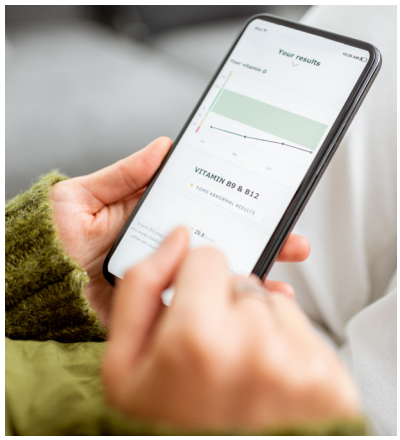


FORESIGHT MISSION

How can we strengthen expertise to foster a paradigm shift in disease prevention?

OCTOBER 2025

HAS

HAUTE AUTORITÉ DE SANTÉ

The decree of 26 January 2017 assigned the Haute Autorité de santé (HAS), French National Authority for Health, the responsibility for conducting each year, on a topic of its choice, a foresight analysis of the healthcare system, including proposals for improving quality, effectiveness, and cost-effectiveness.

This analysis is intended for Government and Parliament.

Summary and proposals

Developing health promotion and disease prevention (HPDP) has been a public health priority for several decades. It has given rise to many initiatives. However, the results have not lived up to the aims announced by public authorities, in part due to a lack of information on the benefit provided, because many initiatives or trials are not subsequently rolled out due to a lack of data demonstrating their benefit.

WHO promotes "evidence-informed decision-making" as a key tool for improving healthcare systems. HPDP interventions must be evaluated before they can be launched, prioritised, or implemented on a long-term basis. In a context marked by tight budget constraints, now, more than ever, public decision-makers need to be able to evaluate the relevance of HPDP interventions, and hence the various benefits that they can expect from such interventions.

However, two components are lacking in order to strengthen the evidence-informed process for decision-makers in France, and thereby ramp up the predicted paradigm shift in disease prevention: a conceptual and methodological framework accompanied by the conditions of its implementation, and dialogue between actors around HPDP evidence.

Providing a "toolkit" to all actors (intervention effectors, evaluation effectors, and funders) does not mean that evaluations will be harmonised: not all HPDP interventions require that all evidence categories, with the same level of evidence, be collected. It is a question of supporting actors in identifying the evidence required for decision-making (effectiveness of intervention, economic evaluation, reproducibility and transferability, measure of externalities).

This "toolkit" would also define discourse on the method. Merely conducting an evaluation is not enough: it also needs to be conducted at the right time, and therefore planned sufficiently in advance of the decision to implement an HPDP intervention, and the budget to be allocated must be gauged. As such, the production of evidence for a paradigm shift in disease prevention **means that public decision-makers must address evaluation** well ahead of intervention implementation.

Then, in order to support informed decision-making, discussions between the different actors need to be facilitated. Drawing from the experience of the Australian Prevention Partnership Centre, to address a shared, consensus-based need, **the HAS recommends establishing a space for dialogue and intermediation** around HPDP evidence. This space should be accessible to a broad panel of actors, particularly to those involved at different decision-making levels (local, national), including outside the health sector, in order to promote **Health in All Policies** and achieve a real impact.

The identification of one (or more) body/bodies to steer this programme should be based on three criteria: scientific foundation, link with research, and interinstitutional dimension.

Introduction

What do we mean by health promotion and disease prevention?

Although the terms "disease prevention" and "health promotion" are frequently used alongside each other, strategies and interventions associated with these concepts differ in their purpose. According to WHO, **disease prevention is viewed in terms of the health problem**, in the aim of preventing onset, detecting the problem early, and preventing degradation, or mitigating its effects or complications [1].

Health promotion refers to a more systemic and less disease-centred approach. As set out in the Ottawa Charter, it is defined as "the process of enabling people to increase control over, and to improve their health" [2]. **Health promotion constitutes a global, political and social process [3].**

Health promotion and disease prevention (HPDP) are **key aspects of public health for achieving health system goals, particularly by improving population health, while reducing social health inequalities, and achieving health-related sustainable development goals [2,4].**

The scope of this project includes **all HPDP interventions**, including interventions not directly within the remit of the health sector, such as environmental initiatives (e.g. promoting green spaces in urban areas, energy retrofitting of homes, etc.), linked with the Health in All Policies approach[1] [5,6].

1. According to WHO, "Health in All Policies" is an approach to public policies that systematically takes into account the health implications of decisions across sectors, in order to improve population health and reduce health inequalities [5].

Issues with establishing a paradigm shift in prevention

In recent decades, developing health promotion and disease prevention (HPDP) has progressively emerged as a public health priority, giving rise to many initiatives[2] reflecting the will of public authorities to bring about a paradigm shift in disease prevention[3].

However, **the results remain inadequate**. By way of illustration, 29% of French people are of the view that "nothing can be done to prevent cancer" [8], even though, according to INCa, almost half of cancers are associated with preventable risk factors (alcohol, sedentary lifestyle, etc.) [9]. France also has poorer uptake than some countries in medicalised prevention programmes (vaccination[4], organised cancer screening [10,11]) and a higher prevalence of certain at-risk behaviours (alcohol consumption [12], tobacco use[5], etc.) than among its neighbours. As such, this observation is concerning, because it has been established that current policies and measures **are not capable of improving health effectively while addressing health inequalities** [13,14]. This is despite the fact that the last decade has seen the emergence of numerous initiatives and trials, proposed by different decision-making levels, public and private actors alike, on a national or local level, without these efforts being maintained in the long term or deployed further. Recent informative studies provide explanatory data for these issues [13-17]. The availability of evidence, not only on effectiveness and cost-effectiveness of HPDP interventions, but also to obtain a shared interpretation and understanding by decision-making actors, is a major requirement for the development of such interventions, as highlighted in the recently published Igas report [17].

Problem: How can we strengthen expertise to foster a paradigm shift in disease prevention?

Support for accelerating and establishing a paradigm shift in disease prevention are key areas of the HAS strategic project for 2025-2030. Therefore, it has decided to initiate an analysis to promote the development and implementation of health promotion and disease prevention interventions within its area of expertise: informing public decisions.

In view of the scope and broad range of areas in health promotion and disease prevention, a wide diversity of actors are concerned (central government, health agencies, local authorities, social protection funds, additional bodies, etc.). This HAS analysis has been carried out on the basis of contributions from actors and a literature review.

2. These include: the national tobacco control programmes (2018-2022, followed by 2023-2027), the interministerial strategy for combatting addictive behaviours (2023-2027), the national nutrition-health programmes (from 2001), the 2021-2030 ten-year cancer control strategy, the first 1,000 days programme (from 2021), the national action plan against the loss of autonomy (2015), the senior citizen fall prevention plan (2022), etc.
3. "Paradigm shift in disease prevention" refers to the goal to achieve a paradigm shift in the health system in France, by rebalancing public action to promote disease prevention beyond curative treatment alone. This consists of updating health policies to establish health promotion and disease prevention as core priorities, in order to reduce preventable premature mortality, limit social and local health inequalities, and increase system sustainability [7].
4. Eurostat statistics: Influenza statistics - Statistics Explained - Eurostat.
5. Eurostat statistics: Tobacco consumption statistics.

Part 1. HPDP evidence-informed decision-making: implementation challenges and issues

I. What do we mean by evidence to foster a paradigm shift in disease prevention?

1. Approach promoted by WHO to achieve public health goals

Inherited from the medical sector through the evidence-based medicine movement, evidence-informed decision-making is now emerging as **a key tool for improving population health**. WHO promotes this evidence-informed decision-making approach, which combines scientific rigour, transparency and accountability [18].

It is important to highlight the scope of the term "**evidence-informed decision-making**", which refers to use of evidence to inform decisions, while recognising that **the decision-maker remains free to determine whether to take evidence into account in the decision-making process**.

Furthermore, in a context of growing distrust in science, **it has become especially important to be able to identify evidence-based interventions according to the latest knowledge and ensure the accessibility of this evidence**. Applying rigour to set out what is known makes it possible not only to settle some debates, but also to guide considerations and public action on genuine issues, where uncertainties remain or choices still need to be made.

2. Which evidence to inform HPDP decision-making?

In 2003, WHO defined health evidence as "findings from research and other knowledge that may serve as a useful basis for decision-making in public health and health care". This relatively broad definition highlights the **difficulty determining what public health "evidence" actually is**. It emphasises the need to consider the context (local, political, resources available, acceptability, etc.), social values, and the purposes of public action. This approach requires a pluralistic vision of evidence, combining scientific knowledge, professional expertise, and citizen participation [19,20].

Conventionally, HPDP evidence is organised according to two complementary categories:

- **problem-based evidence:** for understanding the situation by characterising a health problem (scope, population(s) concerned, risk factor(s) and determinant(s), etc.). It is made up of descriptive epidemiological and sociodemographic data, data on interactions between health determinants, and local data for context.
- **solution-based evidence:** describing "how to act" through three core questions: Is it effective? How cost-effective is it and what are the economic impacts? Which mechanisms are in-volved? What are the conditions for success? This evidence is primarily obtained from **intervention evaluation** [21].

Within the scope of this foresight analysis, the HAS has chosen to focus on **solution-based evidence**. As such, the focus of the remainder of this foresight analysis document is on **intervention evaluation**.

II. HPDP evidence-informed decision-making: merging implementation intentions and challenges

1. Issues around HPDP evidence

Increasing the inclusion of evidence in decision-making relating to HPDP interventions is essential in order to foster a paradigm shift in disease prevention. By **supporting evidence making it possible to fully evaluate the health gains**[6] from these interventions, it will be easier to initiate (or retain) these interventions in a context of tight constraints in terms of human, financial and time resources.

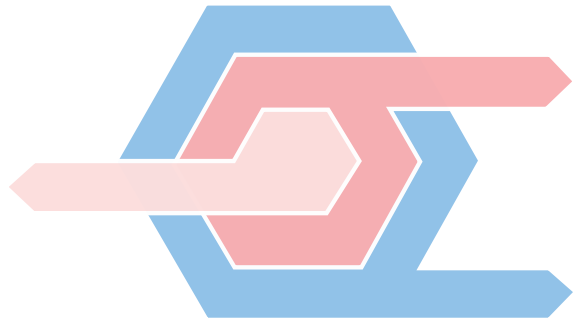
Consideration of evidence on HPDP interventions thus addresses multiple issues: public health, cost-effectiveness of the healthcare system, social security sustainability, and ethics. However, there is consensus that this approach is still **inadequately developed in France**.

In addition, health promotion and disease prevention evidence is especially important in terms of **ethics**, as interventions are often perceived as intrinsically beneficial, or failing that, risk-free. However, a number of publications have revealed the negative impacts of some interventions: stigmatisation of lung cancer patients resulting from a poorly conducted tobacco control campaign [22], extra work-load for professionals [23], growth in health inequalities [24], etc.

2. A move towards evaluation, but fragmented and not yet widely shared

In the evaluation of an HPDP intervention, there are three key roles: intervention effector (e.g. teams of healthcare professionals, local authority proposing an initiative, etc.), evaluation effector[7] (e.g. INSERM, OECD, etc.) and funder (e.g. DGS). Note that a stakeholder may embody one or more of these roles depending on the context.

6. As defined by WHO: improving population health and reducing health inequalities.
7. Evaluation effectors may be from different categories, particularly researchers, specialist bodies, actors in the field, private firms, etc.



Evaluation effector

Aim: produce an evaluation useful for decision-making, discuss with other actors to build the evaluation

Intervention effector

Aim: understand the benefit of the evaluation and how it works, in order to be able to plan and use it as a tool to enhance the intervention

Funder

Aim: understand the benefit of the intervention and how it works via evaluation findings, obtain evidence to inform funding decision-making

Figure 1 – Diagram summarising the expression of needs of evaluation stakeholders, according to their role

Many actors are involved in the area of HPDP evaluation, in particular:

- some agencies (French Public Health Agency, INCa) have the goal of evaluating their HPDP interventions, including economically. These evaluations are conducted in conjunction with effectors (OECD, researchers, contractors, etc.),
- the HCSP conducts the multiannual evaluation of the National Health Strategy, as well as evaluations of disease prevention policies and strategies (including cost-effectiveness). It has been requested in particular to define an evaluation framework for the "Mon Bilan Prévention" (My Disease Prevention Profile) programme.
- the DREES conducts evaluations of public policies (social and economic impacts), and the multiannual evaluation of the National Health Strategy,
- the HAS develops public health guidelines particularly for screening (HIV, CMV, etc.), vaccination, and clinical practice guidelines (e.g. suicide prevention, specialist prevention in the area of Child Protection, tooth decay prevention, etc.),
- within the scope of the "Disease Prevention Challenge"[8], the AIS and the strategic committee of the call for proposals conduct an analysis of evaluation models for presumptively innovative programmes, incorporating an economic dimension,
- the HCFEA conducts evaluations of public policies relating to families, children, and senior citizens,
- from an operational point of view, a very large number of actors conduct evaluations of HPDP interventions: French Regional Health Observatories, OECD, researchers, learned societies, firms, etc.

Insurance Funds also deploy processes for evaluating their HPDP interventions. The CNAM, in cooperation with the DREES, particularly coordinates and tracks evaluations of trials under the Article 51 programme (evaluations conducted by contractors).

8. The aim of the Prevention Challenge call for proposals, led by Bpifrance, is to apply innovation to promote disease prevention. It supports projects seeking to demonstrate their public health impact, while identifying effective technological innovations capable of being rolled out on a larger scale. This call for proposals is part of the Health Prevention Innovation Strategy launched in 2024. Led by the Agency for Health Innovation, this strategy is aligned with the framework of the 2030 health innovation plan.

The CNSA, through the 'Fonds VITAL' fund, has set up cooperation with the French Federation of Geriatric Care Centres in order to evaluate, facilitate scaling up, and promote local initiatives. The CCMSA has conducted an evaluation of its 'Instants santé MSA' prevention programme, aimed at its under-consuming beneficiaries [25].

The SFSP is also involved in various projects targeting HPDP expertise production. It also coordinates the DIPP[9] collective approach, a space for discussion and analysis around the rollout and scaling up of evidence-informed and promising HPDP interventions[10].

In summary, **there is already a move to foster the evaluation of HPDP interventions; however, there appears to be no common understanding of the challenges of evaluation, the data required, the methods to be applied, and the practical role of findings.**

As such, knowledge about evaluation is mixed, and dialogue around evidence remains limited.

One of the problems observed is **the lack of tools** providing a conceptual and methodological framework (glossary, methodological guide), and its implementation guide, in order to facilitate discussions around evaluation.

To increase the availability of evidence and its incorporation in decision-making processes, **appropriate tools are needed**. In the absence of a conceptual and methodological framework and implementation guide, conducting HPDP evaluations remains limited, particularly on account of a mixed level of knowledge of evaluation processes and the interpretation of their findings. This framework is merely a starting point: for evidence to provide useful information, it is necessary to plan their evaluation prior to interventions, and increase dialogue around HPDP evidence.

This foresight analysis has been devised as a **framework aimed at proposing two priority areas of action** to increase support for public decision-making in HPDP:

- **developing a "toolkit"** made up of a conceptual and methodological framework facilitating understanding of theoretical and methodological aspects, and an implementation guide of evaluations facilitating their rollout under appropriate conditions for success;
- **structuring dialogue and intermediation** around HPDP evidence.

N.B. This foresight analysis document is not intended to provide the detailed "toolkit", but seeks to indicate its main characteristics; more in-depth research is required for its development.

9. 'Déploiement des interventions probantes et prometteuses' (Rollout of evidence-informed and promising interventions), an initiative supported by the General Directorate for Health and the French Public Health Agency.
10. Set up since 2022, this initiative is also aimed at developing tools and resources to support evidence-informed or promising HPDP interventions, inform institutional arbitration rationales in supporting scaling up and supporting advocacy based on stakeholders' observations needs.

Part 2. A "toolkit" to foster HPDP evidence-informed decision-making

I. A conceptual and methodological framework to increase understanding and knowledge around HPDP evaluation

In order to develop HPDP evidence-informed decision-making, it is necessary to **develop a conceptual and methodological framework** to harmonise levels of knowledge in evaluation, and help establish a genuine evaluation culture.

This **conceptual and methodological framework** is an essential first step; it must provide actors with the **theoretical and methodological benchmarks** needed to understand HPDP evaluation and HPDP evidence.

Devised for all HPDP interventions, whether they are nationwide programmes or more targeted local initiatives, it must be **adaptable** in order to be able to evaluate a broad array of interventions.

1. A conceptual and methodological framework adapted to the broad array of HPDP interventions

The first component of the "toolkit" aimed at including HPDP evidence, the aim of the conceptual and methodological framework is to **provide actors with the theoretical and methodological benchmarks needed** to understand public health evaluations.

The **conceptual and methodological frame-work must be adaptable** so that it can be applied to the broad array of HPDP interventions, depending on the methods (education, incentive, coercion, etc.) or approaches used (from interventions on individual behaviour to approaches based on living conditions), the type of programme (local initiative, national programme, etc.), intervention maturity, etc. The condition for the success of such a framework is dependent on its scope for use as a flexible tool, adapted to different interventions. During dialogue around framing evaluations, it should be possible to apply this framework **to discuss and confirm the components of the evaluation** between decision-makers, the intervention effector, and the evaluation effector.

In terms of **ethics**, framework adaptability is especially important as an overly strict approach could involuntarily lead to a systematic tendency towards more "easy-to-evaluate" interventions. This would introduce a selection risk, by favouring some interventions over others that are potentially relevant but more complex to evaluate.

2. Evidence expected to inform decision-making

Evaluation of HPDP interventions examines on whom, how, when, why, at what cost, at which performance, under which conditions, and in which contexts interventions produce effects on individual and population health. It is based on **complex methodologies**[11], in turn based on **mixed and mechanistic approaches**[12] **adapted to the specific characteristics of public health**.

The foresight analysis helped identify **four categories of evidence** expected by decision-making actors, for which the framework must provide benchmarks:

Evidence on effectiveness

Economic evidence

Evidence on conditions for successful implementation

Evidence on externalities

For each, the time frame of the effects of the intervention[13] (short, medium, long terms) is also key information for planning and structuring interventions.

However, while it is important to consider compiling evidence in several of these categories, to achieve decision-making and steering ability, **not all these categories are necessarily applied in the same proportions at the time of decision-making**. As such, the proposed framework supports and facilitates the identification of the most relevant evaluation criteria for each intervention.

A. Evidence on effectiveness

a. Requirements in terms of evidence to inform decision-making

Effectiveness evidence forms **essential support for relevance and advocacy** for interventions which help improve health while reducing social health inequalities.

In this context, the aim of effectiveness evaluation is to **measure the positive and negative effects**[14] **of an intervention on health and on social health inequalities**.

The study designs applied must enable decision-makers to measure the effectiveness of the intervention by comparing the change from the initial status prior to implementation and comparing to pre-existing interventions, where applicable.

11. The term "complex methodologies" refers to evaluation frameworks as described by the Medical Research Council framework for complex interventions [26,27], which stresses the importance of combining different methods, analysing mechanisms, contexts and processes, and of considering the multiplicity and variability of the effects of an intervention.
12. Which consists of understanding the mechanisms of action of an intervention (how, why, under which conditions and for which populations, etc.).
13. For example, an awareness campaign about limiting screen time in children may have short-term effects, such as improved sleep, and long-term benefits. such as lowering obesity risk, may only be seen after several years.
14. A public health action may have a positive effect on one indicator, but a negative effect on another. By way of illustration, lockdown measures implemented during the Covid-19 crisis helped restrict the spread of the virus, but they also had adverse impacts on mental health, accentuating social isolation and stress in some populations [28,29], resulting in delayed diagnoses for some conditions [30].

b. Analysis around selection of evaluation criteria

IIt should be noted that in the case of health promotion and disease prevention, use of **intermediate indicators**[15] may prove to be relevant. Insofar as the ultimate health effects of HPDP interventions can be observed most frequently in the long term, ultimate health indicators (e.g. mortality, life years gained, incidence or prevalence of chronic conditions, etc.) may prove to be reductive and not relevant for evaluating the effectiveness of interventions. On the other hand, **intermediate indicators** make it possible to document the early effects of an intervention (e.g. engagement in a tobacco cessation process, overweight in children, vaccination, etc.), and thereby provide **sufficient evidence to inform decision-making**.

B. Economic evidence

a. Requirements in terms of evidence to inform decision-making

Two separate economic analysis approaches are useful for decision-making [31]:
- **the budget approach which addresses the issue of financial sustainability of our healthcare system,**
- **the economic approach which is aimed at optimising collective health and well-being in a context of budget constraint.**

Besides measuring treatment costs, the challenge of economic evaluation is to apply information on the effectiveness of treatments or public health interventions, in terms of health benefits (life years, quality of life, well-being).

While the budget approach is applied routinely in healthcare decision-making, **use of the economic approach to inform decision-making is inadequately developed in France**.

b. Analysis around selection of evaluation criteria

The economic analysis is a toolkit, capable of applying different methods and criteria according to the question addressed.

- The cost-effectiveness criterion makes it possible to align the medical benefit of interventions and budget constraints. It ranks several interventions, by comparing the health benefits provided or expected and the incremental costs that they generate. This criterion is generally expressed as an incremental cost-effectiveness ratio (ICER).
- Cost-benefit analyses can also be used to compare costs generated with expected benefits, but according to a broader and collective acceptance of the concept of benefit (e.g. reduction of violence in the context of addiction mitigation actions, well-being).
- Budget impact analyses can be used to estimate the difference between the costs incurred by an investment and the savings generated from the investor's perspective, compared to a lack of investment.
- More recently, the return on investment (ROI) criterion has often been described as easier to use than the ICER, because it is more intuitive. The information produced is perceived as concrete: it expresses the "return" on each euro invested in prevented treatments.

In this way, economic evaluation makes it possible **not to confine HPDP to their impact on public finances**.

Here again, the framework must support and facilitate the identification of the most relevant evaluation criteria to inform decision-making for each intervention.

15. Indicators replacing other difficult-to-measure indicators or indicators for which evidence is limited, measure short- or long-term changes which are correlated with the ultimate effects.

Focus: Public Health Wales

In 2018, the Welsh government launched the *A Healthier Wales strategy* [32] with the aim of improving population health and reducing inequalities. Nevertheless, some years after launching this strategy, the country observed a degradation of the health state of populations following the Covid-19 pandemic, higher cost of living, and the national and international context.

In a context of growing pressure on public finances, *Public Health Wales* (designated a WHO Collaborating Centre on Investment for Health and Well-being) published a report reviewing evi-dence for informing decision-making in HPDP investment. **Return on investment is particularly used in this report, aimed at promoting engagement to foster disease prevention** and to demonstrate the positive impact of such investments for reducing costs associated with poor health for the health and care system [33].

C. Evidence on conditions for successful implementation

a. Requirements in terms of evidence to inform decision-making

Evidence on the conditions for successful implementation of an intervention is a key contribution to the discussion around its reproducibility[16], rollout[17] and/or transferability[18]. In this context, it concerns:

- **how the intervention works: the decision-maker needs to understand the mechanism(s) on which the intervention is based[19],**
- **implementation conditions (acceptability, organisational concerns, etc.).**

The evaluation of the conditions for successful implementation of an intervention is aimed at fully evaluating several elements [27,36]:

- intervention implementation: what is implemented and how?
- impact mechanisms: what are the theories as to how the intervention works? How does the intervention bring about changes?
- context: how does the context affect implementation and findings?

In this way, the relationship between the implementation of an intervention, the mechanisms whereby the intervention works, and the intervention context must be specified.

16. Reproducibility (or applicability) refers to the degree to which the processes of an intervention in a given context can be imple-mented in another context [34].
17. "Rollout" refers to larger-scale implementation of an intervention. It consists of a structured process aimed at extending an intervention to a greater number of people, often in varied, real-world contexts.
18. Transferability can be defined as "the degree to which the effects of an intervention in a given context can be achieved in another context" [35]. The full intervention is not always transferred; some components may be retained, whereas others will be adapted to the context [34].
19. For example, an intervention aimed at restricting advertising for a harmful product near schools is based on evidence demonstrating the link between exposure to advertising and consumption of that product.

On one hand, the context (which includes the physical and social setting, the characteristics of the actors involved [34]) is a major determinant of HPDP interventions [37], and, on the other, an intervention can modify the context in which it is rolled out [36]. Documenting these interactions allows decision-makers to **gain a clear understanding of how the intervention works and the conditions for its success**.

b. Analysis around selection of evaluation criteria

The selection of evaluation criteria of the conditions for success of an intervention varies greatly according to the decision-making context; whether it is a question of continuing an intervention that has already been rolled out (i.e. without modifying the context), transferring an intervention from another context (e.g. generalised application to several localities), etc.

The **evaluation of transferability**, which consists of "initially estimating the specific elements of the intervention, which need to remain unchanged, as opposed to those to be adapted" [34] is **particularly important for decision-makers**.

D. Evidence on externalities

Evidence on externalities (both positive and negative) is essential for understanding all of the effects of an intervention, and thus informing decision-making more comprehensively.

An externality is the effect (positive or negative) of an activity on an actor not directly involved in this activity, such as passive smoking, environmental degradation or herd immunity [38,39].

This type of evidence is an important tool for **advocacy** in complex decision-making settings, sometimes with conflicting interests. Evaluating the effects of an intervention on health dimensions alongside those of the effects on the populations targeted by the invention and on non-health dimensions (e.g. employment, violence, etc.) makes it possible to obtain convincing evidence.

This approach is especially of interest as it makes it possible to address determinants of health as a whole and support the **Health in All Policies** approach.

II. Conditions of success for HPDP evidence-informed decision-making: implementation guide

The conceptual and methodological framework, built around the theoretical elements mentioned above, is merely one component of a broader set of necessary conditions for developing HPDP evidence-informed decision-making.

Planning is central to the conditions of success of evaluations. On the one hand, it makes it possible to ensure **relevance** by identifying, prior to implementation of the intervention, the evidence required for decision-making, and, on the other, to increase **quality** by preparing operational aspects. As such, **the production of evidence to foster a paradigm shift in disease prevention means that public decision-makers must address evaluation well ahead** of intervention implementation.

Finally, broadcasting of evidence following an evaluation is a key condition: the evidence must be **understood and accessible** for all actors concerned to allow informed decision-making in health promotion and disease prevention.

As a result, alongside the conceptual and methodological framework, the "toolkit" includes guidance to help actors **implement interventions under conditions favourable for their success**.

1. Designing evaluation to inform decision-making

Once the theoretical aspects of the framework have been defined, it is essential to align its use with a **pragmatic approach, focused on producing evidence intended to inform decision-making** in HPDP. It is neither necessary nor relevant to systematically target the best level of evidence for all interventions, or to inform all possible criteria, especially as systematically seeking the highest level of evidence and collecting all data is expensive and utilises substantial resources.

In addition, **planning evaluation before implementing interventions is critical for the quality of findings**. Lack of planning impacts the ability to implement the right evaluation methods, collect the study data[20] required to measure effectiveness and externalities, conduct an economic analysis, and document real-world implementation conditions in detail (resources used, adaptations required, obstacles, etc.). Without this systematic planning from the outset, there is a risk of evaluation being based on non-relevant analyses and on retrospective reconstructions, by limiting rigour with the risk of being partial or biased. This weakens the quality, and hence the strength, of the evidence, and the understanding of context-based factors of success or failure.

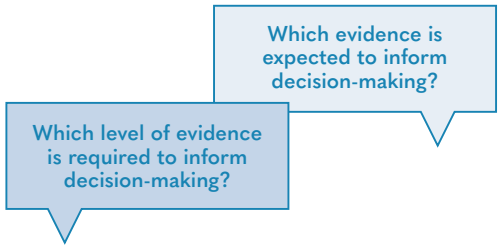
Alongside the conceptual and methodological framework, the "toolkit" must therefore also contain an implementation guide to support actors on these operational aspects.

20. In this document, the term "study data" refers to data collected for analysis purposes within the scope of the evaluation. It differs from the term "evidence", which refers to the findings from these evaluations.

A. Framing evaluation in advance to ensure its relevance for decision-making

HPDP evidence-informed decision-making raises similar issues to those frequently encountered in the realm of medicinal products. **Investing in health promotion and disease prevention can be somewhat of a gamble**, because the expected benefits often appear in the medium- or long-term. **For the gamble to be an informed one, the evaluation must produce the evidence required to inform decision-making.** Furthermore, the scientific approach naturally leads to updates in the evidence available (e.g. updates in knowledge about tobacco use prevention).

Hence, **for each evaluation**, **a discussion phase** between the intervention effector, evaluation effector and funder **must take place prior to implementing the intervention in the aim of addressing two core issues:**



a. Identifying expected evidence

HPDP intervention evaluation expertise must guide actors in **identifying the necessary and sufficient evidence** for decision-making during this phase. The aim of the conceptual and methodological framework is to facilitate this discussion and make it possible to specify the expected evidence. At the time of selection, it should be noted that economic evidence must be applied alongside effectiveness data, and must not be considered independently and separately.

The theoretical and methodological elements of the framework, associated with discussions with the effectors of the project and the evaluation, help reduce this risk and **ensure cohesion in building evaluations**.

b. Defining the levels of evidence required to inform decision-making

> *“Not having the best level of evidence must not be considered as a reason not to take action”*
>
> *Decision-making actor*

Alongside identifying the evidence required to inform decision-making, it is also appropriate to **examine the associated level of evidence**[21]. This may vary according to the context, decision-making time frames, type and degree of maturity of the intervention, etc. This analysis is pivotal because **the decision-making phase does not always coincide that of evaluation**; a time lag may result in launches of actions being rejected, or, conversely, implementation being approved before evidence is available.

In this context, HPDP expertise must allow decision-makers to distinguish between findings that are known with certainty (e.g. tobacco control interventions) and those requiring more corroborated evidence, in specific areas (e.g. health impacts of screen use), in order to define the acceptable levels of evidence for each evaluation.

21. The term “level of evidence” refers the degree of confidence in the findings of a study, according to the methodological rigour and fit between the type of study and the question addressed [18].

Examples: Adaptation of evidence to decision-making needs

A municipality seeking to reduce physical inactivity may use interventions with well-documented effectiveness, cost-effectiveness and implementation conditions (e.g. "Grand Défi Vivez Bougez"[22], floor marking campaigns encouraging people to take stairs [41, 42], etc.). In this case, the evaluation may mainly focus on the process (e.g. uptake among residents, acceptability of measures, reaching the target population, faithfulness of implementation, resources used, etc.), and on a moderate level of evidence.

Conversely, an innovative programme aimed at reducing screen time in children involves a less mature topic, which is the subject of research, and will require a more complex evaluation. Decision-makers may then identify several categories of required evidence (e.g. impact on mental health, economic data, etc.), and also a higher level of evidence.

B. Planning operational aspects of evaluation to ensure its quality

Conscious of the inherent cost of evaluating an intervention, **advance planning of the evaluation must also help guide and adapt evidence searches according to actual decision-making needs** and the associated decision-making timeframe.

The implementation guide must provide benchmarks for intervention effectors, evaluation effectors, and funders, in order to plan the evaluation, and thus **ensure its quality**.

a. Evaluation budget and resources

Evaluation is sometimes perceived by intervention effectors as a constraint and a barrier rather than a method adding value. This perception, reinforced by the time-consuming and costly nature of evaluation, may give rise to a reticence to assign resources to it. In addition, it continues to be inadequately integrated and overly fragmented in some calls for proposals.

In practice, evaluation processes may require substantial budgets and resources: the implementation guide could give actors useful support by **providing concrete benchmarks**, **particularly in terms of costs and requirements** (time, involvement of stakeholders), and adapt to real-world needs.

22. Intervention to promote physical activity in children [40].

Focus: Health Promotion Switzerland

The Health Promotion Switzerland foundation has developed a guide intended to assist effectors of interventions in evaluating the effects of interventions in the realms of nutrition, physical activity and mental health on children, adolescents, and senior citizens.

This guide contains various tools, particularly on the budget to be allocated to evaluation, specifying the differences between trials and routine projects, and the choice between external or internal evaluation. It is specified that "according to the scale of the project and the evaluation, between 5% and 20% of the project budget should be allocated for evaluation" [43].

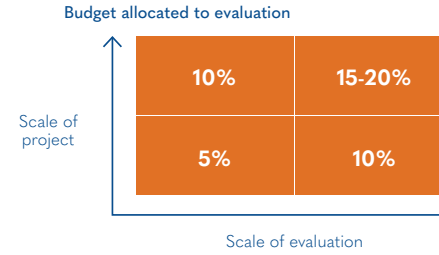


Figure 2 – Diagram taken from Health Promotion Switzerland guide

b. Availability and accessibility of study data

All evaluations require study data; however, **there are still significant issues in terms of data availability[23], accessibility or quality**.

Many evaluations collect their own data or are based on local data. Therefore, the implementation guide must:

- assist actors in planning study data needs,
- during the evaluation framing phase (described above), **the choice of evidence expected in the evaluation must be adapted according to the study data available** in order to reduce costs and facilitate the completion of evaluations.

In parallel, existing nationwide databases (cohorts, registries) [44-47] may be utilised in some cases, having the advantage of not needing to carry out specific collection.

However, issues are observed, and it is necessary to foster data availability and accessibility, and address decompartmentalisation concerns [48]. Several initiatives are progressively being set up to address these issues, such as GD4H[24].

Furthermore, in economic terms, the SNDS[25] is the primary source of medical-administrative data and some data may be lacking (e.g. Maternal and Child Protection vaccination), particularly on account of lack of specific classification (e.g. mammograms with no indication whether they are preventive/curative).

23. Particularly on some topics such as mental health
24. The aim of the Green Data for Health initiative, coordinated by Anses, is to decompartmentalise human, animal, plant, and environmental health databases according to the One Health approach.
25. The SNDS (National Health Data System) is a pseudonymised medical-administrative data warehouse. It contains all care submitted for reimbursement and covers the entire French population. The data contained in the SNDS are initially intended for reimbursement.

2. Broadcasting evidence and supporting upskilling for its use in decision-making

Following evaluation, the evidence must be broadcast and understood by all of the actors concerned. Its clarity, and also support for actors through intermediaries, must be taken into account to promote actually informed health promotion and disease prevention decision-making.

A. Presentation of evaluation findings and interpretation support for decision-makers

The inherent complexity of HPDP interventions results in evaluation findings that are in turn multidimensional and complex, and which may be difficult for users and decision-makers to interpret and process.

Hence, **evidence must be presented in a clear, accessible and informative way**[26]. Where relevant, this presentation must also highlight data subject to change with updates in knowledge.

In addition, decision-making actors may need support for interpreting evidence, and applying it optimally. To address this **need**, scientific advisors should be enlisted to act in this **intermediation** role.

Focus: CNSA Centre of resources and evidence initiative

Observing varying levels of knowledge among operators and decision-makers about resources that can be used in relation to HPDP, the CNSA Centre of resources and evidence aimed at preventing loss of autonomy has set up personalised support for areas via the French Health Promotion Federation.

The aim of this support, which prioritises areas where consumption of funds[27] is under 60%, is to enable:

- **operators to propose evidence-informed HPDP actions**,
- **CFPPA committees to identify and prioritise support for actions appearing to have a positive impact** on maintaining autonomy.

Approximately one third of French departments are receiving support to date.

26. By way of illustration, the "Campus sans tabac" (Tobacco-Free Campus) programme, led by EHESP, is an example of an initia-tive providing tools to assist actors in rolling out an intervention, including a summary guide of evidence on the effects of this intervention.

27. The aim of the Committee of Funders of Actions Against the Loss of Autonomy (CFPPA) is to coordinate, in each French department, actions against loss of autonomy of senior citizens (aged 60 years and over), and their funding. On a national level, this body is led by the CNSA, whereas each department is responsible for leading the committee of funders in its area. As part of this programme, the CNSA provides funds to departments (in addition to existing prevention funding) to enable them to fund disease prevention actions.

B. Making evidence available to facilitate access for a large number of actors

> *"It would be really beneficial to have a labelling system for HPDP actions, like the Nutri-Score system, to support decision-making"*
>
> *Decision-making actor*

Decision-makers need easy access to a summarised version of the latest knowledge about HPDP evidence. A **form of 'labelling of HPDP actions' to support decision-making**, with an identification of best practices for HPDP intervention, while retaining flexibility in implementation and operational use, could be useful for them.

With this in mind, the aim of the DGS-led InSPIRe-ID[28] system was to set up a "national public health knowledge sharing system". One of the areas, aimed at sharing HPDP knowledge, has results in the set-up of the ReperPrev registry[29]. Led by the French Public Health Agency, it inventories HPDP interventions based on evidence from evaluation work. Interventions are selected, evaluated and classified according to 5 levels by an evaluation committee[30].

Focus: Example of another approach for making evidence available: WHO "Quick Buys"

WHO Europe has drawn up of a list of 25 HPDP interventions for addressing non-communicable disease (cardiovascular diseases, diabetes, chronic respiratory diseases, and cancer).

Conscious of the complex contexts associated with public decision-making, WHO chose to select interventions with evidence on their short-term effectiveness (5 years or less) and economic data[31] [50].

28. Public Health Initiative for the Interaction between Research, Intervention and Decision, founded in 2013.
29. ReperPrev.fr.
30. The area of the InSPIRe-ID system aimed at HPDP knowledge sharing has also resulted in the set-up of another registry: the CAPS portal. Co-led by the French Society of Public Health (SFSP) and the French Health Promotion Federation, the aim of this portal is to facilitate public knowledge sharing in line with capitalising on experience and experience-based knowledge. However, it is important to note that a project does not need to have been assessed to be utilised on this portal [49]. Hence, this approach does not fall within the remit of this foresight analysis, which is focused on evidence from intervention assessments.
31. WHO selected interventions with a cost-effectiveness < Int$20,000 per disability-adjusted life year (DALY) averted.

Part 3. Structuring dialogue and intermediation around HPDP evidence

Developing an HPDP evaluation culture appears to be a necessary, but insufficient, condition for strengthening the use of HPDP evidence to inform public decision-making.

Dialogue between actors would appear to be key tool for clarifying and defining goals, targeting evidence needs to prevent redundancy, inform the interpretation of finds, and pool efforts.

In this aim, WHO encourages governments to "institutionalise structures and processes to support evidence-informed decision-making" and ensure that these structures and processes are driven by decision-making, ethical, multisectoral and multidisciplinary[32] and that they are "positioned to coordinate their resources effectively to avoid duplication of evidence production" [51].

I. Example of Australian Prevention Partnership Centre

The Australian Prevention Partnership Centre was established in the aim of improving the availability and relevance of evidence to support public policymaking to prevent chronic diseases. It acts as a strategic bridge between science and policymaking, to foster a rigorous and coordinated systems approach to chronic disease prevention in Australia.

32. The network notes that "given that health is strongly influenced by factors, sectors and actors outside of health, whole-of-governance and whole-society approaches are needed" [51].

1. Goals and role of the Centre

The Australian Prevention Partnership Centre was established in 2013 to strengthen the prevention of chronic diseases. It is part of a complex Australian healthcare system, shared between the Commonwealth (federal government) and Australian states/territories, each playing an important role in HPDP policies.

Its aim is to improve the availability and relevance of evidence to support public policymaking to prevent chronic diseases.

Established from a strong political drive in the 2010s to develop disease prevention, the Centre has received continuous funding, which enabled it to develop a collaborative research and public policy framework around chronic disease prevention from 2014 to 2024. Over this period, the Centre developed and funded research programmes according to priorities identified in consultation with Australian states and territories, and then submitted these programmes to funding bodies.

From 2024, funding has been reduced, but government actors have deemed the model to be effective, and have continued to support it. By capitalising on the maturity gained over the first 10 years of the programme, the Centre has been able to adapt and establish a **new model**. It no longer funds research directly, but **promotes a systems approach to chronic disease prevention, bringing intervention effectors, evaluation effectors, and funders together** to identify needs, priority issues, and the evidence already available.

2. The Centre's work: spaces for dialogue and intermediation

Based on expertise in public health and communication, and on feedback from public decision-makers, the centre produces:

- summaries of available evidence,
- simulations allowing decision-makers to test various intervention options and their potential impacts prior to actual implementation,
- studies on intervention implementation: identifying tools and barriers for a successful and sustainable rollout of interventions.

The Centre sets up **"policy dialogue" exercises** with decision-making actors to examine the different dimensions of the evidence required (What are the problems? Is there any pre-existing evidence? Does some evidence need to be translated for action? Which research should be continued?). **Workshops and webinars are also held, where researchers/evaluators, decision-makers and users (civil society) discuss complex topics together**, such as alcohol and nutrition, etc. In addition, the Centre ensures that the various actors are involved throughout the project process.

The Centre also places an emphasis on evidence communication: making research findings accessible, relevant and usable by decision-makers, from the project design phase. As such, each project needs to provide a knowledge translation plan, and communication experts are recruited.

II. Towards a space for dialogue and intermediation in France?

Many actors are already involved and positioned in the area of HPDP evaluation. However, in order to support evidence-informed decision-making, it is necessary to foster structured dialogue between the different actors involved. To this end, the HAS recommends **setting up a space for dialogue and intermediation** for HPDP evidence.

The purpose of this space is to bring together all of the stakeholders concerned by an intervention (intervention effectors, evaluation effectors, funders, decision-makers), in order to foster a shared understanding of evaluation and collectively discuss expectations with regard to findings and their potential limitations. Within the space for dialogue, this approach would be facilitated by **an actor acting in an intermediation role**; tasked with helping participants specify expectations, identify the necessary and sufficient evidence to inform decision-making, apply that already available, plan for interpretation of findings in relation to the selected criteria, and define the most appropriate evaluation design.

This space for dialogue and intermediation may be set up at different decision-making levels (national, regional, etc.). In any case, it firstly requires institutional support. This consists of **finding an appropriate model for supporting this intermediation role**.

Three criteria have emerged as priorities in embodying this role:

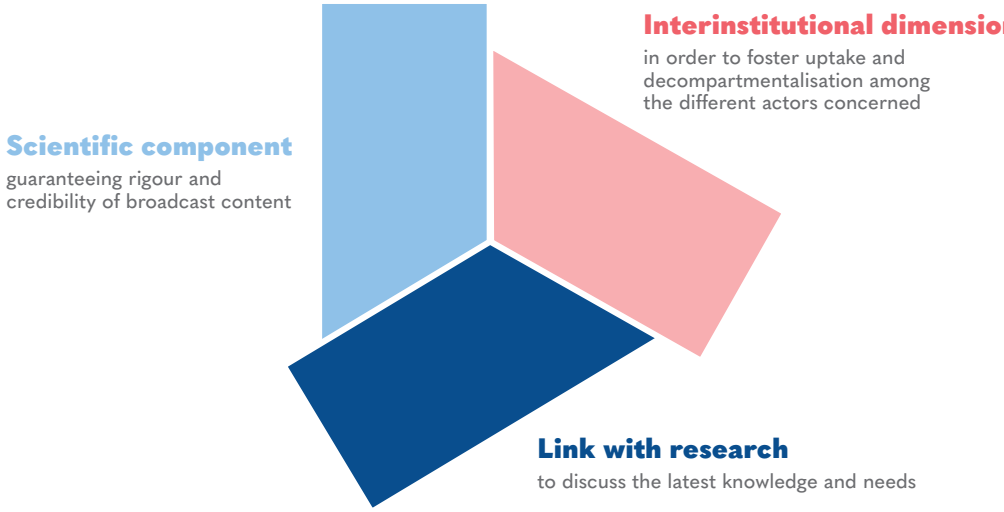


Figure 3 – Criteria for supporting this space for dialogue

The interinstitutional dimension refers to the aim of **bringing all of the actors concerned by decision-making together around an HPDP intervention**:

- the decision-maker(s) including:
  - healthcare actors with national remit (Ministries, national agencies, parliamentarians, etc.) or local remit (Regional health agencies, French departments, local authorities, etc.),
  - actors outside of the healthcare sector per se concerned by HPDP; according to the Health in All Policies approach (environment, education, urban planning, etc.);
- funders;
- intervention effectors;
- evaluation effectors[33].

The scientific component and the link with the research sector will help ensure the quality of evidence, follow the latest knowledge, and identify needs. Note that a multidisciplinary approach is needed. It may particularly recruit public health experts, epidemiologists, statisticians, economists, socio-anthropologists and/or communication science experts.

By way of illustration, the space for dialogue could support a French department seeking to fund a health promotion action in "toolkit" use. This will involve supporting it to:

- plan the evaluation in conjunction with the competent actors (Regional health agencies, federations, etc.),
- understand evaluation challenges, identify the evidence needs for decision-making, distinguishing between existing evidence and that to be produced, agree on the criteria to be selected and applicable study designs.

This space for dialogue and intermediation will first of all focus on HPDP evaluation, However, it is conceivable that such a system could also be used to assist actors in interpreting evidence to select the most relevant interventions for the issue affecting them and in their context, contact intervention effectors (e.g. associations, actors in the field), etc.

In terms of organisation, **several models** may be envisaged for the institutional support of this space for dialogue:

- a new actor as part of a long-term process,
- a temporary new actor, tasked with driving a network process, withdrawn once the approach has been integrated into practice in the long term,
- identifying a pre-existing actor (or actors), capable of embodying this role.

Given the current context and the aspiration to simplify the landscape of public actors, models based on establishing a new actor, whether permanent or temporary, appear to be less suitable. **As such, it seems to be more relevant to identify one or more actors to take on this role**, at least initially.

33. As a reminder, this consists of the key roles involved in assessing an intervention. A stakeholder may embody one or more of these roles depending on the context.

Outlook

This foresight analysis has identified two priority areas of action for strengthening expertise to foster public HPDP decision-making

Developing an HPDP evaluation culture is key, particularly by building and providing a "toolkit", designed to foster the set-up of evaluations under suitable conditions, and thereby inform decision-making usefully. This implies a **co-building approach** involving a broad panel of actors in order to ensure relevance and quality.

Using its expertise and in line with its missions, the HAS will be able to contribute to developing this "toolkit". Developing a methodological guide will be particularly relevant for the economic section of the conceptual and methodological framework, to strengthen economic calculation acceptability and clarity for HPDP intervention evaluation.

Besides developing this culture, actors need **a space for dialogue and intermediation around HPDP evidence**. The creation of such a programme should, at least initially, be institutionalised in order to structure discussions and lead the process around evaluation to inform decision-making. To make a real impact, it is critical that this space be open to all actors in HPDP decision-making, regardless of levels and sectors, including those not directly within the realm of health.

Therefore, it is necessary to **identify an appropriate model for France**; in the current context, appointing an actor (or several actors, as co-leads) to this role appears to be relevant as a solution.

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Acronyms

AIS	Agency for Health Innovation
Anses	French Agency for Food, Environmental and Occupational Health & Safety
ARS	Regional health agencies
CCMSA	Central Fund of the Agricultural mutual benefit social fund
CFPPA	Committee of Funders of Actions Against the Loss of Autonomy
CNAM	French National Health Insurance Fund
CNSA	National Solidarity Fund for Autonomy
DGS	General Directorate for Health
DREES	Directorate of Research, Studies, Evaluation and Statistics
EHESP	French School of Public Health
GD4H	Green Data for Health
HAS	French National Authority for Health
HCFEA	High Council for Family, Children and Age
HCL	Hospices Civils de Lyon
HCSP	French High Council for Public Health
Igas	General inspectorate for social affairs
INCa	French National Cancer Institute
Inspire-ID	Public Health Initiative for the Interaction between Research, Intervention and Decision
NHS	National Health Service (United Kingdom)

OCDE	Organisation for Economic Co-operation and Development
OMS	World Health Organization
ORS	French Regional Health Observatories
PMI	Maternal and Child Protection
PPS	Health promotion and disease prevention
RCDR	Incremental cost-effectiveness ratio
RIVM	National Institute for Public Health and the Environment (Netherlands) Dutch state agency placed under the authority of the Ministry of Health, Welfare and Sport
ROI	Return on Investment
SFSP	French Society of Public Health
SNDS	French National Health Data System
SPF	French Public Health Agency

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