Policy Paper

Comparing patient-reported outcome and experience measures in international health surveys

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Abstract

As healthcare systems increasingly prioritise people-centred care, patient-reported data have become central to assessing health system performance. The OECD Patient-Reported Indicator Surveys (PaRIS) initiative supports international comparison and cross-country learning by developing, standardising and collecting harmonised data on patient-reported outcome and experience measures (PROMs and PREMs) from primary care users and their practices across OECD Member and Partner countries. Beyond PaRIS, other international population-based health and health system surveys include the European Health Interview Survey (EHIS), the International Health Policy (IHP) Survey of the Commonwealth Fund, the People's Voice Survey (PVS) and the Survey of Health, Ageing and Retirement in Europe (SHARE). Although these surveys may appear to collect similar information, they differ substantially in purpose, scope and methodology. This paper positions PaRIS within this wider ecosystem, examining its distinctive value proposition and the benefits of participating in PaRIS alongside existing international surveys, based on methodological comparisons and analyses of overlapping indicators.

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Contact

Candan Kendir (✉ candan.kendir@oecd.org)

Isaura Gutiérrez Vargas (✉ isaura.gutierrezvargas@oecd.org)

Nicolás Larrain (✉ nicolas.larrain@oecd.org)

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Executive summary

International surveys of patient-reported outcome and experience measures (PROMs and PREMs) have become indispensable tools for monitoring people-centredness of healthcare systems, promoting cross-country benchmarking and learning. For policymakers, choosing the right source of information to answer a policy question is not always straightforward. Key factors to consider include whether different initiatives overlap or complement each other, how their results compare, and what unique insights each offers for understanding and improving the performance of health systems.

For the Patient Reported Indicator Surveys (PaRIS), OECD Member and Partner countries work together to collect harmonised PROMs and PREMs from primary care users and their primary care practices. PaRIS uses a two-stage approach, first sampling primary care practices and then patients within those practices. This links patients to the practices where they receive care, allowing outcomes and experiences to be analysed both at the individual level and in relation to how care is organised and delivered.

This paper compares five international patient and/or population health surveys: *PaRIS, the European Health Interview Survey (EHIS), the Commonwealth Fund International Health Policy (IHP) Survey, the People's Voice Survey (PVS) and the Survey of Health, Ageing and Retirement in Europe (SHARE),* which collect data on PROMs and/or PREMs in addition to other indicators. These five surveys represent major sources of comparable self-reported data currently available across OECD countries and beyond.

This report presents results from a comparative analysis based on (1) a comparison of survey design, methodology, target population and conceptual orientation; and (2) a comparison of indicators. The indicator comparison comprised three steps: domain mapping, item-level crosswalks and response-scale harmonisation. First, each question was assigned to an overarching domain. For PaRIS, this followed the PaRIS conceptual framework; for other surveys, questions were mapped to the closest PaRIS domain based on the underlying concept measured. Second, questions within the same domain were paired by topic and assessed for conceptual similarity, wording, reference period and response structure. Third, where items were sufficiently comparable, response categories were harmonised into a binary indicator identifying whether respondents selected one of the two most favourable response options. This "top-three-box" approach was used only when the original scales had the same number of categories and the same number of positive response options. The final set of indicators was restricted to cases where observed differences between surveys for the same country and as-close-as-possible populations could plausibly be interpreted in light of differences identified in the first stage.

Only a limited number of indicators could be harmonised. Of these, a smaller subset including self-rated health and experienced quality of care was selected for detailed comparison based on substantial country coverage across surveys. The emerging key findings show that:

- **International surveys collecting data on PROMs and PREMs offer complementary policy insights.** Population-based surveys such as EHIS and SHARE are designed to monitor health status, behaviours and inequalities across broad populations. Experience-focussed surveys like the IHP survey and PVS, offer timely information on access, affordability and perceived system performance. PaRIS is designed to generate granular and actionable insights on the healthcare system's performance on elements that matter for people with chronic conditions in primary care such as on care co-ordination, outcomes, person-centredness and self-management.

- **Design features shape each survey's policy value and analytical potential.** PaRIS is the only survey with a nested, multilevel structure that links patient-reported measures to primary care practice characteristics, enabling analyses of variation and practice-level improvement levers. SHARE's longitudinal panel design supports analysis of trajectories over time, while rapid-cycle surveys such as the IHP survey and PVS prioritise timeliness and responsiveness.
- **Variation in response rates reflect differences in sampling and fieldwork.** EHIS achieves comparatively high participation because it is delivered through national statistical systems with established data-collection infrastructures. PaRIS maintains relatively strong response rates in most countries by recruiting patients through primary care practices using a two-stage approach. The IHP survey and PVS tend to have lower response rates. SHARE, a longitudinal panel, benefits from following the same respondents across different waves, but requires more complex, resource-intensive recruitment and follow-up.
- **Only a few domains overlap across surveys.** PREMs are included primarily in PaRIS, the IHP survey and PVS while PROMs align more closely across PaRIS, EHIS and SHARE. Only a few indicators overlap across surveys such as experienced quality of care, self-rated health and confidence to self-manage.
- **The share of people reporting positive outcomes differs substantially across surveys, but absolute levels are not directly comparable.** In addition to the methodological differences, these differences also arise because surveys use slightly different question wording and response scales. For example, self-rated health is measured using "excellent to poor" in PaRIS and "very good to very bad" in EHIS, while experienced quality of care is framed as quality ratings in PaRIS and PVS but as satisfaction levels in the IHP survey.
- **Self-rated health**, measured as the percentage of respondents reporting positive outcomes, showed up to 30 percentage points (p.p.) differences between PaRIS and other surveys after restricting to comparable populations and standardising results. In Romania, 43% of patients with chronic conditions reported good health in PaRIS compared to 13% in EHIS. In Greece, 69% of patients with chronic conditions reported good health in PaRIS compared to 46% in PVS.
- **Experienced quality of care**, measured as the percentage of respondents reporting good quality of care, also showed differences between PaRIS and other surveys reaching up to around 17 p.p. in crude comparisons and remain substantial after restricting to comparable populations and standardising results. For example, in Canada, around 79% of patients with chronic conditions reported good quality of care in PaRIS compared to 62% in the IHP survey.
- **Indicators are highly sensitive to differences in the concepts captured by survey questions, even when wording appears similar.** For example, PaRIS measures confidence to manage one's health, while PVS measures the extent to which individuals "feel responsible" for managing their health. Although related, these questions capture different aspects of self-management, resulting in large differences of 20-60 p.p. across surveys.

These findings underline that differences in levels across surveys reflect differences in survey design, target population and measurement. Therefore, policymakers should avoid directly comparing absolute values across surveys and instead use each source for the policy question it is best suited to answer. EHIS can be used to identify population groups with poor health status or unmet needs, rapid surveys such as the IHP survey or PVS can be used to monitor public perceptions of access and system performance. PaRIS adds a distinctive and policy relevant lens with granular information by linking patient-reported measures with how primary care is organised and delivered. When used thoughtfully and in combination with other international data sources, these surveys can substantially strengthen evidence-informed policymaking and support the transition toward more people-centred, high-performing health systems.

1 The patient voice in health policymaking

In recent decades, policymakers and health authorities have increasingly shown interest in transitioning to a people-centred healthcare model, putting the needs and preferences of patients at the centre of care delivery and performance management (OECD, 2021[1]). Reflecting this shift, the renewed OECD Health System Performance Assessment Framework positions people's health needs and preferences both as an objective of health systems, and as a key lever for achieving other policy objectives (OECD, 2024[2]). Although healthcare systems aim to maximise the health and well-being of the people they serve, few systematically assess their performance from people's perspectives. Traditional performance measures have focussed on inputs (such as the number of healthcare professionals), processes (such as the number of prescriptions) and clinical and biomedical outcomes such as mortality or morbidity rates. While this information is highly valuable, an essential piece of information is missing, namely data from the patient perspective.

Patient-reported outcome and experience measures (PROMs and PREMs) have been increasingly filling this gap by assessing health outcomes and care experiences of people through validated standardised tools, without the interpretation of a healthcare professional or others (Valderas and Alonso, 2008[3]). PROMs capture patients' perspectives on health status, physical and social functioning, symptom burden, and psychological well-being. PREMs capture care experiences and interactions with healthcare professionals including communication, co-ordination, shared decision making, and respect.

Patient-reported data, collected through PROMs and PREMs, serve multiple functions across different levels of the healthcare system. At the clinical level (micro), PROMs and PREMs can offer useful insights into individual patients' outcomes and experiences, and improve communication between patients and healthcare professionals, and shared-decision making (Forefront Group, 2019[4]). At the organisational level (meso), aggregated results can inform care delivery and enhance the quality of care (Greenhalgh et al., 2017[5]). At the system level (macro), aggregated results can be used for assessing the performance of healthcare systems in delivering quality of care (Ernst et al., 2022[6]; Kendir et al., 2025[7]; Kendir et al., 2022[8]; Kendir et al., 2026[9]; Kendir et al., 2025[10]).

1.1. International data collections provide standardised and harmonised data, allowing cross-country comparison and learning

International data collections can produce standardised, harmonised datasets, facilitating benchmarking and cross-country learning. The OECD's flagship publication Health at a Glance, published on a biennial basis, includes a set of standardised performance indicators for international benchmarking of healthcare systems' performance on access, quality and health financing (OECD, 2025[11]). Since 2017, a selected set of PROMs and PREMs have been collected through national and subnational data sources and reported internationally in Health at a Glance to benchmark the quality of care from the patient perspective. These indicators include PREMs, patient-reported incidence measures (PRIMs), patient-reported quality of life before and after hip and knee replacement surgery, care experiences among people with mental

health conditions and satisfaction with outcomes following breast cancer surgery (OECD, 2023[12]; OECD, 2021[13]; OECD, 2019[14]). Yet, the international comparability has remained limited due to variations in data sources and methods as well as the limited set of countries which were able to report such patient-reported data (Kendir et al., 2022[8]; de Bienassis et al., 2022[15]).

OECD Member and Partner countries work together in the Patient Reported Indicator Surveys (PaRIS) initiative to develop, standardise and collect harmonised data on PROMs and PREMs from primary care users (OECD, 2025[16]). Following an extensive design and development phase, co-developed with patients, healthcare professionals and academic experts, PaRIS collected data from over 107 000 primary care users in 2023-2024 (van den Berg et al., 2024[17]; Kendir et al., 2023[18]; Kendir et al., 2024[19]). Based on the PaRIS conceptual framework, the questionnaires collected information on patients' physical and mental health, social functioning, well-being, general health, experienced care quality, care co-ordination, people-centredness, trust, as well as sociodemographic characteristics and health behaviours and capabilities (Valderas et al., 2024[20]; Valderas et al., 2025[21]). Complementing the patient questionnaire, a primary care practice questionnaire was used to collect information from their primary care practices regarding the provision of care, allowing analysis of characteristics of primary care associated with better health outcomes and care experiences (Bloemeke-Cammin et al., 2024[22]).

While PaRIS has become an essential source of information, it is not the only international initiative collecting data on PROMs and PREMs. Policymakers have other sources of information at the international level such as International Health Policy (IHP) Survey of the Commonwealth Fund survey, People's Voice Survey (PVS) and European Health Interview Survey (EHIS) (Commonwealth Fund, 2024[23]; Eurostat, 2019[24]; Lewis et al., 2023[25]). While these initiatives may appear to collect similar types of information, they differ in their purpose, scope and methods. This abundance of information can create complexity for policymakers and hamper the selection of the right source of information for a given policy question. Key factors to consider include whether different initiatives overlap or complement each other, how their results compare, and what unique insights each survey offers for understanding and improving the performance of healthcare systems. This paper provides guidance to policymakers on choosing the most relevant data sources for specific policy needs.

This paper compares five major international surveys collecting PROMs and PREMs: OECD's PaRIS, EHIS, the IHP survey, PVS and SHARE. It examines the distinct value proposition of each survey and compares the results across a selected comparable set of indicators. These surveys are selected based on their large international scope and visibility, as well as on the availability of information on the methods and microdata on PROMs and/or PREMs.

Section 2 details the methodological comparison of these selected surveys, including the conceptual domains and questionnaire items assessing PROMs and PREMs. Section 3 compares the results on a selected set of comparable indicators across PaRIS, EHIS, the IHP survey and PVS, and presents the results on selected indicators through strict harmonisation and standardisation. Section 4 provides an overview of the unique value of each survey and includes recommendations for policymakers.

2 Comparing methodologies of five international surveys

Over the past decade, international health surveys have converged towards the use of common, standardised and validated PROMs and PREMs. For example, PaRIS integrates PROMIS® Global Health items including pain and fatigue, the WHO-5 Well-being Index, and P3CEQ, while EHIS employs WHO-5 and PHQ-8, and the IHP survey includes selected PROMIS pain and fatigue items. While the instruments used across these surveys may appear similar at first glance, important differences in the projects' scope, purpose and methodological choices can lead to divergent results that require careful interpretation. This section outlines the characteristics of PaRIS, EHIS, the IHP survey, PVS and SHARE and makes comparisons of their purposes, scopes and methods.

This section provides a structured comparison of PaRIS with EHIS, the IHP survey, PVS and SHARE, highlighting key design features and methodological choices. Differences in survey objectives, target populations, sampling strategies, data collection modes and analytical frameworks shape the type of insights these surveys can generate and the policy questions they can answer. By clarifying where approaches converge and where they diverge, the section lays the groundwork for subsequent analyses of overlapping indicators and supports policymakers in selecting the most appropriate data source for their specific policy questions.

2.1. While all surveys share the overarching goal of improving health systems, each focusses on distinct dimensions for assessment

While each of these surveys aims to provide policymakers and other stakeholders with actionable, comparable evidence on how well healthcare systems deliver for people, each survey uses different assessment parameters.

- PaRIS is designed to assess primary care performance for people living with chronic conditions by linking outcomes and experiences to practice and system-level features that can be strengthened through international benchmarking and cross-country learning.
- EHIS supports public health and health system monitoring across EU countries by describing population health status, determinants, and healthcare use to guide prevention strategies, resource allocation, and equity-focussed policies.
- The IHP survey aims to benchmark access, affordability, care co-ordination, patient experience and system responsiveness across several countries, helping decision makers identify reform priorities and learn from peer systems.
- PVS focusses on measuring utilisation, care quality, system competence, and population confidence in the health system to enhance accountability.
- SHARE primarily informs ageing and social policy by tracking the health, functional status, economic security and care needs of older populations over time, supporting decisions on long-term care, pensions, workforce participation and the sustainability of health and social systems.

Taken together, these differences in purpose highlight that the surveys are largely complementary rather than redundant, and that combining evidence across initiatives is often necessary to support policy-relevant insights.

The distinct but complementary purposes of these surveys make them mutually reinforcing (Box 1). While population-based surveys reveal who is at risk, patient surveys assess how healthcare performs from the perspective of its users. PaRIS focusses on collecting harmonised PROMs and PREMs from primary care users and their practices, with an explicit emphasis on international comparability and policy relevance regarding chronic care across Member and Partner countries. EHIS is a European Union (EU)–wide household survey designed to monitor population health status, health determinants and healthcare use. The IHP survey provides regular, cross-country insights into health system performance and patient experiences, primarily through population-based surveys. PVS offers a globally applicable framework for capturing health system experiences, including in low- and middle-income settings. SHARE is a longitudinal study in Europe focussing on ageing among older populations, together with health and socio-economic conditions.

Box 1. Key features of the surveys

PaRIS, EHIS, the IHP survey, PVS, and SHARE differ substantially in governance, coverage and methodological scope, which is important for interpreting results across the report.

PaRIS is co-ordinated by the OECD on a voluntary basis. Cycle 1 covered 19 OECD Member and partner countries, focussing specifically on primary care users aged 45 and over with recent contact, using a cross-sectional, two-stage sampling design anchored in primary care practices, and primarily online data collection with mixed-method supplementation.

EHIS is co-ordinated by Eurostat and mandatory under EU regulation. The last round covered all 27 EU Member States and surveyed the general population aged 15 and over in private households using harmonised, multi-stage household samples and predominantly face-to-face interviews.

The Commonwealth Fund's IHP survey targets adults aged 65 and over in selected countries, employing cross-sectional, single-stage probability sampling and primarily telephone data collection.

PVS, co-ordinated by the Quality Evidence for Health System Transformation (QuEST) Network. The last round spanned 25 countries including low- and middle-income settings and surveys the general adult population aged 18 and over, using rapid, cross-sectional data collection, mainly through telephone interviews with mixed-mode supplementation.

SHARE, co-ordinated internationally by the SHARE Berlin Institute, is a longitudinal biennial panel survey. The last round covered 27 European countries plus Israel, targeting individuals aged 50 and over (and their partners of any age), with probability-based sampling from population registers and predominantly face-to-face interviews.

Source: Authors, based on the information provided in Table 1.

The intersection of country coverage across the five international surveys remains limited when examined across their latest data collections (Table 1). PaRIS Cycle 1 includes 19 OECD Member and Partner countries, while EHIS Wave 3 covers EU Member States and selected partners; overlap is therefore concentrated in EU countries participating in PaRIS, namely Belgium, Czechia, France, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Romania, Slovenia and Spain. The People's Voice Survey is implemented along with PaRIS in Greece, Italy, Romania and the United States, and in general PVS has a broader geographic scope in low and middle-income countries. Overlap with SHARE Wave 9 is

restricted to European PaRIS participants, including Luxembourg and Switzerland, while Israel participates in SHARE but not in PaRIS Cycle 1. The IHP survey shows limited overlap with PaRIS, including Australia, Canada, France, the Netherlands, Switzerland and the United States.

Table 1. The intersection of country coverage in the last rounds of PaRIS, EHIS, the IHP survey, PVS and SHARE

	Intersection of country coverage with PaRIS
EHIS	Belgium; Czechia; France; Greece; Ireland; Italy; Luxembourg; Netherlands; Portugal; Romania; Slovenia; Spain; and Norway
The IHP survey	Australia, Canada, France, Netherlands, Switzerland, United States
PVS	Greece, Italy, Romania, United States
SHARE	Belgium; Czechia; France; Greece; Italy; Luxembourg; Netherlands; Portugal; Romania; Slovenia; Spain

All five surveys are based on a core survey-specific framework at the international level for collecting information and are implemented through national teams. However, how surveys are conducted in national contexts depends on different types of implementation agents. These implementation agents range from national statistical offices and academic consortia to health ministries and contracted research institutes. Both PaRIS and EHIS are conducted through official contacts across member countries, while other surveys are conducted through partnerships with research institutes and survey agencies.

2.2. Differences in purpose and scope lead to distinct approaches in survey design and implementation

The target populations differ across surveys (Table 2). EHIS includes people aged 15 and over living in private households and PVS surveys people aged 18 and over. PaRIS, the IHP survey and SHARE target older population groups. The IHP survey's target population varies depending on the focus of each wave driven by healthcare priorities of the period. The latest wave, conducted in 2024, targeted people aged 65 and over. SHARE includes people aged 50 and over living in private households and their caregivers. PaRIS has a distinct focus on people aged 45 and above who had contact with their primary care practice in the six months prior to sampling. This is an intentional feature of PaRIS to focus on older people who are more likely to have chronic conditions, which is the main scope of PaRIS.

These differences in age coverage and eligibility criteria have important implications for comparability. Surveys focussing on older populations are more likely to capture individuals with higher prevalence of chronic conditions, greater healthcare needs and more frequent interactions with the health system, which can influence reported outcomes and experiences. By contrast, broader population-based surveys may include a broader age range and generally healthier individuals, which can be an essential source of information for broader population health issues such as inequalities or health behaviours such as participation in screening activities or smoking. PaRIS uniquely restricts its sample to people with recent contact with primary care, whereas in EHIS, PVS, the IHP survey and SHARE a subset of respondents are recent healthcare users, including non-users as well. As a result, PaRIS indicators are more reflective of experiences of users of services and the impact of healthcare on these, while more general population-based surveys are better able to reflect e.g. prevalence rates in the population or figures on access barriers.

Differences in question frameworks, instruments and recall periods influence both what is measured and how comparable results are across surveys. PaRIS combines validated PROMs and PREMs (e.g. PROMIS, WHO-5, P3CEQ) with care-experience items and with the inclusion of care experiences for relatively short recall windows (e.g. 7 days for symptoms, 2 weeks for well-being, last consultation for specific care experiences and past 12 months for overall care experiences), enabling clinically relevant assessment of outcomes and care processes among recent primary care users. The IHP survey relies more on long-

standing standardised experience questions, with fewer validated outcome scales, focussing on access, co-ordination and affordability. EHIS integrates health status, healthcare utilisation and determinants, including some validated tools (e.g. WHO-5, PHQ-8), generally with longer recall frames suited to population surveillance but without provider-level linkage. PVS uses shorter, general measures centred on overall health perceptions, system confidence and trust rather than detailed clinical outcome instruments, tied to recent experiences or general views. SHARE focusses on health, functioning and socio-economic circumstances in ageing populations using validated scales, but not practice-specific experience measures. Shorter recall periods, as in PaRIS, tend to improve reporting accuracy for recent events but may capture more short-term variation, whereas longer recall periods smooth fluctuations but increase recall bias.

Table 2. Comparing the scope of international health surveys

Dimension	PaRIS cycle 1	EHIS wave 3	IHP (2024 round)	PVS cycle 1	SHARE wave 9
Participating countries	19 OECD Member and partner countries (Australia; Belgium; Canada; Czechia; France; Greece; Iceland; Italy; Luxembourg; Netherlands; Norway; Portugal; Slovenia; Spain; Switzerland; United States, Wales, Saudi Arabia, Romania)	27 EU member states (Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Portugal, Romania, Slovak Republic, Slovenia, Spain, and Sweden) and Norway	10 highly industrialised countries (Australia, Canada, France, Germany, Netherlands, New Zealand, Sweden, Switzerland, United Kingdom, the United States)	25 countries including low and middle income (Ethiopia, Kenya, Nigeria, South Africa, China, India, Laos, Korea, Greece, Italy, Romania, United Kingdom, Mexico, United States, Argentina (Province of Mendoza), Colombia, Peru, Uruguay, Germany, Switzerland, Japan, Ecuador, Somaliland, Malawi, and Nepal)	27 European countries (Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Portugal, Romania, Slovak Republic, Slovenia, Spain, and Sweden) plus Israel
Implementation agent	Co-ordinated by OECD with voluntary country participation, implemented through national project managers appointed by Ministries of Health (e.g. health agencies, academics or research institutions)	Co-ordinated by Eurostat with mandatory country participation under EU regulation, implemented by national statistical institutes	Co-ordinated by the Commonwealth Fund; core and national partners	Led by the QuEST Center at Washington University in St. Louis in partnership with QuEST Network member institutions in each participating country	International co-ordination via SHARE Berlin Institute/MEA; implemented by national survey agencies/research teams
Target Population	Primary care users aged ≥45 with recent primary care contact (6 months)	General population aged ≥15 living in private households	General population aged ≥65	General adult population aged ≥18	Individuals aged ≥50 (and their partners regardless of age)
Survey design	Cross-sectional nested design (patients in practices, which are in countries) with multi-stage sampling: probability samples of primary care practices first, then probability sampling patients of these primary care practices	Cross-sectional with multi-stage design: Probability samples from national population or household registers, drawing household clusters with one adult selected per household	Cross-sectional single stage probability sampling using overlapping landline/cell random-digit-dialling in most countries, with registry samples and probability panels	Cross-sectional. Single-stage probability sampling using random-digit-dialling, probability panels, or known-list sampling, supplemented with household surveys in rural areas	Longitudinal (biennial) panel survey with refreshment samples; Single stage probability-based sampling

Dimension	PaRIS cycle 1	EHIS wave 3	IHP (2024 round)	PVS cycle 1	SHARE wave 9
Sampling Frame	Two-stage: primary care practices from national/regional healthcare provider lists, then patients from practice registries or central databases	National population/household sampling frames drawn by national statistical institutes following Eurostat guidance.	Random-digit-dialling overlapping landline/cell phone frames or population registries	Random-digit-dialling or known-list phone sampling; supplemental face-to-face samples where mobile coverage is low; probability-based panels in some high-income settings	Preferred sampling frame: official person register of the residential population (with age info where available); alternatives used if registers unavailable
Sample Size	Over 107 000 respondents (on average 5 600 per country)	Over 321 000 respondents (On average 7 225 per country)	Over 14 000 respondents ((300-4 000 per country)	Over 70 000 respondents (on average 2 000 per country)	Over 160 000 respondents; regular fieldwork collected ~70 000-72 000
Questionnaire design	Two standardised instruments: patient questionnaire with four main domains (PROMs/PREMs notably for chronic conditions, health behaviours and health capabilities) and a primary care practice questionnaire on characteristics	A harmonised Eurostat questionnaire with four modules: health status, health determinants, healthcare use/unmet needs, and background	A standardised questionnaire with core modules on access, affordability, co-ordination and quality	A standardised questionnaire covering patterns of healthcare use, care quality, user experience, system competence, and confidence in the health system	Core questionnaire covering health, socio-economic status and social/family networks, and wave-specific modules
Data Collection Mode	Digital-first (online) with paper/telephone alternatives	Face-to-face interviewing predominates (CAPI*/PAPI**),	Primarily telephone with online options	Primarily CATI*** with mixed-mode alternatives	Primarily CAPI* with additional telephone interviewing in some contexts
Completion time (average)	30-35 minutes	Estimated* about 25-45 minutes	19-30 minutes	20-25 minutes	Estimated* about 45-90 minutes
Field Period	2023-2024 (for practices on average 11.8 weeks (range: 4-20 weeks); for patients on average 13 weeks (range: 5-27 weeks))	2019 (on average 32 months)	2024 (6-14 weeks per country)	2022-2023 (rapid data collection of 4-8 weeks per country)	2021-2022 with varying country-specific timing
Response Rates	Patients: Median 24% (Country range 6%-42%)	Median 44% (Country range 22-78%)	Median 14% (Country range: 2.8%-50.3%)	Country range 3% to 17%	household response rates from ~18% to >90%, with individual response rates often ~70-95%

Note: CAPI: Computer-assisted personal interviews; PAPI: Pen-and-paper personal interviews; CATI: Computer-assisted telephone interviews. Source: 2024 Commonwealth Fund International Health Policy Survey of Older Adults – SSRS Methodology Report – 2024. SHARE Methodology Volume – Wave 9. European Health Interview Survey (EHIS wave 3) – Methodological manual (Eurostat). Population assessment of health system performance in 16 countries using the People's Voice Survey (WHO Bulletin, 2024). PaRIS data and methods chapter – Does Healthcare Deliver?. PaRIS questionnaires (OECD). * Estimations are done by the authors given the length of the questionnaires.

Unlike most international population surveys, PaRIS uses a nested multilevel design in which patients are sampled within primary care practices, which are situated within countries. This allows PROMs and PREMs to be analysed in relation to practice characteristics and care processes, while accounting for clustering at the practice and country levels. By applying a multilevel design, PaRIS can partition variation at patient, practice and country levels, by also comparing not only between countries but also within countries (Groenewegen et al., 2024[26]). Such multilevel approaches are widely recognised as essential in health services and public health research, where outcomes are shaped by factors operating across individual, practice and system levels (Leyland and Groenewegen, 2020[27]).

Differences in data-collection modes have important implications for comparability, response patterns and the types of respondents reached. Face-to-face surveying, used mainly in EHIS and SHARE, typically achieves higher response rates and better coverage of older or digitally excluded populations, but are more costly and may introduce interviewer and social desirability effects. Telephone-based surveys, such as PVS and parts of the IHP survey, are more cost-efficient and easier to standardise across countries but may under-represent individuals less likely to respond to phone surveys. PaRIS uses a digital-first approach complemented by paper and telephone options (in some countries), which enables large-scale implementation and faster processing while reducing interviewer effects but may still introduce biases linked to digital literacy and mode effects. Mixed-mode designs can reduce coverage gaps but may generate mode effects, where responses differ by interview format. Consequently, differences in reported experiences or outcomes across surveys may partly reflect mode-related measurement and coverage effects rather than true differences in health system performance.

Differences in fieldwork periods and timing might also influence comparability. PaRIS involved a fieldwork period of about six months (2023-2024), reflecting the complexity of practice-based recruitment and co-ordination with providers. By contrast, the IHP survey and PVS typically use shorter, more standardised field periods (around 6-14 weeks for the IHP survey and often 4-8 weeks per country for PVS), while EHIS is implemented in multi-year waves within official statistical programmes, and SHARE Wave 9 fieldwork ran from October 2021 to September 2022 with country-specific variation. Longer or staggered field periods increase exposure to temporal effects, such as policy changes or seasonal patterns, whereas shorter, tightly defined periods improve cross-country synchronicity but allow less flexibility to address recruitment challenges.

2.3. Variations in sample size and response rates mirror survey purpose and design

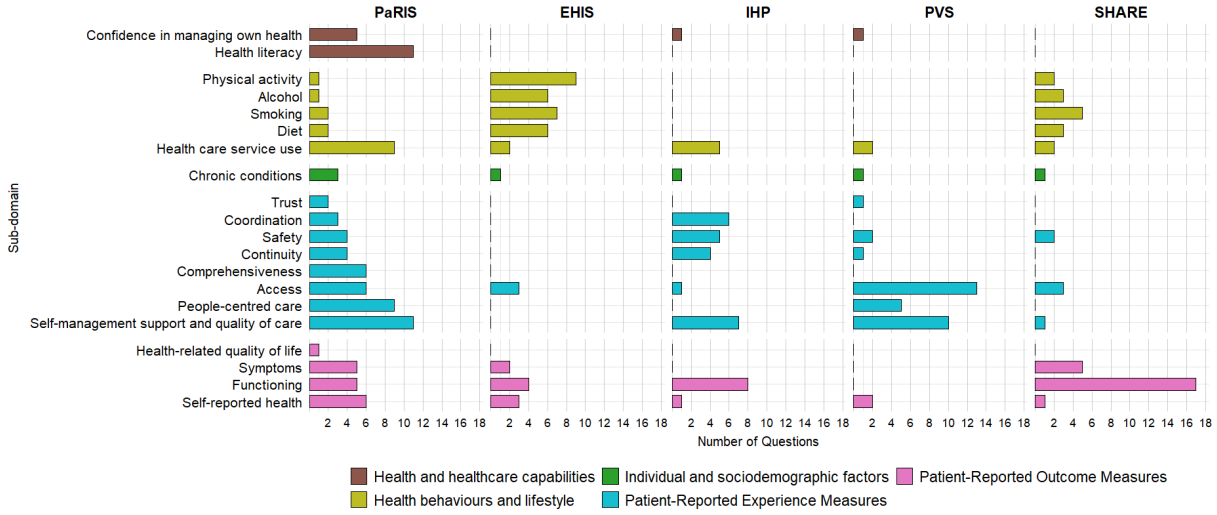
Survey performance, reflected in sample size and response rates, has direct implications for validity and is closely linked to each survey's primary purpose. EHIS and SHARE, with very large samples and generally higher response rates, are well suited for population surveillance and subgroup monitoring, providing stable estimates and broad representativeness, though with less focus on specific healthcare-user groups. PaRIS, while smaller than EHIS and SHARE, achieves substantial within-country samples among primary care users and is designed to analyse care experiences and outcomes in relation to service delivery; its lower and more variable response rates require careful weighting and sensitivity checks, but are partly a function of its more complex multilevel design. It should also be noted that PaRIS Cycle 1 represents the initial implementation of a new international survey. Therefore, these issues are relevant for interpreting the current findings but may be mitigated or resolved in future cycles.

The IHP survey and PVS feature small samples with low response rates, which may limit statistical precision and increase the risk that results reflect respondent selection, but this aligns with their focus on perceptions, policy-relevant signals and rapid cross-country insight rather than detailed system performance measurement. Across surveys, lower response rates heighten the risk of under-representing disadvantaged or less engaged groups, while larger samples improve precision but do not eliminate bias without appropriate adjustment. Consequently, differences in findings across surveys may reflect not only health system performance but also how survey design choices balance feasibility, target populations and intended analytical use.

2.4. While all surveys include patient-reported measures, the overlap in subdomains covered is minimal

Across the five international surveys, coverage does not fully coincide; rather, each survey has specific strengths in the subdomains it was designed to assess (Figure 1). The reference subdomains in PaRIS, EHIS and SHARE include an extensive number of questions on functioning and health behaviours, while the IHP survey and PVS have a higher number of questions regarding care experiences. The approach used to examine the comparability of surveys and questionnaire items are presented in Box 2.

Figure 1. Taking the PaRIS subdomains as the reference, each survey demonstrated a distinct focus, with no single survey fully aligned with the others



Note: EHIS: European Health Interview Surveys, IHP: International Health Policy survey, PaRIS: Patient Reported Indicator Surveys, PVS: People's Voice Survey, SHARE: the Survey of Health, Ageing and Retirement in Europe.
Source: Authors.

2.4.1. PREMs

PREMs-related subdomains show substantial variation. The IHP survey and PVS provide extensive coverage, particularly in access, quality of care, people-centred care, safety, co-ordination, and continuity. Within the quality subdomain, PVS includes distinctive questions assessing perceptions of the overall quality of the healthcare system, representing a system-level evaluative dimension that is less prominent in the other surveys. EHIS includes a smaller number of PREMs-related questions, primarily focussed on access and selected aspects of quality. SHARE contains only limited PREMs content.

2.4.2. PROMs

PROMs are unevenly present across surveys. SHARE includes extensive coverage of functioning and symptoms, consistent with its focus on health and ageing. EHIS includes questions on self-rated health, functioning, and symptoms, though to a more limited extent. The IHP survey includes only a small number of PROMs-related questions, primarily focussing on self-rated health. PVS includes limited PROMs content, with an emphasis on symptoms rather than broader functioning or quality of life. PaRIS covers health status by measuring physical health, mental health, social functioning, overall well-being, general health as well as symptoms such as pain, fatigue and breathlessness.

2.4.3. Health and healthcare capabilities

The health and healthcare capabilities category represents a distinctive dimension within the PaRIS framework. Healthcare capabilities refer to the skills and resources patients need to manage their care and are operationalised through a set of behavioural and self-efficacy based items that collectively capture how individuals understand, navigate and assume responsibility for their care. PaRIS also makes a distinction between active patient engagement and passive action of receiving health information from a healthcare professional.

Box 2. Assessing the comparability of surveys and questionnaire items

Coding and classification procedure

Survey questions from EHIS, the IHP survey, PVS and SHARE were manually reviewed and assigned to PaRIS subdomains. When surveys used constructs or modules that matched PaRIS subdomains, questions were directly classified into those subdomains. If subdomains were not clearly labelled or if overlap was partial, classification was based on a detailed assessment of their description and underlying purpose. Each question was assigned to only one subdomain. Multi-concept questions were classified according to their dominant construct. Sixteen questions were deemed comparable between PaRIS and EHIS, the IHP survey, PVS or SHARE.

Comparative analysis strategy

Subdomain-level comparison assessed the presence or absence of coverage across surveys and the relative breadth of coverage within each PaRIS subdomain.

Indicator-level comparison identified questions that were potentially comparable across surveys based on conceptual alignment, similarity of wording and constructs, as well as recall periods and response formats.

Differences in question wording, recall periods, and response formats were explicitly considered when assessing comparability. Questions were deemed meaningfully comparable only when differences could be reasonably reconciled, for example, through recoding or alignment with response categories. Where response formats could not be harmonised, questions were classified as conceptually related but not strictly comparable.

2.4.4. Health behaviours

Several questions in PaRIS measure health behaviours and attitudes, such as smoking, alcohol use, physical activity and dietary habits, seeking to understand personal health risks, raising concerns when something seems wrong, and bringing externally sourced information to consultations. The category also includes a structured set of self-efficacy questions that assess confidence in managing one's own health and well-being, following professional advice, changing habits or lifestyle, recognising when medical care is necessary, and using online information to make health decisions.

Health behaviours are most extensively covered in EHIS and SHARE. EHIS includes a substantial number of questions related to physical activity, smoking, alcohol consumption, and diet. SHARE similarly includes multiple questions on smoking, alcohol use, diet, and physical activity, consistent with its life-course and ageing perspective. In contrast, the IHP survey and PVS include little or no coverage of these subdomains.

2.5. Only a few indicators are meaningfully comparable across all surveys

Across the five surveys, the number of questions that can be meaningfully compared remains limited, largely due to differences in item design, operational definitions, and survey objectives (Figure 2). The overlapping space is largest in patient experience and care-quality domains (PaRIS-IHP-PVS), moderate in health outcomes (EHIS-SHARE-PaRIS), and minimal in lifestyle indicators (EHIS-PaRIS). This underlines that cross-survey harmonisation efforts must recognise that these instruments are complementary rather than substitutable, each contributing specific clusters of comparable indicators aligned with its core purpose.

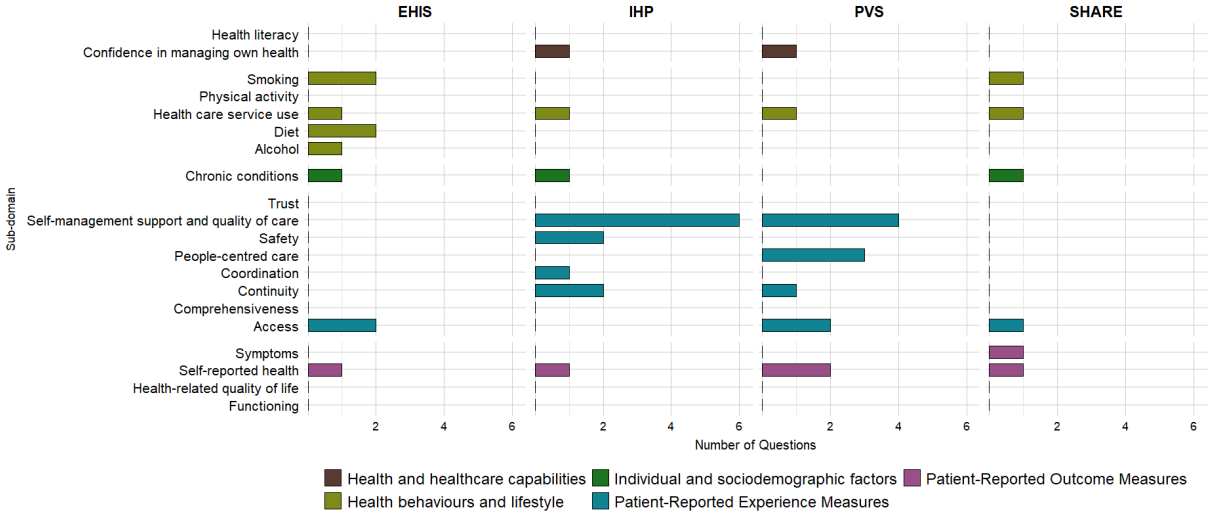
PaRIS, the IHP survey, and PVS show a strong concentration of indicators in patient-centred care dimensions, particularly self-management support and quality of care, co-ordination, continuity, and trust. These domains show high comparable counts for the IHP survey, PVS and PaRIS, indicating that these three surveys share a common design emphasis on measuring people's experience of health services and the performance of healthcare systems. In contrast, EHIS and SHARE contribute few comparable indicators in these domains, reflecting their fundamentally different missions: EHIS as a public health indicator system and SHARE as an ageing and life-course outcomes survey.

EHIS has a strong emphasis on "health behaviours and lifestyle", including alcohol, smoking, diet, physical activity. This dominance reflects EHIS' role in EU population health monitoring and its alignment with non-communicable disease risk-factor surveillance. SHARE contributes some indicators in lifestyle and chronic conditions, but not at the breadth or depth of EHIS. PaRIS, the IHP survey and PVS contribute minimally to these behavioural domains, highlighting that they are not designed as epidemiological surveillance instruments and therefore produce few cross-survey comparable items in these areas.

SHARE includes a comprehensive set of PROMs, including self-reported health, functioning, symptoms, and health-related quality of life, reflecting its longitudinal focus on ageing populations and functional trajectories. EHIS also contributes a notable cluster in these areas, though with more emphasis on general self-reported health and chronic conditions rather than functioning. By contrast, the IHP survey and PVS contribute very few outcome-oriented indicators, again underlining their focus on system experience and performance.

While 16 indicators were identified for general comparison, a stricter comparison was conducted on four selected indicators: experienced quality of care, perceived general health, confidence to self-manage and hospitalisations. The next section focusses on further analysis conducted on the comparable set of indicators across PaRIS, EHIS, the IHP survey and PVS, restricted to countries present in both PaRIS and the relevant comparison survey.

Figure 2. When compared at the indicator level, no single survey produces a complete balanced suite of comparable indicators with PaRIS



Note: EHIS: European Health Interview Surveys, IHP: International Health Policy survey, PaRIS: Patient Reported Indicator Surveys, PVS: People's Voice Survey, SHARE: The Survey of Health, Ageing and Retirement in Europe.

3 Results across selected comparable indicators

Further comparative analysis was conducted on a selected set of indicators from PaRIS, EHIS, the IHP survey and PVS. The comparative analysis was conducted for a selected set of indicators. All surveys were standardised to a common demographic reference using a post-stratification approach in which the PaRIS population served as the reference population, strict harmonisation was applied among service users with chronic conditions and results were compared across countries.

To ensure stricter cross-country comparisons, further analysis was conducted harmonising populations, indicators, and demographic structures across PaRIS, EHIS, the IHP survey and PVS. This analysis compared selected indicators for people aged 45+ who live with chronic conditions and had a recent healthcare contact across PaRIS, EHIS, the IHP survey and PVS (Box 3).

Box 3. Comparing a selected set of indicators through further harmonisation, standardisation and weighting

- Four indicators were examined: self-rated health (PROM), experienced quality of care (PREM), confidence to self-manage, and hospitalisations. To enhance comparability across surveys, response categories were harmonised by recoding the responses.
- Analyses were limited to countries available in both PaRIS and the comparison survey. The PaRIS-EHIS comparison included 13 countries (Belgium, Czechia, France, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Romania, Slovenia, Spain and Norway). The PaRIS-PVS comparison included four countries (Greece, Italy, Romania and the United States). The initial PaRIS-IHP set included six countries (Australia, Canada, France, the Netherlands, Switzerland and the United States). Indicator coverage also differed within the IHP survey: quality of care and self-rated health were available for Canada, Switzerland and the United States, but self-management confidence was only asked in Switzerland.
- **Age scope differed across comparisons.** For PaRIS-IHP, analyses were restricted to respondents aged 65 and over, reflecting the older adult focus of that comparison. For PaRIS-EHIS and PaRIS-PVS, analyses included all respondents aged 45 and over, as both EHIS and PVS provided sufficient sample sizes across this broader age range.
- To improve comparability across surveys, all estimates were standardised to a common age sex reference distribution based on the PaRIS design targets for respondents aged 45 and over. Targets for ages 45-54, 55-64, 65-74 and 75+ were renormalised for the restricted age group and combined with original sex targets (55% female; 45% male) to form a four-cell reference structure. Post-stratification weights were then generated for each survey and country by aligning observed age-sex proportions to these reference targets, with weights normalised to preserve effective sample sizes.

3.1. Self-rated general health

Self-rated health status is measured in PaRIS, EHIS, the IHP survey and PVS using closely related questions, though with some differences in response scales and category ordering. All four surveys ask respondents to assess their health "in general," but EHIS uses a scale ranging from "very good" to "very bad," while PaRIS, the IHP survey and PVS use variations of an "excellent" to "poor" scale, with PVS presenting responses in reverse order. Taking into account these differences in response options and labelling, results were aligned into harmonised outcome categories for comparative analysis (Table 3). The differences in scale construction and threshold placement, particularly the treatment of "fair" health in EHIS, hinder cross-survey comparisons. Nevertheless, the exercise is useful to shed light on the effect of methodological differences in the self-rated general health assessment.

Table 3. Harmonisation of response categories for self-rated general health

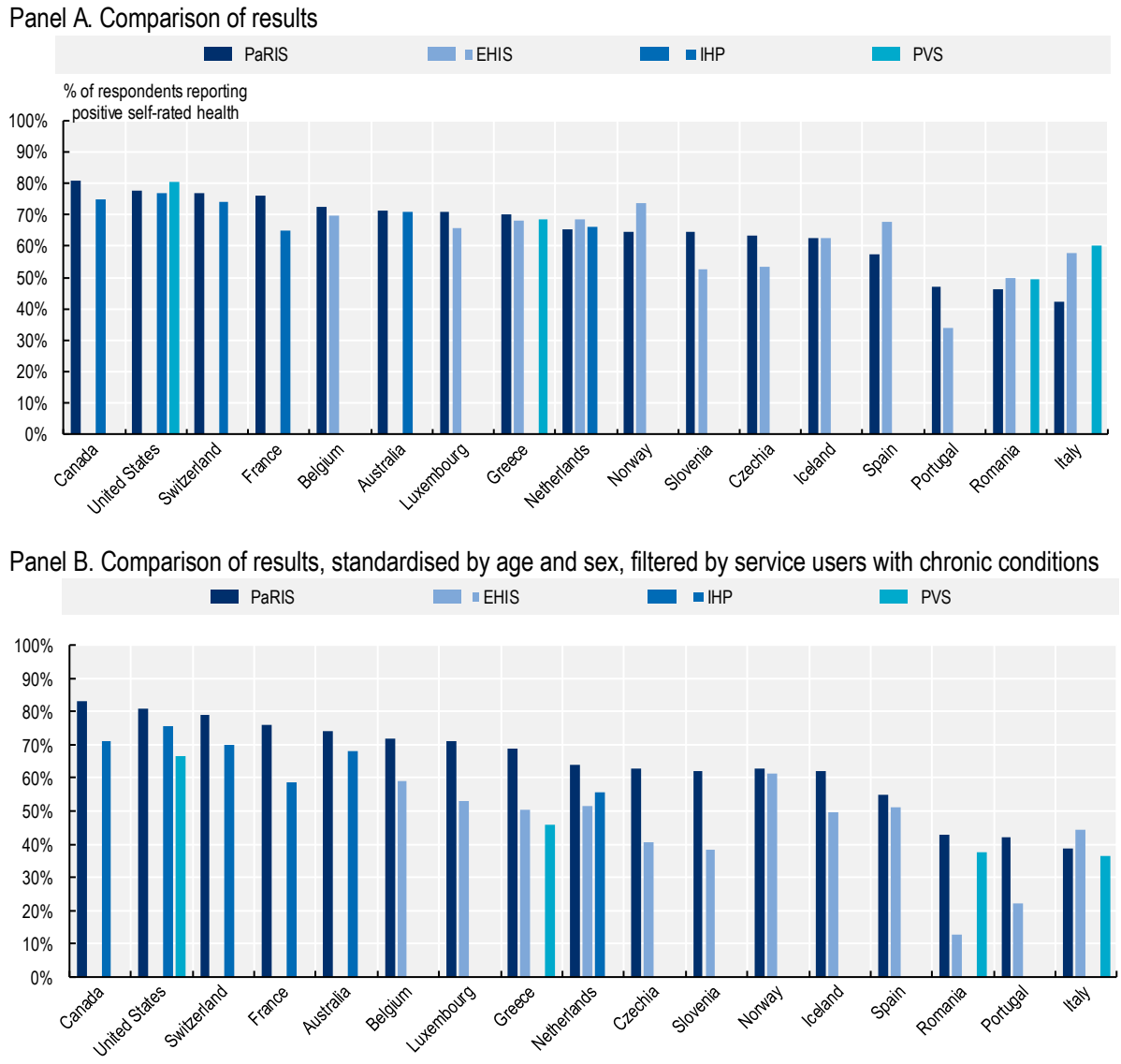
	PaRIS	EHIS	the IHP survey	PVS
Question	*In general, would you say your health is...*	*How is your health in general?*	*In general, how would you describe your own health?*	*In general, would you say your health is?*
Response categories (in original order)	1. Excellent 2. Very good 3. Good 4. Fair 5.Poor	1. Very good 2. Good 3. Fair 4. Bad 5. Very bad	1. Excellent 2. Very good 3. Good 4. Fair 5.Poor	1. Poor 2. Fair 3. Good 4. Very good 5. Excellent
Recoding (and reversing order in PVS)	Positive <- excellent OR very good OR good; compared to fair OR poor	Positive <- very good OR good; compared to fair OR bad OR very bad	Positive <- excellent OR very good OR good; compared to fair OR poor	Positive <- excellent OR very good OR good; compared to fair OR poor
Final reported outcome	Percentage of people reporting positive self-rated health			

Figure 3 shows that cross-survey country gradients remain broadly similar in most countries, but differences in absolute levels become much larger once the comparison is restricted to service users with chronic conditions and standardised to the PaRIS standard population.

In the overall comparison (Panel A), PaRIS and EHIS show broadly consistent rankings but with systematic level differences that vary by country. The differences between PaRIS and EHIS range from +13 p.p. in Portugal and Slovenia where more respondents in PaRIS report positive self-rated health to -16 p.p. in Italy and -11 p.p. in Spain where fewer respondents in PaRIS report positive self-rated health. In the standardised and harmonised comparison (Panel B), EHIS is lower than PaRIS in 11 of the 13 overlapping countries, with gaps ranging from +30 p.p. in Romania and +24 in Slovenia where more respondents in PaRIS report positive self-rated health to +2 points in Norway and -5 points in Italy where fewer respondents in PaRIS report positive self-rated health.

In the comparison between PaRIS and the IHP survey (Panel A), more respondents in PaRIS generally report positive self-rated health than the IHP survey, though the magnitude and direction of differences vary by country. Across the six overlapping countries in the crude comparison, differences range from +11 p.p. in France, +6 points in Canada, and +3 points in Switzerland, where more respondents in PaRIS report positive self-rated health, to –1 point in the Netherlands, where fewer respondents in PaRIS report positive self-rated health. Australia shows alignment between the two sources. In the standardised and harmonised comparison among service users with chronic conditions (Panel B), PaRIS reports higher levels of positive self-rated health than the IHP survey in all six overlapping countries, with gaps widening substantially compared to the crude results. Differences range from +17 p.p. in France and +12 points in Canada to smaller gaps of +6 points in Australia and +5 points in the United States.

Figure 3. Self-rated general health varies on average 6.2 p.p. across surveys



Note. The data are sorted from largest to smallest based on the PaRIS results.

In the comparison between PaRIS and PVS (Panel A), country rankings are broadly aligned but level differences are substantial and consistently favour PVS in most overlapping countries. Among the four countries with data in both sources, differences range from +2 p.p. in Greece, where PaRIS reports slightly higher positive self-rated health than PVS, to –18 p.p. in Italy, where PaRIS reports lower levels than PVS. Smaller gaps are observed in the United States (–3 p.p.) and Romania (–4 p.p.). In the standardised and harmonised comparison among service users with chronic conditions (Panel B), the pattern reverses with more respondents in PaRIS reporting positive self-rated health than PVS in all four overlapping countries, with gaps ranging from +23 p.p. in Greece and +14 in the United States to +3 points in Italy and +5 points in Romania.

PaRIS is used as the reference survey for the restriction and harmonisation exercise, and by construction its results change only minimally when restricted to the standardised population with chronic conditions. Among the remaining surveys, EHIS is the most affected by restriction and harmonisation. The

adjustments lead to large and systematic downward shifts relative to PaRIS, often reversing the direction of differences observed in the crude comparison and substantially widening gaps in many countries. This indicates a sensitivity of EHIS estimates to population composition and survey design, particularly its coverage of the general population compared with service users with chronic conditions.

Another factor that deserves attention is the difference in the wording of the response categories between PaRIS and EHIS. PaRIS uses the North American style scale (*Excellent/ Very good /Good /Fair/ Poor*), whereas EHIS uses the European-style scale (*Very good/ Good/ Fair/ Bad/ Very bad*). Although both scales contain five categories and are conventionally dichotomised at the same cut-off when constructing a "positive self-rated health" indicator, the labels are not psychometrically equivalent. The PaRIS scale is positively skewed in its anchors (four of five categories are non-negative), while the EHIS scale is symmetric and with explicit negative anchors at the lower end. Evidence from survey methodology shows that such differences shift the psychological midpoint of the scale, alter the distribution of responses, and complicate direct cross-survey comparisons of self-rated health (Jürges, Avendano and Mackenbach, 2008[28]).

PVS is also affected, though generally less than EHIS. The IHP survey is moderately affected by restriction and harmonisation. Differences between PaRIS and the IHP survey are already present in the crude comparison and tend to widen after standardisation, but without systematic patterns. In the crude comparison, PVS frequently reports higher levels of positive self-rated health than PaRIS, but after restriction and harmonisation this pattern reverses, with more service users with chronic conditions in PaRIS reporting positive self-rated health.

3.2. Experienced quality of care

Experienced quality of care is measured across PaRIS, the IHP survey and PVS using conceptually similar but not identical questions. PaRIS asks respondents to rate the medical care that they have received in the past 12 months from their primary care centre, while the IHP survey captures overall satisfaction with healthcare received over the past 12 months, and PVS focusses on the quality of care received from a specific healthcare facility over the same period. Response scales also differ slightly, with PaRIS and PVS using quality-based ratings (from "excellent" to "poor") and the IHP survey using satisfaction-based categories (from "very satisfied" to "very dissatisfied"). Table 4 presents the harmonisation of response categories regarding the experienced quality of care outcome. While this recoding enables high-level comparability across surveys, differences in question focus, single consultation versus care over a year, and differences in response framing (quality versus satisfaction) should be considered when interpreting results.

Table 4. Harmonisation of response categories for experienced quality of care

	PaRIS	the IHP survey	PVS
Question	*Overall, how do you rate the medical care that you have received in the past 12 months from your primary care centre?*	*Overall, how satisfied are you with the quality of healthcare you have received during the past 12 months?*	*Overall, how would you rate the quality of healthcare you received in the past 12 months from this healthcare facility?*
Response categories (in original order)	1. Excellent 2. Very good 3. Good 4. Fair 5. Poor 6. Have not received medical care in the last 12 months 7.Not sure	1. Very satisfied 2. Somewhat satisfied 3. Neither satisfied nor dissatisfied 4. Somewhat dissatisfied 5. Very dissatisfied	1. Excellent 2. Very good 3. Good 4. Fair 5. Poor
Recoding	Positive <- excellent OR very good OR good; compared to fair OR poor; NA <- Have not received medical care in the last 12 months OR not sure	Positive <- very satisfied OR somewhat satisfied OR neither satisfied nor dissatisfied; compared to somewhat dissatisfied OR very dissatisfied	Positive <- excellent OR very good OR good; compared to fair OR poor
Final reported outcome	Percentage of people reporting good quality of care		

Figure 4 shows that cross-survey country gradients for experienced quality of care remain broadly similar across PaRIS, the IHP survey and PVS, but, similar to self-rated health, absolute levels diverge more strongly once the comparison is restricted to service users with chronic conditions and standardised to the PaRIS reference population.

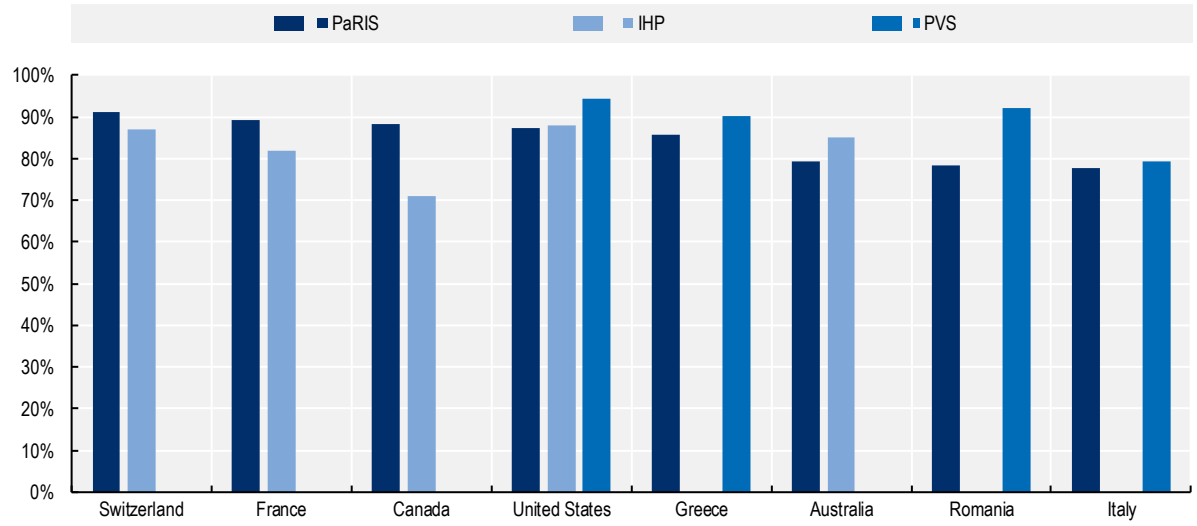
In the overall comparison (Panel A), PaRIS generally reports higher levels of experienced quality of care than the IHP survey, although the size and direction of differences vary by country. Among the five overlapping countries, differences range from +17 p.p. in Canada, +7 points in France, where more respondents in PaRIS report positive experiences of care, to –6 points in Australia and –1 point in the United States, where PaRIS reports lower levels. Comparisons with PVS in the crude data among four overlapping countries show higher levels of positive results for PVS than PaRIS, with gaps ranging from –14 p.p. in Romania and –7 points in the United States, to –2 points in Italy, and –5 points in Greece.

In the standardised and harmonised comparison among service users with chronic conditions (Panel B), PaRIS systematically reports higher experienced quality of care than the IHP survey in all overlapping countries. Differences range from +16 p.p. in Canada and +7 points in Australia to +4 points in Switzerland, France and the United States. Comparisons with PVS show that PaRIS and PVS are closely aligned in the United States and Italy (no difference), while PaRIS reports lower levels in Greece (-15 points) and in Romania (–13 points).

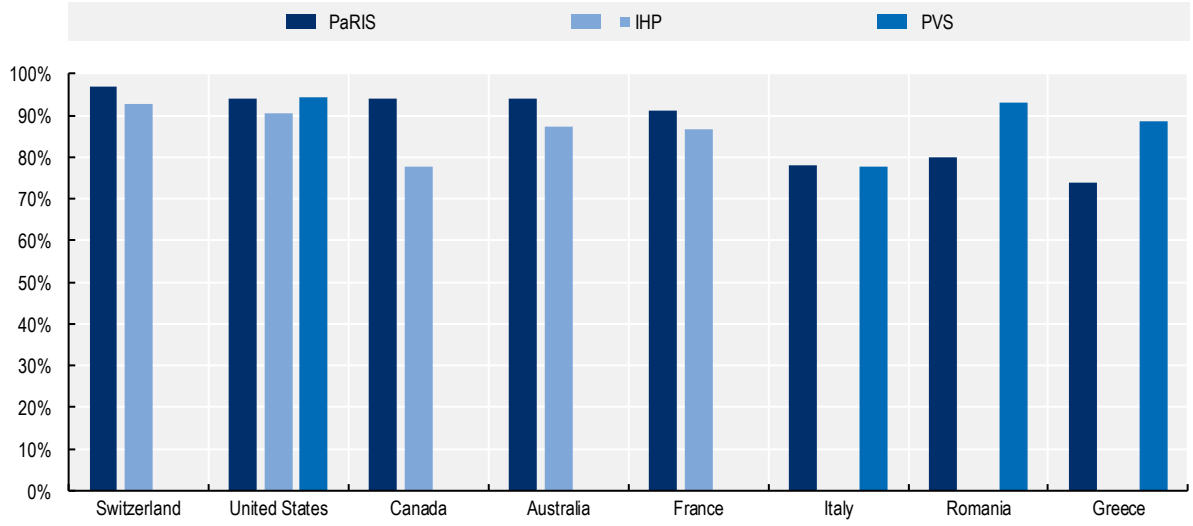
Overall, the results indicate that experienced quality of care is more sensitive to restriction and harmonisation than crude comparisons imply, particularly for the IHP survey, where standardisation and harmonisation reveal systematically higher levels in PaRIS, while differences with PVS remain country-specific.

Figure 4. Experienced quality of care

Panel A. Comparison of results



Panel B. Comparison of results, standardised by age and sex, filtered by service users with chronic conditions



Note. The data are sorted from largest to smallest based on the PaRIS results.

3.3. Confidence to self-manage

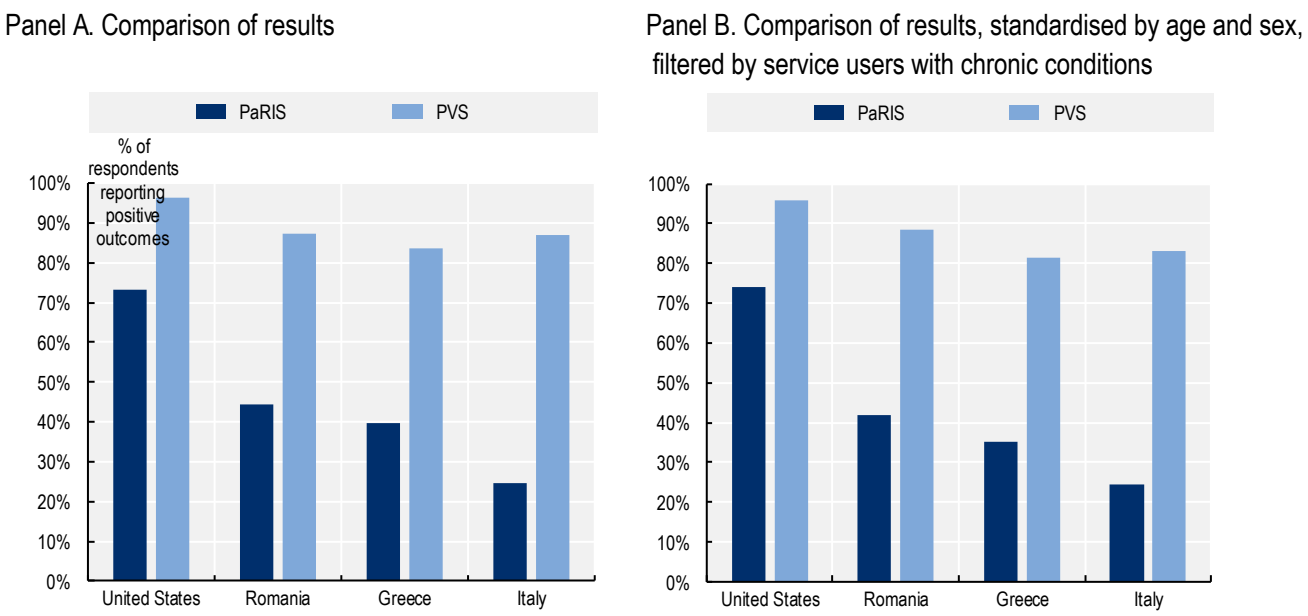
Confidence to manage one's own health is assessed in both PaRIS and PVS using broadly similar but not identical questions. PaRIS asks respondents about their confidence to manage their own health and well-being, while PVS frames the question in terms of personal responsibility for managing overall health. Response categories differ substantially across surveys in wording and scale, but both distinguish varying levels of confidence. For comparative purposes, responses were grouped into a harmonised positive outcome, while noting that differences in question framing and response options may influence interpretation (Table 5).

Table 5. Harmonisation of response categories for confidence to self-manage

	PaRIS	PVS
Question	*How confident are you that you can manage your own health and well-being?*	*When you think about your health, how confident are you that you are the person who is responsible for managing your overall health?*
Response categories (in original order)	1. Very confident 2. Confident 3. Somewhat confident 4. Not confident at all	1. Very confident 2. Somewhat confident 3. Not too confident 4. Not at all confident
Recoding	Confident <-Very confident OR confident; compared to Somewhat confident OR not confident at all	Confident <-Very confident OR somewhat confident; compared to Not too confident OR not at all confident
Final reported outcome	Percentage of people with positive outcomes	

Figure 5 indicates that cross-survey country gradients for confidence to self-manage health are broadly consistent between PaRIS and PVS, but absolute levels differ markedly, reflecting both population coverage and important differences in question framing. While PaRIS asks respondents about their confidence in managing their own health and well-being, PVS focusses more narrowly on whether individuals see themselves as the person responsible for managing their overall health, a formulation that is likely to elicit higher affirmative responses.

Figure 5. More respondents in PVS reported feeling responsible to manage compared to the number of PaRIS respondents having confidence to manage



Note. The data are sorted from largest to smallest based on the PaRIS results.

In the overall comparison (Panel A), PVS reports substantially higher levels of confidence than PaRIS in all four overlapping countries. Differences range from -23 p.p. in the United States (73% in PaRIS and 96% in PVS) to very large gaps of -43 points in Greece, -43 points in Romania, and -62 points in Italy, where PaRIS results are much lower. Despite these large level differences, the relative ordering of countries is broadly similar across the two surveys, with the United States reporting the highest levels and Italy the lowest, suggesting consistent cross-country gradients.

In the standardised and harmonised comparison among service users with chronic conditions (Panel B), results change only marginally compared to the crude comparison. PaRIS estimates remain largely stable or decline slightly (for example from 40% to 35% in Greece), while PVS levels remain very high across all countries. As a result, gaps persist and remain substantial, ranging from -22 p.p. in the United States to -46 points in Greece, -46 points in Romania, and -59 points in Italy.

These large and persistent differences are consistent with differences in question framing and conceptual focus. PaRIS asks respondents about their confidence in managing their health and well-being, which may implicitly anchor responses in the context of chronic conditions and ongoing care needs. By contrast, PVS explicitly frames self-management in terms of personal responsibility for overall health, which may prompt a broader, more normative assessment of agency and control. As a result, the two surveys may be capturing related but distinct constructs, with PVS eliciting generally higher affirmative responses. This highlights the limits of comparability for measures of self-management, even when response categories are harmonised and populations are standardised.

3.4. Hospitalisation

Hospitalisation in the past 12 months is measured in PaRIS, EHIS and PVS using questions focussed on overnight stays, though with minor differences in wording and response formats. PaRIS records the number of overnight hospitalisations, EHIS asks directly about inpatient hospital stays of one night or longer, and PVS refers to overnight stays in a healthcare facility. While response categories vary, from binary yes/no options, to counts of hospitalisations and a “not sure” option in PaRIS, all three surveys were aligned to a harmonised indicator distinguishing between any hospitalisation and none (Table 6). These results are therefore broadly comparable, although small differences in question framing and response options should be considered when interpreting results and cross-survey differences.

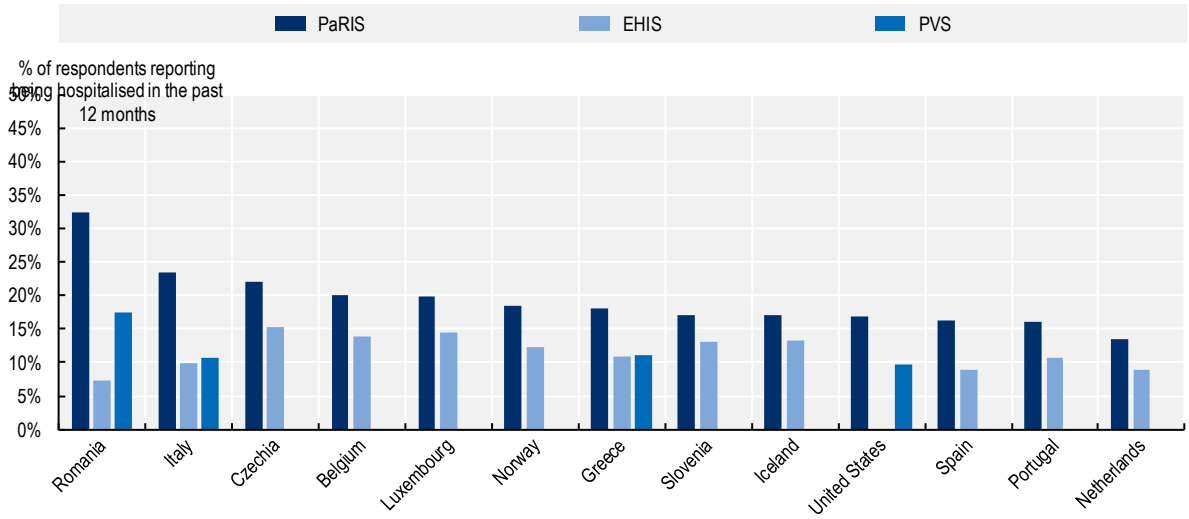
Table 6. Harmonisation of response categories for hospitalisation

	PaRIS	EHIS	PVS
Question	*In the last 12 months, have you been in a hospital for one night or longer?*	*In the past 12 months have you been in hospitals as an inpatient, that is overnight or longer?*	*In the past 12 months did you stay overnight at a healthcare facility as a patient?*
Response categories (in original order)	1. No 2. Yes, once 3. Yes, twice 4. Yes, 3 or more times 5. Not sure	1. Yes 2. No	1. No 2. Yes
Recoding	Hospitalisation: Yes <- Yes, once OR yes, twice OR yes, 3 or more times; Hospitalisation: No <- No; NA <- Not sure	Hospitalisation: Yes <- Yes; Hospitalisation: No <- No	Hospitalisation: Yes <- Yes; Hospitalisation: No <- No
Final reported outcome	Percentage of people reporting being hospitalised in the past 12 months		

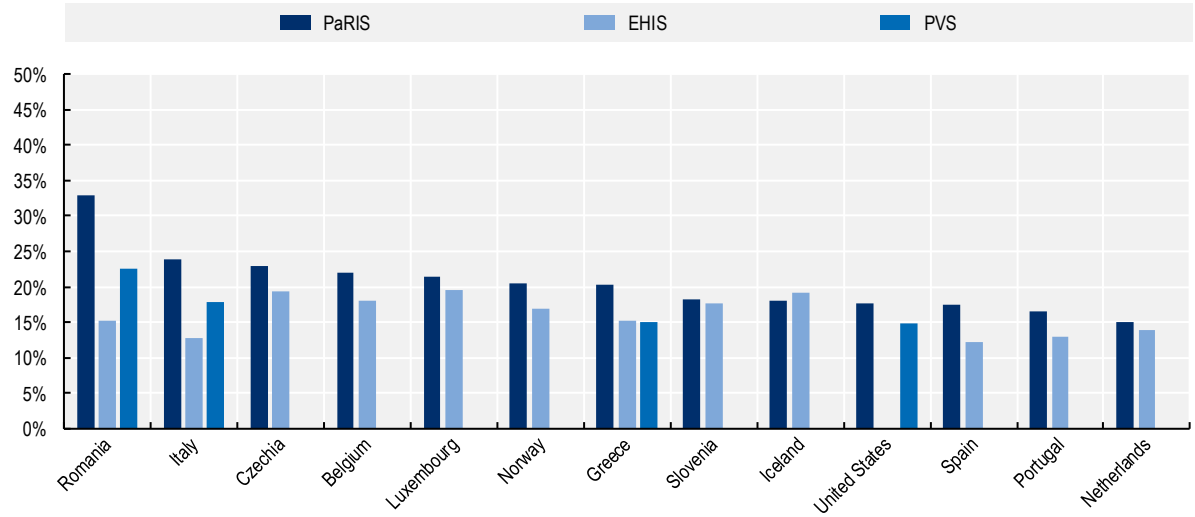
Figure 6 shows that cross-survey country gradients for hospitalisation in the past 12 months are generally consistent across PaRIS, EHIS and PVS, but PaRIS reports higher absolute levels, with differences widening after restriction and standardisation. These patterns reflect both population coverage, PaRIS focusses on service users, many with chronic conditions, and survey framing, as EHIS and PVS capture hospitalisation in the general population.

Figure 6. In general, PaRIS respondents reported higher hospitalisation in the last 12 months compared to other surveys, the gap generally narrowed down after strict comparison

Panel A. Comparison of results



Panel B. Comparison of results, standardised by age and sex, filtered by service users with chronic conditions



Note. The data are sorted from largest to smallest based on the PaRIS results.

In the overall comparison (Panel A), PaRIS consistently reports higher hospitalisation rates than EHIS in all overlapping countries. Differences are particularly large in Romania (+25 p.p.) followed by Italy (+13 points) and go down to +4 points in Slovenia and Iceland. Comparisons with PVS also show higher hospitalisation in PaRIS in most overlapping countries, with gaps of +15 points in Romania, and +12 points in Italy to +7 points in Greece and the United States, indicating greater reported hospital use among PaRIS respondents in the crude data.

In the standardised and harmonised comparison among service users with chronic conditions (Panel B), hospitalisation levels increase across all surveys, but PaRIS remains higher than EHIS in nearly all countries, except Iceland where EHIS respondents are 1 p.p. higher than PaRIS. Differences vary from +18 p.p. in Romania and +11 points in Italy to +1 point in Slovenia and the Netherlands. Comparisons with

PVS show a similar pattern where more respondents in PaRIS report hospitalisation in Romania (+10 p.p.), Italy (+6 points), Greece (+5 points) and the United States (+3 points).

Overall, the results indicate that hospitalisation is sensitive to restriction and harmonisation, with PaRIS consistently capturing higher use of inpatient care than EHIS and PVS. Even after restricting the comparison to service users with chronic conditions and standardising to the PaRIS population, hospitalisation in most countries remains higher in PaRIS than in EHIS. This likely reflects both a higher-risk population and the fact that PaRIS respondents are already connected to primary care and an identified provider. In this context, hospital use may be more frequent not only because needs are greater, but also because primary care is more likely to detect deterioration, initiate referrals, and connect patients to tests, specialist care or treatments that are still often delivered in hospitals (Lyall et al., 2022[29]). Hospital admission may also itself increase subsequent primary care use, since discharge commonly requires closer follow-up, medication review and monitoring to prevent complications that may lead to readmission (Moneme et al., 2023[30]). In settings with structural unmet need, contact with primary care may therefore uncover previously unaddressed conditions and generate further hospital-based care. Romania may illustrate this pattern. Once Romania is excluded, however, cross-country dispersion becomes very similar across PaRIS and EHIS, suggesting that the main difference is not greater system sensitivity in PaRIS, but a population that is both more clinically complex and more connected to care pathways through which hospital need is identified and managed.

4 Key lessons and recommendations

This comparative analysis shows that these five international surveys collecting PROMs and PREMs are largely complementary rather than substitutable. Although they share some overlapping concepts and instruments, differences in purpose, target population, survey design and analytical structure mean that each initiative generates distinct types of policy- and practice-relevant insights. No single survey provides a comprehensive picture of population health, care experiences and health system performance from the patient perspective. Instead, policymakers are best served by understanding the comparative advantage of each survey and using them strategically, either individually or in combination, depending on the policy question at hand.

The analysis confirms that the primary determinant of a survey's usefulness is its underlying purpose. Population-based surveys such as EHIS and SHARE are well-suited for monitoring population health, health behaviours and social gradients, while experience-focussed surveys such as the IHP survey and PVS provide rapid insights into access, affordability, and perceived system performance. PaRIS occupies a distinct position by focussing on people living with chronic conditions who use primary care services, enabling a more granular assessment of care processes, outcomes and self-management support.

Policymakers should therefore avoid direct comparisons across surveys without careful alignment of reference populations. Differences in age coverage, eligibility criteria and sampling frames influence reported outcomes and experiences. PaRIS' multilevel design allows patient-reported outcomes and experiences to be analysed in relation to primary care practice characteristics and system contexts, while accounting for clustering at the practice and country level. This allows assessment of differences both between and within countries (between practices). This analytical capability is largely absent from other international surveys and results in country estimations corrected for the practice effect. This is particularly important for patient experiences where practice effect can account for up to 7% of the variation (OECD, 2025[16]). By contrast, longitudinal designs such as SHARE provide unique insights into trajectories over time, while rapid-cycle surveys such as the IHP survey and PVS prioritise timeliness over depth. These design choices imply trade-offs between causal inference, benchmarking potential, responsiveness to policy change and operational feasibility.

Only a small number of indicators can be meaningfully compared across surveys, and these are concentrated in specific domains. Patient experience indicators show the greatest overlap between PaRIS, the IHP survey and PVS, while PROMs are more comparable between PaRIS, EHIS and SHARE. Lifestyle and behavioural indicators are largely confined to EHIS (and to a lesser extent, SHARE).

Collecting only PROMs and PREMs is not sufficient. A survey's policy value depends on governance arrangements, analytical capacity, and pathways linking data to quality improvement, accountability and system reforms. Surveys differ substantially in the extent to which they are embedded in national health information systems. PaRIS' co-development with countries and its alignment with healthcare system performance assessment frameworks strengthen its potential for policy use, but real impact depends on national follow-up and institutionalisation.

4.1. Choosing the right source of information for a given policy question

The surveys considered in this report differ not only in their substantive focus but also in the balance they strike between methodological rigour, operational complexity and ease of implementation. These differences have important implications for the types of policy questions they are best suited to address.

Surveys such as PVS prioritise speed, flexibility and ease of field implementation. Its rapid data-collection model and predominantly telephone-based approach enable broad geographic coverage, including low- and middle-income countries across all continents, and timely insights into perceived access, barriers to care and experiences of health system responsiveness. However, this efficiency comes with trade-offs. Shorter instruments and reliance on telephone sampling may under-represent populations with greater health needs, including people who are sicker, more frail or less reachable by phone, which should be considered when interpreting results.

By contrast, PaRIS adopts a more resource-intensive and methodologically complex design. It requires substantial upfront investment in field testing, co-ordination with primary care practices and structured patient recruitment, reflecting its two-stage sampling framework anchored in healthcare delivery settings. This complexity allows PaRIS to generate more granular and clinically relevant insights, particularly for people living with chronic conditions, by directly linking patient-reported outcomes and experiences to characteristics of primary care practices. Importantly, PaRIS is the only survey among those reviewed that actively involves healthcare professionals and primary care practices, and it uniquely enables feedback of results at the practice level, supporting local quality improvement and system-level learning.

Geographic scope and comparability also differ markedly across surveys. PVS is the only instrument with truly global reach, covering a diverse mix of low-, middle- and high-income countries. This diversity is a major strength for understanding broad patterns in perceived access and experience but limits direct benchmarking across more comparable health systems. In contrast, PaRIS, EHIS, SHARE and the International Health Policy Survey primarily cover OECD or European countries, facilitating comparison among systems with more similar economic contexts, institutional arrangements and health system capacities.

Policymakers should begin by clearly defining the policy question and then selecting the survey best aligned with that purpose:

- To monitor population health status, health behaviours and equity in Europe, population-based surveys such as EHIS (and SHARE for ageing populations) are most appropriate.
- To assess access, affordability and perceived system performance, the IHP survey provides timely insights, as does the PVS survey, which assesses confidence in the health system.
- To benchmark healthcare performance for people living with chronic conditions across OECD Member and partner countries, link outcomes and experiences and identify practice-level levers for improvement, PaRIS offers unique added value.

Rather than viewing surveys in isolation, policymakers should develop strategies that combine insights across initiatives. For example, EHIS can identify population groups with unmet needs, while PaRIS can shed light on how care is delivered to those groups once they contact the healthcare system. Such a layered approach improves diagnostic precision and supports more targeted interventions.

Direct comparisons of indicator levels across surveys should be avoided unless populations, recall periods and response categories are carefully aligned. Where comparisons are needed, policymakers should rely on standardisation to a common reference population and transparent documentation of methodological differences. Headline comparisons without such adjustments risk misleading conclusions and inappropriate policy responses.

Countries participating in PaRIS should actively leverage its multi-level design to examine how primary care organisation, structures and care processes are associated with health outcomes and care experiences. This includes identifying practice-level variation and informing targeted quality improvement initiatives. PaRIS data are particularly well-suited to informing chronic care strategies, primary care strengthening and people-centred care reforms.

Embedding PROMs and PREMs in routine performance assessment and quality improvement cycles is essential for translating measurement into meaningful change. To maximise impact, countries should invest in analytical capacity to interpret patient-reported data, clear governance arrangements defining ownership and use, and feedback mechanisms that return results to healthcare professionals, policymakers and the public.

International surveys of patient-reported outcomes and experiences have become indispensable tools for people-centred health system governance. This analysis demonstrates that their value lies in the diversity of design and purpose. PaRIS adds a distinctive and policy-relevant lens by linking what matters to patients with how primary care is organised and delivered. When used thoughtfully and in combination with other international data sources, these surveys can strengthen evidence-informed policymaking and support the transition toward more people-centred, high-performing health systems.

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Annex A. Full list of comparable indicators in each survey per subdomain

The tables show the list of indicators which measure similar concepts across surveys.

Table A A.1. Patient-reported experience measures (PREMs)

PaRIS	The IHP Survey	PVS
Overall, how do you rate the medical care that you have received in the past 12 months from your primary care centre?	Overall, how satisfied are you with the quality of healthcare you have received during the past 12 months?	Overall, how would you rate the quality of healthcare you received in the past 12 months from this healthcare facility?
Are you involved as much as you want to be in decisions about your care?		How would you rate whether your provider involved you as much as you wanted to be in decisions about your care?
	Is there one doctor you usually go to for your medical care? Is there one doctor's group, health centre or clinic you usually go to for most of your medical care?	Is there one healthcare facility or healthcare provider's group you usually go to for most of your healthcare?
Did this healthcare professional explain things in a way that was easy to understand?		How would you rate whether your provider explained things in a way you could understand.
Did this healthcare professional spend enough time with you? (Last consultation)	How would you rate the amount of time your provider spent with you?	
How many different medications as prescribed by a doctor or a nurse are you taking on a regular or ongoing basis?	How many different medications as prescribed by a doctor or a nurse are you taking on a regular or ongoing basis? **	
In the past 12 months, has a healthcare professional reviewed with you all medications you take?	In the past 12 months, has a healthcare professional reviewed with you all the medications you take? **	
How often did you feel that the healthcare professionals at your primary care centre encouraged you to talk about any concerns about your healthcare?		And how confident are you that you can tell a healthcare provider concerns you have even when he or she does not ask?
Which of the following best describes the type of care you received? Overall, how would you rate the quality of this consultation?		Thinking about your last virtual or telemedicine visit, how would you rate the overall quality of care you received?

Table A A.2. Patient-reported outcome measures (PROMs)

PaRIS	EHIS	The IHP Survey	PVS
In general, would you say your health is...	How is your health in general?	In general, how would you describe your own health?	In general, would you say your health is?
In general, how would you rate your mental health, including your mood and your ability to think?			In general, how would you rate your mental health, including your mood and your ability to think?
How much did pain interfere with your day-to-day activities?			

Table A A.3. Health capabilities

PaRIS	PVS
How confident are you that you can manage your own health and well-being?	When you think about your health, how confident are you that you are the person who is responsible for managing your overall health?

Table A A.4. Access

PaRIS	EHIS	The IHP survey	PVS
How often did you have a health problem but did not seek care, or did take a prescription medicine because of the cost?	Was there any time in the past 12 months when you needed the following kinds of healthcare, but could not afford it?		In the past 12 months, was there a time when you had a health problem and needed medical attention, but you did not get healthcare from a provider?"
How often did you have a health problem but did not seek care because of difficulties in travelling to your primary care centre?	Have you experienced delay in getting healthcare in the past 12 months due to distance or transportation problems?		The last time this happened, what was the main reason you did not receive healthcare? High cost, Far distance, Long waiting time, Poor healthcare provider skills, staff don't show respect, medicine and equipment are not available, illness not serious enough
How long after initially trying to book the appointment did the appointment take place?		Last time you were sick or needed to see a doctor, how quickly could you get an appointment? How many days did you have to wait for an appointment? How many weeks did you have to wait for an appointment?	How long did you wait in days, weeks, or months between making the appointment and seeing the healthcare provider?

Table A A.5. Other healthcare use

PaRIS	EHIS	PVS
In the last 12 months, have you been in a hospital for one night or longer?	In the past 12 months have you been in hospitals as an inpatient, that is overnight or longer?	In the past 12 months did you stay overnight at a healthcare facility as a patient?

Table A A.6. Health behaviours

PaRIS	EHIS
Have you ever smoked tobacco products (excluding electronic cigarettes or similar electronic devices) daily, or almost daily, for at least one year?	For how many years have you smoked tobacco daily? Count all separate periods of smoking daily. If you don't remember the exact number of years, please give an estimate.
In the past 12 months, how often have you had an alcoholic drink of any kind (beer, wine, cider, spirits, cocktails, premixes, liquor, homemade alcohol …)?	In the past 12 months, how often have you had an alcoholic drink of any kind (beer, wine, cider, spirits, cocktails, premixes, liquor, homemade alcohol …)?
How often do you eat fruit, excluding juice squeezed from fresh fruit or made from concentrate?	How often do you eat fruit, excluding juice squeezed from fresh fruit or made from concentrate?
How often do you eat vegetables or salad, excluding potatoes and fresh juice or juice made from concentrate?	How often do you eat vegetables or salad, excluding potatoes and fresh juice or juice made from concentrate?
Do you smoke any tobacco products (excluding electronic cigarettes or similar electronic devices)?	Do you smoke any tobacco products (excluding electronic cigarettes or similar electronic devices)?

Policy Paper

Comparing patient-reported outcome and experience measures in international health surveys

As healthcare systems increasingly prioritise people-centred care, patient-reported data have become central to assessing health system performance. The OECD Patient-Reported Indicator Surveys (PaRIS) initiative supports international comparison and cross-country learning by developing, standardising and collecting harmonised data on patient-reported outcome and experience measures (PROMs and PREMs) from primary care users and their practices across OECD Member and Partner countries. Beyond PaRIS, other international population-based health and health system surveys include the European Health Interview Survey (EHIS), the International Health Policy (IHP) Survey of the Commonwealth Fund, the People's Voice Survey (PVS) and the Survey of Health, Ageing and Retirement in Europe (SHARE). Although these surveys may appear to collect similar information, they differ substantially in purpose, scope and methodology. This paper positions PaRIS within this wider ecosystem, examining its distinctive value proposition and the benefits of participating in PaRIS alongside existing international surveys, based on methodological comparisons and analyses of overlapping indicators.