Methodology Report

2025 International Health Policy Survey of Primary Care Physicians

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Overview

The Commonwealth Fund (Fund) is a private foundation dedicated to promoting a health care system that achieves better access, improved quality, and greater efficiency, with a focus on society's most vulnerable groups. As part of its mission, the Fund has been conducting the International Health Policy (IHP) Survey in 10 countries for more than two decades. In a triennial cycle, the IHP survey targets different populations, including physicians, older adults, and the general adult population. The population for the 2025 survey is physicians.

The Commonwealth Fund and other country partners contracted with SSRS to oversee all aspects of survey administration for the 2025 IHP survey conducted among physicians in Australia, Canada, France, New Zealand (NZ), the United Kingdom (UK), and the United States (US). SSRS fielded the survey in the US and Canada and collaborated with fieldwork partners to field the survey in other countries. Specifically, SSRS partnered with: Efficience 3 (E3) to field the survey in France; The Royal New Zealand College of General Practitioners (RNZCGP) to field the survey in New Zealand; TKW Research Group (TKW) and Ekas to field the survey in Australia; and Adkins Research Group (Adkins) to field the survey in the UK. SSRS also provided project oversight and data integration for Germany, the Netherlands, Sweden, and Switzerland. The Federal Ministry of Health (BMG) contracted with the Robert Koch Institute (RKI) to manage the data collection process and field the survey instrument in Germany. Radboud University fielded the survey in the Netherlands. The Swedish Agency for Health and Care Services Analysis (Vardanalys) contracted with Statistics Sweden to manage the data collection process and field the survey instrument in Sweden. The Switzerland Federal Office of Public Health (FOPH) contracted with M.I.S. Trend to do the same in Switzerland.

The 2025 study was designed to explore and collect reliable health-related data for the following topics:

- Access to care
- Use of telehealth
- Care management for patients with chronic conditions and other special needs
- Care coordination with other providers
- Care coordination with home care and social service providers
- Office systems and use of information technology
- Provider experiences with their practice
- Mental health
- Perspectives on the health care system, artificial intelligence, and climate change
- Practice profile and demographic data

As in past iterations of the IHP Survey of Primary Care Physicians, different modes (and for several countries, multiple modes) were used for data collection. These modes are tailored to best practices for reaching primary care physicians in each country and are generally consistent with modes used in 2022[1] and past iterations of the IHP Survey of Primary Care Physicians. Table 1 outlines the total number of completed interviews and modes used for each country for recruitment and completion. Fieldwork

[1] In Australia, a physicians panel was introduced to the sample design for a portion of the interviews achieved.

occurred between March 12 and September 8, 2025. The field times varied by country and are specified in Table 1.[2]

TABLE 1: Modes of Recruitment/Completion Used, Completed Interviews, and Fieldwork Dates for each Country

	Modes of Recruitment/Completion	Final N	Field Start Date	Field End Date
Australia	Phone/email recruit to online	409	4/2/2025	7/1/2025
Canada[3]	Postal mail recruit to online/mail	1,797	3/19/2025	9/4/2025
France	Postal mail recruit to online/mail	318	4/4/2025	9/8/2025
Germany	Postal mail/email recruit to online	1,773	4/4/2025	6/2/2025
Netherlands	Postal mail recruit to online/mail	415	5/1/2025	9/22/2025
New Zealand	Email recruit to online	363	3/19/2025	9/2/2025
Sweden	Postal mail recruit to online	2,157	3/13/2025	5/16/2025
Switzerland	Postal mail recruit to online	1,313	3/24/2025	9/1/2025
UK	Phone recruit to phone (CATI)/online	1,003	3/17/2025	7/11/2025
US	Postal mail recruit to online/mail	1,347	3/12/2025	9/4/2025

The report is organized into five sections. The project Overview is provided in the first section. Sample Design and the Response Rate for each country are outlined in the second section. The third section provides information on Data Collection procedures for each country. The final sections describe Weighting procedures, and project Deliverables/Updates.

[2] Field time ranged from nine to 25 weeks.

[3] In early September 2025, data were pulled and processed for Canada while data-collection for the oversamples sponsored by CIHI, MSSS, and Ontario Health continued in order to ensure timely delivery of the main sample's weighted data and deliverables to the Fund and the survey's partners across countries. An updated dataset with the remaining Canada interviews was delivered to the Canadian partners.

Sample Design and Response Rates by Country

The survey utilized random samples of primary care physicians in ten countries. Since primary care physicians in many countries treat adults and children (e.g., Australia, New Zealand, the Netherlands, and the UK), pediatricians were also included in countries where primary care physicians exclusively treat adults (US, Germany, and Switzerland) to make the samples across the countries equivalent.

Efforts were made to release sample in batches/waves to allow for oversampling, as needed, of specific geographies, and 'work' the sample throughout the field period in order to ensure that the final sample of completed interviews would be representative of both those who respond more quickly and those who require additional contacts (via phone, email, or mailings) to complete the survey.

The response rates for this study were calculated using AAPOR's RR3 and are provided in each country's sample design section below.

Australia

The PCP sample design in Australia utilized two different sources. The main sample was drawn by TKW from a national list of physicians provided by the MDA (Medical Directory of Australia), similar to previous IHP physician surveys. The list contains over 25,000 Australian physicians and is updated on a monthly basis. Where possible, TKW leveraged contact information from their own physician database, matching any records from the database to the random sample drawn from the MDA. Physicians sampled corresponded to general practitioners. The sample was stratified by region. 4,185 records were selected from the MDA.

New to IHP 2025, Australia data collection also utilized a physician panel via SSRS's partner Ekas[4]. Ekas hosts the largest healthcare panel in Australia, with more than 44,000 practicing medical professionals included. Introducing a physician panel for this wave allowed SSRS to leverage the operational efficiency of a panel while also mitigating increasing costs for physician research in Australia. SSRS provided Ekas with targets by demographic subgroups, and a total of n=151 physicians were invited to take the survey.

TABLE 2: Final Dispositions – Australia

Total records	4,336
Ineligible[5]	47
Valid sample	4,289
Completes	409
Response Rate	24.8%

[4] https://www.ekas.com.au/

[5] This group was mainly composed of PCPs who screened out as not being involved in primary care. In Australia (similar to NZ), a screener was implemented asking PCPs whether they want to participate and if they are involved in direct patient care or not.

Canada

The PCP sample in Canada was drawn from a national list of physicians provided by Professional Targeted Marketing (PTM). The list was derived from the Canadian Medical Directory master file. The list contains over 91,000 Canadian physicians and is updated on a monthly basis. PTM databases include office-based mailing addresses for all of the physicians and email addresses for approximately 64% of physicians. Physicians sampled were general practitioners and family practitioners. Sample was randomly selected among each of these groups and certain provinces were oversampled. 11,630 records were selected.

TABLE 3: Final Dispositions – Canada

	Total Canada
Total records	11,630
Non-deliverables and ineligibles[6]	18
Valid sample	11,612
Completes	1,797
Response Rate	16.1%

France

The sample for physicians in France was randomly selected from a comprehensive list of general practitioners provided by SSRS's partner, Sample Solutions[7]. This list was created by aggregating physician information across several publicly-available databases of physicians in France (e.g., the Health Directory[8], 118,000 Telephone Directory[9], OpenDataSoft[10], etc.). For waves 2 and 3, sample was pulled exclusively from the Health Directory and OpenDataSoft, as those sources yielded the highest response. The resulting sample frame, which encompasses 142,932 physicians, includes mailing address for all records and phone number, email address, or both for a subset. A total of 6,700 records were selected across three sample releases.

TABLE 4: Final Dispositions – France

Total records	6,700
Ineligibles	48
Valid sample	6,652
Completes	318
Survey Response Rate	5.6%

[6] The "ineligible" category corresponded in most instances to a small group of respondents who directly contacted SSRS about not being in primary care, being retired or for whom information about being deceased was obtained.
[7] https://sample.solutions/
[8] https://annuaire.sante.fr/ - The Health Directory is a public list of health professionals registered in the national RPPS and ADELI directories and their practice situations. These data come from the authorities responsible for their registration.
[9] https://www.118000.fr/ - The 118,000 is a public telephone directory (i.e., Yellow Pages) of professionals and businesses, including healthcare professionals.
[10] https://public.opendatasoft.com/ - OpenDataSoft, now known as HuWise, is a repository of public data, including healthcare professionals.

Germany

For Germany, the sample for the survey was drawn from the Federal Physician Register of The National Association of Statutory Health Insurance Physicians (KBV), the organizing body of public insurance covered physicians in Germany. The Federal Physician Register lists every physician or psychotherapist participating in statutory health insurance coverage, including pediatricians. A random 24,997 physicians were drawn from the list of 62,871 physicians for this study, including an oversample of pediatricians.

TABLE 5: Final Dispositions – Germany

Total records	24,997
Ineligibles	31
Valid sample	24,966
Completes	1,773
Survey Response Rate	7.2%

The Netherlands

The Dutch PCP sample was randomly drawn from the database of the Netherlands Institute of Health Services Research (NIVEL). The database contains approximately 4,800 practices. Physicians sampled corresponded to primary care physicians. A selection of 1,500 practices was employed.

TABLE 6: Final Dispositions - The Netherlands

Total records	1,500
Completes	415
Response Rate	27.7%

New Zealand

In New Zealand, SSRS partnered with the Royal New Zealand College of General Practitioners (RNZCGP) to use their membership list for the sample for the IHP survey. RNZCGP is the professional body and postgraduate educational institute for general practitioners and rural hospital doctors in New Zealand. Invitations were sent to 3,851 GPs in the RNZCGP list.

TABLE 7: Final Dispositions - New Zealand

Total records	3,851
Ineligible[11]	10
Valid sample	3,741
Completes	363
Response Rate	9.6%

[11] This group was mainly composed of physicians who screened out as not being involved in primary care. In New Zealand, similar to Australia, a screener was implemented asking sampled physicians whether they want to participate and if they are involved in direct patient care or not.

Sweden

PCPs in Sweden were sampled from the Occupational Register (YREG) combined with the registry on Educational attainment (UREG). Both the YREG and UREG are updated every year, however the YREG updates are based on data from two years prior (e.g., 2025 updates based on 2023). YREG was the primary source for the sample frame, with a requirement that a physician was classified as gainfully employed in November 2023. These individuals were then checked with UREG. Only persons who have completed a medical education according to UREG, were included in the sampling frame. 6,000 records were selected.

TABLE 8: Final Dispositions – Sweden

Total records	6,000
Ineligibles	224
Valid sample	5,776
Completes	2,157
Response Rate	39.5%

Switzerland

The sample in Switzerland was provided by The Swiss Medical Association (FMH) member file. The sample was then randomly selected. The Italian and French Linguistic regions were oversampled, as well as pediatricians. Initially only one release was planned; however, due to an error in the first release that inadvertently excluded pediatricians, a smaller second release sampled pediatricians only. 3,900 records were selected from the list in total across both sample releases.

TABLE 9: Final Dispositions – Switzerland

Total records	3,900
Ineligibles[12]	35
Valid sample	3,865
Completes	1,313
Response Rate	34.4%

The United Kingdom

The UK sample of PCPs was drawn from an online source provided by Specialist Info and Adkins' proprietary panel. This list is updated daily and has details on 80,147 general practitioners. The London, Scotland, Wales and Northern Ireland regions were oversampled. A total of 2,393 records were selected from the sample list.

TABLE 10: Final Dispositions – UK

Total records	2,393
Ineligibles	2
Valid sample	2,391

[12] Includes respondents who said they are not PCPs, bad addresses, PCPs who died, or cases where the postal address nor the phone number is working.

Completes	1,003
Response Rate	42.0%

The United States

SSRS procured the sample for PCPs in the United States from RediData, an official licensee of the American Medical Association (AMA) Masterfile. Updates to the AMA list are handled through various methods, including verification calls and physician self-inquiries. Additionally, the database leverages AMA activities such as membership and publishing and also allows licensed physicians to update their information online. Physicians sampled were internal medicine physicians, family medicine physicians, general practitioners, or pediatricians. The sample was randomly selected among each of these groups, with pediatricians being undersampled relative to their proportion in the PCP universe and rural physicians oversampled.

RediData databases include mailing addresses of preference for all of the physicians (office-based or home-based) and email addresses for more than three-quarters of physicians. 7,449 records were selected for this study via RediData.

TABLE 11: Final Dispositions – US

Total records	7,449
Ineligibles	38
Valid sample	7,411
Completes	1,347
Response Rate	19.9%

Data Collection

Questionnaire Development, Translations and Cultural Adaptations

In the fall and winter of 2024, the IHP 2025 questionnaire was developed and revised by The Commonwealth Fund and its international partners. SSRS reviewed the final questionnaire and provided feedback about question wording, order, clarity, logic/programming, and other issues related to questionnaire quality and design across modes. The survey consisted of paper, online and computer-assisted telephone interviews of random samples of primary care doctors in ten countries, using a common questionnaire that was translated and adjusted for country-specific wording as needed. A few countries included an additional set of questions specific to their country. SSRS worked with each country partner in designing questions that would better suit their data collection requirements by providing feedback on structure, wording, length and overall design.

SSRS created a master Web/CATI questionnaire for online and telephone administration and a preferred paper survey format.[13] The Web/CATI questionnaire included programmer and interviewer instructions

[13] For most countries where data were collected online, the "www.internationaldoctorstudy" domain name was used. The top-level domains were differentiated as follows: Canada used (.ca), NZ: (.org.nz), the UK: (.uk), and the US: (.org or .com). For Australia, the www.internationaldoctorsurvey-au.org domain was selected. For France, the www.etudeinternationaledesmedecins.fr was selected.

that were to be used in the various modes. The Web/CATI questionnaire contained all country-specific introductions, questions, and instructions for countries that offered the survey in web and telephone formats. A preferred paper template was developed based on best practices in paper survey design aimed at promoting respondent completion by making the survey more user friendly, easy to understand, and consistent in format. SSRS provided an English language paper questionnaire in the preferred format to all countries using a paper survey mode. Each of the countries adapted the paper survey format, as needed, based on their survey administration requirements.

Upon approval from The Commonwealth Fund research team, SSRS prepared the questionnaire for translation and new and revised questions were translated into Canadian-French, French, German, Dutch, Swedish, Swiss-Italian, Swiss-French, and Swiss-German. SSRS's translation partner, THG Fluently, translated the Canadian-French and French instruments and other mailing materials (e.g., invitation letters, reminder letters, and endorsement letters in Canada). RKI translated the German instrument, Radboud translated the Dutch instrument, M.I.S. Trend translated the Swiss-Italian, Swiss-German, and Swiss-French instruments, and Statistics Sweden translated the Swedish instrument.

The translated documents were reviewed by the Fund's international partners for both new and previously translated questions to confirm that they were comprehensible, meaningful for respondents and comparable to the English-language versions of each question. Throughout the translation process, efforts were made to ensure that the question meaning of the translated questions would not deviate from the unified questionnaire or disrupt trend.

Survey Procedures by Country

Australia

SSRS's fielding partners, TKW and Ekas, fielded the survey in Australia. The survey was in field from April 2 – July 1, 2025. Prior to the field period, SSRS programmed the study into SSRS's Web Interviewing system for online data collection in Australia. For consistency purposes across countries, the web domain used in Australia was www.internationaldoctorstudy-au.org. Extensive checking of the programs was conducted to assure that skip patterns followed the design of the questionnaire. The SSRS team paid close attention to mobile optimization, as the use of mobile devices to complete online surveys continues to rise.

Pretest interviews were conducted in Australia in late January to early February 2025. Overall, the instrument worked quite well, and respondents seemed to be engaged in the interview. TKW conducted five cognitive pretest interviews in Australia. Fieldwork managers confirmed that all interviewed respondents were comfortable talking about their health experiences as a healthcare provider.

During the field period, TKW contacted physicians in a two-step process: The first step involved inviting respondents (via the phone or email) to participate in the study. Once doctors agreed to participate, the second step consisted of sharing a confirmation letter with a link to the online survey via email. Reminders were attempted with physicians who had not responded. To encourage participation, PCPs were offered an incentive of AUS$120.

Ekas contacted physicians on their panel via email, with invited panelists receiving an invitation email and one reminder. Ekas performed targeted outreach to their panel based on collaboration with the SSRS project team to maximize response from demographic sub-groups by age, gender, and region in Australia. To encourage participation, PCPs were offered an incentive of AUS$85.

Canada

SSRS fielded the survey in Canada. Similar to previous physician surveys, oversamples were collected at a national level as well as in Quebec and Ontario[14]. For the 2025 study, a census was conducted in Prince Edward Island (PEI) and the Canadian territories.

The survey was in field from March 19 – September 8, 2025[15]. All respondents were recruited via postal mail and invited to participate in a paper-copy or online version of the survey. Prior to the field period, SSRS programmed the study into SSRS's Computer-assisted online interviewing system (webCATI) for data collection in Canada. For consistency purposes across countries, the web domain used in Canada was www.internationaldoctorstudy.ca. Additionally, a process was implemented where Canadian respondents who by mistake typed the ".com" or ".org" top-level domains (which were the US top-level domains) were automatically re-directed to the ".ca" version. Extensive checking of the programs was conducted to ensure that skip patterns followed the design of the questionnaire. The computer-assisted instruments were tested to ensure that all of the language inserts were working properly. The SSRS team paid close attention to mobile optimization, as the use of mobile devices to complete online surveys continues to rise. SSRS also designed a paper survey to be used in Canada following best practices to maximize usability and respondent completion.

Six pretest interviews were completed in Canada between January 13 and January 28, 2025. Two were conducted using the web program in English, two in English using the paper survey, one using the web program in Canadian French, and one using the paper survey in Canadian French[16]. Every effort was made to complete interviews among as representative of a population as possible. Respondents were asked to provide feedback on the instrument/program and invitation letter. Upon completion of the pretest interviews, SSRS provided a memo of the pretest findings to the Fund and also provided feedback to the Canadian partners.

To encourage participation, primary care doctors were mailed an endorsement letter[17], an incentive check of $25 USD (included with the first paper questionnaire), and a list of publications based on previous International Health Policy surveys (See Table 3 below). Additionally, to maximize response rates and

[14] Ontario was not oversampled in IHP 2022.
[15] Due to delays in receiving completed paper surveys from the Canadian mail partner to the US-based processing partner, fieldwork was extended until October 17, 2025 in Canada.
[16] Canadian French pretest interviews were conducted in English with bi-lingual physicians who assessed the Canadian French versions of the survey and other materials.
[17] In the first wave, the Canadian Institute for Health Information (CIHI) provided endorsement letters for all sampled physicians. In the second wave, Ontario Health provided endorsement letters for sampled physicians in Ontario, the Ministère de la Santé et des Services sociaux (MSSS) provided endorsement in letters for sampled physicians in Quebec, and CIHI provided endorsement letters for sampled physicians in all other provinces and territories

based on pretest feedback, similar to IHP 2022, SSRS implemented a strategy that allowed respondents in Canada to provide their email address so that highlights on the survey results can be shared when they are available. Respondents across all provinces had the option to complete the survey in English or Canadian French online.

Doctors in Canada received an advance invitation including the web link and up to seven additional contacts/reminders during the field (i.e., three paper questionnaires, one reminder letter, and up to three email reminders). Sample was released in three waves: wave 1 included physicians proportionally by province, wave 2 included an oversample of physicians in Quebec and Ontario, and wave 3 included physicians only in Quebec and Ontario. Detailed specifications for each contact/wave are outlined below. Doctors in Quebec were sent all postal mailings in English and Canadian French; emails were sent in Canadian French to doctors in Quebec. Email reminders were sent to the sample for which email addresses could be appended by the sample provider (Professional Targeted Marketing (PTM)).

TABLE 12: Canada Contact Schedule

Contact	Type of Contact	Wave 1	Wave 2	Wave 3	Documents included
1	Postal	3/19/25	7/7/25	8/1/25	Personalized letter, with color logo, URL and passcode to complete survey online
					List of The Commonwealth Fund's publications
2	Postal	4/2/25	7/16/25	8/6/25	Personalized letter, with color logo, URL and passcode to complete survey online
					Endorsement letter
					8-page paper questionnaire with 1-page insert
					Postage-paid reply envelope
					$25 USD check (except in Northwest Territories)
3	Postal	4/16/25	7/21/25	8/11/25	Personalized letter, with color logo, URL and passcode to complete survey online
					8-page paper questionnaire with 1-page insert
					Postage-paid reply envelope
4	Email	4/21/25	7/30/25	8/12/25	Email with passcode-embedded web link
5	Postal	4/29/25	7/25/25	--	Reminder letter
6	Email	5/6/25	8/12/25	--	Email with passcode-embedded web link
7[18]	Postal	7/16/25	--	--	Personalized letter, with color logo, URL and passcode to complete survey online
					8-page paper questionnaire with 1-page insert
					Postage-paid reply envelope
					$25 USD check
8	Email	8/12/25	--	--	Email with passcode-embedded web link

Table 13, below, shows the completes by mode.

[18] To maximize completes in provinces with lower populations of physicians (New Brunswick, Newfoundland & Labrador, and Nova Scotia), an additional mailing and email were send to nonresponding physicians from Wave 1 in these provinces.

TABLE 13: Canada Completes by Mode

	Quebec	Ontario	Rest of Canada	Total Canada
Web	289	455	441	1,184
Paper	140	184	288	612
Total	429	639	729	1,797

SSRS maintained a master file of contacts initiated by Canadian respondents throughout the field period. This file included information about the reason behind the communication established with the respondent and the decisions made to proactively address the issue raised. In addition, hand-written comments in paper surveys were saved into an excel file.

Given the multi-modal nature of this survey, there were some duplicate cases (i.e., respondents who complete a paper and web survey or two or more paper surveys) that needed to be addressed.

For duplicate cases, the following rules were followed to select the cases that were kept in the final data file.

- If duplicate cases for a particular respondent had different modes of completion (i.e., mail and online), the online case was kept.
- The case with the earliest date of completion was selected for duplicate cases with identical completion response rates and mode of completion (e.g., two mail-based interviews from a single respondent).

France

SSRS's fielding partner, E3, fielded the survey in France. The survey was in field from April 4 – September 8, 2025.

Five pretest interviews were completed in France between February 5 and February 12, 2025. Three were conducted using the web program, and two using the paper survey. Every effort was made to complete interviews among as representative of a population as possible. Respondents were asked to provide feedback on the instrument/program and the invitation letter. Upon completion of the pretest interviews, SSRS provided a memo of the pretest findings to the Fund.

Prior to the field period, SSRS programmed the study into SSRS's Web Interviewing system for online data collection in France. For consistency purposes across countries, the web domain used in France was www.etudeinternationaledesmedecins.fr. Extensive checking of the programs was conducted to assure that skip patterns followed the design of the questionnaire. The computer-assisted instruments were tested to ensure that all of the country-specific language inserts were working properly. The SSRS team paid close attention to mobile optimization, as the use of mobile devices to complete online surveys continues to rise.

Fieldwork in France was broken up into three waves. Across all waves, sampled doctors were invited via mail outreach with an invitation letter and a paper survey, with an option of completing the survey online.

In wave 1, a random subset of doctors were selected based on availability of additional contact information in the sample-frame to receive phone or email reminders. As these proved unsuccessful in reaching doctors, no further phone or email reminders were performed in waves 2 or 3. Sampled physicians in wave 1 were offered an incentive of 30 euros for participation. In wave 2, a reminder letter with an increased incentive of 50 euros was offered to physicians who did not respond to the invitation letter for that wave. Sampled physicians in wave 3 were offered an increased incentive of 50 euros for participation in the initial invitation letter that they received.

Table 14 below shows the completes by mode.

TABLE 14: France Completes by Mode

	Total France
Web	170
Paper	148
Total	318

Germany

The Federal Ministry of Health (BMG) contracted with the Robert Koch Institute (RKI) to conduct the survey in Germany. The survey was in field from April 4 – June 2, 2025.

Before starting the field, RKI pretested the German version of the instrument with thirteen primary care doctors using a cognitive validation format. The interviews were conducted between March 17 – March 25, 2025. Based on the pretest, minor translation updates were made.

Primary care doctors were recruited via postal mail and invited to participate in an online version of the survey. About three weeks after the invitation letter was mailed, any non-responders were sent a reminder letter asking them to complete the survey, followed by a second reminder letter two weeks later. Physicians for which an email address was available (roughly half of the sample) were sent a final email reminder two weeks after the second reminder letter.

TABLE 15: Germany Contact Schedule

Contact	Date	
1	**4/4/25**	Invitation letter
2	**4/28/25**	First reminder letter
3	**5/12/25**	Second reminder letter
4	**5/27/25**[19]	Reminder email

[19] A prior email reminder was sent on May 22, however there was a technical error with this reminder, and a replacement communication was sent on May 27.

The Netherlands

The Netherlands conducted the fieldwork via the Dutch Ministry of Health, part of the Radboud University Medical Center. The survey was in field from May 1 – September 22, 2025.

Before starting the field, the Dutch Ministry of Health pretested the Dutch version of the instrument with four primary care doctors using a cognitive validation format. The interviews were conducted between April 20 and April 29, 2025. Two interviews were conducted by web, and participants provided feedback via email, and two interview were conducted via phone. Based on the pretest, some contextual translation edits were made in the Netherlands.

Primary care doctors were recruited via postal mail and invited to complete the survey via web. Non-responders were first sent one reminder letter, including the link to take the survey online. After two waves of invitations yielded low response, a paper questionnaire was developed. Non-responders were then sent up to two reminder letters, along with the paper questionnaire. No financial incentive was offered in the Netherlands.

TABLE 16: The Netherlands Contact Schedule

Contact	Wave 1	Wave 2	Netherlands
1	5/1/25	6/3/25	Invitation with link to online survey
2	5/15/25	6/17/25	Reminder with link to online survey
3	7/18/25	7/18/25	Reminder letter
			11-page paper questionnaire
4	8/15/25	8/15/25	Reminder letter
			11-page paper questionnaire

Data management was performed with Microsoft Access Database. The paper questionnaires were entered in the format of the online questionnaire. If questions had been left blank or if multiple answers had been entered, answers were adjusted using SPSS syntax.

New Zealand

SSRS partnered with the Royal New Zealand College of General Practitioners to field the instrument in New Zealand. The survey was in field from March 19 – September 2, 2025. SSRS programmed the study into SSRS's Web Interviewing system for online data collection in New Zealand. For consistency purposes across countries, the web domain used in New Zealand was www.internationaldoctorstudy.org.nz. Extensive checking of the programs was conducted to assure that skip patterns followed the design of the questionnaire.

Six pretest interviews were completed in New Zealand between February 11 and February 19, 2025. Respondents were asked to provide feedback on the instrument/program. Upon completion of the pretest interviews, SSRS provided a memo of the pretest findings to the Fund.

RNZCGP managed email outreach to its members, inviting them to take the survey. An invitation email was sent to the full sample, explaining the study and providing a personalized link to take the survey online. Up to three reminder emails (electronic direct messages or eDMs) were sent to physicians who had not yet completed the survey. Additionally, the survey was promoted by the RNZCGP in multiple releases of their weekly bulletin, ePulse, with preliminary unweighted trends in the data across countries highlighted to encourage participation. In the April 2025 edition of the monthly e-magazine, GP Voice, the Fund collaborated with RNZCGP to write an article highlighting the importance of the survey. Lastly, RNZCGP promoted the survey at planned intervals throughout fieldwork via social media.

Sweden

Sweden contracted with Statistics Sweden (SCB) to manage the data collection process and field the instrument in Sweden. The survey was in field from March 13 – May 16, 2025.

SCB programmed the survey for online data collection. In general, SCB designed their web program in keeping with best practices for online surveys. Pretest interviews were not conducted in Sweden.

PCPs were recruited via postal mail and invited to participate in an online version of the survey. Actively practicing doctors and those who have been actively practicing within the past six months were screened into the survey. Doctors in Sweden received a letter including the web link and up to three additional reminders during the field. No financial incentive was offered in Sweden.

TABLE 17: Sweden Contact Schedule

Contact	Contact Type	Date	Switzerland
1	Postal	3/13/25	Cover letter with web link, passcode, and QR code
2	Postal	3/27/25	Reminder letter #1 with web link, passcode, and QR code
3	Postal	4/9/25	Reminder letter #2 with web link, passcode, and QR code
4	Postal	4/24/25	Reminder letter #3 with web link, passcode, and QR code

Switzerland

Switzerland contracted with M.I.S. Trend to field the survey in Switzerland. The survey was in field from March 24 – September 1, 2025.

M.I.S. Trend programmed the survey for online data collection. SSRS tested M.I.S. Trend's programmed survey to ensure that the programming was consistent with the web surveys in other countries. Prior to fieldwork, ten pretest interviews were conducted in Switzerland over the three linguistic regions. These interviews included just a selection of questions to test rather than the full survey. A few minor changes were made based on the pretest findings.

Primary care doctors were recruited via postal mail and invited to participate in an online version of the survey. In the first sample release, about one month after the invitation letter was mailed, any non-responders were sent a reminder letter asking them to complete the survey, followed by a second reminder one month later. Due to an error in the first release that inadvertently excluded pediatricians, a

second sample release was needed that sampled pediatricians only. Because of timeline constraints this second release did not include a second reminder letter, but otherwise followed the same protocol as the first release.

TABLE 18: Switzerland Contact Schedule

Contact	Contact Type	Wave 1	Wave 2	Switzerland
1	Postal	3/24/25	7/14/25	Cover letter with web link, passcode, and QR code
2	Postal	4/29/25	8/4/25	Reminder letter with web link, passcode, and QR code
3	Postal	5/28/25	--	Reminder letter with web link, passcode, and QR code

The United Kingdom

SSRS's fielding partner, Adkins Research Group (Adkins), fielded the survey in the UK. The survey was in field from March 17-July 11, 2025.

Between January 16-20, 2025, Adkins conducted five pretest interviews in the UK. Overall, the instrument worked well, and respondents seemed to be engaged in the interview. Upon completion of the pretest interviews, SSRS provided a memo of the pretest findings to the Fund and also provided feedback to the UK partner.

Prior to the field period, SSRS programmed the study into SSRS's Web Interviewing system for the UK data collection. For consistency purposes across countries, the web domain used in the UK was www.internationaldoctorstudy.uk. Extensive checking of the program was conducted to assure that skip patterns followed the design of the questionnaire. Data were checked throughout the field period to confirm that skip patterns were correctly followed. The program was created in a way that allowed for both a CATI-optimized interface that included interviewer instructions and voluntary responses and a web version that was optimized for self-administration (e.g., allowed respondents to skip questions), depending upon the mode of completion for the respondent.

For the UK, primary care doctors were recruited and screened via the phone and invited to participate in a phone or online version of the survey. In addition to identifying respondents who were willing to participate, the screener served to screen out PCPs who did not spend more than 50% of their time in direct patient care, who were not general practitioners, who refused to provide a current job title or who practiced in regions that were over quota. Respondents who qualified were invited to participate in the core instrument via the phone (at a time convenient for the respondent) or online. Respondents who preferred the online option were asked to provide their email address, which was then used to share the information about how to access the web link. To encourage participation, an endorsement letter was shared with respondents[20] and PCPs were offered an incentive of £30 upon completion of the survey. An additional £30 was offered to a subset of respondents in order to bolster additional completes in Scotland, Wales, and Northern Ireland. An average of five call attempts were made on active sample.

[20] The Health Foundation was provided endorsement for the UK.

Table 19 below shows the completes by mode.

TABLE 19: UK Completes by Mode

	Total UK
Web	867
Phone	136
Total	1,003

The United States

SSRS fielded the survey in the US. The survey was in field from March 12 – September 4, 2025. Prior to the field period, SSRS programmed the study into SSRS's Web Interviewing system for data collection in US. For consistency purposes across countries, the web domains used in the US were www.internationaldoctorstudy.org or www.internationaldoctorstudy.com; respondents were allowed to enter the .org or .com top-level domains but all the invitation materials displayed the .org version. Extensive checking of the programs was conducted to ensure that skip patterns followed the design of the questionnaire. SSRS also designed a paper survey to be used in the US following best practices to maximize usability and respondent completion.

Once the instrument was finalized, a total of five cognitive pretest interviews, two web and three paper, were conducted from December 16 to December 26, 2024. Respondents varied by age, gender, and region, in order to represent the population as much as possible. Interviewers conducted semi-structured cognitive interviews and solicited feedback on the instrument/program and prenotification letter. SSRS provided a detailed memo of the pretest findings to the Fund. Based on the respondent feedback, minor changes were made to the instrument and web program. Changes to the questionnaire were made across countries. SSRS had the changes translated and provided updated translation materials to all country partners and vendors.

Primary care doctors were recruited via postal mail and invited to participate in a paper-copy or online version of the survey. Fielding was dividing into two waves. To encourage participation, PCPs were mailed a pre-incentive prior to completing the survey and a list of publications based on previous International Health Policy surveys.

In wave 1, doctors in the US received an invitation letter including the web link and a paper questionnaire, followed by up to 9 additional contacts/reminders during the field (i.e., one additional paper questionnaire, one reminder letter, one reminder postcard, and up to five email reminders). The specifications for each contact/wave are outlined below. Email reminders were sent to the 82% of the sample for which email addresses could be appended by the sample provider (RediData). During the first wave, SSRS noted that response was less than anticipated. With the goal of improving response and informing the protocol for the second wave, an experiment was implemented for the final reminder letter, with a second incentive offered to doctors. Three-quarters of non-responders received a visible $50 non-contingent check in the envelope with their reminder letter, and the remaining one-quarter of the sample received a promised $50 instant virtual gift card upon completing the survey.

Ahead of wave 2, SSRS redesigned the outreach protocol with the aim of boosting response in the second sample release. Based on the results of the experiment in the final mailing of wave 1 showing a visible check being more productive than a promised post-incentive, a visible $25 check was inserted into the first mailing, replacing the $20 bill from the first mailing of wave 1. The third mailing, a reminder letter similar to wave 1, included a second visible $25 check. Due to the low response from email outreach in wave 1 and the cost associated with appending that contact information, emails were not included in the wave 2 protocol.

TABLE 20a: US Contact Schedule – Wave 1

Wave 1 Contact	Date	Type of Contact	Documents Included
1	3/12/25	Postal	Personalized letter with URL to complete survey online
			List of The Commonwealth Fund's publications
			8-page paper questionnaire
			Postage-paid reply envelope
			$20 cash pre-incentive
			Fed-Ex envelope
2	3/25/25	Email	Email with passcode-embedded web link
3	3/27/25	Postal	Personalized letter, with color logo, URL and passcode to complete survey online
			8-page paper questionnaire
			Postage-paid reply envelope
			USPS Priority Flat envelope
4	4/9/25	Email	Email with passcode-embedded web link
5	4/28/25	Postal	Personalized letter, with color logo, URL and passcode to complete survey online, includes either $50 visible check (75% of sample) or mentions $50 post-incentive (25% of sample)
6	4/28/25	Email	Email with passcode-embedded web link
7	5/12/25	Email	Email with passcode-embedded web link
8	8/5/25	Email	Email with passcode-embedded web link
9	8/11/25	Postal	Personalized reminder postcard, with color logo, URL and passcode to complete survey online
10	8/18/25	Email	Email with passcode-embedded web link

TABLE 20b: US Contact Schedule – Wave 2

Wave 2 Contact	Date	Type of Contact	Documents Included
1	6/20/25	Postal	Personalized letter with URL to complete survey online
			List of The Commonwealth Fund's publications
			8-page paper questionnaire
			Postage-paid reply envelope
			$25 visible check pre-incentive
			9x12 windowed envelope
2	6/27/25	Postal	Personalized letter, with color logo, URL and passcode to complete survey online

			8-page paper questionnaire
			Postage-paid reply envelope
			Fed-Ex envelope
3	7/15/25	Postal	Personalized letter, with color logo, URL and passcode to complete survey online, includes $25 visible check
4	8/11/25	Postal	Personalized reminder postcard, with color logo, URL and passcode to complete survey online

SSRS kept track of a master file of contacts initiated by US respondents throughout the field period. This file included information about the reason behind the communication established with the respondent and the decisions made to proactively address the issue raised.

As part of the back-end process, there were some duplicate cases in the US data because respondents took two or more surveys (i.e., both web and paper or two paper surveys). If duplicate cases were found, the following rules were followed to select the cases that were kept in the final data file.

- If duplicate cases for a particular respondent had different modes of completion (i.e., mail and online), the online case was kept.
- The case with the earliest date of completion was selected for duplicate cases with identical completion response rates and mode of completion (e.g., two mail-based interviews from a single respondent).

Table 21 below shows the completes by mode by sample type.

TABLE 21: US Completes by Mode

	Total US
Web	618
Paper	729
Total	1,347

Data Processing and Quality Control

Prior to the field period, SSRS developed a set of instructions for processing paper surveys. While the project team anticipated that most providers would follow instructions and complete the survey correctly, SSRS's standard of practice is to provide guidelines for editing and coding completed paper surveys. These procedures were provided to all partners/vendors that were processing paper surveys. Examples of information communicated in this memo include instructions regarding: (1) processing of data when skip patterns were not followed; (2) write in responses of "Don't know," "Not sure," and "Refused;" (3) processing of multiple response for single-response questions.

SSRS developed a standardized data map to be utilized by all the international partners when structuring their data in ASCII format. The back-end programmer created a program consisting of instructions derived from the skip patterns designated on the data map and editing and coding memos that were shared with each survey-fielding partner. The program confirmed that data were consistent with the definitions of the preset codes and ranges and matched the appropriate bases of all questions. By the end of field, once the integrated data were compiled, an independent checking of all variables was carried out to ensure that all

variables were accurately constructed, had the correct number of cases, and were coded according to specifications provided. Frequencies were also run against clean data and reviewed as a further verification of valid codes and skip patterns.

SSRS provided reporting data and disposition reporting templates to each of its survey-fielding partners. On a weekly basis, SSRS reviewed the status of data collection and provided feedback regarding the distribution of completes, field progress, and dispositions. Based on this feedback, SSRS was able to monitor sample productivity, track quotas and deadlines, and provide guidance on how to best handle other fielding aspects.

For the online program, SSRS and its survey partners created a variable that calculated a respondent's completion rate. The calculation was based on the following formula:

$$\frac{\text{Total Questions Asked} - \text{Total Questions Skipped}}{\text{Total Questions Asked}}$$

The same calculation was done for all mail or online-based completed interviews at the end of field. The SSRS team reviewed cases that had a completion rate below 80% as well as short interview lengths.

Detailed Weighting Procedures by Country

Overview

Data from each country were weighted to ensure the final outcome was representative of the PCP population[21]. The weighting procedures accounted for the sample design and probability of selection, as well as systematic non-response across known population parameters. To the extent possible, the weighting procedure replicated the 2022 weighting protocol.

The following table provides the calibration variables and PCP definition per country, as well as outlines the oversampling, if any, that was put in place.

[21] Weighting was accomplished by raking sample distributions to target population distributions using iterative proportional fitting. This procedure balances each calibration variable to target benchmarks individually and iteratively. The entire set of calibration variables is cycled through until the weights converge across all dimensions. To handle missing data among some of the parameter variables, consistent with prior waves of this study, we employed a technique called hot decking. Hot deck imputation replaces the missing values of a respondent randomly with another similar respondent without missing data. We use an SPSS macro detailed in 'Goodbye, Listwise Deletion: Presenting Hot Deck Imputation as an Easy and Effective Tool for Handing Missing Data' (Myers, 2011).

TABLE 22: Post-Stratification Variables and Respondent Qualifications

	Post-stratification Variables	Respondent	Oversamples
Australia	Gender, age, urbanicity, Australian state (region), practice ownership by age, and patient advocacy group participation by age	General practitioners	None
Canada	Gender, age, Canadian province (region)	General practitioners, family medicine doctors	Minimum sample-sizes for Ontario and Quebec, best efforts across remaining provinces
France	Gender, age, NUTS1 region	General practitioners	None
Germany	Gender, age, NUTS1 region, specialty	General practitioners, internal medicine doctors, pediatricians	Pediatricians
Netherlands	Gender, age, NUTS2 region	General practitioners	None
New Zealand	Gender, age, region	General practitioners	None
Sweden[22]	Gender, age, urbanicity (degree of urbanization)	Primary care clinic physicians (specialists, interns, residents, other physicians)	None
Switzerland	Gender, age, linguistic region	General practitioners, internal medicine doctors, pediatricians	Pediatricians, Italian and French linguistic regions
UK	Gender, age, region	General practitioners	Minimum sample-sizes in Wales, Scotland, Northern Ireland, London, and England (excluding London)
US	Gender, age, Census region, specialty code, personal residence CDC USR code	General practitioners, family medicine doctors, internal medicine doctors, and pediatricians	Non-pediatric specialties, CDC USR-defined rural doctors

[22]As in previous IHP surveys, Sweden's data were not weighted by region upon consultation with Vårdanalys. SSRS checked to ensure that the region distribution was aligned with population parameters.

How to Analyze Data with Oversamples

It is a common practice to oversample certain groups of interest to provide larger sample sizes for analysis. When groups are oversampled, weighting will correct for the oversampling by "weighting down" the groups to their proper proportion of the sample.

It is important for researchers to understand the weighting implications of these oversamples. SSRS typically computes "balancing weights" which means that the weights across the entire sample sum to the total number of interviews. If we have oversampled a group, the sum of that group's balancing weight will then be less than the number of interviews we completed with the group – because that group has been weighted down in the aggregate. If such data were analyzed with a basic statistics package like SPSS, the margin of error for the oversample population would reflect the weighted n-size and not the number of interviews, which would lead to an overestimate of the sample variance.

The following table shows an example of population and interview n-sizes when an oversample is used. For this example, a main cross-section sample of 1,000 was combined with an oversample of 800 among some subpopulation of interest. While the researcher did 920 interviews with the oversample population, the statistical software will run statistical tests as though only 216 interviews were completed.

Example of Oversample N-Sizes

	Natural Population Distribution (%)	Example Study Sample Completes:			Weighted N-size
		Main Sample	Over-sample	Total	
Non-oversample population	88%	880 (88%)	0	880 (49%)	1,584 (88%)
Oversample population	12%	120 (12%)	800	920 (51%)	216 (12%)
Total	100%	1,000	800	1,800	1,800

There are two solutions to this problem. The first is to utilize a statistics package that can apply a Taylor Series Linearization to the data. Under this procedure, the researcher would enter a strata variable[23] into the statistics package that indicates the sample selections upon which under/oversampling occurred. In effect, this will allow the statistics package to calculate proper margins of error for estimates based on the true sample sizes of groups. Taylor Series Linearization will also account for the impact of any complex sample design features, such as stratification, on sample variances. The researcher will also attain a margin of error appropriate to the number of interviews rather than the weighted N-size, which can be a problem in some statistical software packages such as SPSS. Statistics packages with the capability to compute linearized variances estimates include SAS with the survey procedures module, R with the *survey* package, Stata, and SPSS with the Complex Samples module.

If one does not have access to such a package, SSRS can provide a secondary weight to be used to conduct analyses within oversampled groups or between oversampled groups and other respondents, as the main weight supplied with the data will be appropriate for analysis of the overall population only.

[23] Or a Primary Sampling Unit (PSU) for a multi-stage sample design

Researchers should be aware that these two methods will obtain equivalent point estimates; however, they may not obtain equivalent sample variances, meaning that results of statistical tests could differ depending on the method used. In general, when the two methods differ, Taylor Series Linearization will obtain the most accurate sample variances and statistical tests, both overall and within subgroups. Therefore, if the researcher has access to software that can conduct Taylor Series Linearization, this is the preferred method.

Regardless, SSRS will identify the applicable strata and PSU variables, whenever they are applicable, so that researchers can properly analyze their data with the correct margins of error.

Australia

The PCP data in Australia were weighted to account for: (1) differential sampling between the Medical Directory of Australia (MDA), including those matched to TKW's database, and Ekas' panel of GPs, and (2) systematic non-response along known geographic and demographic parameters.

Base Weight

Design Weight

The design or sampling weight for each sample piece drawn from the MDA via TKW per stratum i is given by $d_{0i} = N_i/n_i$, where N_i represents the number of records in the sample-frame for stratum i, and n_i denotes the number of records released in stratum i. The MDA sample-frame's strata are defined by whether or not a record is matched to TKW's database of GPs.

Non-response and Unknown Eligibility Adjustment

The non-response and unknown eligibility (NRUE) adjustment for the sample released from the MDA via TKW distributes the design weights of [1] eligible non-respondents among respondents and [2] records whose eligibility cannot be determined among records for whom eligibility is known. Starting with design weight, d_0, the NRUE adjustment can be written as:

$$f = \frac{\sum_{R,c} d_0 + \sum_{N,c} d_0 + e * \sum_{U,c} d_0}{\sum_{R,c} d_0}$$

where:

$$e = \frac{\sum_{R,c} d_0 + \sum_{N,c} d_0}{\sum_{R,c} d_0 + \sum_{N,c} d_0 + \sum_{I,c} d_0}$$

That is, the NRUE adjustment factor, f, is the sum of the design weights for respondents, eligible non-respondents, and eligibility-adjusted unknown-if-eligible records, divided by the sum of the design weights for respondents. The eligibility factor, e, is the design-weighted percentage of records with known eligibility status that are, in fact, eligible. Match status between the MDA and TKW's database of GPs was used to define two adjustment cells. The NRUE-adjusted design weight, d_1, is calculated as:

$$d_1 = \begin{cases} d_0 \times f, & for\ respondents \\ 0, & otherwise \end{cases}$$

Ekas Panel of Physicians

Respondents from Ekas' physicians panel were assigned a base weight value of 1.

Final Base Weight

The final base weight for Australia's sample of completed interviews was standardized overall, to sum to the number of interviews.

Calibration

With the base weight applied, the data were calibrated to balance the demographic profile of the sample to target population benchmark distributions. The variables used for the Australia calibration were gender, age, urbanicity, region, practice ownership by age, and patient advocacy group participation by age. Benchmarks for gender, age, urbanicity, and region were derived from the National Health Workforce Dataset's 2023 data. Benchmarks for practice ownership by age and patient advocacy group participation by age were derived by separately weighting the interviews from the MDA via TKW, using gender, age, urbanicity, and region as calibrators.

Weighting was accomplished by raking sample distributions to target population distributions using iterative proportional fitting. This procedure balances each calibration variable to target benchmarks individually and iteratively. The entire set of calibration variables is cycled through until the weights converge across all dimensions.

Weights were trimmed at the 4th and 96th percentiles, to ensure that individual respondents do not have too much influence on survey-derived estimates.

Table 23 compares weighted and unweighted sample distributions to population parameters for Australia.

TABLE 23: Weighted and Unweighted Distributions and Population Parameters for Australia

		Parameter	Unweighted	Weighted
Gender	Male	50.5%	50.4%	50.1%
	Female	49.5%	49.6%	49.9%
Age	<35	7.9%	11.5%	8.1%
	35-44	28.7%	28.6%	29.5%
	45-54	26.0%	23.5%	26.7%
	55-64	22.6%	23.5%	22.9%
	65+	14.8%	13.0%	12.8%
Urbanicity	Major Cities	73.6%	73.6%	74.0%
	Inner Regional	17.0%	15.6%	16.4%
	Outer Regional	7.0%	8.6%	7.1%
	Remote	2.4%	2.2%	2.5%
Region	New South Wales (NSW)	29.7%	28.1%	28.8%
	Australian Capital Territory (ACT)	2.0%	2.4%	2.0%
	Victoria (VIC)	24.8%	24.9%	24.7%

	Queensland (QLD)	21.9%	22.0%	22.4%
	South Australia (SA)	7.2%	8.3%	7.4%
	Western Australia (WA)	10.8%	10.8%	11.0%
	Tasmania (TAS)	2.6%	2.4%	2.6%
	Northern Territory (NT)	1.1%	1.0%	1.1%
Practice Ownership by Age	Owner/Co-owner, <45	3.9%	4.4%	4.0%
	Owner/Co-owner, 45+	23.5%	20.8%	22.4%
	Not owner/co-owner, <45	32.7%	35.7%	33.7%
	Not owner/co-owner, 45+	39.9%	39.1%	39.9%
Patient Advocacy Group Participation by Age	Yes	0.1%	1.7%	0.3%
	No, <45	36.6%	39.4%	37.6%
	No, 45+	63.3%	58.9%	62.2%

Canada

The PCP data in Canada were weighted to account for: (1) disproportionate stratification in the sample based on province and (2) systematic non-response along known geographic and demographic parameters.

The weighting was conducted in two stages; a base weight followed by post-stratification.

Base Weight

Design Weight

The initial design or sampling weight for each sample piece drawn from the frame per stratum i is given by $d0_i = N_i/n_i$, where N_i represents the number of records in the sample-frame for stratum i, and n_i denotes the number of records released in stratum i. The sampling strata are defined by Canadian province, with the Canadian territories combined into one stratum.

Non-response and Unknown Eligibility Adjustment

The non-response and unknown eligibility (NRUE) adjustment for the sample released distributes the design weights of [1] eligible non-respondents among respondents and [2] records whose eligibility cannot be determined among records for whom eligibility is known. Starting with design weight, $d0_i$, the NRUE adjustment can be written as:

$$f = \frac{\sum_{R,c} d0_i + \sum_{N,c} d0_i + e * \sum_{U,c} d0_i}{\sum_{R,c} d0_i}$$

where:

$$e = \frac{\sum_{R,c} d0_i + \sum_{N,c} d0_i}{\sum_{R,c} d0_i + \sum_{N,c} d0_i + \sum_{I,c} d0_i}$$

That is, the NRUE adjustment factor, f, is the sum of the design weights for respondents, eligible non-respondents, and eligibility-adjusted unknown-if-eligible records, divided by the sum of the design weights for respondents. The eligibility factor, e, is the design-weighted percentage of records with known

eligibility status that are, in fact, eligible. Province crossed with the sample-flag for Best Cut[24] (Y, N) were used to define 22 adjustment cells. The NRUE-adjusted design weight, d_1, is calculated as:

$$d_1 = \begin{cases} d0_i \times f, & for\ respondents \\ 0, & otherwise \end{cases}$$

The final base weight for the Canada sample of completed interviews was standardized overall, to sum to the number of interviews.

Calibration

With the base weight applied, the data were calibrated to balance the demographic profile of the sample to target population benchmark distributions. The variables used for the Canada calibration were gender, age, and province. Benchmarks were derived from Scott's Medical Database via CIHI, using 2023 data. Data for each province were weighted separately, so that each subsample (and the country as a whole) accurately represents the corresponding population. The weights within each province were adjusted to their correct share among Canadian PCPs, by applying the combined per-province weights as a base weight and calibrating the total sample to the national distributions of the aforementioned geographic and demographic dimensions.

Weights were trimmed at the 2nd and 98th percentiles to prevent individual interviews from having too much influence on the final results.

Tables 24 though 34 compare weighted and unweighted sample distributions to population parameters for Canada, by province and overall.

TABLE 24: Weighted and Unweighted Distributions and Population Parameters for Alberta

		Parameter	Unweighted	Weighted
Gender	Male	53.5%	57.9%	53.6%
	Female	46.5%	42.1%	46.4%
Age	<35	17.3%	11.7%	17.5%
	35-44	26.5%	31.0%	26.5%
	45-54	26.2%	25.7%	26.2%
	55-64	18.7%	18.7%	18.6%
	65+	11.3%	12.9%	11.2%

TABLE 25: Weighted and Unweighted Distributions and Population Parameters for British Columbia

		Parameter	Unweighted	Weighted
Gender	Male	52.8%	48.2%	52.9%
	Female	47.2%	51.8%	47.1%
Age	<35	20.8%	11.8%	21.2%
	35-44	22.1%	31.2%	22.1%
	45-54	20.0%	25.9%	20.0%
	55-64	21.8%	17.6%	21.7%
	65+	15.2%	13.5%	15.0%

[24] "Best Cut" defines office-based doctors in generalized practices (with no specialty in clinical activity) with at least 30 daily patient visits and 20 prescriptions who are no more than 65 years of age.

TABLE 26: Weighted and Unweighted Distributions and Population Parameters for Manitoba

		Parameter	Unweighted	Weighted
Gender	Male	57.3%	49.7%	57.3%
	Female	42.7%	50.3%	42.7%
Age	<35	22.0%	13.3%	22.4%
	35-44	23.0%	30.8%	23.0%
	45-54	20.8%	24.5%	20.8%
	55-64	21.6%	20.3%	21.5%
	65+	12.6%	11.2%	12.4%

TABLE 27: Weighted and Unweighted Distributions and Population Parameters for New Brunswick

		Parameter	Unweighted	Weighted
Gender	Male	48.7%	47.9%	48.6%
	Female	51.3%	52.1%	51.4%
Age	<35	19.1%	10.1%	19.4%
	35-44	20.1%	32.8%	20.1%
	45-54	20.8%	18.5%	20.8%
	55-64	19.8%	24.4%	19.7%
	65+	20.3%	14.3%	20.0%

TABLE 28: Weighted and Unweighted Distributions and Population Parameters for Newfoundland

		Parameter	Unweighted	Weighted
Gender	Male	52.1%	50.5%	52.0%
	Female	47.9%	49.5%	48.0%
Age	<35	18.2%	10.5%	18.5%
	35-44	22.9%	30.5%	22.9%
	45-54	25.6%	22.1%	25.6%
	55-64	17.5%	22.1%	17.4%
	65+	15.8%	14.7%	15.6%

TABLE 29: Weighted and Unweighted Distributions and Population Parameters for Nova Scotia

		Parameter	Unweighted	Weighted
Gender	Male	49.6%	56.3%	49.6%
	Female	50.4%	43.7%	50.4%
Age	<35	19.9%	11.9%	20.3%
	35-44	20.0%	23.8%	20.0%
	45-54	21.6%	22.2%	21.6%
	55-64	23.2%	23.8%	23.1%
	65+	15.3%	18.3%	15.1%

TABLE 30: Weighted and Unweighted Distributions and Population Parameters for Ontario

		Parameter	Unweighted	Weighted
Gender	Male	51.8%	52.3%	51.8%
	Female	48.2%	47.7%	48.2%
Age	<35	19.4%	9.9%	19.8%
	35-44	23.0%	29.2%	23.0%
	45-54	22.1%	21.8%	22.1%
	55-64	21.0%	20.1%	20.9%
	65+	14.5%	19.0%	14.3%

TABLE 31: Weighted and Unweighted Distributions and Population Parameters for Prince Edward Island

		Parameter	Unweighted	Weighted
Gender	Male	57.6%	53.8%	57.8%
	Female	42.4%	46.2%	42.2%
Age	<35	15.8%	7.7%	16.1%
	35-44	17.6%	26.9%	17.6%
	45-54	24.2%	19.2%	24.2%
	55-64	24.8%	42.3%	24.7%
	65+	17.6%	3.8%	17.3%

TABLE 32: Weighted and Unweighted Distributions and Population Parameters for Quebec

		Parameter	Unweighted	Weighted
Gender	Male	40.4%	45.4%	40.4%
	Female	59.6%	54.6%	59.6%
Age	<35	11.5%	21.2%	11.8%
	35-44	24.7%	27.6%	24.8%
	45-54	20.1%	17.5%	20.1%
	55-64	23.6%	16.0%	23.5%
	65+	20.0%	17.8%	19.8%

TABLE 33: Weighted and Unweighted Distributions and Population Parameters for Saskatchewan

		Parameter	Unweighted	Weighted
Gender	Male	55.8%	50.7%	55.8%
	Female	44.2%	49.3%	44.2%
Age	<35	17.6%	16.2%	17.9%
	35-44	24.9%	20.9%	24.9%
	45-54	26.9%	31.8%	26.9%
	55-64	18.6%	22.3%	18.5%
	65+	12.0%	8.8%	11.8%

TABLE 34: Weighted and Unweighted Distributions and Population Parameters for the Canada Total

		Parameter	Unweighted	Weighted
Gender	Male	49.6%	50.7%	49.6%
	Female	50.4%	49.3%	50.4%
Age	<35	17.8%	13.3%	17.8%
	35-44	23.5%	28.5%	23.5%
	45-54	21.9%	22.7%	21.9%
	55-64	21.3%	20.1%	21.3%
	65+	15.4%	15.4%	15.4%
Province	Alberta	11.3%	10.5%	11.3%
	British Columbia	15.8%	10.6%	15.8%
	Manitoba	3.2%	12.9%	3.2%
	New Brunswick	2.4%	10.9%	2.4%
	Newfoundland	1.4%	7.8%	1.4%
	Nova Scotia	2.7%	9.9%	2.7%
	Ontario	35.6%	13.7%	35.6%
	Prince Edward Island	0.4%	1.8%	0.4%
	Quebec	23.9%	8.8%	23.9%
	Saskatchewan	3.0%	12.2%	3.0%
	Territories (Yukon, Nunavut, Norwest Territories)	0.3%	0.8%	0.3%

France

The PCP data in France were weighted to account for: (1) differential sampling across strata, and (2) systematic non-response along known geographic and demographic parameters.

The weighting was conducted in two stages; a base weight followed by post-stratification.

Base Weight

Design Weight

The design or sampling weight for each sample piece drawn from the frame per stratum i is given by $d_{0i} = N_i/n_i$, where N_i represents the number of records in the sample-frame for stratum i, and n_i denotes the number of records released in stratum i. The sampling strata are defined by [1] the main sample-source per sampled record, [2] availability of region data on the sample-record, and [3] whether or not the address on the sample-record is unique to one doctor on the frame.

Non-response and Unknown Eligibility Adjustment

The non-response and unknown eligibility (NRUE) adjustment for the sample released distributes the design weights of [1] eligible non-respondents among respondents and [2] records whose eligibility cannot be determined among records for whom eligibility is known. Starting with design weight, d_0, the NRUE adjustment can be written as:

$$f = \frac{\sum_{R,c} d_0 + \sum_{N,c} d_0 + e * \sum_{U,c} d_0}{\sum_{R,c} d_0}$$

where:

$$e = \frac{\sum_{R,c} d_0 + \sum_{N,c} d_0}{\sum_{R,c} d_0 + \sum_{N,c} d_0 + \sum_{I,c} d_0}$$

That is, the NRUE adjustment factor, f, is the sum of the design weights for respondents, eligible non-respondents, and eligibility-adjusted unknown-if-eligible records, divided by the sum of the design weights for respondents. The eligibility factor, e, is the design-weighted percentage of records with known eligibility status that are, in fact, eligible. The 11 sampling strata crossed with wave of release were used to define 33 adjustment cells. The NRUE-adjusted design weight, d_1, is calculated as:

$$d_1 = \begin{cases} d_0 \times f, & for\ respondents \\ 0, & otherwise \end{cases}$$

The final base weight for France's sample of completed interviews was standardized overall, to sum to the number of interviews.

Calibration

With the base weight applied, the data were calibrated to balance the demographic profile of the sample to target population benchmark distributions. The variables used for the France calibration were gender, age, and region. Benchmarks were derived from the ASIP-Santé RPPS, DREES processing with data as of January 2023.

Weights were trimmed at the 2nd and 98th percentiles, to ensure that individual respondents do not have too much influence on survey-derived estimates.

Table 35 compares weighted and unweighted sample distributions to population parameters for France.

TABLE 35: Unweighted Distributions and Population Parameters for France

		Parameter	Unweighted	Weighted
Gender	Male	48.9%	47.5%	49.0%
	Female	51.1%	52.5%	51.0%
Age	<35	15.4%	14.8%	15.5%
	35-44	21.8%	30.8%	21.9%
	45-54	18.0%	15.7%	18.1%
	55-64	28.5%	20.4%	28.4%
	65+	16.4%	18.2%	16.1%
Province	Grand Est	8.3%	12.3%	8.4%
	Nouvelle Aquitaine	10.5%	11.6%	10.5%
	Auvergne-Rhône-Alpes	13.0%	16.0%	13.0%
	Bourgogne, Franche-Comté	4.1%	6.0%	4.1%
	Bretagne	5.9%	6.0%	5.9%
	Centre-Val de Loire	3.1%	2.2%	3.1%
	Corse	0.6%	0.6%	0.6%
	Île-de-France	16.6%	7.5%	16.2%
	Occitanie	9.9%	8.8%	9.9%

	Hauts-de France	8.6%	9.1%	8.6%
	Normandie	4.6%	6.0%	4.6%
	Pays de la Loire	5.8%	5.7%	5.8%
	Provence-Alpes, Côte-dAzur	9.1%	8.2%	9.1%

Germany

The PCP data in Germany were weighted to account for: (1) the oversampling of pediatricians, (2) differential contact protocols implemented dependent upon available information on the sample-frame, and (3) systematic non-response along known geographic and demographic parameters.

Base Weight

A weight was applied to balance the distribution of PCPs' availability of email address by specialty to the parameter, according to the National Association of Statutory Health Insurance Physicians (Statistische Informationen aus dem Bundesarztregister).

Table X: Germany Base Weight[25]

	Parameter[26]	Unweighted	Base Weight
GP/Internal Medicine, Has Email Available	45.0%	40.3%	1.1
Pediatrician, Has Email Available	6.7%	17.8%	0.4
GP/Internal Medicine, No Email Available	42.8%	30.5%	1.4
Pediatrician, No Email Available	5.4%	11.4%	0.5

Calibration

With the base weight applied, the data were calibrated to balance the demographic profile of the sample to target population benchmark distributions. The variables used for Germany calibration were gender, age, region, and self-reported specialty. Population benchmark distributions were derived from the National Association of Statutory Health Insurance Physicians (Statistische Informationen aus dem Bundesarztregister), as of December 2024.

Weights were trimmed at the 2nd and 98th percentiles to prevent individual interviews from having too much influence on the final results.

[25] Email Address Availability by Sample-based Specialty is the PSU variable (the crossing of Q542 and Q540 in the dataset, respectively). Please refer to the "How to Analyze Polling Data with Oversample" section for more information.

[26] The sample-frame at the time that the survey's sample was drawn serves as the parameter for this adjustment.

TABLE 36: Weighted and Unweighted Distributions and Population Parameters for Germany

		Parameter	Unweighted	Weighted
Gender	Male	51.7%	51.3%	51.2%
	Female	48.3%	48.7%	48.8%
Age	<35	2.3%	1.1%	1.1%
	35-44	18.9%	17.1%	17.1%
	45-54	32.9%	28.4%	28.3%
	55-64	35.9%	34.6%	34.5%
	65+	9.9%	18.8%	19.0%
Region	Schleswig-Holstein	3.7%	4.2%	3.7%
	Hamburg	2.5%	2.1%	2.5%
	Niedersachsen	9.4%	9.5%	9.5%
	Bremen	0.9%	0.8%	0.9%
	Nordrhein-Westfalen	20.6%	19.8%	20.6%
	Rheinland-Pfalz	4.8%	3.7%	4.6%
	Saarland	1.2%	1.2%	1.2%
	Hessen	7.4%	6.8%	7.4%
	Baden-Württemberg	12.9%	14.7%	13.0%
	Bayern	16.5%	15.5%	16.4%
	Berlin	4.8%	5.1%	4.8%
	Mecklenburg-Vorpommern	2.1%	2.1%	2.1%
	Brandenburg	3.0%	3.2%	3.0%
	Sachsen-Anhalt	2.7%	3.1%	2.7%
	Thüringen	2.6%	2.4%	2.6%
	Freistaat Sachsen	5.0%	5.9%	5.0%
Specialty	General Practitioner/ Internal Medicine	86.8%	70.7%	86.7%
	Pediatrician	13.2%	29.3%	13.3%

The Netherlands

The PCP data in the Netherlands were weighted to account for differential non-response along known geographic and demographic parameters.

Calibration

The variables used for the Netherlands calibration were gender, age, and region. Population benchmark distributions were derived from the Netherlands Institute for Health Services Research, using 2024 for gender and age and 2025 data for region.

Weights were trimmed at the 2nd and 98th percentiles to prevent individual interviews from having too much influence on the final results.

TABLE 37: Weighted and Unweighted Distributions and Population Parameters for the Netherlands

		Parameter	Unweighted	Weighted
Gender	Male	36.8%	47.0%	36.9%
	Female	63.2%	53.0%	63.1%
Age	<35	6.3%	5.1%	6.3%
	35-44	36.4%	29.2%	36.3%
	45-54	29.6%	30.6%	29.6%
	55-64	22.9%	28.9%	23.0%
	65+	4.8%	6.3%	4.8%
Region	Drenthe	2.9%	3.1%	2.9%
	Flevoland	2.2%	1.4%	2.2%
	Friesland	3.7%	4.3%	3.7%
	Gelderland	12.9%	13.7%	12.9%
	Groningen	3.4%	2.4%	3.2%
	Limburg	7.0%	8.0%	7.0%
	Noord-Brabant	14.3%	12.5%	14.3%
	Noord-Holland	16.9%	20.2%	16.9%
	Overijssel	6.3%	7.0%	6.3%
	Utrecht	8.6%	6.7%	8.6%
	Zeeland	1.9%	3.1%	1.9%
	Zuid-Holland	20.0%	17.3%	20.0%

New Zealand

The PCP data in New Zealand were weighted to account for systematic non-response along known geographic and demographic parameters.

Calibration

The variables used for the New Zealand calibration were gender, age, and region. Population benchmark distributions were derived from the RNZCGP member database as of April 2025.

Weights were trimmed at the 4th and 96th percentiles to prevent individual interviews from having too much influence on the final results.

Table 38 compares weighted and unweighted sample distributions to population parameters for New Zealand.

TABLE 38: Weighted and Unweighted Distributions and Population Parameters for New Zealand

		Parameter	Unweighted	Weighted
Gender	Male	44.2%	38.0%	44.0%
	Female	55.8%	62.0%	56.0%
Age	<35	4.9%	4.7%	4.9%
	35-44	23.1%	16.3%	22.9%
	45-54	22.8%	22.6%	22.9%
	55-64	30.2%	34.7%	30.3%
	65+	19.0%	21.8%	19.1%
Region	Northern/Auckland	36.7%	30.9%	36.5%
	Central North Island	19.3%	17.4%	19.3%
	Lower North Island	17.4%	22.0%	17.4%
	South Island	26.7%	29.8%	26.8%

Sweden

The PCP data in Sweden were weighted to account for differential non-response along known geographic and demographic parameters.

Calibration

The variables used for the Sweden calibration were gender, age, and urbanicity (degree of urbanization). Population benchmark distributions were derived from the Swedish Occupational Register (YREG) and the Swedish Register of Education (UREG), using data from 2023.

Weights were trimmed at the 2nd and 98th percentiles to prevent individual interviews from having too much influence on the final results.

Table 39 compares weighted and unweighted sample distributions to population parameters for Sweden.

TABLE 39: Weighted and Unweighted Distributions and Population Parameters for Sweden

		Parameter	Unweighted	Weighted
Gender	Male	45.0%	44.3%	45.0%
	Female	55.0%	55.7%	55.0%
Age	<35	18.1%	13.5%	18.1%
	35-44	33.7%	35.1%	33.7%
	45-54	22.8%	24.2%	22.8%
	55-64	16.3%	16.1%	16.3%
	65+	9.2%	11.0%	9.2%
Region	City or urban area	51.5%	47.6%	51.5%
	Suburb or small town	37.2%	39.8%	37.2%
	Rural or remote area	11.3%	12.7%	11.3%

Switzerland

The PCP data in Switzerland were weighted to account for: (1) the oversampling of pediatricians, (2) the oversampling of Italian and French linguistic regions, and (3) systematic non-response along known geographic and demographic parameters.

The weighting was conducted in two stages; a base weight followed by post-stratification.

Base Weight

A weight was applied to balance the distribution of linguistic region by specialty to the parameter, according to the Swiss Medical Association (FMH).

TABLE 40: Switzerland Base Weight[27]

	Parameter[28]	Unweighted	Base Weight
German/Rhaeto-Romansch, Internal Medicine	47.6%	45.5%	1.0
German/Rhaeto-Romansch, GP	8.5%	6.5%	1.3
German/Rhaeto-Romansch, Pediatrician	10.5%	9.6%	1.1
French, Internal Medicine	16.9%	16.8%	1.0
French, GP	5.3%	4.6%	1.1
French, Pediatrician	6.1%	6.1%	1.0
Italian, Internal Medicine	3.4%	8.1%	0.4
Italian, GP	0.8%	1.8%	0.4
Italian, Pediatrician	0.8%	1.0%	0.8

Calibration

The variables used for Switzerland calibration were gender, age, and linguistic region. Population benchmark distributions were derived from the FMH, using data as of December 2024.

Weights were trimmed at the 2nd and 98th percentiles to prevent individual interviews from having too much influence on the final results.

Table 41 compares weighted and unweighted sample distributions to population parameters for Switzerland.

[27] Linguistic Region by Specialty is the PSU variable (the crossing of Q570 and Q575 in the dataset, respectively). Please refer to the "How to Analyze Polling Data with Oversample" section for more information.
[28] The sample-frame at the time that the survey's sample was drawn serves as the parameter for this adjustment.

TABLE 41: Weighted and Unweighted Distributions and Population Parameters for Switzerland

		Parameter	Unweighted	Weighted
Gender	Male	50.3%	48.7%	50.3%
	Female	49.7%	51.3%	49.7%
Age	<35	1.9%	3.0%	1.9%
	35-44	22.2%	23.2%	22.2%
	45-54	29.2%	30.7%	29.2%
	55-64	29.6%	27.7%	29.6%
	65+	17.1%	15.3%	17.0%
Linguistic Region	German	66.6%	61.6%	66.6%
	French	28.4%	27.5%	28.4%
	Italian	4.9%	10.9%	4.9%

The United Kingdom

The PCP data in the UK were weighted to account for: (1) the oversampling of PCPs in some regions and (2) systematic non-response along known geographic and demographic parameters.

Base Weight

A weight was applied to balance the distribution of PCPs by region to the parameter according to the General Medical Council (GMC).

TABLE 42: UK Base Weight[29]

	Parameter	Unweighted	Weight
England excluding London	68.8%	47.9%	1.4
London	14.7%	20.2%	0.7
Scotland	9.4%	12.9%	0.7
Wales	4.2%	11.1%	0.4
Northern Ireland	2.9%	8.0%	0.4

Calibration

With the base weight applied, the data were calibrated to balance the demographic profile of the sample to target population benchmark distributions. The variables used for the UK calibration were gender, age, and region. Population benchmark distributions were derived from the General Practitioner Register from the GMC, as of April 2025.

Weights were trimmed at the 2nd and 98th percentiles to prevent individual interviews from having too much influence on the final results.

[29] Region (S4 in the dataset) is the PSU variable. Please refer to the "How to Analyze Polling Data with Oversample" section for more information.

TABLE 43: Weighted and Unweighted Distributions and Population Parameters for the UK

		Parameter	Unweighted	Weighted
Gender	Male	42.1%	37.8%	42.1%
	Female	57.9%	62.2%	57.9%
Age	<35	10.7%	13.1%	10.7%
	35-44	37.4%	53.0%	37.4%
	45-54	29.7%	23.8%	29.7%
	55-64	17.2%	7.8%	17.2%
	65+	5.1%	2.3%	5.1%
Region	England excluding London	68.8%	47.9%	68.8%
	London	14.7%	20.2%	14.7%
	Scotland	9.4%	12.9%	9.4%
	Wales	4.2%	11.1%	4.2%
	Northern Ireland	2.9%	8.0%	2.9%

The United States

The PCP data in the US were weighted to account for: (1) disproportionate stratification in the sample based on specialty and rurality across multiple sample-releases and (2) systematic non-response along known geographic and demographic parameters.

The weighting was conducted in two stages; a base weight followed by post-stratification.

Base Weight

Design Weight

The initial design or sampling weight for each sample piece drawn from the frame per stratum i is given by $d0_i = N_i/n_i$, where N_i represents the number of records in the sample-frame for stratum i, and n_i denotes the number of records released in stratum i. The sampling strata are defined by specialty code (internal medicine, family medicine, general practitioner, pediatrician). This initial design weight is adjusted by a separate factor to account for the disproportionate stratification based on personal residence CDC USR code (rural, not rural) in the second sample-pull, $a_i = P_i/p_i$, where P_i is the proportion of the first wave's sample-release in stratum i and p_i is the proportion of the second wave's sample-release in stratum i.

Non-response and Unknown Eligibility Adjustment

The non-response and unknown eligibility (NRUE) adjustment for the sample released distributes the design weights of [1] eligible non-respondents among respondents and [2] records whose eligibility cannot be determined among records for whom eligibility is known. Starting with design weight, $d0a_i$, the NRUE adjustment can be written as:

$$f = \frac{\sum_{R,c} d0a_i + \sum_{N,c} d0a_i + e * \sum_{U,c} d0a_i}{\sum_{R,c} d0a_i}$$

where:

$$e = \frac{\sum_{R,c} d0a_i + \sum_{N,c} d0a_i}{\sum_{R,c} d0a_i + \sum_{N,c} d0a_i + \sum_{I,c} d0a_i}$$

That is, the NRUE adjustment factor, f, is the sum of the design weights for respondents, eligible non-respondents, and eligibility-adjusted unknown-if-eligible records, divided by the sum of the design weights for respondents. The eligibility factor, e, is the design-weighted percentage of records with known eligibility status that are, in fact, eligible. Specialty code (internal medicine, family medicine/general practitioner, pediatrician) crossed with wave of release were used to define six adjustment cells. The NRUE-adjusted design weight, d_1, is calculated as:

$$d_1 = \begin{cases} d0a_i \times f, & for\ respondents \\ 0, & otherwise \end{cases}$$

The final base weight for the US sample of completed interviews was standardized overall, to sum to the number of interviews.

Calibration

With the base weight applied, the data were calibrated to balance the demographic profile of the sample to target population benchmark distributions. The variables used for the US calibration were gender, age, region, specialty code, and personal residence CDC USR code. Benchmarks were derived from the sample-frame (the AMA File via RediData as of April 2025), adjusted for eligibility status of the released sample[30].

Weights were trimmed at the 2nd and 98th percentiles, to ensure that individual respondents do not have too much influence on survey-derived estimates.

Table 44 compares weighted and unweighted sample distributions to population parameters for the US.

TABLE 44: Weighted and Unweighted Distributions and Population Parameters for the US

		Parameter	Unweighted	Weighted
Gender	Male	51.8%	57.2%	52.3%
	Female	48.2%	42.8%	47.7%
Age	<35	5.9%	5.0%	5.9%
	35-44	21.5%	15.5%	20.9%
	45-54	23.7%	23.3%	23.8%
	55-64	25.4%	30.4%	25.7%
	65+	23.5%	25.8%	23.8%
Region	North	18.5%	17.9%	18.5%
	Midwest	21.0%	23.1%	21.1%
	South	36.1%	33.4%	35.8%
	West	24.4%	25.6%	24.5%
Specialty Type	Internal medicine physicians	36.4%	35.3%	36.8%
	Family medicine physicians	39.9%	47.7%	40.4%
	General practitioners	1.3%	2.3%	1.4%

[30] The benchmark for Age could not be adjusted for eligibility status because this dimension is not available on the sample-frame.

	Internal medicine – Pediatric/Pediatricians	22.4%	14.7%	21.4%
CDC USR	Urban	35.6%	30.4%	35.2%
	Suburban	47.4%	47.1%	47.6%
	Rural	17.0%	22.5%	17.2%

Alternate Weights for Analyzing Q13 Series – Canada, France, and the US

During the questionnaire development phase, SSRS and the Fund determined that the Q13 series would not be administered to respondents completing the questionnaire via paper in order to maintain a reasonable page-length and ensure data quality. As each item in the Q13 series depends on the response to the corresponding item in the Q12 series, there was not an easy and user-friendly way to administer the Q13 series via this mode. As a result, only respondents who completed on the web in Canda, France, and the US were asked the Q13 series, depending on their responses to the Q12 series. To ensure accurate analyses of the weighted data for these three countries at Q13, separate weights were computed exclusively for those respondents who completed the survey via web. Specifically, the base weights per country were rebalanced to the sample of web interviews and applied in calibrating the web interviews to each country's population parameters utilized in the total sample's weighting procedure[31].

Design Effect and Margin of Sampling Error

Post-data collection statistical adjustments require analysis procedures that reflect departures from simple random sampling. SSRS calculates the effects of these design features so that an appropriate adjustment can be incorporated into tests of statistical significance when using these data. The so-called "design effect" or *deff* represents the loss in statistical efficiency that results from a disproportionate sample design and systematic non-response.

SSRS calculates the composite design effect for a sample of size n, with each case having a weight, w, as:[32]

$$deff = \frac{n \sum w^2}{(\sum w)^2}$$

The survey's margin of error is the largest 95% confidence interval for any estimated proportion based on the total sample — the one around 50%. Margins of error for subgroups will be larger.

It is important to remember that the sampling fluctuations captured in the margin of error are only one possible source of error in a survey estimate. Other sources, such as respondent selection bias, questionnaire wording, and reporting inaccuracy, may contribute additional error of greater or lesser magnitude.

[31] Within the weighting process for Canada's web interviews, respondents in PEI were assigned their previous weight from the total sample's calibration due to the small sample-size that were asked Q13 (n=13).
[32] Kish, L. (1992). Weighting for Unequal Pi. Journal of Official Statistics, Vol. 8, No.2, 1992, pp. 183-200.

TABLE 45: Design Effect and Margin of Error by Country

	N-size	Design Effect	Margin of Error
Australia	409	1.66	±6.2
Canada	1,797	1.40	±2.7
Newfoundland and Labrador	95	1.10	±10.5
Prince Edward Island	26	1.79	±25.7
Nova Scotia	126	1.09	±9.1
New Brunswick	119	1.17	±9.7
Quebec	326	1.11	±5.7
Ontario	463	1.12	±4.8
Manitoba	143	1.13	±8.7
Saskatchewan	148	1.08	±8.4
Alberta	171	1.05	±7.7
British Columbia	170	1.15	±8.1
Territories (Yukon, Nunavut, Northwest Territories)[33]	10	--	--
France	318	1.61	±7.0
Germany	1,773	1.25	±2.6
Netherlands	415	1.10	±5.0
New Zealand	363	1.08	±5.3
Sweden	2,157	1.03	±2.1
Switzerland	1,313	1.05	±2.8
UK	1,003	1.42	±3.7
US	1,347	1.17	±2.9

Deliverables/Updates

Bi-weekly and Periodic Updates

Throughout the field period, SSRS provided the Fund with bi-weekly updates of key information tracking overall progress in each country. These reports, designed to provide snapshot information of key variables of interest, included tables for completes per mode of interview by gender, age, region, and language of interview (where applicable). Along with the bi-weekly data reports, SSRS reported on any field-related concerns via conference calls.

In May and June 2025, SSRS provided each international partner with an interim status update on data collection, including details on challenges experienced across countries with the level of response being observed as well as plans to finish data-collection.

Preliminary Data

SSRS delivered preliminary weighted SPSS datasets to The Commonwealth Fund in May and July 2025.

[33] Due to the sample size of interviews in the Canadian Territories (n=10), no design effect or margin of error is reported.

Final Data

SSRS delivered the following to The Commonwealth Fund and sponsoring organizations: (1) final weighted SPSS dataset, (2) final weighted, all-country and country-specific banners in Microsoft Word and Excel formats, (3) a weighted tracking banner that tracks key questions from previous IHP waves, (4) final methodology report, (5) final versions of the questionnaires in English as well as the translated versions, (6) final created variable and banner specification memos.