation between certain attributes and aspects of health care. Although it has been put forward that patient satisfaction is the sum of the evaluation and the expectations that we hold (also called belief strength), this has not been shown in empirical studies. It is stressed that expectations should be studied better to get more insight into patient satisfaction.

Williams et al state that the outcome of a patient’s evaluation of services is based on three factors: a positive or negative experience, the perceived function of the service, and the culpability of the service for their experience. This theory explains why most patients in general rate health services as satisfying. In the view of the patient there are many mitigating circumstances that lead to a positive evaluation despite negative experiences. Ratings are even more positive in cultures where overt criticism is not acceptable. As well as expectations, personal patient characteristics such as age and education determine patient satisfaction. Furthermore, the rating of satisfaction can be biased by social and psychological factors. Social desirability, ingratiating response, and cognitive consistency are all reported as causes of satisfaction ratings that are too high.

Most authors agree that there is no such thing as the satisfaction with health care, but that satisfaction is a multidimensional concept. To find out about aspects of care that influence patient satisfaction most, hundreds of patient satisfaction surveys have been combined in literature reviews and meta-analyses. From these studies it can be concluded that in physician-patient encounters aspects such as the attitude of the professional rank as the most important in the overall evaluation of the experience by a patient. Dimensions that make up satisfaction are interpersonal manner, technical quality, accessibility, finances, efficacy, continuity of care, physical environment, and availability (table 1). However, there is no unanimity about these different dimensions. They are criticised for representing too much the nimity about these di

<table>
<thead>
<tr>
<th>Table 1 Aspects of general health care that influence patient satisfaction in order of importance</th>
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<tr>
<td>1. Overall quality</td>
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<td>3. Competence</td>
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<td>5. Facilities</td>
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<td>7. Access</td>
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| 11. Attention to psychosocial problems |}

By contrast with the abundant literature on patient satisfaction there are few studies on client satisfaction in business in general. From the work that has been done, the concept of client satisfaction does not seem to be different from patient satisfaction. Dimensions of client satisfaction seem to be little different from patient satisfaction. For both patients and clients interpersonal manner and communication rank high in the order of components of satisfaction. Reliability, credibility, and security of the service provider are aspects that appear among the 10 most important determinants of client satisfaction and that are not named among the determinants of patient satisfaction. By contrast with what might be expected, the costs of a service are not among the major determinants of client satisfaction.

Literature about measuring client satisfaction in general seems to be much more pragmatic. In business a full roster of satisfied clients is the most precious asset any business can have. Byls gives obvious but valuable advice on how to keep clients satisfied—such as choose the clients that are the right ones for your firm, do not assume that every prospect will become a quality buyer, and every now and then give something away free. However, services are more difficult to evaluate than products. Compared with goods, services are intangible, are heterogeneous due to variations between providers and between days, and production and consumption are often inseparable. Parasuraman et al state that customers become dissatisfied if gaps or discrepancies exist between customers’ expectations on the one hand and service providers’ perceptions of the quality of their services on the other. The analysis of these gaps would provide leads for quality improvement. So a survey of client satisfaction would stress different aspects of OHSs than would a survey of patient satisfaction.

SURVEYS OF SATISFACTION WITH OHSs
By contrast with the many studies on patient satisfaction in health care in general, there are only a few reports about satisfaction with services provided by OHSs (table 2). All but one of the patient surveys are descriptive in nature, but sometimes it is possible to analyze satisfaction based on a specific aspect of the service provided. In general, patients seem to be quite satisfied with OHSs, and the levels of satisfaction are comparable with those found in health care in general. Comparing study
### Table 2 Characteristics and results of surveys on patient and client satisfaction with occupational health services (OHS) or occupational health (OH) programmes

<table>
<thead>
<tr>
<th>Author</th>
<th>OH intervention evaluated</th>
<th>Measurement instrument</th>
<th>Setting</th>
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<td><strong>Consumer satisfaction with occupational health services</strong></td>
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<td><strong>275 programme</strong></td>
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<td><strong>Client surveys:</strong></td>
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<td>Mitchell et al, 1999</td>
<td>OH programme</td>
<td>Questionnaire on service quality with 25 items; 5 point Likert scale</td>
<td>Government office, USA</td>
<td>n=200 Randomly chosen employees</td>
<td>Average satisfaction score 3.8–4.1</td>
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<td>Plomp, 1999</td>
<td>Rehabilitation, consultation, health examination</td>
<td>Interviews: were you satisfied? 3 point scale: positive, moderate, negative</td>
<td>OHS of three companies, the Netherlands</td>
<td>n=286 Employees that visited OHS in past year</td>
<td>38%–76% Satisfied</td>
</tr>
<tr>
<td>Van der Weide et al, 1999</td>
<td>Occupational rehabilitation for low back pain</td>
<td>Questionnaire on several dimensions of satisfaction; 24 items; 5 point Likert scale</td>
<td>Eight OHS participating in randomised controlled trials</td>
<td>n=59 Patients rehabilitated according to guidelines by occupational physicians</td>
<td>Mean (SD) score 66(14) % of maximum attainable score; score 11 points higher if guidelines were followed better</td>
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<tr>
<td><strong>Patient surveys:</strong></td>
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<tr>
<td>Cobere et al, 1992</td>
<td>Case management programme</td>
<td>Mailed questionnaire on 16 aspects of case management; 5 point Likert scale</td>
<td>OHS, USA</td>
<td>n=61 Participants in case management programme past 4 years</td>
<td>55% Very satisfied or satisfied, average score 3.37</td>
</tr>
<tr>
<td>Rogers et al, 1993</td>
<td>OH programme on care and prevention, mainly periodic health examinations</td>
<td>Mailed questionnaire on aspects of consultation process and administrative aspects; 5 point Likert scale</td>
<td>OHS related to one pharmaceutical company, USA</td>
<td>n=494 Employees visiting OHS one week before questionnaire in three months period</td>
<td>62–77% Very satisfied with doctor; 64–80% Very satisfied with nurse, average score 4.5–4.8</td>
</tr>
<tr>
<td>Bosma et al, 1996</td>
<td>Rehabilitation of sick workers</td>
<td>Questionnaire with 16 items on satisfaction; 5 point Likert scale</td>
<td>20 Occupational physicians from different OHSs, the Netherlands</td>
<td>n=166 Patients directly after visit</td>
<td>97% Very satisfied or satisfied, average satisfaction score 4.3</td>
</tr>
<tr>
<td>Kuusinen, 1997</td>
<td>OHS in general</td>
<td>Mailed questionnaire with 4 point Likert scale</td>
<td>Wood processing company, Finland</td>
<td>n=546 Employees (377 made use of OHS in past 6 months)</td>
<td>76% High degree of satisfaction in general</td>
</tr>
<tr>
<td>Antti-Poika et al, 1998</td>
<td>OH in general</td>
<td>Mailed questionnaire with 7 point scale ranging from 4 to 10</td>
<td>Two companies in Finland</td>
<td>n=1266 Employees</td>
<td>Average satisfaction score 8.7</td>
</tr>
<tr>
<td>Mitchell et al, 1999</td>
<td>OH programme</td>
<td>Questionnaire on service quality with 25 items; 5 point Likert scale</td>
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</tr>
<tr>
<td>Wood et al, 1987</td>
<td>OHS in general</td>
<td>Questionnaire yes or no satisfied, average percentage satisfied</td>
<td>OHS related to 32 firms, Australia</td>
<td>n=143 Managers (n=32), employees (n=76), OH professionals (n=35)</td>
<td>Employees less satisfied than managers</td>
</tr>
<tr>
<td>Kahn et al, 1995</td>
<td>Occupational hygiene services</td>
<td>Postal questionnaire; 5 point Likert scale</td>
<td>Occupational Hygiene Service, Israel</td>
<td>n=144 Clients during a 2 year period</td>
<td>76.1% Mostly or completely satisfied with services in general</td>
</tr>
<tr>
<td>Weel et al, 1996</td>
<td>New form of service delivery of OHS</td>
<td>Interview</td>
<td>OHS related to seven firms in the Netherlands</td>
<td>n=7 Company officials</td>
<td>Opinion on quality of OHS was more positive after than before experiment</td>
</tr>
<tr>
<td>Dyck, 1996</td>
<td>OHS, managed rehabilitation care (MRC) and employee assistance programme (EAP)</td>
<td>Questionnaire about service quality; gaps between expectations and providers perceptions</td>
<td>OHS gas and oil company, Canada</td>
<td>n=57 OHS, n=48 MRC, n=17 EAP; Employees, managers and caregivers</td>
<td>No gaps between clients’ expectations and providers’ perceptions; quality high</td>
</tr>
<tr>
<td>Hooiveld et al, 1999</td>
<td>OHS in general</td>
<td>Postal questionnaire; 5 point Likert scale; 10 point general satisfaction rating.</td>
<td>All OHSs in the Netherlands</td>
<td>n=481 Workers’ councils</td>
<td>50% Satisfied or very satisfied with OHS; average satisfaction rating 5.3 to 6.8 (out of 10)</td>
</tr>
</tbody>
</table>

Results, it has to be borne in mind that studies differ in the instruments that were used to measure satisfaction, the services that were evaluated, the type of participants in the survey, and the time when participants were asked for their measure of satisfaction.

The findings in the studies vary from satisfaction levels as low as 38%, to those as high as 97%. The differences in results between these studies can partly be explained by the different interventions that were used to measure satisfaction. Interviews generally yielded lower scores than questionnaires. However, a more interesting explanation for lower levels of satisfaction is a potential conflict of interests between the employees and employers. This was reported by Plomp in the Netherlands where employees criticised the OHSs for not being independent enough.

There was also a report in the United States of case management by an OHS where workers criticised the programme for being too much in the interest of the employer. Apparently, when a conflict of interest is perceived between the employees and employers, satisfaction with OHSs is lower. Bosma et al reported also that satisfaction was lower when the reason for seeing the occupational physician was unclear to the patients. In another study consumer dissatisfaction was related to poor knowledge of working conditions by the professionals. The authors think that this may be due either to real poor knowledge or to poor communication between the OHS and the workers.

In the two studies where satisfaction with visits to occupational health nurses and occupational physicians were both measured, patients expressed higher satisfaction with the visits to nurses than physicians.

In none of the descriptive studies was it made clear whether the study results led to an improvement in services. For some it was just a confirmation that care was of good quality or that the instrument used was not sensitive enough to show deficits in quality. Van der Weide et al related satisfaction of patients to compliance of the occupational physicians with guidelines. Satisfaction of patients was 11% higher if occupational physicians complied with guidelines.

Satisfaction of clients is studied even less often.

There are three studies that are descriptive, one that measures the outcome of an experiment, and one study that is meant to facilitate choice of an OHS. Kahan et al were able to link satisfaction ratings of clients to

www.occenvmed.com
To enable works councils to make a better choice for an OHS, the Netherlands Trade Union Confederation has made a Consumers Guide to OHSs (table 3). Data were gathered with a questionnaire that mostly comprised questions about the involvement of the workers and works councils in daily occupational health practice. All Dutch OHSs were asked to send this questionnaire to 20 works councils that belonged to their client organisations and were then asked to make a self evaluation based on the same questionnaire. Answers were summed up in six categories and in a total score ranging from 0 to 10, with 10 being the best possible score. If both the self evaluation score and assessment by the works councils were above 5.5 one star was awarded, and two or three stars if ratings were higher. Table 3 shows scores of a two star and a no star OHS. There are some methodological flaws in this study—such as a very low response rate of works councils (16%), and difficulties in making an assessment of an OHS with so few works councils as clients. However, it is the first worthwhile attempt, that we know of, to use consumer information in OHSs.

GUIDELINES FOR MEASURING CONSUMER SATISFACTION IN OCCUPATIONAL HEALTH

There are many instruments available to measure patient satisfaction. However, none of them are immediately ready for use in evaluating occupational health services because they are usually made for other healthcare situations that do not correspond completely to the situation in OHSs. So, when you want to conduct a satisfaction survey you are first faced with the question of whether you can use an existing questionnaire or if you have to design your own. The benefits of using an existing one are that you do not have to worry about the methodological problems of designing a questionnaire, at least if the designers have made clear that their instrument is valid, reliable, and sensitive. A simple choice for an existing questionnaire might be the client satisfaction questionnaire that exists in an 18 item and an eight item short form. A drawback of using this instrument in its short form is that it only asks quite general questions and does not give many leads for quality improvement. Another choice that has the advantage of being easily available through the internet is the consumer assessment of health plans, which is in use in the United States to facilitate decision making on health plans.

The next step will be to decide what information you want to gather on your own services (table 4). Make sure that consumers are involved from the beginning so that your questionnaire covers items that are important to them. One way to do this is to make use of focus group discussions. Decide whether it is going to be a questionnaire for patients or for clients because different items should be included for each. For patients these would include interpersonal manner and technical skills. For clients there would be questions on reliability and credibility of the OHS. Questions which influence satisfaction with OHSs should be included such as the independence of the occupational physician, clarity of the aim of the procedures, and the extent of knowledge the OHS professionals have about working conditions of the patient or clients. Some authors argue that more questions should be asked about outcome—such as “As a result of your visit to the doctor today, do you feel you are able to cope with life . . . much better, the same, or less.”

The reliability of the questionnaire increases if more questions are asked about one specific dimension and the answers are combined into a scale. The wording of the questions and the type of answers that are used also influence the results. Words and answers should be used that facilitate understanding and that increase

<table>
<thead>
<tr>
<th>Stars</th>
<th>OHS Douwe Egberts, Joure</th>
<th>OHS Arbounie Rijnmond</th>
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<tbody>
<tr>
<td></td>
<td>Self assessment</td>
<td>Workers’ council report</td>
</tr>
<tr>
<td>Cooperation with workers’ council</td>
<td>7.9</td>
<td>5.5</td>
</tr>
<tr>
<td>Expertise</td>
<td>9.2</td>
<td>7.3</td>
</tr>
<tr>
<td>Organisation</td>
<td>7.6</td>
<td>5.1</td>
</tr>
<tr>
<td>Return to work policies</td>
<td>8.2</td>
<td>7.8</td>
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<tr>
<td>Standard procedures</td>
<td>6.1</td>
<td>6.0</td>
</tr>
<tr>
<td>Relations with workers</td>
<td>7.7</td>
<td>6.8</td>
</tr>
<tr>
<td>Total score</td>
<td>7.8</td>
<td>6.6</td>
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Douwe Egberts, Joure is a two star occupational health service, and Arbounie Rijnmond has no stars.
the variability of response. To make the filling in of the questionnaire easier it is advised that your questions follow the healthcare process chronologically. If you are looking for leads for quality improvement, ask for concrete experiences such as “How long was the time you had to wait for your visit?” These will give a greater variability of answers than asking about satisfaction with waiting times. Do not use double negatives, such as occurs in the question “The doctor did not let me say everything I wanted” with the answers never, sometimes, often, always. Most people are inclined to agree with answers that are already given, which will lead to so-called response acquiescence. This can be avoided by the use of reversed worded questions. Furthermore, it is better to use a personal referent in the answers “I am very satisfied with the care I received” instead of a general referent “Doctors let their patients tell them everything that the patient thinks is important”.

Structured answers should be offered in the format of a so-called Likert type scale, using a five point scale with answers ranging from strongly disagree to strongly agree. For practical purposes, it is a convenient way of measuring satisfaction ratings. You have to decide to which type of consumers you are going to present the questionnaire. Consumers who have not had recent contact with the service tend to evaluate services more negatively than those who have. The variance of the answers is largest if the questionnaire is completed just before or just after the visit to the OHS.

When you have designed your questionnaire it should be given as a pilot test among a restricted number of respondents. Ask them about the clarity of the questions and the answering possibilities. Adapt the questionnaire according to their comments.

The decision on the number of patients or clients to include in your survey is a difficult one. If you have many clients or patients, a random sample would be needed, with the number of people to include depending on the precision of the answers you want. For practical purposes this is usually too complicated to organise. Instead of a random sample a systematic sample of the answers you want. For practical purposes, it is a convenient way of measuring satisfaction ratings. You have to decide to which type of consumers you are going to present the questionnaire. Consumers who have not had recent contact with the service tend to evaluate services more negatively than those who have. The variance of the answers is largest if the questionnaire is completed just before or just after the visit to the OHS. When you have designed your questionnaire it should be given as a pilot test among a restricted number of respondents. Ask them about the clarity of the questions and the answering possibilities. Adapt the questionnaire according to their comments.

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