

„Foundation stone for the development of healthcare s

Prof. Dr Oliver Gröne, Chief Scientific Officer and Head of Research at OptiMedis AG and member of the PaRIS-SUR consortium, believes that the OECD Patient-Reported Indicator Survey (PaRIS) initiative will have a similar significance to the OECD Programme for International Student Assessment (PISA). The first flagship report was recently presented to the public. The survey is to be carried out every four years in future and, according to Gröne, will provide a 'truly unique set of indicators' for the further development of the participating (so far) 19 countries. However, Germany and Austria, unlike Switzerland, are not yet represented as German-speaking countries.

Im Interview: Prof. Dr. Oliver Gröne,Chief Scientific Officer and Head of Research at OptiMedis AG

>> The Patient-Reported Indicator Survey (PaRIS) is an OECD initiative in which a number of countries are working together to develop, standardise and implement a new generation of indicators that measure the healthcare outcomes and experiences that matter most to people. The stated aim of the survey, initiated in 2017 on behalf of OECD health ministers (1): to develop a new international survey methodology for PROMs and PREMs, leading to a stronger focus of healthcare systems on patient-centred care. The first results were recently presented (2): What, Professor Gröne, have you done as a member of the PaRIS-SUR consortium (3) to date? What took you so long, knowing full well that after eight years some of the study results will be out of date?

„'Of course, we all hope that Germany, as a large and important country in Europe, will take part in this important study next time.'“

That is certainly a legitimate question. In 2017, the OECD Health Ministerial Meeting chaired by UK Health Secretary Jeremy Hunt - incidentally, the then German Federal Minister of Health Hermann Gröhe was one of the two deputy chairs - laid the foundations for PaRIS. This was the first time that it was ever discussed what exactly they wanted to know and what they wanted to achieve.

The purpose of this meeting in January 2017 of the 35 OECD member stateswas to exchange options for designing and implementing the 'next generation of health reforms' (4). Among other things, the OECD countries were asked to base the reorganisation of healthcare systems on more knowledge. In short: PaRIS was born.

further systems”

Precisely. However, this was initially only a request from the OECD health ministers to their countries to facilitate such a survey. Incidentally, PaRIS is absolutely comparable to the international school performance surveys that have been carried out in many OECD member states since 2000 under the now universally recognised term 'PISA'. When the 'Programme for International Student Assessment', or PISA for short, was conceived, it was not introduced from one day to the next. At that time, we first had to think very carefully about what an education system actually was, what it had to achieve and how the different systems could be compared with each other. It was precisely this fundamental work that we faced with PaRIS.

How did you proceed?

Within the OECD, various committees spent two years discussing what this study should look like and what it should achieve. The work to develop the survey's methodology was then put out to international tender and won by a consortium including the Netherlands Institute for Health Services Research (NIVEL) as consortium leader, the University of Exeter, the Avis Donabedian Research Institute (FAD), IPSOS and Optimedis. The design and development phase began in 2019, followed by the first field trial two years later and the main survey in 2023. The results derived from this on a whole range of variables from over 100,000 patients and 1,800 GP practices in 19 countries were finally presented to the public in February 2025.

This means that the survey has actually only been active for around four years.

That's right. But in these four years, the previously designed instruments and measurement criteria have been tested, compared, revised and further developed. And not to forget: very extensive discussions were held with representatives from over 25 countries. And all this in a very difficult time dominated by corona. Then a recruitment strategy had to be developed in practices in the participating countries, translated into various languages and implemented, which in turn was used to recruit patients. Now the Patient-Reported Indicator Surveys are to be conducted every four years as the first international survey of their kind and provide a truly unique set of indicators. These will show how people aged 45 and over who suffer from chronic diseases experience the services of primary care models and how this affects their lives - regardless of gender, income level or education.

An investment in the future.

Of course it is. The work we have done so far will be far less in the future. What is special, however, is that long-term comparisons will now also be possible. Even if the first current results - which will certainly be the case - are outdated at some point, they will represent a kind of zero point that is missing in many other studies. We have thus laid a very solid foundation for the further development of PaRIS and thus of all healthcare systems in the participating countries.

But not for Germany and five other countries, including Austria. What were the reasons for their abstention?

There were certainly a number of reasons, which were also asked about in the public presentation of the results by the OECD (5).

In your opinion, why did Germany and Austria, which were both in dialogue with the OECD, not participate?

Of course I can't answer for the countries, they have to do that themselves. But it was probably a series of reasons or simply not the right time. Perhaps the decision-makers also lacked an insight into what exactly the study would look like. Or as it was put at the OECD meeting at the beginning of February: 'The brave ones got on a train without knowing exactly where it was going. The direction was roughly known, but not the specific variables and measuring instruments. And above all, nobody knew in advance where their country would end up. This will now be a little easier in the second phase because we know exactly what is being surveyed and can predict with greater certainty in advance where we will rank in comparison

to other countries and systems. The OECD is currently in talks with other countries and, of course, with Germany. Of course, we all hope that Germany, as a large and important country in Europe, will take part in this important study next time.

Why was and will the study only be conducted in the outpatient sector? Primary care cannot be seen in isolation from the overall care process.

That is true. That's why it was very important for us to see how patients perceive their continuity of care. We all know that there are many construction sites at the transition between sectors - especially in Germany. We also see internationally that there is enormous potential for development at the transition from outpatient to inpatient care and that the 'coordination' factor should certainly be mentioned here first and foremost.

Why was only primary care included in PaRIS?

Of course, integrated care is crucial for the overall success of treatment and is therefore also a major topic at the OECD, which is being investigated in various studies. However, the approach of mapping GP care in an international comparison is difficult enough. Trying to map the entire care process is simply too complex.

In addition, this report only publishes the results of ten key indicators in all participating countries. Why is that? What do you mean by key indicators?

The key indicators favoured by the OECD in the PaRIS flagship report include five PROMs and five PREMs (7), all based on validated and tested instruments and selected after discussions with the PaRIS working group, the Health Committee and other experts - including the PaRIS-SUR consortium led by Nivel, of which Optimedis is a member (3) - and stakeholders.

Why exactly 10?

These 10 were considered by the OECD to be central to the report. We should also focus on them.

Was this done for political or truly scientific reasons? The results are different depending on which indicators you choose.

You are absolutely right. However, the OECD commissioned the ParSIS-SUR consortium, of which I am personally a member, to develop the methods required for the survey and to collect and analyse the data. At the end of the evaluation phase, the OECD received a large package of different analyses from us, a selection of which has now been incorporated into this report. I certainly believe that we as a consortium can claim that the analyses published in the current report are also the most important ones that we as a consortium have proposed as authoritative. In addition, the almost 300-page report contains many further analyses.

So there doesn't seem to have been any cherry-picking. What surprised you, both negatively and positively, about the results?

The negative aspect is actually that we saw a high degree of variability in the countries analysed. It was already clear beforehand that there was variability. However, the extent of this variability was often very high and really surprised us. The extent revealed here shows us more than clearly that, on the one hand, all ratings with rankings and comparisons must be treated with the utmost caution. On the other hand, this extent also shows us that we have not yet managed to reduce the reasons for this in all countries.

What are these reasons?

There are major inequalities in all healthcare systems, and this is one of the biggest issues highlighted by this study.

Could you define the term inequalities in more detail?

Firstly, there is the gender aspect: Many studies show that women are often disadvantaged in medicine. Other inequalities are linked to income, social position, language skills and health literacy. All of the factors mentioned here form a kind of cemented inequality in all healthcare systems around the world. The myriad of gaps triggered by them means that the very people who often need good healthcare the most fall through the cracks of the primary healthcare system and reappear elsewhere with higher healthcare needs and far higher healthcare costs.

The conclusion?

No healthcare system in the world is doing itself a favour if, for whatever reason, the socially weak and vulnerable patient groups are not given sufficient consideration and care.

Does this have to do with access or quality or both?

I would say both. The access factor alone has many components and dimensions. It can be physical access. Or even the fundamental problem of identifying the right doctor's surgery, finding the way there or reaching the surgery in the first place - access for the disabled, for example, is unfortunately not available everywhere. In German cities, for example, a doctor's surgery is on average less than one kilometre away from a person's home, whereas this is not the case in many other countries. There are also many other questions, such as: How do I choose a good doctor? Or: How do I get an appointment promptly? What do I get reimbursed for and what not? All of these factors create many barriers to access that hit vulnerable groups particularly hard compared to those who are better off financially and in terms of their health literacy.

Are there any positives to report?

One positive finding is that, on the one hand, high-quality care only correlates with healthcare expenditure to a certain extent. On the other hand, there are also good examples of countries that achieve very good results with lower healthcare expenditure.

'PaRIS shows that although countries that spend more on health tend to achieve better health outcomes, it is also possible to achieve good results with lower health expenditure,' said OECD Secretary-General Mathias Cormann at the presentation of the PaRIS results.

Countries such as Australia, Canada and Switzerland spend above-average amounts on healthcare and therefore achieve above-average results in terms of patients' assessment of the quality of care. However, the (moderately) positive correlation between healthcare expenditure only applies to three of the ten core indicators. On the other hand, countries such as France, Slovenia and the Czech Re-

public spend less than the average, but still achieve very good results. The majority of the core indicators are not primarily dependent on healthcare expenditure. This is an important realisation, especially for countries like Germany, which already invest an enormous amount in healthcare.

Let's take a look at a results chart in which the participating countries are listed in order to show where they lie in comparison to the OECD average. At the top of the list is Switzerland: a true model country for primary care (6)?

It is important to note that this is a comparison with the average. Switzerland ranks very highly in this comparison and has performed very well in many of the ten key indicators. This is a good result for our neighbouring country. However, this does not mean that the Swiss can sit back and relax. More in-depth analyses show that Switzerland should not sit back and relax despite its high healthcare budget. We have seen high variability not only between but also within countries. In some cases, there are considerable regional differences as well as serious variability in the results at practice level. Knowing this alone is a gain in itself: now, on the basis of such an analysis, further questions can be asked, such as: Why is one canton, i.e. federal state, doing better than others? Why is it that some practices in the same region of a country achieve excellent results and others do not? The number of well-trained doctors and nurses is very relevant in the current survey. But practice organisation (digitalisation, linking) also has a significant impact on patient experience and health outcomes.

For you personally, what were the most important key indicators that enable healthcare systems to improve?

The recently published report is almost 300 pages long and describes all 150 indicators and the many results they generate in great detail. Depending on how you analyse these indicators or which indicators you combine with each other, more and more findings emerge. Although I certainly have personal favourites, I do believe that the ten indicators selected by the OECD are very well able to provide a coherent summary of what we have collected.

What is your key finding?

Here, too, I have to refer to the report because the results are simply too varied and all equally important. But one finding is not explicitly stated in it: you have to combine PROMs and PREMs if you want to generate results that are relevant to the goal. Only the mixture of results and patient-reported experiences gives us very important clues as to how patients not only experience care, but what they personally get out of it. Of course, the whole thing must not be detached from the actual health outcomes achieved, but these are relativised to a certain extent. I was therefore very pleased that the consortium managed to anchor two aspects in this study that were perhaps not intended in this depth.

What do you mean?

The first is coordinated care and the second is self-management, or to be more precise: confidence in self-management and self-management skills per se. This is actually quite logical, as the PaRIS survey is a survey of chronically ill people, for whom self-management is central. We know from many studies, for example, that in the care of diabetics, two hours of contact with a doctor are offset by around 6,000 hours of self-management - per year, of course.

This surely raises the question of how wecan empowerpatientsto take an even more active role in the self-management of their health and what role the medical profession has to play.

These are my two personal favourites. On the one hand, the survey gives us good evidence of what should actually be done to improve self-management; on the other hand, it shows us exactly the current situation in primary care and the large gap between what is expected and the reality. Of course, we already know from many other sources that there is an enormous need for development here, but the PaRIS analyses of the indicators surveyed give us excellent pointers for the further development of self-management.

For example, whether or not pilots are used in certain healthcare systems?

This is certainly a model that could be analysed on the basis of the findings available with PaRIS. This was not the case in this study because although the pilot concept is known internationally, it has not yet been used in a standardised way, so it is not possible to compare the improvements in outcomes that can be achieved with it.

Would it not be possible to draw conclusions from the more than 150 indicators contained in two questionnaires - one for patients and the other for doctors?



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Surely that would be possible. PROMs and PREMs depict the current state of health experienced on the basis of social and structural characteristics - that is the 'patient' unit. The provider fees developed by Optimedis add results that reflect the structural reality of care: How is the practice set up in terms of data networking? How does a patient get appointments? How long does it take? Does it work electronically?

To come back to the question of the pilot function ...

... we included some questions on the subject of 'care planning' and 'care management' in the doctors' questionnaires. Here we asked how the planned care process is being handled by the GP in relation to what happened before and what should happen afterwards. This includes questions such as: 'How does the GP receive information about what other groups of doctors - including specialists - have done?' 'How does the treating doctor pass on the information required for further treatment?' 'Is there even a treatment plan for the patient?'

Is there such a plan?

Rarely. In many countries, care even for the chronically ill is rather sporadic and the patient comes back the next quarter on their own initiative. In Canada, for example, the concept of the care plan is very well established, where a precise treatment plan is drawn up for a year or six months, detailing what should happen and when. The plan and actions are then recorded and reviewed in a structured manner.

Could a pilot function be investigated at this point?

You certainly could. The important question is not only how to fulfil the plan once it has been drawn up, but also how patients can and must be supported to participate as actively as possible. This is precisely the task of a pilot. Let's see if we see any hints on this in further reports. After all, this 300-page flagship report is just the first of many more. But there are so many other ways to analyse the data we have - there are already 20 papers in the pipeline.

What can the participating countries learn in order to improve their healthcare systems?

That depends on the system in question. With younger systems - I'm thinking of Saudi Arabia, for example - I see great opportunities for change. Older, long-established systems, on the other hand, have usually developed a high degree of path dependency, which makes it difficult to initiate further development. Nevertheless, it is worthwhile for everyone to take a closer look at the data now available. Very interesting insights can be gained by comparing at the level of individual indicators which country is doing particularly well and which is not, and analysing the reasons for this in greater depth in a second step.

What could the new or old health minister learn, even if Germany did not take part in the first survey?

The future health minister, whoever it is, could first of all inform himself about the study and should think very carefully about whether Germany should take part in Round 2 in four years' time. Secondly, consideration should be given to how PROMs and PREMs can be more firmly anchored in healthcare, of course only where it makes sense, instead of using the famous German scattergun approach to collect everything - and therefore a lot of useless information. Thirdly, based on the PaRIS results, it would make sense to consider how primary care, which is very strong in Germany, can be better integrated into the overall treatment process and how all stakeholders can be better linked in terms of information. The EHR, which is now in the rollout phase, can play a very important role here if it succeeds in creating a meaningful continuity of information and transforming it into a tangible, coherent continuity of care in the long term. If technically feasible, it will also make sense to integrate PROM and PREM into the EPR at the same time. However, this needs to be analysed in detail beforehand.

Prof Gröne, thank you for talking to us. <<

The interview was conducted by editor-in-chief Peter Stegmaier..

Literature

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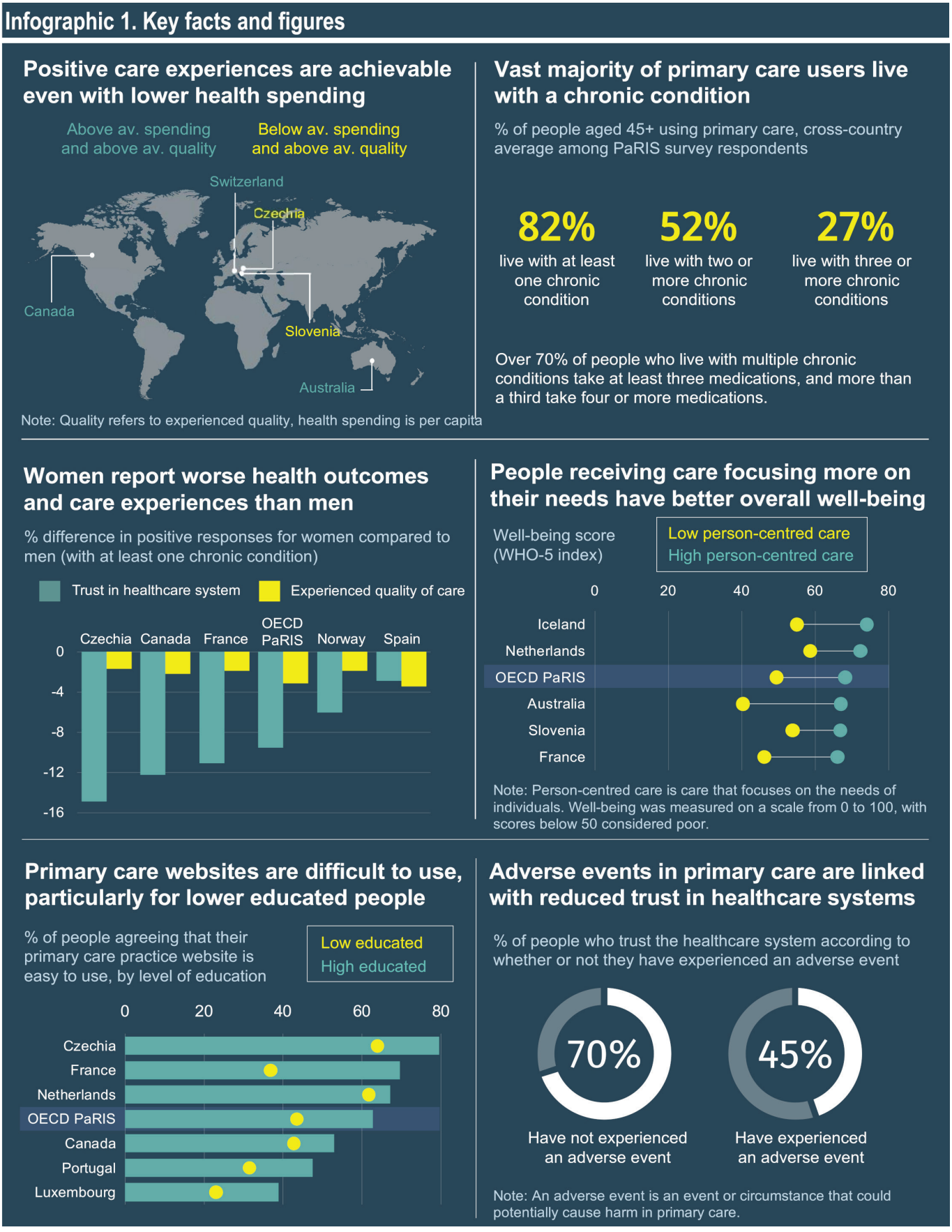


Fig. 1: Infographic 1: Key facts and figures. Source: OECD flagship report 'Does Healthcare Deliver?', p. 18.