

Improving quality of care through the OECD Patient Reported Indicator Surveys (PaRIS)

Using patient-reported data to support health policy



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Abstract

The OECD Patient-Reported Indicator Surveys (PaRIS) demonstrate the value of patient-reported outcomes and experiences in strengthening people-centred primary care. Drawing on evidence from the 19 countries which participated in the first cycle of PaRIS, the report shows how results are already informing reforms in care co-ordination, digital health and quality monitoring. The report highlights key enablers such as early engagement, clear governance, communication planning and sustained investment to integrate patient-reported outcome and experience measures (PROMs and PREMs) into healthcare system performance assessment.

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Executive summary

International comparisons of health-system performance still rely heavily on administrative and clinical data, which say little about how patients experience healthcare or whether care improves people's day-to-day health. This report describes what happens when countries add patient-reported information to that picture and use it to support policymaking processes. The report focusses on the Patient-Reported Indicator Surveys (PaRIS), an OECD programme designed to assess primary care from people's perspective, and to support improvements in quality and in how people-centred health services are. The first cycle of PaRIS, which ran between 2018 and 2025, surveyed over 107 000 patients using primary care services and more than 1 800 primary care practices in 19 countries, and provides a large, internationally comparable dataset that countries can use to benchmark performance, identify gaps, and track reforms using measures reported directly by primary care users.

Drawing on interviews and written exchanges with country delegates and national project managers of PaRIS in March 2026, this report identifies how PaRIS results have been disseminated, interpreted and used in health policy and practice in the 19 countries that participated in PaRIS Cycle 1 (*Australia, Belgium, Canada, Czechia, France, Greece, Iceland, Italy, Luxembourg, the Netherlands, Norway, Portugal, Romania, Saudi Arabia, Slovenia, Spain, Switzerland, the United States and Wales (United Kingdom)*). The analysis follows a Knowledge to Action framework, a structured way to examine how evidence is adapted to the local context, communicated, applied, monitored and sustained. The outcomes focussed on dissemination of PaRIS results at the national level, policy and practice use of PaRIS results, mechanisms supporting dissemination and use for health policy, and the long-term impact of PaRIS.

Results from Cycle 1 of PaRIS were widely disseminated at the national level. Many countries published national reports or summary outputs, often structured around the PaRIS-10 indicators, and organised policy dialogues, stakeholder meetings or targeted briefings. For example, Australia, Belgium, Czechia, France, the Netherlands, Norway, Portugal, Spain and Switzerland produced national level reports, and Belgium, Czechia, Italy, Romania and Slovenia held dedicated national events involving decision makers, primary care professionals and patient organisations. These activities were frequently complemented by infographics, webinars and websites as seen in Australia, Luxembourg, Saudi Arabia, Spain and Wales, to support interpretation and facilitate dissemination.

PaRIS findings are informing policy discussions and reform processes. Seven countries, including Czechia, Greece, Iceland, Italy, Luxembourg, Slovenia and Wales, reported using PaRIS to identify gaps in primary care, particularly in care co-ordination and digital health. Belgium, Greece, Norway and Portugal reported using PaRIS to confirm previously identified healthcare challenges from the patient perspective. Czechia, Iceland, Italy, Luxembourg, Norway, Portugal, Saudi Arabia, Slovenia, Wales reported using PaRIS as an evidence base for ongoing reform.

PaRIS has also contributed to long-term impact and sustainability by facilitating **the integration of key patient-reported measures into national frameworks for healthcare system assessment and quality monitoring.** Greece, Iceland, Italy, Luxembourg, Norway, Portugal, Slovenia, Wales reported embedding or planning to embed PaRIS indicators into national healthcare performance measurement and quality monitoring systems. Other examples include embedding into accreditation programmes such as in Portugal.

Overall, PaRIS Cycle 1 highlights both the feasibility of collecting patient-reported outcomes and experiences on an international scale and the conditions under which such data can be effectively translated into policy and practice. The experience of the participating countries shows that early stakeholder engagement, clear governance arrangements, adequate analytical and dissemination capacity, and alignment with national priorities are critical to turning patient-reported evidence into actionable insights. At the same time, resource constraints, limited familiarity with PROMs and PREMs, and competing policy pressures can hamper uptake.

The lessons from Cycle 1 point to practical actions that countries can adapt to their context to strengthen the sustainable use of patient-reported measures. The findings from this report highlight several **short- and medium- term recommendations** for countries to strengthen the uptake of PaRIS at the national level:

- **Convene a stakeholder group from early stages:** Relevant stakeholders should be mobilised to discuss the study design in the national context, support recruitment and data collection, disseminate results, interpret findings, and develop policy priorities. Such a stakeholder group should include patients, healthcare professionals and other key stakeholders in the national context.
- **Plan the communication and dissemination strategy ahead of time:** Such a strategy should be developed with the stakeholder group and included as a budget line during project planning. The strategy should also consider the team composition and the relevant resources needed to realise the strategy, for example a communication officer, graphic designer or behavioural scientist.
- **Ensure close collaboration between policymakers and project team:** Establishing a steering committee that includes key actors in the implementation and use of results can strengthen impact. Such a committee should include the Ministry of Health, the national project manager (if not sitting at the ministry) as well as key national authorities and providers.
- **Increase knowledge on PROMs and PREMs among patients, healthcare professionals and policymakers:** Learning sessions should be planned to increase awareness, knowledge and learning capacity among key stakeholders including patients, healthcare professionals and policymakers. Invite key experts on the topic for the learning session to share high-level information as well as concrete examples of how to collect, communicate and use PROMs and PREMs.

The findings also point to several **recommendations whose implementation will depend on continued, long-term investment and effort:**

- **Commit to systematically assessing PROMs and PREMs at the national level:** A national plan should prioritise the collection and use of patient-reported measures to assess the performance and quality of healthcare system. Maximise cross-country learning opportunities across PaRIS cycles through targeted collaborations.
- **Invest in sustained systems (institutionalise) to systematically collect PROMs and PREMs data:** Interoperability in data systems should be achieved to link data across databases to improve interpretability of the findings in the broader national context. Prepare legal frameworks, where needed, for governance and sustainability.

1 Measuring healthcare performance through the OECD Patient-Reported Indicator Surveys (PaRIS)

The OECD Patient-Reported Indicator Surveys (PaRIS) assess the performance of healthcare systems in delivering primary care from people's perspective. Gathering patient-reported data from over 107 000 primary care users linked to more than 1 800 primary care practices across 19 countries, results from Cycle 1 provide comparable evidence on what patients report about their care experiences and health outcomes. Results from Cycle 1 have been widely disseminated through OECD reports, policy papers, and academic papers and additional analytical work is ongoing. In addition, the results have been presented and discussed in various events with policymakers and stakeholders. This chapter outlines the key features of PaRIS, along with its international dissemination and communication activities.

The first cycle of PaRIS collected data in 2023-2024 from 107 011 patients linked to 1 816 primary care practices across 19 countries, making it the largest international survey of patient-reported outcomes and experiences to date (OECD, 2025^[1]). Unlike most existing patient-reported measurement frameworks, which focus on specific conditions or procedures, PaRIS takes a whole-person, people-centred approach that considers the ongoing experiences of people living with chronic conditions, who are mainly managed in primary care. PaRIS also links patient-level data with primary care practice characteristics and the health system context through its nested study design, enabling analysis of how primary care delivery and system factors relate to patient outcomes and experiences.

PaRIS focusses exclusively on primary care service users aged 45 years and older who had at least one contact with a primary care practice in the six months preceding sampling. It does not aim to estimate population-level prevalence but to capture the firsthand experiences of those who actively use primary care services, an area that has often not been measured or is poorly understood in many countries.

People living with chronic conditions constitute the largest and fastest-growing group of healthcare users in OECD countries. Primary care serves as the cornerstone of chronic disease management, aiming to provide continuous, co-ordinated, and comprehensive care over time. By concentrating on a patient group that is universally relevant across health systems, PaRIS enables meaningful international comparisons. These comparisons help identify system strengths and weaknesses, inform policy development and healthcare reforms, and foster the sharing of best practices and innovative solutions across countries.

The first cycle of PaRIS gathered extensive information on the experiences and outcomes of primary care users

The first cycle of PaRIS gathered data from more than 107 000 patients and 1 800 primary care practices across 19 countries and followed a structured collaborative design process (Annex A). By capturing the views of people who interact regularly and recently with primary care, with a focus on people living with

chronic conditions, PaRIS provides a detailed picture of how care is organised and functioning from people's perspective. The breadth and depth of the dataset enable countries to identify policy priorities in their respective countries, while allowing cross-country comparisons with other participating countries.

The insights from PaRIS have the potential to inform a wide range of policy objectives from strengthening primary care delivery to improving digital access, equity, and continuity of care. As the indicators reflect outcomes that matter directly to people, they provide a powerful tool for identifying areas where systems perform well, spotlighting gaps, and guiding reforms aimed at improving responsiveness and quality. Understanding how these data translate into real-world policy and practice use requires examining how countries have interpreted, communicated, and integrated the findings into their decision-making processes.

The PaRIS results were discussed at policy dialogues and stakeholder events

The international launch of the PaRIS flagship report marked a key milestone in disseminating results to a global audience. Hosted by the Portuguese Ministry of Health in Lisbon on 20 February 2025, the event convened high-level policymakers, senior health system leaders, healthcare professionals, patient representatives, and researchers from participating countries and beyond. It provided a platform to present the main findings, highlight cross-country comparisons, and initiate policy discussions on how patient-reported data can inform healthcare system performance and people-centred care. The launch also facilitated media outreach and set the stage for subsequent national and international dissemination activities.

The Secretariat has contributed to a wide range of international conferences, policy forums, and expert meetings to present the PaRIS results and methodological advances. These include OECD Health Committee and Working Party meetings, stakeholder group discussions, and major international conferences in health services research and primary care such as the European Forum for Primary Care and the World Organisation of Family Doctors (WONCA) annual conferences. Through these engagements, the Secretariat has ensured sustained visibility of PaRIS and fostered dialogue on the integration of patient-reported measures into routine healthcare system monitoring.

The Secretariat organised a series of thematic webinars to provide in-depth analysis of key findings. Each webinar focussed on a specific chapter of the flagship report (e.g. multimorbidity, person-centred care, trust, methods and inequalities (planned on 16 April 2026)), allowing for detailed discussion of results, methodological considerations, and policy implications. These webinars targeted policymakers, stakeholders, and researchers, and encouraged interactive exchanges between policymakers, patients and healthcare professionals on how findings can be translated into national policy contexts. Recordings of the webinars are available on the PaRIS website.¹

In addition to thematic webinars, dedicated stakeholder webinars were organised to engage specific audiences, including healthcare professionals and patient organisations. These sessions aimed to strengthen understanding of PaRIS concepts by different stakeholders, promote uptake of patient-reported measures, and gather feedback on the future development of the initiative. They also served as a platform to share experiences and good practices. PaRIS findings have been featured in a variety of external events organised by international and national organisations as well as other stakeholders. These include the WONCA World 2025 conference, the 2025 annual conference of European Forum for Primary Care, and several events organised by national health authorities. In several cases, PaRIS results have been used to inform panel discussions, keynote presentations, and workshops on measuring what matters to patients and strengthening people-centred healthcare systems.

PaRIS data informed OECD publications, policy briefs and academic papers

The PaRIS flagship report, *Does healthcare deliver? Results from the Patient-Reported Indicator Surveys (PaRIS)*, was the main vehicle for disseminating the first set of results. It provides internationally comparable evidence on patient-reported outcomes and experiences in primary care, alongside analyses of inequalities and healthcare system characteristics associated with better performance. The report has been widely disseminated and serves as a reference for policy discussions on people-centred care.

PaRIS data and insights have been integrated into broader OECD analytical outputs. Selected indicators and findings have contributed to editions of *Health at a Glance 2025* (OECD, 2025^[2]), enriching the monitoring of healthcare system performance with patient-reported dimensions. In addition, PaRIS results have informed thematic work on chronic conditions, including cardiovascular disease and cancer (OECD, 2025^[3]; OECD/European Commission, 2026^[4]), by providing complementary evidence on patient experiences and outcomes beyond clinical indicators.

Several OECD policy briefs have drawn on PaRIS findings to highlight actionable insights for policymakers. These briefs focus on topics such as digitalisation in healthcare (OECD, 2026^[5]) and prevention and health promotion in cardiovascular diseases (OECD, 2026^[6]). They aim to translate complex analytical findings into concise, policy-relevant messages tailored to policymakers.

PaRIS data are expected to contribute to upcoming OECD work streams, including publications on the health workforce, public health, and ageing. In particular, patient-reported measures offer valuable perspectives on primary care workforce performance, responsiveness to the needs of ageing populations and prevention among people with chronic conditions. These forthcoming outputs will further expand the use of PaRIS data to inform cross-cutting policy priorities.

PaRIS data will be made available to support analysis and research. PaRIS-10 key indicators have been published on the OECD Data Explorer (OECD, 2025^[7]). In addition, 13 countries are making their national PaRIS data available as public-use files to strengthen analytical work and inform policy and research.

A series of analytical papers are also planned. These papers focus on key policy issues, including person-centred care, care co-ordination, care continuity, multimorbidity (two or more chronic conditions), emergency care, as well as comparative analysis with other international surveys. Such papers target academics, policymakers, healthcare professionals and other stakeholders who are interested in gaining further insights on broader healthcare issues.

Understanding how participating countries have leveraged PaRIS results showcases its added value for national policymaking and informs future cycles

While the international activities are essential in disseminating the PaRIS results to a broad audience, whether PaRIS fulfils its objective of improving healthcare system performance and quality of care will also depend on national activities. “*To what extent have these findings been disseminated, communicated, and ultimately used to inform health policy, practice, and decision making at national and local levels*” has been the main question guiding this work.

To examine how Cycle 1 findings are being used in the participating countries, the Secretariat conducted semi-structured interviews in March 2026 with representatives from 16 countries (Belgium, Canada, Czechia, Greece, Iceland, Italy, Luxembourg, Norway, Portugal, Romania, Saudi Arabia, Slovenia, Spain, Switzerland, the United States and Wales (United Kingdom) which participated in Cycle 1, complemented by written input from Australia and France (Annex B). The interviews had two main objectives: 1) to examine the policy and practice impact of PaRIS, identifying concrete examples of good practices and 2) to enable cross-country learning by gathering insights on effective mechanisms that support the dissemination and use of PaRIS data for health policies.

To elucidate how countries are using and applying the PaRIS data, the Secretariat developed a semi-structured interview guide (Annex C) based on Knowledge-to-Action framework (Graham et al., 2006^[8]). The seven-stage action cycle of the framework which represents the activities that are needed for knowledge application guided the development of the interview guide (Annex D).

This report

This report synthesises early findings from country interviews and provides an initial assessment of how PaRIS Cycle 1 results are shaping health policy and practice. By consolidating national experiences with good practice examples, this report aims to guide further work and inform preparations for future cycles of PaRIS. Section 2 focusses on the dissemination and communication activities; Section 3 on how countries have been using the PaRIS data and results for health policy and practice; Section 4 on sustainability efforts; and Section 5 provides key lessons by analysing the experienced barriers and enablers, and shares recommendations to enhance the use of PaRIS data for health policies.

2 Communication and dissemination

Dissemination and communication of findings, and engagement of key stakeholders has been a priority in all countries. Almost all of them published a national report, summarising the key findings from PaRIS Cycle 1 to their national audience. PaRIS-10 key indicators have been the driving main content in most national reports and most of the time were presented along with other themes. Most countries organised policy dialogues with the participation of key stakeholders to enhance policy relevance and uptake of findings. National project managers presented the findings at various additional events, including academic conferences as well as sessions hosted by ministries to raise awareness. Some countries also produced analytical reports and academic papers drawing on additional analysis of their national data. This section details the dissemination and communication activities carried out at the national levels.

Dissemination and communication of the results from Cycle 1 were largely led by national project management teams, which varied in composition by country depending on the local context. In some countries, national project management was assigned to the Ministry of Health which also contributed from a policy perspective, while in others national project management was assigned to another institution. In some countries, regional and local authorities also took a role in the project management, by implementing the survey in their local context.

Project Management teams led by the ministry of health with academic advisors characterised **Portugal** and **Spain**. Portugal worked through the Ministry of Health and ACSS with the National School of Public Health as methodological partner, along with an advisory board of professional and patient organisations. Spain's Ministry of Health also co-ordinated with autonomous communities, scientific associations and patient groups.

National project management was led by academic institutions in collaboration with the Ministry of Health in **Czechia, Greece, Italy and Luxembourg**. **Czechia** appointed an academic family doctor affiliated with the Medical Faculty of Charles University to manage delivery with a designated Ministry of Health liaison to keep policy and implementation aligned. **Greece** placed overall responsibility with the Ministry of Health while the University of Athens led operations and survey implementation. **Italy** appointed the delegates to the Working Party on PaRIS from the Ministry of Health with survey implementation and analysis co-ordinated by the Sant'Anna School of Advanced Studies. In **Luxembourg**, the operationalisation of PaRIS in the country was conducted by the Luxembourg Institute of Health, which was mandated by the Directorate of Health within the Ministry of Health and Social Security.

A ministry and public health institute model operated in **Australia, Belgium, The Netherlands, Norway, Romania, Switzerland and Wales**. In **Australia**, the Australian Commission on Safety and Quality in Health Care implemented the survey on behalf of the Department of Health, Disability and Aging. **Belgium** mandated Sciensano to run the project with a scientific steering committee including the health insurance institute and regional authorities. In **the Netherlands**, the Netherlands Institute for Health Services Research (NIVEL) was appointed the national project manager by the Ministry of Health, Welfare and Sport. **Norway** appointed the National Institute of Public Health as the national project manager and as the delegate to the Working Party on PaRIS. **Switzerland** appointed Unisanté as the operational hub and co-ordinated with the Federal Quality Commission for decision making. In **Romania**, the National Authority for Quality Management in Healthcare was delegated by the Romanian Government to manage delivery.

Wales located delivery in the NHS Wales Value in Health Centre with policy direction from the Welsh Government.

The United States ran PaRIS within the Medicare Current Beneficiary Survey at Centres for Medicare and Medicaid Services (CMS) with the policy implementation sitting largely decentralised from the project management team, and **Saudi Arabia** placed leadership with Centre for Value in Health (a policy think tank) under the national health insurance authority and drew in ministries, the health sector transformation programme, the primary care directorate, the national patient experience centre and private payers.

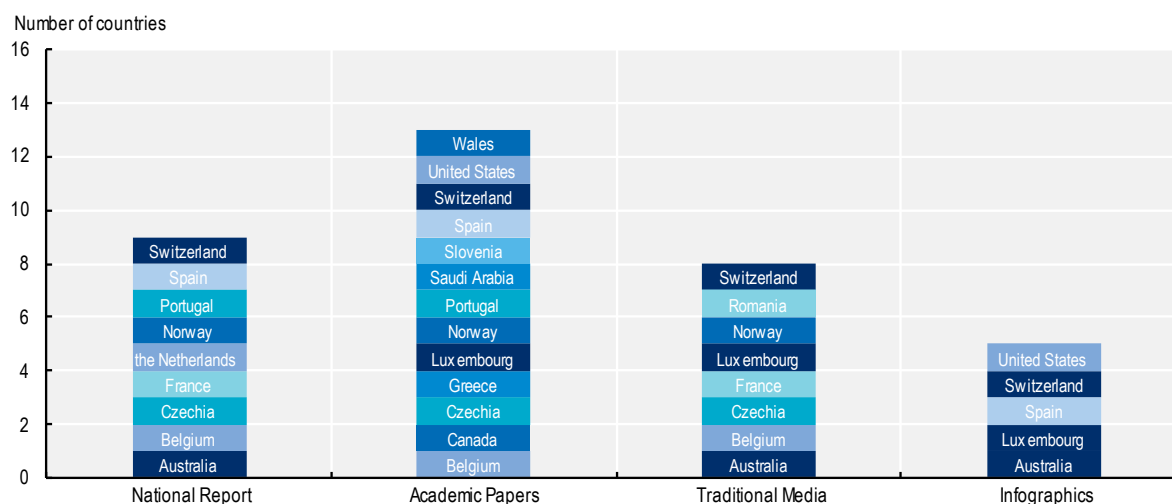
Local service and ministry combination characterised **Slovenia**, where the Ljubljana community health centre led with a deputy from the Ministry of Health and close co-operation with the National Institute of Public Health, the Family Medicine Department and professional bodies.

Canada organised co-ordination through the Canadian Primary Care Research Network with national project management teams from academia and provincial leads engaging each provincial ministry during fieldwork and follow-up. In **Iceland**, the national project management and delegation was completely transferred to the University of Iceland, who also provided financing for Cycle 1.

Dissemination activities focussed on national reports, policy dialogues and other channels

Dissemination centred on a national report or summary in every country, paired with structured policy dialogues that brought policymakers, primary care professionals and patient groups to a shared view of findings and next steps, while visual materials, targeted events and webinars widened reach and tailored fit to national governance contexts. Figure 1 shows how countries used different dissemination channels.

Figure 1. Nine countries published national reports, and most countries complemented them with additional dissemination channels



Note: All participating countries from Cycle 1 are included in the figure. Traditional media refers to print media, trade publications and television.

Almost all countries published national reports or other summaries of national findings

Almost all countries produced a national-level report (some of them being publicly available) or equivalent summary document, though approaches differed (Table 1). **Australia, Belgium, Czechia, France, the**

Netherlands, Norway, Portugal, Spain and Switzerland prepared structured national publications with methods sections and nationally focussed key findings, drawing on the PaRIS-10 key indicators. Common elements included descriptions of sampling and weighting, instrument design and data collection, and presentation of core experience and outcome measures. Several reports also offered sub-national breakdowns and downloadable materials to support reuse. **Australia's** national report summarised results across 10-key indicators and set out key insights for quality improvement. **Czechia's** national report, prepared with the Institute of Health Information and Statistics, combined international comparison with detailed national analysis. **Norway's** report followed a standard policy format with key messages, executive summary, methods, results, discussion and conclusions tailored to the national context. **Spain's** Ministry of Health hosts a dedicated PaRIS webpage with the national report, methodological notes, microdata access and infographics for each autonomous community.

Several countries complemented their reports with visual and digital materials to broaden reach. **Luxembourg, Saudi Arabia, Spain and Wales** developed infographics to support communication with lay audiences, **Czechia** and **Switzerland** produced short videos to explain results, and **Luxembourg** and **Switzerland** host dedicated PaRIS webpages to consolidate national content.

Table 1. Some countries made national reports publicly available

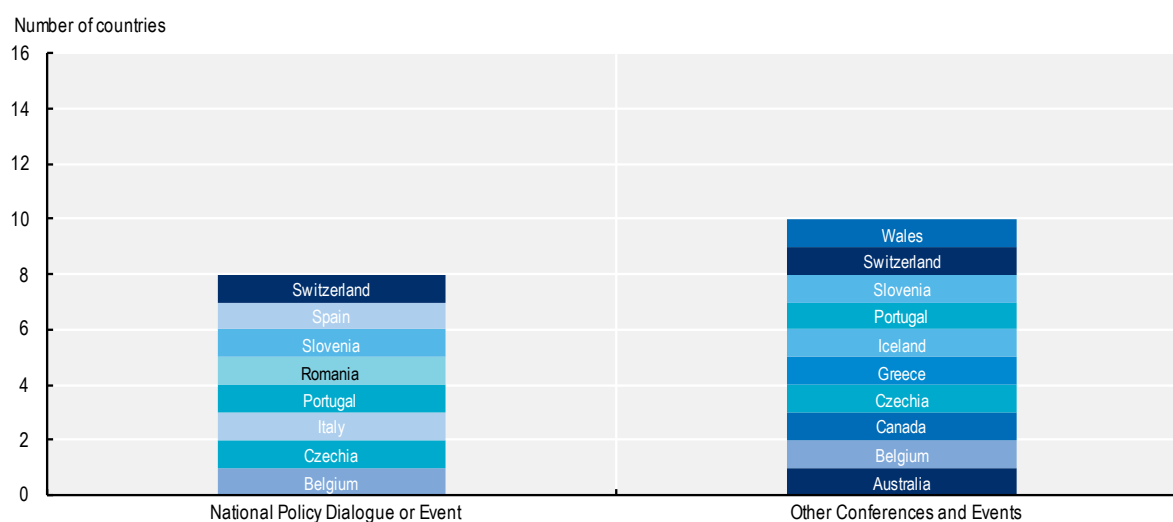
Country	Title/Link
Australia	OECD Patient-Reported Indicator Surveys (PaRIS): Australian national report 2025
Belgium	Patient-Reported Indicator Surveys (PaRIS): Insights from Belgium
Czechia	Národní Zpráva o Projektu PaRIS
France	Les patients de 45 ans ou plus sont globalement satisfaits de leur prise en charge en médecine générale Premiers résultats de l'enquête PaRIS, en France
The Netherlands	Ervaringen van mensen met chronische aandoeningen met de huisartsenzorg in Nederland
Norway	OECD's Patient-Reported Indicator Surveys (PaRIS) Norsk resultatrapport
Portugal	A saúde vista pelos utentes em Portugal
Spain	Proyecto PaRIS : Indicadores de Resultados y Experiencias Referidos por los Pacientes Atendidos en Atención Primaria
Switzerland	Enquête PaRIS Rapport Phase 3 : Mise en œuvre de l'enquête PaRIS en Suisse et ses résultats principaux

Most countries organised or attended policy dialogues to discuss their national findings with policymakers and other stakeholders

Almost all participating countries organised or attended policy dialogues by bringing a wide set of stakeholders together to collaborate on the interpretation of PaRIS results and develop policy priorities and actions where possible (Figure 2). In **Belgium**, Sciensano in collaboration with federal authorities (Federal Public Service Health, Food Chain Safety and Environment) and the National Institute for Health and Disability Insurance, organised a national conference based on the findings from the national report. At the event, various panel discussions took place with policymakers, regional health agencies, healthcare professionals and patients. The outcomes of the event led to a press release statement. In **Czechia**, the Ministry of Health organised a policy dialogue including healthcare professionals, patients and journalists. Brochures including the main PaRIS findings in plain language were disseminated at the event, along with a press conference to further raise public awareness. In addition, a short video was prepared (based on the international PaRIS video prepared by the Secretariat for the Ministerial Meeting in January 2025). **Italy's** Ministry of Health held a national meeting in July 2025 and a national workshop for regions that was widely streamed and drew strong participation from primary healthcare staff and academics. **Portugal's** national project management team organised a policy dialogue in July 2025 and convened its advisory board and Ministry of Health representatives to review findings and identify priority areas informed by PaRIS. In **Romania**, a national event was held with stakeholders from patient associations, public institutions, professional organisations and international organisations. In addition, written briefings were

provided to the Ministry of Health and the Prime Minister to inform them of the PaRIS results. A proposal is now under consideration to establish a working group on primary care quality to draft policies addressing issues identified through PaRIS. Similarly to Czechia, in **Slovenia**, the Ministry of Health organised a national policy dialogue where several stakeholders, including patient representatives, healthcare professionals and the National Institute of Public Health attended to discuss the PaRIS findings. The Secretariat was also present at these national events to share the perspectives at the international level.

Figure 2. Several countries organised dedicated national policy events and most presented at conferences and other events



Note: The figure is based on the interviews with 16 countries participated in PaRIS Cycle 1.

In countries where no national events took place with broader stakeholder groups and other participants, national project managers briefed the Ministry of Health orally or in writing. In **Australia**, briefings were made at high-level executive meetings at the Department of Health, Disability and Aging to support ongoing work in primary care policy development. National project managers from **Canada** presented the findings to Health Canada and other stakeholders. Given the provincial implementation of PaRIS in Canada (i.e. the implementation was led by provincial project managers across 10 provinces), the dissemination activities were also held by provincial leads at the province level. **Greece** presented the results at policy dialogues in addition to other national conferences and bilateral events. In **Iceland**, national project managers presented the results to the Ministry of Health, followed by discussions with the Directorate of Health and the Development Centre for Primary Healthcare in Iceland. In **Luxembourg**, national project managers briefed the Directorate of Health on the results, and counterparts engaged in working groups on patient-centred care and integrated care. In **Norway**, several high-level policy meetings were held. The National Project Management Team (on behalf of the National Institute of Public Health) presented findings to the Ministry of Health, including a separate meeting with the State Secretary and other policymakers. The results were also presented to the national reference group for PaRIS in Norway, with representatives from patient organisations, municipalities, primary care and the health directorate. The **United States** briefed the results in different meetings and shared the results broadly, including an infographic now used by the Department of Health and Human Services.

Australia and **Wales (United Kingdom)** also held various proactive, bespoke presentations to different stakeholder groups. In **Australia** presentations were made to the National Rural Health commissioner to support discussions on primary care, and to the National Multidisciplinary Primary Care Consortium Think

Tank, to support discussions on primary care reform. In **Wales**, several tailored meetings were held with the Welsh Government, Health Boards and other stakeholders, where PaRIS results were contextualised further by using additional data and information sources.

Stakeholder dialogues were also designed to generate tangible outputs for decision making. **Portugal** presented the results confidentially to its advisory board ahead of the official launch event. The outcomes of the discussions supported the interpretation of the findings in the country's context. In July 2025, another policy dialogue was organised at the Ministry of Health by gathering advisory board members as well as other relevant stakeholders. The outcomes of this meeting identified three policy priorities for the Portuguese policy activities (see Section 3). **Switzerland** specifically acquired additional funding after the launch of the flagship report to convene a stakeholder meeting in April 2025. Around 20 people attended the meeting in person in Bern to discuss the results and deliver concrete policy and practice recommendations. From this meeting Switzerland produced a stakeholder dialog report to communicate the findings and recommendations to the public, as well as a factsheet, one-page infographic, six videos and a press release.

Most countries organised additional events and activities to further disseminate the findings among stakeholders

Countries organised audience-specific events and workshops and spoke directly with practitioners to extend the reach of PaRIS results and support practical use. **Australia** held a dedicated conference at the Royal Australian College of General Practitioners focussing on the Australian results and providing a list of recommended actions for general practices. **Greece** presented both pilot and final findings at national conferences, ISPOR Europe conferences and delivered other online presentations, for example at the Longevity Centre. **Czechia** and **Slovenia** presented at the national family doctors' congress, while **Switzerland** shared results at the Swiss Public Health Conference.

Czechia, Canada, Portugal and Slovenia organised a joint workshop to present the findings and lessons learned at the WONCA World conference in 2025. **Wales** engaged stakeholders by delivering the results to a wide range of conferences and events and strategically tailored presentations for each conference to ensure that healthcare professionals, managers and researchers could engage with the most salient evidence.

Some countries also spoke directly to practitioners and healthcare centres, such as **Slovenia**, which delivered internal briefings for healthcare centres as well as **Wales** presenting at NHS clinical group meetings. **Belgium** presented the findings to the Commissie Gezondheidszorgdoelstellingen (GDOS), which advises on healthcare objectives and evaluates policy results and related budget proposals using concrete indicators, providing policy-oriented evidence and proposals for specific objectives and measures. **Canada** also presented at the Canadian Primary Care Research Network, the North American Primary Care Research Group, the International Conference on Integrated Care and the Annual Family Medicine Forum. In **Iceland**, outreach included presentations at the national primary care conference, the national nursing research conference and sessions with university students.

Traditional media channels also supported dissemination of PaRIS results. **Australia** released two radio programmes with its national broadcaster, as well as publications in newspapers and healthcare trade publications. **Luxembourg** featured the findings in national magazines targeted at healthcare professionals. In **Belgium**, an article on the PaRIS results, as well as the conference were published in trade publications. In **Czechia**, national television and journal news covered the project and its results. In **Norway**, the Norwegian Institute of Public Health collaborated with patient organisations to produce a research news article on the OECD flagship report, including commentary on the main findings for Norway. **Romania** organised TV interviews to disseminate the national findings and many countries also published press releases, such as **Australia, France, Luxembourg and Switzerland**.

Digital channels also expanded reach and stakeholder engagement. In **Canada**, each provincial lead ran webinars and social media outreach. Canada is also building future research capacity by working with the Canadian Primary Care Research Consortium and TUTOR-PHC to give graduate students access to the database. Some additional dissemination focussed on building internal awareness of PaRIS within government. In Saudi Arabia, the Centre for Value in Health delivered a four-part webinar series focussing on PaRIS at a glance, PROMs and PREMs, care capabilities and international comparisons led by regional health directorates. The webinar series was complemented with presentations at the Global Health Exhibition, national conferences, events and in universities, while Greece also used virtual webinars to engage wider audiences. In Spain, national project managers presented PaRIS findings to Ministry of Health staff, and this continues to be included in induction training so that incoming Ministry of Health staff are familiar with the results (see Section 4).

Countries conducted additional analysis on their national data and produced academic papers

Countries used PaRIS data to deepen analysis and publish peer-reviewed work (Table 2). The themes addressed in these publications were mainly driven by the international analysis and each country's initial national analysis, especially in areas where the country identified gaps, demonstrated strong performance or had specific policy priorities. **Australia** is currently working on a research article on PaRIS focussing on the methodology, Australian results and key insights for quality improvement. **Canada** is assembling a special journal issue of ten articles using PaRIS data, covering topics such as self-management support, mental health and how patient characteristics relate to experience, while **Italy** is assessing the impact of care co-ordination on trust and health status. **Czechia** has published articles on patient-reported experience and outcomes alongside a commentary. **Luxembourg** is advancing national studies on access to primary care and on obesity care, using PaRIS data for further analysis. **Norway** has a wide research pipeline examining predictors of PREMs and PROMs, clustering at the GP level, cancer-specific analyses and psychometric testing of the Norwegian version of the PaRIS questionnaires. **Slovenia**, reported publications for professional and scientific audiences, including work on field testing, cultural adaptation and patient perspectives on primary care quality. **Spain** published further analysis on trust in the healthcare system (Ministry of Health, Spain, 2026^[9]) and is currently preparing national reports on the 10 key PROMs and PREMs indicators and a study on mental health. In **Saudi Arabia**, the Centre for Value in Health has been working on several publications concerning multimorbidity and care experiences, care co-ordination, determinants of trust, confidence to self-manage, disparities across age groups, primary care characteristics, comparison between people with and without chronic conditions, and socio-economic disparities.

Cross-country collaboration is also emerging, with teams from **Belgium, Luxembourg and Switzerland** undertaking a joint study on perceptions of care co-ordination.

Wales built a bank of analyses and a stakeholder-oriented dashboard, which allows tailored products such as maps on co-ordination of care and workforce readiness to be delivered quickly to stakeholders when requested.

Table 2. Countries published academic papers, editorials and infographics

Country	Title/Link	Type
Australia	Managing Chronic Conditions in Australia	Infographic
Belgium	Investigating care outcomes and experiences of adults with Long COVID through patient-reported indicators (PROMs and PREMs) in Belgium	Academic Paper
Belgium	Exploring health outcomes and care experiences of adults with post-COVID-19 condition in Belgium	Academic Paper
Canada	International effort harnessing the collective voice of primary care	Commentary
Canada	Evaluating the Participatory Processes within the OECD PaRIS Project in Saskatchewan: Lessons Learned about Recruitment and Engagement	Academic Paper
Canada	Participatory Evaluation of the OECD PaRIS Dashboards in Saskatchewan: Grounded in Relationships	Academic Paper
Canada	OECD Patient-Reported Indicators Survey (PaRIS) in Canada: Results From the National Study Annals of Family Medicine	Academic Paper
Canada	Design and Performance of an Email-Based Patient Recruitment Campaign in Primary Care Research: Formative Secondary Analysis	Academic Paper
Czechia	Pružkum zkušeností chronicky nemocných s péčí poskytovanou v ordinacích praktických lékařů a hodnocení výstupu této péče	Academic Paper
Czechia	PRACTICUS	Editorial
Czechia	Zdravotní Péče Ocima Pacientů	Policy Paper
Greece	Implementation of the Patient Reported Indicator Surveys (PaRIS) in Greece: A Cornerstone in Systematic Investigation of Patient Reported Experiences and Outcomes from Primary Health Care Services	Academic Paper
Luxembourg	PaRIS Survey Results for Your Country	Infographic
The Netherlands	Nieuw onderzoek naar ervaringen van patiënten met een chronische aandoening Huisarts en wetenschap	Research Note
The Netherlands	PaRIS-onderzoek: zorg bij chronische aandoeningen	Academic Paper
Norway	International survey of people living with chronic conditions (PaRIS survey): effects of general practitioner non-participation on the representativeness of the Norwegian patient data	Academic Paper
Norway	Identifying patient and provider determinants of primary care experiences and outcomes for persons with chronic conditions: a multilevel analysis of a nation-wide survey in Norway	Academic Paper
Portugal	How Person-Centered Care shapes patients' trust in healthcare: Insights from Portugal's PaRIS study	Academic Paper
Saudi Arabia	The Patient Reported Indicators Survey (PaRIS) in Saudi Arabia: Measuring Patient Reported Outcomes and Experiences in Adults Aged 18-44	Academic Paper
Slovenia	Cultural Adaptation of Patient-Reported Indicator Surveys (PaRIS) Patient and Primary Care Practice Questionnaires to the Slovenian Context	Academic Paper
Slovenia	Patient Reported Indicator Surveys (PaRIS): Methodological Considerations of a Field Trial in Slovenia	Academic Paper
Slovenia	Patient perspectives on the quality of primary care for chronic conditions in Slovenia: evidence from the PaRIS survey	Academic Paper
Spain	Infografías elaboradas por el Ministerio de Sanidad con los resultados nacionales de la encuesta PaRIS presentados por CCAA	Infographic
Spain	Encuesta Internacional de Indicadores de Salud Referidos por los Pacientes: el protocolo del Estudio PaRIS en España	Academic Paper
Spain	Proyecto PaRIS : Confianza En Los Profesionales Sanitarios	Research Paper
Switzerland	PaRIS Fact Sheet	Fact Sheet
Switzerland	PaRIS Infographic	Infographic
Wales	The use of PROMIS as part of a population needs assessment in Wales - Advances in Patient-Reported Outcomes	Academic Paper
Wales	Shared-decision-making, trust in the healthcare system and health literacy are associated with self-reported pain levels: a population-based cross-sectional study in individuals living with a chronic health condition in Wales	Academic Paper
Wales	Confidence to Self-Manage in Diabetes: An All-Wales Cross-Sectional Population Study	Academic Paper
United States	Fruit and Vegetable Consumption Among the Medicare Population	Infographic

PaRIS has raised awareness of the collection and use of patient-reported measures in healthcare performance assessment

PaRIS raised awareness of the collection and use of patient-reported measures across participating countries. Often PaRIS was the first time PROMs and PREMs were collected at national scale for healthcare performance assessment, or the international benchmarking was an important additional layer in countries where existing PROMs and/or PREMs data collections took place. Beyond the PaRIS results, available PaRIS instruments such as validated standardised patient questionnaire and this visibility often inspired broader collection in other healthcare settings.

PaRIS influenced the broader collection of patient-reported measures across healthcare systems and services

Across countries, PaRIS helped catalyse broader efforts to expand patient-reported measurement beyond the survey itself. Countries described using PaRIS as a starting point for a wider shift toward routine monitoring of patient-reported outcomes and experiences. In **Canada**, the Canadian Primary Care Research Consortium used PaRIS as a part of a wider movement to encourage the systematic use PROMs and PREMs. The province of Québec has now started several research initiatives, collecting patient reported experience measures from primary care practices, and in Saskatchewan, a collaboration between teams during the implementation of PaRIS led to the creation of practice-based research and learning network that continues to operate after Cycle 1. **Italy** has also used a similar approach in using PaRIS to disseminate the concepts of patient reported experience across national and regional levels. **Luxembourg** is using patient-reported information for the first time inside the ministry and the Observatoire de la Santé, which is raising the profile the patient perspective in policy and practice. **Romania** is exploring the implementation of PaRIS-inspired PROMs and PREMs indicators in hospital settings, with a view to potentially use them as part of accreditation processes to monitor and improve quality of care. **Saudi Arabia** has been exploring how PaRIS can guide the development of patient-experience tools in hospitals and clinics, using it as a reference for validated question design. In **Slovenia**, PaRIS helped redirect attention toward quality assessment in primary care, a domain that was dominated by secondary care, and encouraged discussions on how patient-reported indicators could be embedded in routine monitoring.

The influence of PaRIS has informed the creation of new programmes collecting patient reported measures. **Greece** has developed instrument for hospitals to assess patient-reported experience, drawing on PaRIS alongside other sources. Additionally, the Greek national patient organisation drew on PaRIS instruments to produce a shorter, locally tailored tool to record patient reported experience, the results of which are now being finalised following completion of its first survey round. **Belgium** is looking to integrate PaRIS questions or use them as a guide to develop indicators on integrated care; and PaRIS is currently the only national-level source for patient-reported measures in primary-care. In **Italy**, by utilising the administrative data flows established during PaRIS, the regions of Tuscany and Veneto have continued patient-reported experience measurement, allowing them to provide granular feedback to facilities and local areas. **Slovenia** plans to develop an e-platform which will collect PROMs and PREMs after each primary care visit, making it relevant for individual patient care. **Norway** has integrated PaRIS-10 indicators into the annual national PREM survey for general practice, conducted with patient samples from all 356 municipalities. These indicators complement the existing standardised PREM measures at both national and municipal levels, subject to adequate discrimination, reliability, and validity. In **the United States**, MCBS now tests some additional trust items following the influential results observed in PaRIS. Some of these efforts are supported by sustainable integrated structures allowing continuous measurement of selected PaRIS items or their derivatives at a more granular level (see Section 4).

PaRIS data and results have been used by other national authorities and stakeholders

Countries maximised the use of PaRIS data by making it available to other parties or preparing results for other national authorities and stakeholders on demand. In **Belgium**, Federaal Kenniscentrum – Centre fédéral d'expertise (KCE) gets access to the PaRIS data, as part of the broader reporting on the performance of Belgian healthcare system. In **Greece**, the National Statistical Service and Directorate of Health accessed the PaRIS data to conduct further analysis on areas concerning access and unmet needs. **Spain** and **the United States** published public use files for broader analysis and use of the PaRIS data at the national level. In **the United States**, the historical data from Medicare were linkable to the PaRIS data providing 4 000 analytical variables, making it a significant source of information for researchers. In **Portugal**, the priority programmes on cardiovascular disease, cancer and diabetes have used PaRIS data in their annual reports. In **Wales**, the Health Board wants to use the data to assess strategic delivery. In addition, Wales provides access to researchers following a data access protocol and the team has prepared a Power-BI dashboard to facilitate the use of results by other stakeholders.

Australia created a secure, purpose-built online practitioner portal featuring an interactive dashboard. This provided participating practices with benchmarked feedback based on the aggregated results of their patient cohort, supporting local interpretation and quality improvement. A general practice that participated in the PaRIS Survey used the results from its patient cohort to strengthen team-based care, improve co-ordination with external providers, and improve communication with patients about medication management and care plans.

From collection to use of PaRIS data and results

Participating countries in Cycle 1 have put extensive efforts to communicate and disseminate PaRIS results to their national audience and more broadly. Policy briefs, technical papers, academic articles, national policy dialogues as well as tailored targeted outreach to key stakeholders has been useful for the dissemination of findings and raising awareness of PaRIS and broader patient-reported measurement. All these activities form the first step in reaching the overall PaRIS goal of making healthcare systems more people centred.

However, the translation from data to health policy is not automatic, even though it is often seen as the natural next step. The next section outlines how countries have been using or planning to use PaRIS data and results for health policy and practice.

3 Use of PaRIS data for health policy and practice

PaRIS results were published about a year before the interviews for this paper took place, which is a short period given the usual length of policy cycles. Nevertheless, most countries have already used the results for health policy and practice, and some have concrete action plans for implementation. The results show that PaRIS has helped countries identify systemic gaps in how care is organised and experienced from the patient perspective, including primary care and digital health. PaRIS has also confirmed known challenges, but this time from patients' perspectives, giving healthcare performance assessment a new angle. Governments and healthcare providers have been using these insights to plan practical changes, refine contracts and incentives, align ongoing reforms and strategies, and link with administrative data to guide local improvement and policy decisions. This section details how countries have been using the PaRIS data and results for health policy and practice.

Policymakers and stakeholders have been waiting a long time for PaRIS. While the results were published in 2025, the development and implementation of PaRIS took seven years. During these seven years, countries worked together to design the survey in the international context, develop the PaRIS instruments, translate and cognitively test them, and field-test both the survey design and the instruments. All these activities have been necessary to develop a robust study and prepared the terrain to welcome the study results.

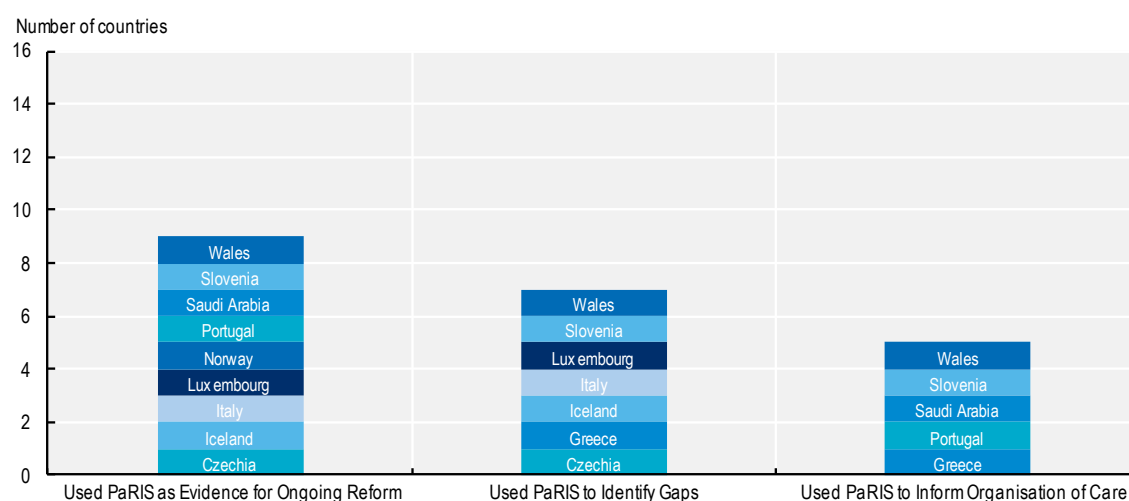
While it might still be early to see the policy and practice impact of PaRIS, many countries have already been using insights to identify gaps and advance policies and reforms. In some cases, PaRIS filled a knowledge gap or supported what has been already known in the country. The additional value of PaRIS has been bringing patient perspective into the topic, making it more policy relevant. While the next edition of the impact study might reveal more results, the initial examples are already providing inspiration to advance the use of PaRIS data for health policy and practice in the future.

Most countries used PaRIS to identify systemic gaps in their healthcare systems

OECD Member and partner countries have a long tradition of collecting health data and benchmarking the results for cross-country learning. Over the past decades, such health data, mainly derived from administrative and clinical sources, have helped countries identify gaps in their system, highlight areas where it performs well and learn from others to strengthen their healthcare system performance. Such an approach supports learning health systems.

PaRIS enriches value to this long tradition of learning health systems culture by adding patient-reported data. Beyond collection, using such data to improve health policies and practices help healthcare systems to become more people centred, addressing the needs of their patients. Figure 3 provides an overview of how countries used PaRIS data and results for health policy and practice.

Figure 3. Most countries used PaRIS to identify gaps, support evidence-based policy and inform care organisation



Note: The figure is based on the interviews with 16 countries participated in PaRIS Cycle 1.

Seven countries used PaRIS findings to identify gaps in their health system

Countries described using PaRIS findings to identify gaps in how care is organised and experienced, particularly concerning key functions of primary care and digital health. **Czechia** noted that the digital health domain was weaker than expected. Despite progress with e-prescribing and digital services, the international comparison suggested that it is still behind peers. **Greece** highlighted that, even with a fragmented system, trust in health professionals appeared high, which challenged prevailing narratives and warranted closer analysis of what drives trust in the country. **Iceland** found low confidence in self-management to be unexpectedly prominent, pointing authorities toward additional research and support for patient capability. **Italy** said the results drew attention to trust differences by age, with lower trust among younger people prompting further discussion. **Luxembourg** used the results to identify areas for improvement in its digital health record system (i.e. *dossier medical partagé*), which is informing reform. **Slovenia** reported that it previously lacked data on core family practice competencies such as person-centredness and care co-ordination, and that PaRIS provided the evidence on these subjects.

These insights are already being used to steer practical changes and guide planning. The **Welsh** Value in Health Centre is using PaRIS to map where self-reported breathlessness is most common and is planning “breathlessness hubs” to improve timely diagnosis and access to expertise. PaRIS has also filled primary care information gaps by providing data on workforce readiness in addition to PROMs and PREMs. Data are being linked with other administrative datasets to identify priority cohorts, for example people in the last year of life or those with low confidence managing diabetes. Welsh teams are also applying the findings at cluster level to learn from positive outliers, such as deprived areas reporting higher access to care plans and greater trust in the healthcare system and then conducting site visits to understand what is working.

Four countries reported using PaRIS to confirm previously identified healthcare challenges

PaRIS has helped countries confirm known challenges from the patients’ perspective. In **Belgium**, findings largely corroborated existing diagnoses, with evidence confirming low digital health literacy, which contrasted with high levels of digitalisation. Additionally, PaRIS strengthened evidence for prior investment in care plans for diabetes and chronic kidney disease. In **Greece**, PaRIS is underlining the known issue of

care co-ordination in the country. The role of the general practitioner is new in Greece and there is a need for clearer roles in primary healthcare and co-ordination, and Greece reported that PaRIS insights would feed into ongoing reform. In addition, PaRIS stimulated further interest in out-of-pocket payments and policy discussions around them, which has received policy attention following the OECD's broader comparative work on the topic. In **Norway**, access to digital services is already a government priority, and PaRIS further showed that digital services are lagging, providing further evidence to support reform. Additionally, ongoing issues with co-ordination of services were widely acknowledged and informed new policies regarding task-sharing, notably with nurses, which has recently been implemented in the country. In **Portugal**, results were described as an extra layer of evidence that confirmed high digital health maturity in the country giving policymakers and stakeholders confidence that reforms are having an effect.

Nine countries used PaRIS data as an evidence base for ongoing reform

Across countries, PaRIS is being used to underpin existing strategies and track reforms as they are implemented. **Portugal** intends to establish systematic, national collection of PREMs beyond PaRIS. Legislation from 2014 requires healthcare providers to collect patient experience and satisfaction, but implementation has been uneven and infrequent. Some providers collect annually, others every five years, and there is no clear guidance on how to do it well. To address this, Portugal is developing a national platform to collect PREMs and standardise methods and frequency, drawing on PaRIS as the evidence base. In **Slovenia**, PaRIS results supported the decision to include PREMs and PROMs in the national strategy for primary healthcare. Slovenia reported that PaRIS was useful for policymakers as it is providing concrete evidence when developing policies and recommendations.

Italy is using PaRIS to monitor the roll-out of new community health facilities launched in 2022 as part of a wider EUR 7 billion investment in community health. PaRIS results are being fed back to local health authorities at the community level and used to assess progress on implementation. Authorities also plan to use Cycle 2 of PaRIS to examine the equity of these reforms across the 19 regions and two autonomous provinces, with a focus on whether patient-reported experiences are improving consistently in the new community health centres and related digital services (See Section 4).

Czechia reported that having strong, positive results from PaRIS during their primary care reform period was critical in sustaining momentum and supporting ongoing efforts. Additionally, the international comparison from PaRIS helped point to best practice targets for care co-ordination and national project managers expect subsequent cycles of PaRIS to support implementation. **Luxembourg** is integrating PaRIS data into the national cancer report to shed light on quality of life, mental health and primary care-led follow-up, and the Observatoire de la Santé is applying the data to examine socio-economic inequalities in cardiovascular health. In **Saudi Arabia**, where a broader health sector transformation is separating provider, payer and regulatory functions, PaRIS results serve as an analytical tool that identifies challenges and barriers. **Norway** has used PaRIS findings as evidence in a white paper on the future of general practice services, with the project and its results cited throughout. **Wales** is using PaRIS to establish a baseline for monitoring the national Women's Health Plan.

Iceland described PaRIS as reinforcing the direction of ongoing reforms and supporting efforts to improve patients' first contact with primary care. Before PaRIS, the Reykjavik health system had already moved to open more phone services and expand web access, while increasing capacity by adding staff such as nutritionists, physiotherapists and psychologists. Iceland reported that the PaRIS findings provided further evidence to support these ongoing changes. Iceland also pointed to an increase in the activity of healthcare professionals reviewing medicines with patients, which has emerged as a practical signal of more person-oriented and co-ordinated care. This activity has gained traction recently and PaRIS was perceived to be influencing these activities.

Countries have used PaRIS results to shape policy discussions on the organisation of care delivery

PaRIS results are being used to inform discussions on how care is funded and organised. In **Slovenia**, primary care reimbursement was reformed to increase capitation rates, in recognition of the greater complexity of caring for people with multimorbidity, and policymakers indicated that PaRIS findings reinforced the case for this change. In **Greece**, lower patient satisfaction and access to care reported in rural areas supported work with the Panhellenic Medical Association on offering a more balanced package of incentives to attract and retain doctors in rural areas. **Portugal's** financing agency (ACSS) is working to add patient experience metrics to contracts with local health units, as currently contracts primarily focus on production and access. The PaRIS indicators have also advised reform in **Saudi Arabia**, where the public payer is considering mandatory collection of patient-reported outcome measures and is exploring the use of validated, cognitively tested instruments from PaRIS. In **Wales**, an element on co-ordination of care is planned to be added to contracting with general practitioners, with PaRIS used to establish the baseline and track the effect of the contractual change over time in subsequent cycles. Wales is also working with health boards to reshape community management of musculoskeletal conditions. Teams are linking administrative datasets with PaRIS to understand demand and capacity across primary and secondary care, tailor services to system activation levels and patient access patterns and provide granular feedback to inform service adjustments.

From use of results to quality improvement and assurance

Participating countries in Cycle 1 have been maximising the use of PaRIS data to better understand their policy priorities. Even though it has only been a year since the release of the flagship report, PaRIS identified knowledge gaps, challenged existing assumptions in the country, supported well-known issues, and provided evidence for national strategies and reforms. Additionally, PaRIS has already been shaping policy discussions on the organisation of care delivery in some countries.

Advancing from using PaRIS data to improving and assuring quality of care will also depend on the extent to which these activities are sustainable. Several countries have already been incorporating PaRIS results into the broader systematic quality measurement efforts in the country, which have also become part of public reporting. In addition, some countries have been developing systems to institutionalise the collection of PROMs and PREMs as part of PaRIS and other programmes. The next section outlines the broader efforts by countries to ensure long-term impact of the results and sustain PaRIS data collection and use.

4 Long term-impact and sustainability

Across countries, PaRIS indicators are starting to be built into national measurement and quality monitoring. Many countries have begun routine PREMs and PROMs collection, integrating them into national registers and are planning to link indicators to accreditation. Countries are also putting in place governance arrangements, budget lines and data pipelines to sustain the work through political and fiscal changes. Participation in Cycle 2 is reinforcing these efforts by providing a longitudinal dataset that supports trend analysis, comparison and continued use.

PaRIS was built to systematically measure healthcare system performance (in delivering primary care) from people's perspective. Its overall goal is to improve the quality of primary care. The long-term impact of PaRIS will depend on the systematic collection of data, the effective use of these data to inform health policies and practices, and the sustained implementation of quality monitoring strategies. Such quality assurance strategies can focus on “setting standards” through regulation of pathways, “monitoring” through feedback and accreditation, and “assuring improvement” through public reporting (Eu et al., 2019_[10]).

Countries have been working to ensure the long-term impact of PaRIS through sustainable structures which institutionalise the collection and use of PROMs and PREMs data. While this requires a forward-looking perspective, country examples show how PaRIS can stimulate and support broader quality measurement, improvement and assurance activities in the long term.

Eight countries reported embedding or planning to embed PaRIS indicators into national measurement and quality monitoring systems

Countries are planning to embed or have already begun embedding, the routine use of PaRIS indicators in broader quality monitoring at the national and local level. **Australia** is exploring ways to embed PaRIS within its broader work on chronic conditions and primary care, and to integrate it into national quality and performance improvement systems. Prior to PaRIS, **Greece** lacked quality indicators for primary healthcare. As such, Greece is developing stronger indicators to measure co-ordination across primary healthcare, drawing on the indicators used in PaRIS. **Norway** is testing PaRIS indicators to embed a selected set in the general practice PREM survey. This approach will generate patient reported indicators at the municipality level, across all municipalities, creating comparable measures for general practice performance including patient-perceived collaboration within and across healthcare levels. These data will support policy and practice, including the work of the Ministry-appointed committee on health system organisation, which is due to present its recommendations in 2026.

Portugal is reviewing its accreditation processes and is working to include PREMs in the accreditation cycle so that patient experience becomes part of routine oversight. **Iceland** is adding PaRIS-derived questions to an ongoing government service survey run by the Ministry of Economics to track year-on-year changes in how people access and experience services, partly influenced by PaRIS. **Italy** is revising its National Guarantee System and plans to add indicators that all regions can feasibly measure, using PaRIS as the foundation for selection. Additionally, selected PREMs indicators, based on PaRIS, are being prepared as a non-core, pilot measure with the aim of moving them to core status if feasible, and unmet needs are already included among non-core indicators. Authorities in **Italy** are also planning to use Cycle 2

of PaRIS to examine the equity of recently introduced reforms in community healthcare. Using longitudinal data across cycles they plan to explore whether patient-reported experience is improving consistently across the country, after the rollout of new community health centres and related digital health services. Italy is also exploring including of at least one PaRIS indicator in periodic national statistics surveys to secure regular measurement. **Luxembourg** is using PaRIS to inform the creation of patient-reported indicators in its national HSPA, with emphasis on patient empowerment and integrated care. **Slovenia** has established a new national agency for quality in healthcare, and the current project team has proposed that it prioritise PaRIS indicators for long-term monitoring, including tracking implementation of new legislation such as the digital health law. The proposal under discussion is to run short, continuous surveys using PaRIS-based items at the individual level. **Wales** is using PaRIS to monitor the impact of changes made to the General Medical Services contract to improve quality and continuity of care, with baseline analyses complete and metrics ready to auto-populate in Cycle 2. In parallel, Welsh officials are considering PaRIS as a five-year touchpoint to complement yearly reporting for the Patient Experience Framework. Some countries are working towards institutionalisation of PaRIS to ensure long term sustainability.

Countries are exploring possible options to institutionalise the collection of PROMs and PREMs by developing new structures or changing existing governance structures. **Norway** is exploring the possible inclusion of PREMs and PROMs in national registries to enable continuous measurement. Such an arrangement would be placed at the National Institute of Public Health and allow data linkage with individual level data on PREMs and PROMs across healthcare levels over time. **Slovenia** implemented a National Law on Quality of Care, which is aligned with PaRIS, allowing the collection of PROMs and PREMs data. **Portugal** is implementing structures to make PaRIS stable and institutional by preparing a ministerial decree that will formalise governance, set out clear responsibilities across agencies, and tie the work to explicit policy objectives. The draft is ready for submission to the ministry, with the intent to secure continuity at the institutional level so that implementation is maintained regardless of changes in government.

Participation in Cycle 2 has played a key role in sustaining momentum and integrating PaRIS into broader quality improvement and assurance frameworks

Countries are using participation in Cycle 2 to keep momentum and make PaRIS part of routine work. **Australia** aims to continue participating in future PaRIS cycles to build a time-series dataset that supports analysis of national and international trends in PROMs and PREMs. These data will enable ongoing monitoring and help assess the impact of primary care reforms implemented by policymakers and healthcare providers. **Czechia** sees Cycle 2 as essential because repeat collection is needed and will use the new data to support primary care reform planned for 2035. **Greece** aims to continue PaRIS to address quality issues in primary care. **Italy** plans to use data from Cycle 1 as a baseline to track programme changes in Cycle 2. **Norway** has PROMs and PREMs data collection, including PaRIS, as a policy priority for the coming decade. Longitudinal results derived from multiple cycles will be valued and Norway is planning how it will apply Cycle 2 outputs, including in evaluation of policy initiatives informed by PaRIS and other knowledge sources. **Slovenia** plans to stay in PaRIS long term and is already preparing suggestions for the next cycle and has also reported that strong uptake of individual feedback by practices is a key motivator. **Wales** has set up monitoring streams that will auto populate when Cycle 2 data arrive. Sustainability efforts are hampered in countries where Cycle 2 remained uncertain.

5 Key lessons and recommendations

PaRIS Cycle 1 generated five key practical lessons for dissemination and communication, analysis and policy use. (1) Early steering and advisory bodies helped tailor communication activities and turn results into next steps. (2) Targeted engagement with healthcare professionals and patients helped to close knowledge gaps on PROMs and PREMs. (3) Dedicated budgets and the reuse of existing resources supported dissemination. (4) Alignment with national reforms and data institutions enabled uptake. (5) Closer links between project teams and policymakers, alongside institutionalisation, helped mitigate competing priorities and fragmented governance. Moreover, countries expressed interest in joint research to share efforts and strengthen findings. This section presents the key lessons from PaRIS Cycle 1, particularly challenges and enablers concerning communication, use and sustainability activities. It also provides recommendations to facilitate the use of data for health policies, based on the learning from the OECD PaRIS Cycle 1.

The first cycle of PaRIS created practical learning opportunities for all groups involved, from survey design, fieldwork, analysis, communication and policy use. The unprecedented scope of collecting PROMs and PREMs at an international scale meant teams had to build capacity, test governance and data flows, and refine how results are translated for decision makers. The findings that follow translate these lessons into actions that countries can adapt to their context, with a focus on strengthening governance and resources, tailoring communication to different audiences, and ensuring the collaborative effort of stakeholders.

Establishing steering and advisory bodies at early stages facilitated the dissemination of results and the use of findings

Early, structured engagement made PaRIS more relevant in each national context. Steering and advisory bodies brought ministries, primary care professionals, academics and patient groups into the process from the outset, which kept communication consistent and tailored outputs. By creating a clear forum for interpreting results, these groups eased dissemination and helped convert evidence into practical next steps.

Establishing steering committees from early stages brought key stakeholders on board and facilitated dissemination

Across participating countries, establishing governance arrangements early provided a practical forum to organise dissemination of PaRIS results. In **Australia**, a PaRIS Governance Committee brought together representatives from consumer, professional and Aboriginal community-controlled health organisations and research councils, Primary Health Networks, digital health agencies and academic partners. The Committee played a key role in communicating and promoting the initiative to relevant organisations, advising on appropriate stakeholders for consultation and involvement, and representing the perspectives of key stakeholder groups in shaping the project. Additionally, The Royal Australian College of General Practitioners (RACGP) assisted in promoting the PaRIS Survey and its results through its website and communication channels, including a media release and commentary at the launch of the Australian national report. **Belgium** convened a steering committee from the outset, that brought together scientific

and health authorities, the national health insurance institute, regional health agencies, academic partners, general practice organisations and patient representatives from both Flanders and Wallonia. In **Portugal**, an advisory board was in place from the initiation of PaRIS and met ahead of the release to review results and steer the launch, with patient and professional organisations closely aligned and active in dissemination. In both Belgium and Portugal, the committees reviewed written outputs, supported the national conference and ensured that perspectives from different parts of the system were reflected. In **Romania**, a consultative council bringing together relevant health-system stakeholders was established following the PaRIS field trial and served as a consistent source of guidance throughout the project. Following the release of the results, the consultative council concluded that a strategic plan should be developed to guide the implementation of changes informed by the PaRIS findings. In **Saudi Arabia**, the steering committee gathered the main system actors, including the Centre for National Health Insurance, the Ministry of Health, primary care leadership, the Health Sector Transformation Programme and the patient-centred experience unit, creating a channel to engage experts across sectors and discuss how the findings could be used in practice. **Slovenia** combined ministry leadership with involvement from community health centres, the National Institute for Public Health, alongside representatives of nurses, family doctors and other healthcare professionals. The ministry was central to supporting the preparation of results and co-ordinating the involvement of key stakeholders through its established networks.

Stakeholder groups and advisory bodies supported the contextualisation of findings and identifying priority areas

Stakeholder groups have helped interpret PaRIS evidence in local contexts and identify priority areas. In **Australia**, PaRIS results have been used by the Royal Australian College of General Practitioners in broader policy advocacy highlighting the need for investment in Medicare to support continuity of care and longer consultations, particularly for patients with chronic conditions. In **Belgium**, the steering committee co-produced the national report and was described as essential in identifying priorities such as increased investment in care plans and providing direction. In **Canada**, stakeholder engagement was integral to data collection: in Saskatchewan, a partnership with an Indigenous community embedded patient-oriented research and mobilised more than 50 people to work with the provincial lead through cycles of engagement, and in Québec there were monthly touchpoints with 13 to 14 clinics during data collection which created a collaboration. In **Greece**, the Panhellenic Medical Association worked with academia and government to align the findings with efforts to rebalance staffing between remote and rural areas. National patient organisations were also engaged throughout, including the cancer patient association and the national longevity centre, to shape survey design, dissemination and follow-up. Additionally, the national nurses' association held a dedicated panel at nursing conferences to translate findings for frontline practice. **Italy** involved healthcare professionals in both collection and interpretation at the regional and local health authority level and included them in dissemination, which supported implementation. In **Norway**, the national reference group with representatives from patient organisations, GPs, policymakers and researchers discussed the results from the PaRIS survey and helped contextualise the results. The Norwegian Institute of Public Health and the patient organisations also collaborated on a research news article about OECDs Flagship report and with comments on the main Norwegian results. **Portugal's** ministry-hosted stakeholder dialogue brought together the ministry, ACSS, patient and practice stakeholders and translated the findings into three concrete policy priorities and a plan for follow up (Section 2). In **Switzerland**, the advisory body ensured the results were interpreted through a regional lens, emphasising the canton-specific perspective to reflect heterogeneity in service organisation and to guide targeted follow-up. **Wales** drew on well-developed links with national clinical networks and clinical leads from local health boards who they regularly worked with to interpret results and guide system-level transformation.

Limited familiarity with PROMs and PREMs constrained communication and policy use, but targeted engagements promoted further understanding

In many countries, a lack of familiarity with patient-reported indicators and their use constrained dissemination and communication of PaRIS results among healthcare professionals and policymakers. In **Czechia**, PROMs and PREMs methodology and use was new for primary care and further communication was considered a priority. **Greece** reported limited familiarity among stakeholders and a need to deepen health literacy on PREMs and PROMs; while discussion has started, understanding was not yet at a level that supports everyday decision and policymaking. Limited familiarity among patients with patient-reported measures also affected dissemination. Greece reported patients were not aware of the importance of assessing their own experience, due to the lack of tradition in collecting patient-reported experience measures, making participation and understanding a priority for future initiatives. In **Saudi Arabia**, uncertainty about the meaning and application of patient-reported data, combined with the newness of the project, left providers unsure how to use results for decision making and what policy actions to take from the first cycle.

Targeted engagement with stakeholders can promote further understanding of patient-reported measures

Targeted engagement of stakeholders on patient-reported measures could help address barriers and make findings more actionable. **Greece** explicitly addressed the lack of familiarity with patient-reported measures by convening dedicated sessions to explain what PROMs and PREMs capture and how they can be integrated into routine practice. Additionally, for patients, Greece is making participation and understanding of patient-reported measures a priority for future initiatives.

Other countries also spoke directly to healthcare professionals to build familiarity and contextualise results. **Luxembourg** is planning workshops and seminars with healthcare professionals to take discussions beyond infographics and general feedback. **Saudi Arabia** organised general information webinars as part of their webinar series, focussing on introducing PROMs and PREMs. This approach plans to increase awareness and knowledge ahead of the wider distribution of the international and national results. **Slovenia** presented results to healthcare centres during an education week on quality in healthcare. **Wales** brought tailored findings to NHS clinical group meetings and adjusted messages to the needs of each audience. These approaches can help strengthen understanding and support more confident use of patient-reported evidence over time.

Limited resources hampered dissemination and use, while the use of international resources have the potential to support countries

Limited analytical capacity, the absence of dedicated dissemination budgets and the scale of the dataset constrained further use of PaRIS results. In **Australia**, the significant time and resources required to interpret, contextualise and disseminate results to multiple stakeholder groups proved to be a barrier in dissemination. In **Greece** analysis fell largely to two academic leads and the lack of a dissemination budget made it difficult to plan and resource activities. In **Iceland**, a university-led two-person team faced limited capacity to analyse and translate findings. In **Italy**, plans to incorporate PREMs at the national level are slowed by the absence of digital infrastructure and incomplete data flows across regions. In **Saudi Arabia**, the size and complexity of the dataset challenged stakeholders' ability to interpret results without additional synthesis. **The Netherlands** cited a limited budget as a limitation to dissemination and use of the PaRIS results. In **Wales**, the team reported they would have liked to do more dissemination and data analysis however the small team restricted the amount that could be undertaken.

Use of PaRIS-10 Indicators helped countries guide their outputs

The PaRIS-10 indicators were widely used by countries and guided dissemination and communication in many national reports. Many countries, including **Australia and Belgium**, used the PaRIS-10 as a core frame for reporting to the community, with the radar chart providing a quick way to communicate comparative performance. Additionally, the metrics are being taken further, with **Norway** integrating selected PaRIS-10 indicators into its PREMs survey and **Spain** planning a report on each of the ten indicators in the Spanish context. The use of these metrics provided a common foundation for countries to structure their dissemination.

Countries expressed a desire to increase research collaboration between participating countries to enrich academic results

Countries indicated that collaboration on academic research could help extend capacity and enrich outputs. **Norway** noted that planning and co-ordinating research projects with similar goals across more than one country will strengthen academic research and add value. **Wales** expressed interest in more international collaboration so that when one country invests in a topic others can align, and the combined output is richer. Cross-country work is already emerging, with **Belgium, Luxembourg and Switzerland** undertaking a joint study on perceptions of care co-ordination. These collaborative approaches can share analytical effort, support common methods and produce findings that are more useful for policy.

Including a budget line for dissemination and release of results can ensure broader outreach

Allocating dedicated resources for dissemination helps teams plan design, production and timely release of outputs. **Australia** engaged with established media contacts through the Commission's communications team to obtain media coverage of the PaRIS initiative and the Australian results. In **Canada**, teams noted increased engagement among decision makers when results were accompanied by clear visuals or practical tools and noted that allocating specific resources to dissemination was essential. One provincial team employed a graphic designer who developed templates that were reused by other provinces, which expanded impact. Teams also highlighted that the window of opportunity following a major release is short, so effective dissemination strategy was important. **Greece** aims to address constraints in resourcing for dissemination by requesting additional funds for dissemination in a second cycle. These experiences indicate that a defined budget line for dissemination can improve accessibility, timeliness and uptake of results.

Competing national priorities hampered the use of PaRIS results while alignment with national reforms and capacity enabled it

In several countries, pressures on healthcare access and the workforce reduced the space to act on PaRIS insights and made it harder to keep PaRIS findings prominent in policy discussions. In **Canada**, policy attention is concentrated on access to care, and the fiscal climate with federal staffing reductions and provincial deficits has made it challenging to prioritise new patient-experience measurement when there are immediate issues such as keeping emergency departments open and addressing workforce pressures. Similarly, **France** mentioned the policy priority of access difficulties, notably in medical deserts. **Portugal** described the same challenge of agenda-setting, noting that media and political pressure around the lack of family doctors and overloaded emergency departments kept access above quality in the hierarchy of priorities. **Romania** indicated that financial constraints, alongside wider contextual pressures beyond the national health system, constrained the use of PaRIS results for policy development. In **Slovenia**, public roundtables with patients and clinicians quickly centred on workforce shortages and why people could not

see their chosen family doctor, making it difficult to communicate the results without first addressing those immediate problems. In addition, the variations in response rates across countries made some countries like **Belgium, France and Norway**, more cautious about the use of data for health policies.

The European Union funded National Recovery and Resilience Plans (NRRP) have also shaped timelines and priorities for PaRIS at the national level, especially in digital health. In **Portugal**, NRRP projects took precedence, so a national platform for PREMs and PROMs was deferred because it was not in the initial plan; the intention is to use PaRIS indicators to specify standards and integration once NRRP milestones are met. Conversely, in **Italy**, NRRP funding accelerated digital health investment, and authorities plan to use PaRIS Cycle 2 to assess whether these investments improved access, experience, continuity and equity across regions.

In addition, the waiting period between the data collection and the publication of the flagship results challenged countries in maintaining momentum with stakeholders and policymakers. In **Australia**, the time to receive the international results and reporting materials, constrained the national project management teams capacity to provide timely reporting to participating practices. In **Canada**, the waiting for the international results also challenged the national project management team to keep policy attention on PROMs, PREMs, and their use for policymaking. In **Norway**, the nearly 2-year waiting period between measurement and the release of results made it challenging to keep the attention of participating general practitioners, ultimately resulting in little interest in provider level reports when the results were published.

Countries aligned PaRIS with their national priorities and joined forces with other stakeholders

Implementation of PaRIS was influenced by existing data institutions, performance monitoring capacity and alignment with ongoing reforms. Countries engaged national statistical and analytical bodies to leverage data and ensure compliance. In **Czechia**, work with the national institute of health statistics helped navigate GDPR and regulatory requirements, with planned co-ordination on efforts to embed PROMs and PREMs in routine monitoring. In **Greece**, collaboration with the national statistical service supported access to and interpretation of data for policymaking; and in **Wales**, Digital Health and Care Wales led data management, digital infrastructure and analysis. Some countries like **Spain, Norway and Wales** excelled at implementing PaRIS in their national context, reaching the target sample size. Extra sampling in Wales enabled them to conduct further analysis on the national dataset to gain a better understanding of policy priorities.

Capacity to act on findings was strengthened where performance and quality monitoring institutions were readily available: in **Belgium**, PaRIS data will be used by the Belgian Health Care Knowledge Centre (KCE) to report on care evaluation, including primary care performance. Alignment with national strategies further supported uptake: in **Czechia**, PaRIS complemented an ongoing primary care reform and provided evidence to continue and strengthen the reform; in **Greece**, PaRIS ran in parallel with initiatives to reorganise primary healthcare; and in **Slovenia, Portugal, Saudi Arabia**, national efforts on primary care and patient-reported measurement were co-ordinated with PaRIS.

Fragmented national governance of PaRIS made policy use more challenging, while closer link among different bodies supported translation into action

Where implementation teams sat apart from decision levers, or where authority was devolved, the use of PaRIS results proved more difficult. In **Canada**, the provincial and territorial organisation of the health system, combined with geographic spread, required a dedicated project lead in each jurisdiction to liaise with ministries and health authorities and this dispersed set up made translation of PaRIS results into practice more complex. In **Spain**, the devolution of healthcare delivery to autonomous communities meant

the Ministry of Health, which was responsible for PaRIS, reported difficulty in tracking or co-ordinating the use of PaRIS data, creating a gap between evidence generation and operational change. Similarly in **Switzerland**, responsibility for healthcare delivery is distributed across 26 cantonal health systems. Therefore, there is limited decision making capacity at the federal level on quality and service delivery, making the use of PaRIS data more challenging. In addition, some countries noted that a liaison function alone was not sufficient; strong ministry buy-in, timely communication and action as well as shared ownership were needed to translate findings into practice.

Greater collaboration between national project managers and policymakers enhanced the use of results for health policies

Tighter co-ordination between national project managers and policy leaders helped move from findings to concrete steps and mitigated some of these constraints. In **Slovenia**, the deputy project manager was responsible for national implementation and liaised with international affairs and finance, while the Ministry of Health acted as an enabler by helping prepare dissemination and convene stakeholders. The government also provided visibility that drew the right actors into the discussion. In **Portugal**, the national project manager sat within the Ministry of Health and now serves as Director-General for Health, and a close consortium with the funder ACSS and subsequent policy dialogue helped turn results into concrete priorities.

Institutionalising PaRIS can help address competing priorities and dispersed authority by establishing routine processes for data collection and use. In **Portugal**, a ministerial decree to formalise governance would clarify responsibilities across agencies and support continuity across political cycles (see Section 4). Steps like these ensure PaRIS remains embedded in national systems and can continue to inform policy and practice over time. In **Norway**, a long-standing and close dialogue between the Ministry of Health and the Norwegian Institute of Public Health on the PaRIS initiative helped ensure that findings from the flagship report were taken up in central policy initiatives, including their timely inclusion in a white paper on the future of general practice services.

From PaRIS data to supporting health policy: Key recommendations

PaRIS has changed the PROMs and PREMs landscape both at the international and national levels. Beyond the international publications and activities, countries produced national reports, academic papers, infographics and organised policy dialogues, stakeholder events and bespoke meetings. One year after the release of the flagship report, PaRIS data and results have served as a useful source of evidence for policy discussions.

Key lessons learned highlight that PaRIS Cycle 2 will be stronger when stakeholders are engaged at the very beginning in a continuous manner, as well as when knowledge and training are strengthened among patients, healthcare professionals and policymakers. Careful planning for budgeting, including dissemination and communication plans, as well as the use of international and cross-country resources will further support dissemination. The learnings also stress that a closer link between national project management teams and policymakers is beneficial so that PaRIS can align with and address policy priorities in a timely manner. Sustainability through systematic collection of PROMs and PREMs data across PaRIS cycles remains essential to move from data to health policy. Box 1 shares the recommendations to assist countries in their next steps for moving from PaRIS data and results to quality improvement in primary care.

Box 1. Data to health policy: Recommendations based on the OECD PaRIS

The findings from this report highlight several **short- and medium- term recommendations** for countries to strengthen the uptake of PaRIS at the national level:

- **Convene a stakeholder group from early stages:** Relevant stakeholders should be mobilised to discuss the study design in the national context, support recruitment and data collection, disseminate results, interpret findings, and develop policy priorities. Such a stakeholder group should include patients, healthcare professionals and other key stakeholders in the national context.
- **Plan the communication and dissemination strategy ahead of time:** Such a strategy should be developed with the stakeholder group and included as a budget line during project planning. The strategy should also consider the team composition and the relevant resources needed to realise the strategy, for example a communication officer, graphic designer or behavioural scientist.
- **Ensure close collaboration between policymakers and project team:** Establishing a steering committee that includes key actors in the implementation and use of results can strengthen impact. Such a committee should include the Ministry of Health, the national project manager (if not sitting at the ministry) as well as key national authorities and providers.
- **Increase knowledge on PROMs and PREMs among patients, healthcare professionals and policymakers:** Learning sessions should be planned to increase awareness, knowledge and learning capacity among key stakeholders including patients, healthcare professionals and policymakers. Invite key experts on the topic for the learning session to share high-level information as well as concrete examples of how to collect, communicate and use PROMs and PREMs.

The findings also point to several **recommendations whose implementation will depend on continued, long-term investment and effort:**

- **Commit to systematically assessing PROMs and PREMs at the national level:** A national plan should prioritise the collection and use of patient-reported measures to assess the performance and quality of healthcare system. Maximise cross-country learning opportunities across PaRIS cycles through targeted collaborations.
- **Invest in sustained systems (institutionalise) to systematically collect PROMs and PREMs data:** Interoperability in data systems should be achieved to link data across databases to improve interpretability of the findings in the broader national context. Prepare legal frameworks, where needed, for governance and sustainability.

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Annex A. Design process of PaRIS

PaRIS followed a structured collaborative design process

PaRIS has been developed through a multi-year design process (2018-2024) combining extensive collaboration with national stakeholders, methodological development, and systematic cross-country testing. This strong foundation ensures the reliability and comparability of the patient-reported measures generated through Cycle 1. Before large-scale implementation, PaRIS instruments underwent a multi-country Field Trial (van den Berg et al., 2024^[11]), which provided key evidence on sampling, questionnaire performance and fieldwork logistics. Feedback from national project managers, the former PaRIS-SUR Consortium and other stakeholders informed refinements for the Main Survey.

The development of PaRIS questionnaires followed a rigorous process and collaborative procedure

The PaRIS conceptual framework was co-developed with policymakers, patients, primary care professionals and academics (Valderas et al., 2024^[12]). It reflects the understanding that patient outcomes and experiences depend not only on individual factors, but also on primary care organisation and broader system contexts. PaRIS uses two complementary questionnaires: the Patient Questionnaire (PaRIS-PQ), covering PROMs, PREMs, health behaviours, demographics and chronic conditions, and the Primary Care Practice Questionnaire (PaRIS-PCPQ), covering care organisation and chronic care management (Valderas et al., 2025^[13]; Bloemeke-Cammin et al., 2024^[14]). Both underwent translation and cognitive testing using the TRAP-D model (Harkness, Vijver and Mohler, 2003^[15]) and were piloted in the Field Trial before finalisation.

Key stakeholders have been engaged in PaRIS since its early stages

PaRIS was built through co-creation with countries and experts to ensure the instruments reflected diverse health system priorities (Kendir et al., 2023^[16]; Kendir et al., 2024^[17]). National experts, academics, primary care professionals and patient representatives helped shape the conceptual framework so that indicators reflected what matters most to patient (Valderas et al., 2024^[12]).

- Established in 2018, the Patient Advisory Panel ensured that PaRIS remained centred on patient priorities (Barlow-Noone et al., 2025^[18]). The panel refined questionnaire items, advised on accessibility and respondent burden, and guided how findings should be communicated from a patient perspective.
- The Primary Care Professional Network ensured that the survey was feasible and aligned with routine clinical practice (Kendir et al., 2024^[17]). Its members supported practice engagement, identified implementation challenges and helped interpret results in light of clinical workflows and care models.
- The International Expert Group provided methodological oversight throughout development and implementation. Its guidance ensured scientific rigour, cross-country comparability and robust analytical approaches, supporting credible and policy-relevant interpretation of results.

Annex B. Interview participants

Table A B.1. List of contacts who participated in the interviews

Country	Names	Affiliation
Australia (sent a written response)	Kerryn Viana	Australian Commission on Quality and Safety in Healthcare
Belgium	Dagmar Annaert	Sciensano
Canada	Marie-Eve Poitras	Université de Sherbrooke
	Sabrina Wong	University of British Columbia/CPCRC
Czechia	Bohumil Seifert	Charles University
	Ladislav Vilček	Ministerstvo Zdravotnictví České Republiky
France (sent a written response)	Denis Geleyn	Direction de la Recherche, des Études, de l'Évaluation et des Statistiques (Drees)
Greece	Daphne Kaitelidou Olga Siskou	University of Athens
Iceland	Herdís Sveinsdóttir	University of Iceland
	Inga Þórsdóttir	University of Iceland
Italy	Modesta Visca	Istituto Superiore di Sanità
	Massimiliano Gallo	Istituto Superiore di Sanità
	Milena Vainieri	Scuola Superiore Sant'Anna
	Elisa Conti	Scuola Superiore Sant'Anna
Luxembourg	Aline Lecomte	Luxembourg Institute of health
	Mohammed Iddir	Luxembourg Institute of health
Netherlands (sent a written response)	Judith de Jong	Netherlands Institute for Health Services Research (Nivel)
Norway	Øyvind Andresen Bjertnæs	Norwegian Institute of Public Health
Portugal	Andre Peralta Santos	Portuguese Ministry of Health
Romania	Florin Ciocan	Autoritatea Națională de Management al Calității în Sănătate
	Gratiela Denisa Iordache	Autoritatea Națională de Management al Calității în Sănătate
Saudi Arabia	Sara Al Munif	Centre for Value in Health
Slovenia	Vesna Zupancic	Ministry of Health
	Zalika Klemenc-Ketiš	Community Health Centre Ljubljana
Spain	Iria Rodriguez	Ministerio de Sanidad
Switzerland	Chantal Arditi	Unisanté
	Isabelle Peytremann-Bridevaux	Unisanté
Wales	Sarah Puntoni	Welsh Value in Health Centre
	Christian Newman	Welsh Value in Health Centre
United States	Marina Vormovitsky	Centres for Medicare and Medicaid Services (DHHS)

Annex C. Semi-structured interview guide

PaRIS

Patient Reported Indicator Surveys

This is a document by the OECD Secretariat for the purpose of informing participants of the background and proposed questions for the PaRIS from Data to Health Policy interviews.

Background

The aim of this interview is to explore how countries use PaRIS data and results from Cycle 1 in their national quality and performance improvement initiatives.

The interview has two objectives: 1) to examine the policy and practice impact of PaRIS, identifying concrete examples of good practices and 2) to enable cross-country learning by gathering insights on effective mechanisms that support the use of PaRIS data.

The results of this work will be presented in a detailed report describing the mechanisms and operational approaches that help transform PaRIS data into meaningful policy and practice impact.

To elucidate how countries are using and applying the PaRIS data, the following interview guide was based on the **Knowledge to Action framework**.² This framework consists of seven-stage action cycle which represents the activities that are needed for knowledge application.

The OECD PaRIS team.

Interview guide

Introduction and understanding national context

Can you tell us briefly about your role in PaRIS in your country?

Could you expand upon the involvement and role of others (such as any stakeholder groups) in the project in your country?

Dissemination and Communication

Could you tell us about the activities organised over the past year to interpret the PaRIS findings for the audience in your country?

Could you tell us how you contextualised the PaRIS results to better suit your country context?

Could you tell us a bit more about how you experienced enablers and barriers to disseminating the PaRIS results?

Using PaRIS data and insights

Could you describe any instances where the PaRIS results informed policy discussions or was a useful source of information for policymakers?

Could you tell us more about the use of PaRIS data and insights by healthcare providers, regional authorities, or primary care networks?

Can you describe some early programmatic or implementation-level impacts that the PaRIS results have had in your national context? (e.g. Digital Health & Surveillance, Primary Care Planning, Service Redesign and Program Adaptation).

Monitoring, evaluation and sustainability

Recognising that implementation may still be at an early stage, can you tell us a bit more about how the long-term impact of PaRIS will be monitored?

Will PaRIS data be integrated into ongoing national quality and performance improvement systems?

What steps are being taken to ensure sustained use of PaRIS data and results? (e.g. being part of national performance indicators, incorporated into accreditation and certification programmes, incorporated into continuous professional development).

Future directions and next steps

What additional information (data points or metrics) might increase the relevance of PaRIS findings to your health policy and practice activities?

Is there anything we have not covered that you think is important?

Do you have any other questions for us?

Annex D. Interview analysis framework

The interview guide was structured around the Knowledge-to-Action Framework (Graham et al., 2006^[8]) to assess how PaRIS evidence was disseminated, interpreted and used in policy and practice. The framework recognises that knowledge translation is not linear: its stages are dynamic, interconnected and may occur in any order depending on national context.

Table A D.1. Knowledge to Action stages applied to the interview guide

Stage on Cycle	Question Asked
Adapt knowledge to local context	Explores how PaRIS (Patient-Reported Indicator Surveys) findings were interpreted and tailored for national audiences, aligning messages and formats with domestic health-system priorities and communication needs
Identify problem	Explores how PaRIS results surfaced priority policy issues and evidence needs, informing agenda-setting for policymakers and practitioners
Assess barriers to knowledge use	Examines the conditions that facilitated or impeded dissemination and implementation
Select tailor implement interventions	Explores how PaRIS insights were translated into concrete policy and service-delivery actions, including use by policymakers, practitioners and regions, and early implementation decisions (e.g. digital health, planning, service redesign)
Monitor knowledge use	Identifies the outcome measures and additional metrics needed to appraise the effects of PaRIS-informed actions on policy and practice
Evaluate outcomes	Additional information on what was missing or what could be added into Cycle 1
Sustain knowledge use	Explores steps taken or planned to embed PaRIS in routine operations, including performance indicators, accreditation and continuing professional development

Source: Adapted from Graham et al. (2006^[8]), “Lost in knowledge translation: Time for a map?”, <https://doi.org/10.1002/chp.47>.

Notes

¹ PaRIS website, <https://www.oecd.org/en/about/programmes/patient-reported-indicator-surveys-paris.html>.

² See Graham et al. (2006^[8]).

Improving quality of care through the OECD Patient Reported Indicator Surveys (PaRIS)

Using patient-reported data to support health policy

The OECD Patient-Reported Indicator Surveys (PaRIS) demonstrate the value of patient-reported outcomes and experiences in strengthening people-centred primary care. Drawing on evidence from the 19 countries which participated in the first cycle of PaRIS, the report shows how results are already informing reforms in care co-ordination, digital health and quality monitoring. The report highlights key enablers such as early engagement, clear governance, communication planning and sustained investment to integrate patient-reported outcome and experience measures (PROMs and PREMs) into healthcare system performance assessment.