BEHAVIOURAL SCIENCE AND HEALTH
INTERSECTIONAL PERSPECTIVES FOR CHANGE

APRIL FOUNDATION EXPERT GUIDE

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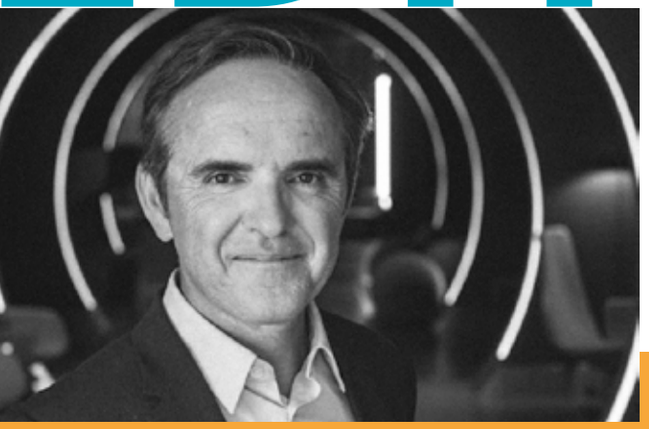
EDITORIAL



Éric Maumy
President of the APRIL group

Céline Falco
Emergency Doctor with SOS Médecins,
President of the APRIL Foundation

Our healthcare system, which offers one of the world's highest levels of protection, now stands confronted with a major challenge: how to secure its long-term stability and efficacy in the face of changing lifestyles, scientific and technological progress, the difficulties reported by healthcare professionals and institutions, growing social and territorial inequalities, and the emergence of new and increasingly complex pathologies.

Underpinning all of these issues is the question of how to fund our healthcare system, and the hitherto underexplored contribution which could be made by preventive healthcare, which has been something of a public policy blind spot in the past.

At APRIL, we are firmly convinced that not only is it possible to establish a culture which promotes health, but that such a culture represents an indispensable stepping stone towards the implementation of a truly systemic preventive health policy. In (re)establishing the APRIL Foundation, a forward-looking public interest initiative, we have demonstrated our continuing commitment to developing new areas of research and study, exploring and experimenting with new approaches to promoting healthy living and risk prevention, sharing the benefits of learning and bringing together all stakeholders across all territories, working more closely than ever before with people, communities and healthcare professionals.

It is a great source of pride to lead the APRIL Foundation in this new direction, working to accelerate change and make health promotion and prevention a central priority for the decade ahead.

Health is defined by a complex array of factors and variables, over which we have varying degrees of control (including heredity, social milieu, family background, environmental factors and lifestyle choices, to name but a few).

Promoting health and preventing disease requires a 360° approach which combines scientific rigour with a multidisciplinary spirit.

The idea of promoting healthy behaviour and preventive care opens up vast horizons of expertise and experimentation, in fields already being actively explored by numerous public, private and charitable institutions. In order to focus our work and amplify our impact, the APRIL Foundation has chosen to focus on one particular area which has previously received relatively little academic attention in France: the potential of behavioural sciences to inform our thinking on matters of health.

What can we learn from neuroscience, social psychology, cognitive sciences, sociology, anthropology etc. which might help us as healthcare professionals, but also as non-medical specialists working on the front line of public services, to bring about lasting behavioural change and improve the all-round health of communities and individuals? That is the question which the new-look APRIL Foundation sets out to answer, acting as a catalyst to dialogue, innovation and action involving all stakeholders.

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BEHAVIOURAL SCIENCE AND HEALTH

AN INNOVATIVE APPROACH FOR MORE EFFECTIVE ACTION

Behavioural sciences and the promotion of better health and preventive care: principles, recent events and challenges

When it comes to promoting preventive approaches and a better understanding of health, the question of behavioural change is of central importance.

As well as the state of knowledge, awareness and intentions, the general health of the population is largely dependent upon the behavioural choices that people make, in terms of risk prevention and lifestyle decisions conducive to better health.

For many years, studies have highlighted a significant disparity between knowledge, awareness and intentions and the way that people actually behave. Sometimes described as the "gulf" between knowledge and behaviour, this disparity is one of the primary topics of research in the "behavioural" sciences.

The behavioural sciences comprise those scientific disciplines devoted to studying the sources of human behaviour, exploring the factors which can prompt individuals and groups to change their lifestyle habits and practices.

The behavioural sciences are a diverse set of disciplines, encompassing fields such as cognitive sciences, focused on human perception and reasoning, neuroscience, devoted to exploring the functional mechanisms of the brain, and also psychology and social psychology, with their emphasis on individual and collective mindsets and modes of thought. Research in these fields has demonstrated that it is possible to understand and explain individual behaviour, particularly in relation to health. By taking full account of the emotional, cognitive and social dimensions of our relationship to health and sickness, by considering the influence of environmental factors on health decisions, and by analysing the dynamics of health-related communication, the behavioural sciences have succeeded in identifying the primary determinants of our health-related behaviour.

Nicolas Fieulaine,
Researcher in social psychology,
Université de Lyon

A researcher in social psychology at Lyon 2 University, Nicolas Fieulaine is currently lecturing at INSP on how to incorporate social psychology into public policy design.

He founded the Master's programme in Applied Social Psychology in Lyon, and co-founded a global network of HSS researchers with a shared interest in temporal perspectives. His main research interests are temporal perspectives and the ways in which individuals and groups comprehend change, as well as the impact of context on day-to-day experiences and behaviour and the role played by government action and social participation in shaping environmental dynamics. He spends much of his time working with those on the front line of such issues (charities, institutions, NGOs etc.), designing and testing systems and actions to facilitate change management.

Behavioural sciences and decision-making systems

Research has shown how a variety of cognitive short cuts and reflexes interfere with our choices and our behaviour, in ways which are often imperceptible. For example, we may display a tendency to prioritise short-term consequences over more long-term consequences when making behavioural decisions (giving precedence to the present), or else to make certain choices by default, i.e. taking what appears to be the most obvious or easiest option at the time.

KAHNEMAN'S SYSTEMS OF THOUGHT

Intuitive /innate
short cuts/quick

SYSTEM 1

SYSTEM 2

rational/systematic
slow/considered

Source: *Thinking, Fast and Slow*, Daniel Kahneman, 2011

The activation of these short cuts is dependent upon the environment, which may be more or less conducive to taking the time to reflect or consider different alternatives before making a decision. Time is a necessary luxury if we are to pass from thought system number 1 (intuitive, rapid, automatic) to number 2 (more considered, making more use of our knowledge instead of relying solely on habit and reflex).

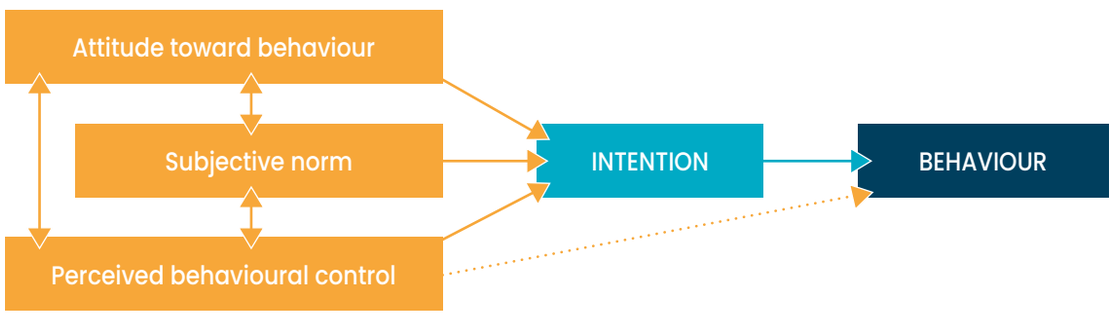
Furthermore, previous studies have extensively documented the fact that, in order for behaviour to change, the intention to make that change needs to be present. Intention is dependent upon a number of key parameters, which must be strong and persistent enough to overcome any obstacles.

There are three elements in particular which work to forge solid, lasting intentions: first among them is our attitude towards the behaviour in question, i.e. our (positive or negative) emotional impression of that behaviour. More than knowledge, attitudes are informed by questions of taste and desire, the degree of pleasure we associate with certain behaviour.

The second factor corresponds to social mores, i.e. the image we have of other people's behaviour and what we consider to be acceptable. These norms have a profound influence on our choices and decisions, since social image, and particularly within one's social group, is an essential motivating factor in human choices and behaviour.

The third and final factor is what we call behavioural control, which corresponds to our own impression of our capacity to behave in a certain way, our degree of self-belief and our perceived efficacy.

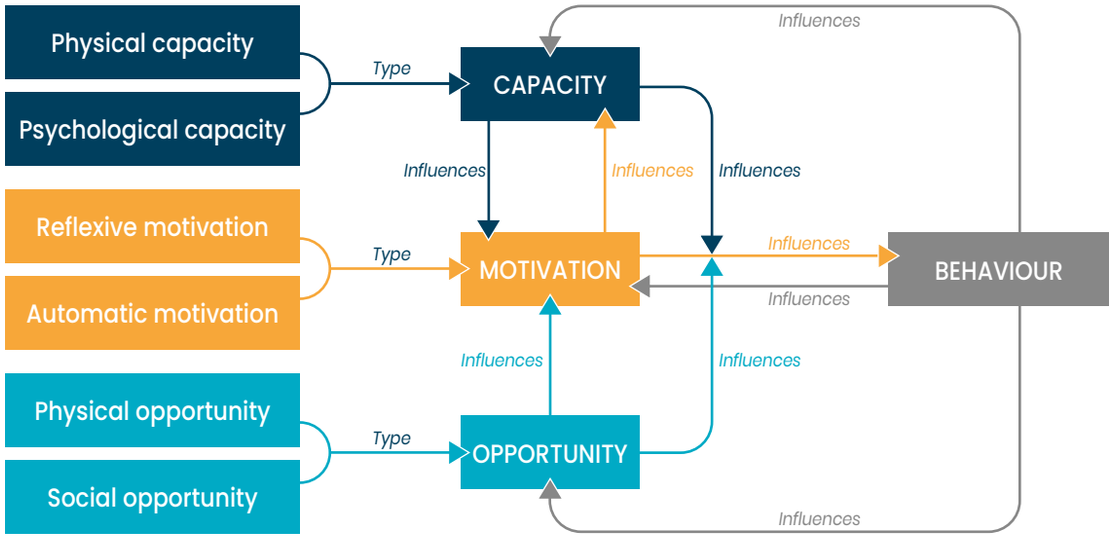
FROM INTENTION TO ACTION



To summarise the broad strokes of this research with the help of a more recent model: in order to understand and act upon behaviour, we must take proper account of the essential dimensions which underpin them and which in turn are shaped by different forms of motivation (explicit and implicit), opportunities for action (defined by contexts and norms) and the capacity (objective and perceived) to make behavioural changes.

Source: Ajzen, 1991

FACTORS INFLUENCING BEHAVIOUR



Source: Michie & al., 2011

These models serve to illustrate the different prompts which can be used to encourage behavioural changes conducive to better health, while taking environmental factors into consideration. Strong intentions, it has been shown, can help us to better resist environmental pressures conducive to unhealthy behaviour. These studies also highlight the role of environmental factors in the construction of our attitudes, norms and perceptions of capability. The spaces in which we operate, the information we receive and the interactions we have with other people are all essential building blocks in the construction of our intentions, which are not exclusively a matter of individual will, but are also largely determined by our interactions with our lived environments.

Developments in the scope of behavioural sciences

In recent decades, new discoveries in this field have opened up new horizons for intervention, focused on making subtle adjustments to perceptional and decision-making environments with a view to stimulating positive behavioural change (better known as *nudge theory*).

For example, encouraging people to exercise may take the form of repetitive messages and long-term health education, but it may also involve making certain environmental adaptations, making our surroundings more conducive and better adapted to healthier practices.

A freshly-painted staircase, for instance, may appear more attractive than a lift. This may act as a subtle call to action, engendering a positive experience which people will feel eager to repeat.

Another example is the way in which food options are presented in cafeterias: reorganising this presentation can help to drive down consumption of fatty foods, sweet dishes and meat-based products, while making healthier options feel like an easier, more logical choice.

MONTE project, Lyon 2014

Factors at the root of health-related behaviour

The importance of properly understanding the motivating factors and obstacles associated with behavioural change - at the cognitive, psychological and social levels - is all the more acute in light of the prevalence of social inequalities in health. These inequalities can be partly attributed to structural factors (standard of living, environment, access to healthcare etc.), but also to the inadequate impact of health promotion strategies and risk prevention campaigns.

For example, taking into account factors such as our relationship to time can help us to better understand how health promotion and risk prevention discourse and interventions may end up being not only ineffectual, but even counterproductive. For those living in precarious social circumstances, imagining the future may be rendered difficult or even impossible by the ambient sense of social insecurity. In such conditions, messages championing the future benefits of behavioural changes which may be costly in the present may fall on deaf ears, with the intended audience overestimating the cost and underestimating the benefits of healthier choices.

In these circumstances, not only may public health messages prove to be ineffective; they may in fact exacerbate social inequalities in matters of health. As our past research has shown, exposure to public health campaigns may actually reduce the intention of the least future-focused groups to adopt the recommended behaviour.

Understanding the psychological, cognitive and social circumstances of our target audiences can thus help us to ensure that interventions are better tailored to their specificities, and particularly to prevent the risk of counterproductive consequences caused by false assumptions, reminding us that the people we want to convince do not always share our point of view.

Behavioural sciences: a cross-cutting perspective

While the behavioural sciences certainly can provide a framework for understanding certain health-related beliefs and practices, their scope of application is necessarily limited and misuse of these techniques risks distracting attention from the real, structural problems which underpin so many public health issues.

For example, focusing on behavioural change is pertinent in cases where actors are indeed able to change their behaviour and in possession of the resources needed to make this change.

If, however, the nature of food availability means that foodstuffs of higher quality are not accessible to all, then encouraging people to change their dietary habits may prove to be counterproductive and give rise to (legitimate) negative reactions.

The use of behavioural sciences must always be accompanied by thoughtful analysis of the “choice landscape” in which people find themselves: not only their access to material and financial resources, but also the psychological resources required to make the necessary changes. Last but not least, we must be sure that environmental factors do indeed allow for the adoption of healthier practices.

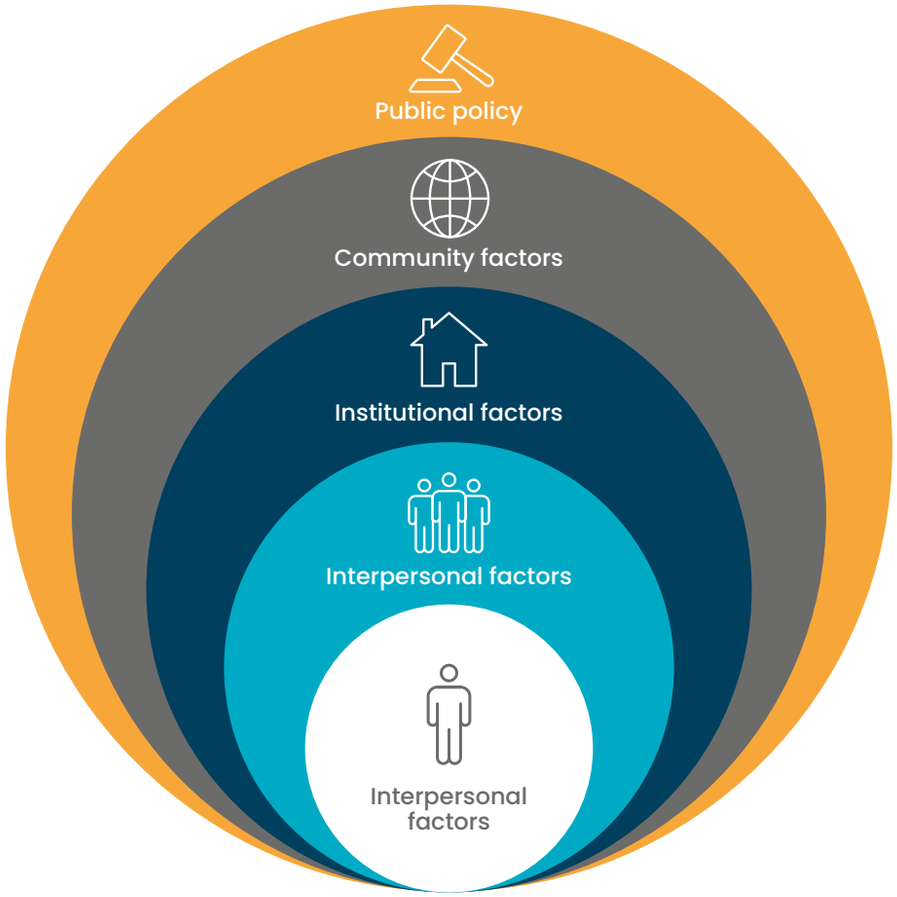
There are many potential levels of analysis and intervention which coexist and interact, and which may all benefit from the input of behavioural sciences in different ways: to remodel public policy, to act at collective/community level, or to target specific interaction situations or support individual changes.

In the field of behavioural sciences, as elsewhere, opportunities for intervention are multifaceted and often complementary.

While some may be primarily concerned with subconscious psychological mechanisms, others may lean more towards supporting individual awareness and reflection on health-related matters.

It is important to remember that, in all cases, the ability to make lasting, collective and autonomous changes to one's health practices requires the development of actionable psychosocial resources and capacities, capable of underpinning various lifestyle changes. In this respect, the issue of capacities is of central importance not only in matters of public health, but also to the ecological transition and to the social integration of the most vulnerable groups.

INTERDEPENDENCY OF INFLUENCING FACTORS



Source: Bronfenbrenner, 1986

Behavioural design, an approach to public policy design influenced by the behavioural sciences

FRÉDÉRIQUE PAIN

Design is something which spans all sectors. It is about adopting a fundamentally user-centric vision. In the context of health, where users are better known as patients, designers need to come up with responses tailored to their specific requirements.

That is where *behavioural design* comes in. It is a fairly recent field of research which focuses on the cultural background, social environment and behaviour of patients. It also enables us to engage with the representations that people associate with certain tools, to encourage their dissemination and to respond more effectively to the strong demand from patients for support which goes beyond the purely clinical context.

Affordance is a term used to describe how form can suggest function, prompting a reflex conducive to the intended action, for example opening a door using a handle, or turning on a tap. The concept of affordance is a good example of how design studies combine practicality with formal aesthetics.

When it comes to developing new technologies, designers must work in close collaboration with behavioural scientists in order to develop the necessary affordances.

The creative input of designers thus plays a central role when it comes to developing solutions that are effective, efficient, useful, practical and attractive, as well as being innovative.

Frédérique Pain,
Director of the French National Institute for Advanced Studies in Industrial Design (ENSCI)

With over twenty years of professional design experience, Frédérique Pain is Director of the French National Institute for Advanced Studies in Industrial Design (ENSCI).

She was formerly a Research and Innovation director at Bell Labs. In 2013 she was appointed Research Director at STRATE Design School, later becoming Director of the Paris Campus. Her ambition for ENSCI is to boost the prominence, both nationally and internationally, of this unique institution which combines design and industrial fabrication with academic research, entrepreneurship and active engagement with societal, economic and environmental issues.

The impact of design-based approaches in the health field

APPLIED EXAMPLES FROM ENSCI LES ATELIERS

DESIGN & RESEARCH TECHNOLOGIES, INNOVATION, USES AND SERVICES

The behavioural sciences are invaluable tools for observing and defining so many issues.

Drawing upon advances in social and cognitive psychology, the psychology of work and even anthropology, designers can gain a better understanding of user issues and the reasons which prompt certain people to act in certain ways.

HOSPITALS AND TRANSFORMATION

- **National Centre for Ophthalmology**

Concept design and programming for a multipurpose welcome, support, prevention and training facility for patients with visual impairments. The aim of the project was to develop a system of signs enabling partially sighted patients to arrive at their destination autonomously.

Guest designers:
Gaël Guillou and Lucile Sauzet (2022)

MENTAL HEALTH AND MORALE

- **GHU Paris Psychiatry and Neuroscience Lab-ah, the Welcome & Hospitality Lab**

PsySon - A sensory, cognitive approach to mental health. Development and testing of a new headboard equipped with an acoustic system, emitting vibrations designed to calm patients in periods of crisis.

Sound Design Studio,
Roland Cahen (2018 - 2019 - 2022)

A new sense of perspective

FROM CURE TO CARE, A HOLISTIC APPROACH TO TRANSFORMING HEALTH-RELATED BEHAVIOUR

Expert insights from Daniel Benamouzig and Henri Bergeron with a focus on political science

What is your perspective on the state of preventive health in France, as it stands?

Daniel Benamouzig

Traditionally, prevention policies have not been a great strength of the French healthcare system.

We have long-standing preventive policies in a whole host of domains - cancer screening, for example - as well as public policies designed to tackle some of the big health threats, such as smoking.

And yet, all things considered, the French healthcare system does not devote a lot of resources to prevention.

Prevention is considered as being far less important than care.

"In France, prevention is defined in terms of access to care, rather than as a question of staying in good health. That would require a clearer position on the major determinants of good health - lifestyles, housing, transportation... The issue goes far beyond illness."

Now these are all factors which do not fall within the realm of medicine, nor should they, and yet they play a decisive role in determining the state of the nation's health.

In some respects we are still beholden to this excessively curative worldview, even in the way that we frame the concepts and our collective understanding of how to deal with them.

Henri Bergeron

French public healthcare policy exhibits what we might call a curative tropism. Moreover, we can see a clear trend in the government messaging for targeting individual behaviours which are harmful to health.

That means seeking to encourage people to smoke less, drink less, exercise more etc. We all have our own personal understanding of which factors are the most important.

That provides a starting point for the big budget public health campaigns launched by the government, and also provides a fillip to behavioural science projects which seek to shape behavioural changes.

But it seems pretty clear that unhealthy behaviours are not randomly distributed across our society.

For example, the most determined and recalcitrant smokers are more likely to belong to the most underprivileged socioeconomic categories.

"The key determinants of health-related behaviours are not solely individual; they are also shaped by more collective factors."

There can be no real public health policy without proper, coordinated policies for employment, housing and the fight against poverty.

Most French people are aware of what is good and bad for their health. And yet, that knowledge is not always reflected in their actions. How do you account for that?

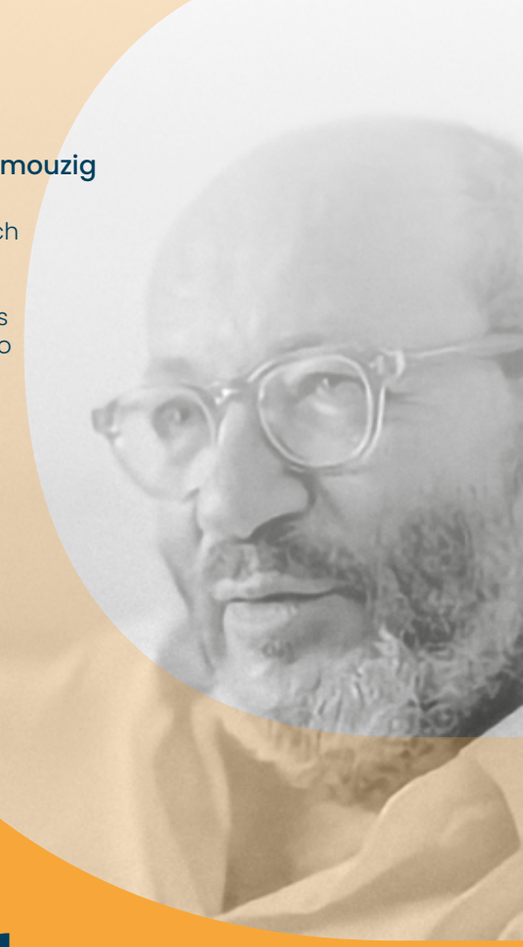
Henri Bergeron

"Eating habits and addictive behaviours, which are major determinants of health, are often deeply socially rooted."

For example, sociology offers insights into the eating habits of families, which vary considerably between social groups.

With regard to excess weight, for example, we know that in certain social milieus a certain portliness is regarded as a sign that a child is well fed. Being a little overweight is regarded as a sign of good health.

Daniel Benamouzig
Sociologist, CNRS Research Director and Professor of Health Studies at Sciences Po



Daniel Benamouzig is a sociologist and CNRS research director at the Centre for the Sociology of Organisations.

He is Professor of Health Studies at Sciences Po and chairs the Scientific Committee of the EHESP School of Public Health. He also sits on France's National Nutrition Council, and has been a member of various public health bodies.

From 2020 to 2022, he was a member of the National Scientific Committee on Covid-19. His principal research interests are institutional governance and regulation in the healthcare sector. Daniel Benamouzig is particularly interested in economic actors and reasoning. He is the author of numerous academic articles and books, including a recent work co-authored with Joan Cortinas-Munos entitled Des Lobbys au menu, les entreprises agroalimentaires contre la santé publique, 2022 (Éditions Raisons d'agir).

These studies have shown that, in less privileged socioeconomic settings, people find it more difficult to imagine their future lives - what the economists call intertemporal projection. The promise of living a few years longer doesn't mean much when you're not even sure that you'll get a decent pension, for example.

But it becomes a lot more interesting when you're confident that your autumn years will be spent living in a certain degree of comfort. We now know that a lot of addictive behaviours cannot be understood solely in terms of psychological resistance.

Daniel Benamouzig

In addition to our understanding of time, there are other mechanisms in play here. One thinks in particular of the phenomenon of denial - individual, or on a broader scale - in relation to situations which appear to be distant, and which may thus deteriorate if no sufficient response is forthcoming.

"Hence the importance of thinking seriously about the interconnection of individual behaviours and our socially constructed environments, with a view to promoting more positive behavioural choices. That requires a form of collective action. The appropriate level for that collective action may be the national or regional government, but it may just as well involve other stakeholders such as the insurance sector and businesses, on matters of occupational health among other things."

In any case, finding the right balance between the individual and the collective is essential.

This means that there is little interest in focusing exclusively on psychological determinants, since these factors are themselves shaped, channelled or distorted by environmental factors and variables which belong to the realm of sociology.

To give you another example, numerous studies have attempted to comprehend why some smokers are so resistant to health messages, and why warnings about the risks of cigarette addiction do not have more dissuasive power.

THE 4 GREAT ERAS IN THE EVOLUTION OF PREVENTIVE HEALTH POLICY

By Henri Bergeron

Vichy Regime 1940 - 1944	**Post-war period** After 1945	**Simone Veil appointed Minister for Health** 1974	**The influence of behavioural sciences** today
Large scale hygienist policy complete with recommended and proscribed behaviours	Policy based on bombarding citizens with information.	Policy based on mobilisation of market forces, making use of identification mechanisms	Policy aimed at modifying the choice architecture
Objective: To impose behavioural rules	Objective: Provide information to make people aware of "best practices" for healthy living, encouraging the adoption of these rational measures	Objective: Appeal to citizens' attitudes and beliefs in order to change health-related behaviour	Objective: To transform attitudes and beliefs in order to influence health behaviour

Author's note: *Preventive policies tend to build up over time, rather than succeeding one another.*

Henri Bergeron

Scientific Coordinator of the Health Studies Department at Sciences Po-FNSP, Co-Director of the Healthcare division for Sciences Po University Press

A CNRS Research Director and author of Le biais comportementaliste, Henri Bergeron's current research interests include public health policy and the evolution of practices within the medical profession, touching upon topics such as illegal drugs, alcohol, obesity and medical research.

His work makes use of tools derived from the sociology of public action and social movements, and particularly the sociology of organisations, in order to better comprehend the dynamics at play in the process of public policymaking, as well as the reconfiguration of organisational and institutional fields. He is particularly interested in the relationship between knowledge, expertise and policy, as well as the digital transformation of organisations and organisational fields, and institutional change more broadly.

In your opinion, what are the fundamental requirements of an approach informed by the behavioural sciences?

Henri Bergeron

The idea behind the behavioural sciences is to look to experimental psychology and psychosociology for mechanisms which can help us to understand why we do not always take decisions in our own best interest, or in the best interests of society. To a certain extent, it is about explaining why we do not always function rationally.

"We know that cognitive bias takes many forms, and that we need to target them in order to guide behavioural change at an individual level, without trying to change people's beliefs, convictions or education."

For example there is a form of bias known as anchoring: if you ask people to think within a certain range of figures, they will tend to continue using that range as a point of reference.

Hyperbolic discounting, meanwhile, is the tendency to value immediate rewards more highly than promised future rewards.

Routine bias is the tendency to keep on going once we are accustomed to a certain activity. An example of an action to disrupt that routine would be to put a few red crisps in each packet, to prompt people into thinking about what they are doing.

You also hear a lot about escalation of commitment: one study focusing on obesity found that when people had to pay for weight loss treatment, they felt more committed than if they didn't have to pay.

There are any number of ways of harnessing these forms of bias, in order to improve the uptake of behaviour which is more conducive to public health and general well-being.

What makes these mechanisms more effective than other approaches?

Daniel Benamouzig

One of the great strengths of this approach is its capacity to yield evidence in quantified, experimental, measurable form. That makes it possible to implement systems whose results can be quantified, at the individual level.

One of the advantages of behavioural approaches is that they make use of arguments which - although they offer a simplistic view of reality - are conducive to measurable conclusions. That goes some way to explaining their powers of persuasion, including when it comes to winning over people in decision-making positions.

Has the interest and respect for behavioural approaches yet to translate into genuine impact on public policy?

Daniel Benamouzig

In the public policy arena, the problems we are dealing with are necessarily complex, involving a large number of stakeholders with divergent interests. That means that the simple mechanisms which we demonstrate, measure and test in academic publications are not necessarily commensurate with the high stakes of actual policymaking.

But behavioural sciences did give us *nudge theory*, the idea of steering people towards certain actions without forcing their hand. How could that be of interest to prevention policies?

Henri Bergeron

"With approaches based on behavioural sciences, experimentation allows us to obtain quantifiable results, which are always welcome."

For example, Esther Duflo (winner of the Nobel Prize for Economics) is a firm believer in experimentation as an essential instrument of public policymaking. Nonetheless, it is important to bear in mind that transposing experimental results into real-life situations can often be quite a disappointing experience.

Furthermore, although at first sight it may seem as if implementing policies to modify the choice architecture will not cost very much, there are often hidden costs involved. They include the time and effort required to negotiate with all of the relevant decision-makers, to mobilise different audiences, to evaluate the methods etc. Those costs can really add up: the introduction of the Nutriscore tool is a good case in point.

But the use of such practices is already quite commonplace in fields other than health policy. We know that Uber, for example, regularly *nudges* drivers. They cannot directly tell the drivers what to do, as this would constitute a relationship of professional subordination and the company could thus be regarded as the legal employer of the drivers, with all of the obligations applicable to employers. So Uber uses other methods to restrict the autonomy of drivers, to make sure that they are not all concentrated in the same zones at the same time, for instance.

Nevertheless, it is interesting to note that people are starting to question the long-term impact of such impacts.

Prompts which act upon routine bias are one of the few types of*nudges* which actually encourage people to think. The vast majority of *nudges* attempt to influence people without their knowledge, without requiring them to think. When people become aware of the mechanism, its effectiveness decreases.

Another downside is that nudges do not fulfil the educational role which citizens also expect to see from public policy. Imagine, for example, that we were to develop a *nudge* that helped to reduce discrimination (ethnic discrimination, gender discrimination etc.) in the recruitment process. That would be great (if it worked), because discrimination would go down. But the role of good policy is also to educate and inform, convincing our fellow citizens that, in the long term, discrimination is a phenomenon that we want to eliminate.

"*Nudge theory* also raises issues of long-term integration: how do we ensure that individuals continue to make positive behavioural choices, without constant prompts?"

Are there examples of prevention policies from other countries which could be sources of inspiration?

Henri Bergeron

The literature shows that individualised (*or targeted*) and collective preventive efforts - such as those conducted by governments via the media - are more effective in contexts where there is an existing culture of temperance, something which is particularly true in the Nordic countries.

Some in the food industry have already made this argument, suggesting that France's dietary traditions offer a form of protection against obesity. The fact that we continue to eat lunch and dinner together, across the table from one another, acts as a form of social control, on portion sizes for example.

Daniel Benamouzig

"These cultural elements are not the only factors which influence national practices. There is also the phenomenon of international emulation."

Anti-smoking policies offer an interesting example: there is a certain mimetic phenomenon in play which has led a considerable number of countries all over the world to adopt very similar public policies. That is a major factor in the success of policies of this kind. It also serves to put some of the culture-based explanations into perspective. Some very different countries have ended up adopting approaches which are broadly similar.

HEALTH IS A SHARED RESPONSIBILITY, AND WE ALL NEED TO ACT TO MAKE CHANGE HAPPEN

The expert perspective of Serge Guérin, professor of sociology

Serge Guérin,
Sociologist and professor at INSEEC GE

Serge Guérin is a sociologist and consultant, Professor and Research Director at INSEEC GE where he is head of the Hospital Management MSc programme.

A specialist and pioneer of studies on ageing and intergenerational relations, his research interests also include the dynamics and manifestations of solidarity within societies.

He is the author of over forty books, including La Silver économie pour les Nuls (First 2023, with D. Boulbès), Les Quincados (Calmann-Lévy, 2019), La Silver économie (La Charte, 2018, with D. Boulbès), La guerre des générations aura-t-elle lieu? (Calmann-Lévy, 2017, with PH Tavoillot) and Silver génération. 10 idées fausses à combattre sur les séniors (Michalon, 2015).

What is your view of existing prevention policies in the field of public health?

"The French health system is more geared towards *curing* than *caring*."

Too often, we wait for a problem to arise before we do anything. And yet, investing massively and collectively in prevention would actually be very "profitable," on both a financial and a human level, in the medium-to-long term. In some areas, society is moving in that direction.

It is worth noting that "prevention" has now been added to the job title of the Minister for Health, for the first time. Nonetheless, there is still a long way to go at the institutional and societal levels.

What do you make of the most prominent preventive health campaigns?

In France, we often approach prevention from an egalitarian perspective which can be somewhat infantilising, without making the effort to adapt the discourse or the method.

Promoting these broad, general messages in large-scale information campaigns is just not enough.

"Social, behavioural and geographical differences have a huge influence on the way we comprehend health issues, and we will never be able to tackle them effectively without taking those differences into consideration."

For example, the slogan "Eat 5 a day" for fruit and vegetables only speaks to around 15% of the population.

The challenge is to make prevention more personalised: the message needs to be tailored to the audience, not the other way around. We need to take people's actual practices and perceptions as our starting point.

You consider prevention to be a social priority. In concrete terms, what action is required?

It starts with making prevention a lifelong priority. It starts during pregnancy, within the family sphere. It should then be present at school and at work, and of course in the way we look after older people. The government is planning to introduce three regular health check-ups for everybody at the ages of 25, 45 and 65. That's a positive sign.

But we need to see more support and intervention before and after those milestones, taking into account the fact that some groups are more vulnerable than others to economic and cultural obstacles to good health.

Obesity, for example, is much more prevalent among the least well-off in society, who find it more difficult - for reasons both economic and symbolic - to maintain a high-quality diet. Experiments have already been launched in this domain, particularly in the North of France where average life expectancy is lower than it is elsewhere in the country. Helping people to relearn good eating habits, to exercise more regularly and to change their way of thinking about certain subjects can deliver positive results in the medium term, attenuating that harmful social determinism.

How do we get the message across effectively to different audiences?

Thinking solely in terms of constraints does not work. Pleasure is an integral part of prevention, and makes it more approachable. If there is no pleasure involved, then there is no motivation to live longer and take care of your health.

"We need to avoid focusing exclusively on the prohibitive side, in order to promote a more attractive discourse focused on the benefits in terms of both health and quality of life. To do that we need to turn to social and behavioural psychology, in order to appeal to people's imaginations"

You say that we need to make the switch from a culture of cure to a culture of care. What do you mean by that?

Prevention is one of the key dimensions of *care*. Taking action upstream - by changing behaviours and lifestyles in ways which are better for us and better for the environment - enables us to reduce the risk of illness and a loss of autonomy.

This shift will require input from all actors in the health sector, for example home help professionals working with vulnerable patients, or chefs preparing meals in retirement homes.

The challenge is to make prevention a much more prominent part of the medical experience. Medical schools should do more to include integrative health and preventive medicine in their programmes.

We also need to see new specialist training units on these subjects, perhaps even university diplomas in preventive health. At the same time, the concept of prevention needs to be firmly established in the thinking of businesses, local authorities and public policymakers of all stripes.

For example, we could imagine more effective forms of intervention in the home or at the workplace, involving healthcare professionals, specialist outreach workers, mediators, experts in complementary medicine and so on. We could also make use of other contexts, such as leisure activities, to get preventive messages across.

What about those groups who face greater health risks at work and in terms of their housing?

The law passed on 2 August 2021 aims to reduce health risks at work. For employers, it's also a good way to stand out from the competition and hold onto their employees.

The association Siel Bleu, for example, has been experimenting with starting each day with a bit of physical activity. That has led to a downturn in work-related accidents, which is a great economic concern for companies in the building and public works sector. The aim is to work with employees to reduce individual risk factors, as well as the risk to the company's reputation. In terms of housing, MaPrimeAdapt' is a major project focusing on refurbishing the homes of elderly people before it is too late, particularly in order to reduce the risk of falls.

You champion the idea of co-responsibility for individual health. Some people have criticised the *care* philosophy for placing too much responsibility on the individual, and glossing over structural factors.

It's worth remembering that health is determined 20% by genetics and 80% by epigenetic factors. Of course contextual factors such as social background and geographical circumstances play a role, but we mustn't let ourselves becomes hostages to determinism.

"Not everybody lives in the same conditions, and not everybody has the same degree of autonomy, but we all have room for manoeuvre when it comes to adopting habits which will improve our health and our quality of life."

We need a government with a long-term vision, capable of structuring and coordinating prevention policies. But we also need to see greater mobilisation from civil society, local authorities and individual citizens. We are all jointly responsible.

Town councils in France, for example, are responsible for school canteens. There are plenty of ways of getting children and their families involved in the choice of dishes and ingredients, promoting growing your own fruit and vegetables, using local producers, working to reduce waste etc.

You could also get local associations and housing authorities on board. The aim is to strike the right balance between individual and collective responsibility. We need support, but we also need to learn how to do things for ourselves. People often find that prevention makes more sense when they have that personal investment. And it's more effective in the long term.

In the professional arena, employees are keen to see more well-being and health initiatives in the workplace, such as yoga sessions or health screenings. All of which raises the question of where we draw the line with employers' involvement in prevention.

Where do you think employers' involvement should begin and end?

That depends in part on the perceived legitimacy of the employer in health-related matters. The Covid crisis has shown us that many employees feel that their companies have a legitimate role to play in matters of health and prevention.

As long as individual integrity and freedom of choice are respected, the real question now is how to make sure that companies' discourses, practices and internal cultures are coherent.

"We might call it tri-responsibility, between the government, the company and the individual."

You would like to see more bespoke health monitoring, but that raises questions as to the use of individual patients' personal data.

We have the good fortune to live in Europe, where the regulatory framework continues to evolve. We should soon be able to combine information from general medical records and occupational medicine records.

Of course, individual patients are entitled to oppose information sharing at any time. Without trust, there can be no progress. But that trust has to be earned.

Combining prevention with pleasure, an effective alternative to guilt-inducing health messages?

BY MICHEL BILLÉ

While we are all responsible for our health, that doesn't make us guilty. On this point, Michel Billé is categorical. While everybody has a role to play in looking after their own health, there are certain limits to what we can do.

Our health may be harmed by our work, or compromised by our living conditions. This does not mean that nothing can be done to improve our health, but people should not be considered guilty of causing whatever health problems they may encounter. Our lives shape and define our health potential, which is the fruit of the interaction between our genetic inheritance and our environment.

When the environment is favourable and the genetic capital is positive, you have scope to exercise your responsibility. But when the environment is poor or even actively hostile, you have to question the limits of responsibility.

Attentive to the inequalities and disparity which beset our relationship to health and prevention, Michel Billé is wary of one-size-fits-all preventive messages which tend to conflate responsibility with culpability.

Michel Billé,
Sociologist and author of
La tyrannie du bienvieillir

Michel Billé is a sociologist and former deputy director of IRTS Poitiers.

He also chaired the National Union for Retirees and Older People and sat on the Scientific Committee of France Alzheimer.

He is director of the series of the collection 'L'âge et la vie - prendre soin des personnes âgées et des autres' for publishing house Eres Editions, alongside Christian Gallopin and José Polard.

Recent publications: *La société malade d'Alzheimer (érès, 2014) ; Lien conjugal et vieillissement (érès, 2014) and Dépendance quand tu nous tiens, co-authored with D. Martz & M.-F. Bonicel (érès, 2014), La tyrannie du Bien vieillir (Le Bord de l'eau, 2010).*

A positive approach

We need to find a positive way of expressing things, prompting people to think and to analyse situations, rather than muscling in with guilt-inducing injunctions.

Michel Billé insists upon the importance of reformulating preventive messages to make them more positive, providing reassurance instead of anxiety and guilt.

Much of the medical lexicon implies control and prohibition: we get "checked up" or "monitored" by doctors who "issue prescriptions." We could replace those terms with words that evoke a certain freedom: a doctor "keeping an eye" on us, "suggesting" treatments.

And when it comes to sport, we need to make a clear distinction between physical activity and athletic performance. We should focus more on the pleasure of movement, which is something that everybody can enjoy.

Thinking further ahead

COORDINATION AND ENGAGEMENT AT LOCAL LEVEL TO FURTHER THE CAUSE OF HEALTH PROMOTION

Daniel Guillerm's expert perspective on the importance of nursing

What is your perspective on prevention in healthcare, and what role do nurses have to play?

Independent nurses (there are about 135,000 of them in France) could play a major role in prevention.

A lot of preventive work already goes on, without always being recognised or appreciated. For example, when taking a blood sample for a cholesterol check, a nurse may give a patient some nutritional advice. That is essentially a preventive act, which in this case occurs during another medical procedure, namely a blood test.

We would like to see nurses doing preventive check-ups, and greater recognition of patient education within the health system. Prevention and patient education go hand-in-hand.

Nurses also have a particular advantage in this respect: 98% of their work involves going into patients' homes. From a preventive perspective that is very important, because prevention is more effective when it engages with patients within their own psychosocial milieu.

"The challenge we face now is to ensure that every time a health professional interacts with a patient, preventive actions are discussed and implemented to complement the medical care."

How can we encourage and promote the preventive work done by independent nurses?

First and foremost, nurses want to see greater recognition of their role in prevention. The new Draft Bill on Social Security Funding includes three preventive medical check-ups for everybody, at the ages of 25, 45 and 65. Our concern is that these three preventive milestones will turn into specifically medical appointments. We want to be involved in those check-ups. For example, the doctor might diagnose the patient, detect a risk and propose a plan of action: that is where the nurses come in.

Many rural areas are currently suffering from a chronic lack of doctors, which means that those doctors who are present have less and less time for this sort of work: they rely on the support of other professionals, particularly nurses.

We also want to see a new category added to the official classification of professional nursing acts. All of the healthcare professions have their own official classification, which defines the different types of acts those professionals perform. Apart from vaccination, the nursing classification includes very little in the way of preventive measures.

Misuse and misunderstanding of medical treatments cause 15 billion euros of direct and indirect waste every year (hospital stays which could have been avoided, improper use of medicines, drug waste etc.).

More preventive action - including help with prescriptions and making sure that patients take their medicines properly at home - could create a virtuous circle, allowing us to reduce that waste. That requires greater recognition of the role that nurses play in patient care.

You support the creation of a new category of "designated nurses." How do you define that role?

"A designated nurse would not replace your GP or your pharmacist. The designated nurse would work with those two colleagues as part of a triumvirate, a solid basis from which to tackle the twofold challenge of population ageing and the rise of chronic diseases."

Nursing, as a profession, offers an array of advantages: the large number of active nurses, even though they are not spread evenly across the country, but also the fact that they make regular home visits, and continuity of care is one of their key obligations. When a nursing surgery takes on a patient who requires daily care, the surgery must make the necessary arrangements to be there every day, at any time of day or night. That gives nurses a real advantage over other professions.

Daniel Guillerm,
President of the French National Nursing Federation

After obtaining his National Nursing Diploma from IFSI Morlaix (1985), Daniel Guillerm worked as an independent nurse in Saint-Thégonnec from 1989 to 2016.

In January 2008 he became Vice-President Delegate of the French National Nursing Federation, becoming President in 2018. In 2012, he founded Sphère Consulting Santé. In addition to his functions as President of the nursing federation, he has also chaired the French Federation of Healthcare Practitioners since 2019.

Nurses have a major role to play in the "outreach" strategy favoured by the national health authorities, because most of our work takes place within patients' homes. That gives us access to information which is not always visible in public. Some patients are socially isolated, and we only find that out by visiting them at home.

Moreover, as per the recommendations of the World Health Organization (WHO), we would prefer to use the term "family nurse" rather than designated nurse. Family structure may have changed, but the family is still an important presence at the heart of our lives.

"The family nurse allows us to embed the concept of prevention into an approach that focuses on both individuals and families."

There is a clear link here with the importance of taking patients' psychosocial context into consideration.

There have already been various initiatives in this direction. What needs to be done to make them more effective?

One of the big challenges is how to effectively coordinate these actions within the framework of a population-wide approach within a given territory. The structures are there, particularly the Territorial Healthcare Professional Communities (CPTS). In recent years there have been three major reforms to the healthcare system: the Bachelot Act in 2009, the Touraine Act in 2019, and the My Health Act in 2022.

Those three laws define different levels of coordination for patient care. The first is local clinical coordination, focused on individual patients. The second level is the population-wide approach, which is where the CPTS come in.

The third level concerns forms of care which are complex for medicosocial reasons, and which are governed by Coordination Support Systems (DAC).

The question is how best to use and organise these different structures. In spite of their important social role, multidisciplinary health centres only account for around 15% of the total number of clinics. They are struggling to catch on, and we need to look for alternative solutions. CPTS are gaining a foothold, but it is not yet possible to quantify their benefit for the health system as a whole. CPTS are not yet present across the whole of France. More needs to be done to get certain professions involved in projects addressing public health priorities. The system does not have limitless resources, and we need to make savings in some areas in order to invest more in others. With regard to prevention, we also need to see a framework law which sets out long-term objectives for the next 5 to 10 years. The consequences will be felt for generations, so talking about prevention on a year-by-year basis makes no sense.

What about making prevention part of the training programme for nurses?

It's true that prevention does not feature prominently enough in the current curriculum. If we want to make the transition from a cure to a care-based system, we need to place a greater emphasis on prevention.

It occupies slightly more space on continuing education courses. We would also like to see more training on patient compliance, with 40-hour training modules. We also provide training in line with the new vaccination prerogatives, but there needs to be proper recognition of these actions, and the training needs to be seen as opening up new economic opportunities, or else the risk is that nurses won't be interested.

I think coming at this issue from a behavioural science perspective is a very interesting idea. Among the most important preventive determinants, psychocognitive capacities and health literacy are particularly decisive. The behavioural approach offers an apposite framework through which to approach prevention, particularly in matters of communication, since we cannot hope to reach all generations in the same way.

"The paradigm shift we need to make now is to establish the fact that prevention is everybody's business, not just healthcare professionals."

Farmers and town planners can make real contributions to preventive health. It's not the sole preserve of healthcare professionals, who often have a very humble understanding of their role in prevention.

Rethinking the health system and its many actors. Could reshuffling roles make our system more effective?

LAURE MILLET'S VIEW

Laure Millet,
Director of the Social Studies Department, Institut Montaigne

Head of the Social and Territorial Cohesion Unit at Institut Montaigne, Laure Millet studied Economics at Sciences Po Paris after first obtaining a BA in Philosophy from Université Paris Nanterre. Her studies also included a spell at Singapore's Nanyang Technological University.

She subsequently worked as a project manager for Université Paris Descartes' iLumens digital simulation department. She also worked as a consultant for a start-up developing VR medical training solutions.

Since 2018, Laure Millet has worked at Institut Montaigne. She joined the institute to lead its Health programme, working on numerous projects in the fields of digital and therapeutic innovation, and organisational change in the health system. She has since been appointed Director of the Social Studies Department. Laure Millet is currently one of the Commonwealth Fund's Harkness Fellows for the year 2023-2024.

The preventive measures deployed by the French government, particularly with a view to curbing alcohol and tobacco consumption, have not had the desired effect. Laure Millet also highlights the delays in detecting certain types of cancer in France. Are these the results of underinvestment?

Laure Millet argues that it is not really possible to directly compare the budgets allocated to prevention efforts, since the way the sums are counted varies too much from one EU nation to the next.

In France, certain acts which we would define as primary or secondary prevention are classified as medical interventions (including screening).

One thing that is easier to compare, on the other hand, is the way in which resources are divided between different departments: the countries leading the way in prevention, especially in Scandinavia, tend to have highly decentralised healthcare systems. This ensures that actors at the local level have the resources at their disposal to effectively promote prevention policies. For example, if a nurse who visits a patient every month gives them a gentle reminder of the need for screening then that message may be more readily received than the information campaigns launched by impersonal national bodies, such as Assurance Maladie in France.

Laure Millet believes that the proximity of prevention professionals is one of the most decisive factors in the success of prevention programmes, along with the human dimension it brings. The real problem is not necessarily the expense involved (spending on prevention remains low, even in other EU nations), but the distance. It's time to get serious about the D-words: Decentralising, Decompartmentalising, Delegating.

Letting territories lead the way

Laure Millet sets out her vision of this transformation in the report she co-authored for Institut Montaigne in May 2022: Making Use of Health Data to Gain a Better Understanding of Different Populations at the Regional or County Level. This approach would make it possible to set broad national objectives (e.g. cutting heart disease in half) and then break them down into territorial targets for local health actors, the professionals best-placed to tailor their work to the lifestyles of citizens and the disparities which exist within and between territories.

Mapping the data allows us to compare per capita health spending between *départements*. The data also provide invaluable information such as the rural to urban population ratio, as well as figures for alcohol consumption, the rate of chronic illnesses, psychological conditions, unemployment and the age structure of the population.

Within each territory, the roles of the various prevention actors need to be defined. In order to reduce the prevalence of certain diseases, hospitals need to be able to focus on delivering critical care, whereas GPs' surgeries and home visits can provide the necessary treatment for chronic conditions. In this respect Laure Millet agrees with Daniel Guillerm about the need to rethink the allocation of certain responsibilities between doctors and nurses, and the idea of family nurses, all part of the broader debate about decompartmentalising preventive healthcare. It is important to recognise the contribution of nurses making home visits to prevention work, but healthcare professionals in schools and workplaces could also play a bigger part.

Thinking bigger

MULTIPLYING CONNECTIONS TO TRANSMIT INFORMATION MORE EFFECTIVELY

Expert insight from Jean-Christophe Masseron, from a medical perspective

In your opinion, what are the biggest challenges of prevention?

First of all, we face some crucial challenges in the fields of mental health and the health of our young people. I'm thinking particularly of sexually transmitted diseases and addiction problems (not just smoking). We have seen a sharp rise in risky behaviour and addictive behaviour among adolescents over the past few years. What we need to do now is develop a culture of active prevention, in the school system in particular.

The other big subjects I would highlight are cancer detection and prevention, and occupational health.

How do you account for the fact that a majority of French people are aware of the types of behaviour which are harmful to health, but that this awareness is not reflected in their actions?

People often assume that they are immortal, and that illness is something that happens to other people. Until, that is, they start to encounter serious problems. I often encounter that sense of denial in my own work. Patients with heart conditions, for example, find it very difficult to change their behaviour when it comes to smoking. Some patients may struggle to find the resources and support they need to help them. In that respect, the role of prevention is to guide patients towards the relevant professional resources.

Do you think the medical profession is well-equipped to support patients as they seek help in this way?

Prevention is an integral part of the work done by general practitioners, but the degree of commitment to that preventive role can vary from one GP to the next. Some doctors have a keen interest in prevention, while others do not have the same level of knowledge when it comes to steering patients in the right direction.

"Prevention is a long-term undertaking, which is often not compatible with the way that GPs work, going from consultation to consultation all day long. In that respect, I think that better coordination would facilitate the task of prevention."

Medical professionals other than doctors could thus run workshops, dispense patient training and do awareness-raising work, in parallel to consultations. Doctors could then concentrate on the consultations themselves, as well as addiction treatment interviews, support strategies and any therapeutic solutions they deem necessary. In this context, working as a team is essential in order to ensure that GPs do not bear the whole burden of prevention.

Dr. Jean-Christophe Masseron,
President of SOS Médecins France

Originally hailing from Cherbourg, after qualifying as a GP in 2011, Dr. Jean-Christophe Masseron began working as a family doctor as soon as he received his DES diploma of general medicine, with a doctoral thesis focusing on the current state of emergency care and its territorial reorganisation. In 2014 he joined SOS MÉDECINS Chambéry, becoming President in 2018. He was appointed to the Board of Directors of the national federation of emergency doctors SOS MÉDECINS FRANCE in 2019. In October 2020, Dr Jean-Christophe Masseron was appointed President of SOS MÉDECINS FRANCE, the country's largest network of emergency doctors and care units, whose membership comprises 1300 GPs affiliated with 64 associations spread across the country.

Don't medical consultations offer a setting particularly conducive to preventive work, regardless of the type of doctor?

Yes certainly, although the work of emergency doctors is slightly different. The doctors of SOS Médecins often do preventive work, but in a spontaneous manner. We do have the advantage of seeing patients in their own homes, and that allows us to observe their environment. Sometimes we will bring that up during the consultation, if we spot a cause for concern. Broadly speaking, primary prevention is about monitoring patients over the long term, whereas the work done by emergency doctors is more about secondary prevention.

In terms of what you observe in patients' home environments, what resources do you need to make sure that the information gets through to their GP?

"In my opinion, we need to develop better digital connections between GPs and other healthcare professionals who interact with patients."

Getting the information to the right person is essential. At SOS Médecins, we telephone the patient's GP directly when we encounter a sensitive situation. One good example involves babies suffering from bronchiolitis in the winter. When we arrive at the family home, we can soon tell if they are being affected by passive smoking.

In such cases we immediately send the necessary messages, and we may go so far as to call for an intervention if the baby is in serious danger. We have also seen a number of patients suffering from chronic obstructive pulmonary diseases (COPD) who are not taking their long-term medication.

Some people are not registered with a GP and only see a doctor as a last resort, even though they know that this is not the right attitude. So emergency doctors have to raise the alarm sometimes.

What do you think of the recent decision to introduce regular health checks at the age of 25, 45 and 65?

I support that policy. Young adults who are still in good health are very hard to reach. In many cases, they only see a doctor in September to get their sport-related certificates. Introducing a health check at 25 would provide an opportunity to address a number of subjects, such as addiction, health at work, lifestyles and psychosocial risks.

Nonetheless, I think that 25 is perhaps a little bit too late when you think about the problems young people are likely to encounter during the transition from adolescence to adulthood. This is a period which has crucial consequences for the rest of people's lives.

A little later on, doctors need to be able to spot problems with the work/life balance. That means identifying early symptoms of professional burnout or depression.

"The interns in my department often ask me why patients are so keen to tell us about their lives. I tell them that is the moment when they really have the opportunity to understand someone's health."

Nurses and other paramedical professionals play a more prominent role in treating certain chronic conditions. How do you think that cooperation could help to further prevention?

"Paramedical professionals are at the forefront of prevention in France."

Doctors are sometimes reluctant to acknowledge this, because of old corporatist impulses or perhaps out of fear that their power will be eroded. But it is important to make a clear distinction between the delegation of tasks and the transferral of responsibility. While it is relatively easy to delegate certain tasks under the supervision of a doctor, transferring responsibility for those tasks to nurses - which means that the doctor no longer has authority over them - makes some doctors uneasy.

They do not want to give up a part of their authority, nor transfer too much risk to the professionals who will be performing the tasks. There needs to be proper advance preparation, making it clear who does what and subject to which protocol. We also need to rethink the way medical professionals are paid.

At present, doctors make much of their income from simple medical acts. But these are precisely the sort of tasks that could be easily delegated to nurses. We need to attach greater value to complex tasks, in order to make treatments more pertinent and fully capitalise on the value added by doctors. Nevertheless, it is important to remember that doctors and nurses are on the same side, working in tandem. We don't want to run the risk of playing one side off against the other.

How much space does prevention take up in the initial training provided to doctors?

Very little space, if any at all. It's more present in continuing education modules, although even there it has waned. Doctors choose their studies based on their interests. So it depends on their individual preferences.

France is not a country where prevention ranks very highly in those interests. We tend to focus on treating people who are already sick. Paradoxically, the whole discourse of personal development is gaining traction: self-improvement in a society which is suffering.

SOS Médecins plays a major role in epidemiological monitoring, passing on daily data updates to France's public health authorities.

That's right, we pass on a substantial quantity of information to the health authorities because, proportionally, we see more patients suffering from acute health problems than our GP colleagues. That means we can provide early indicators when an epidemic appears. We are now trying to go even further, taking patients' sociological backgrounds into account. Home visits are essential to gauging such things.

One of our forms, for example, includes a box to tick for patients with "no registered GP." We then pass on the reason for the appointment and the results of the consultation to *Santé Publique France*. Hence the importance of active communication between healthcare professionals, in order to ensure that GPs are properly informed of their patients' conditions.

"We are always more effective when we work together. With that in mind, we need to push back against medical drifting and nomadism"

Data: the future of health research?

BY STÉPHANIE COMBES

Stéphanie Combes,
Director of the Health Data Hub

Stéphanie Combes is a graduate of Polytechnique (class of 2005), ENSAE (2009) and the Paris School of Economics (2010). She began her professional career as an economist for the Treasury Directorate at the Ministry for the Economy, Finance and Industry, where she worked from 2010 to 2014. She was then tasked with establishing the Big Data department at INSEE, before moving on to DREES (Directorate for Research, Studies, Evaluation and Statistics) in 2017 to lead its Health Lab. In 2019 she was appointed Director of the Health Data Hub, a public interest organisation working to guarantee simple, unified, transparent and secure access to health data for professionals engaged in research and innovation.

Raising public awareness of the reuse of health data

In order to co-construct a culture of health data and inform citizens of the benefits that the use of their health data can yield, and of course of their rights in relation to their personal data, HDH has established a citizen outreach department focusing on four strategic priorities: information and engagement with citizens, organising accessible educational sessions on health data, supporting studies conducted by civil society partners and patients' rights associations, and thinking of new ways to involve citizens in governance. HDH is already collaborating with France Assos Santé on various actions, for instance.

The need to create large databases of clinical data

HDH is also working with the Directorate General of Health Services (DGOS) to create health data warehouses within hospitals.

By establishing a national network, in the long run HDH will be able to connect vast quantities of clinical data which constitute an essential resource for research projects. For instance, such data would allow for more forensic analysis of the role played by certain factors, including alcohol and tobacco consumption, in the development of medical conditions.

A similar project is taking shape now for GPs. One of the projects backed by HDH is working to create a warehouse for data from GPs' surgeries, building a database using a specific sample of professionals and patients. Thanks to that process, data from consultations could be reused for research purposes.

Nonetheless, Stéphanie Combes is quick to highlight two of the major challenges facing the project: structuring the data, and harmonising data collection from doctors.

One major shortcoming is the lack of contextual data from primary prevention contexts.

In Stéphanie Combes' view, establishing sector-specific data hubs would represent an important breakthrough as such a system would make it possible to report data concerning specific health issues, providing invaluable material for further research.

HDH is also open to collaborations with companies developing applications of connected devices for the purpose of collecting behavioural or contextual data. These data, when cross-compared with data from other sources such as Assurance Maladie in order to reconstruct the treatment pathways, could be analysed using innovative methods including AI, in order to predict the impact of preventive measures and public policies over the next 5 to 10 years.

Nevertheless, it will be important to remain attentive to potential selection bias: such applications are generally used by people who already have a good awareness of health issues. Putting people in the driving seat of their own health is a cultural challenge.

Mon espace santé is a step in this direction, informing users about the data they share and allowing them to update their preferences.

Mon espace santé could eventually be used to gather all sorts of behavioural and contextual data, in which case it would become an extremely important and flexible tool capable of reaching the entire French population.

Instigating progress

THE APPROACH ADOPTED BY THE APRIL FOUNDATION

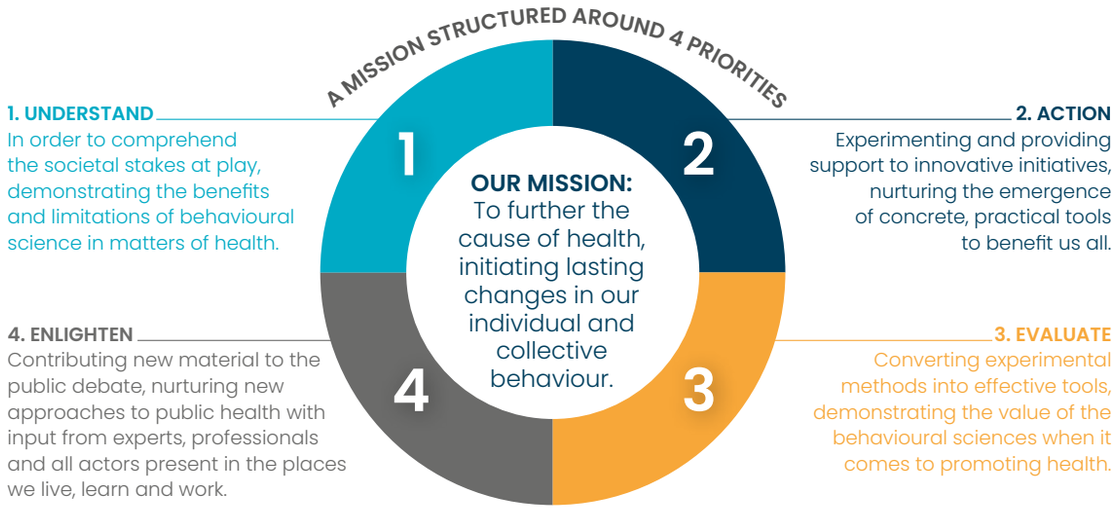
Instigating progress

Established in 2008 on the basis of a firm conviction that *everybody is capable of taking charge of their own health, as long as they have the keys to understand and the tools to preserve their "health capital,"* the guiding mission of the APRIL Foundation is to promote a culture of health with an emphasis on preventive behavioural improvements, an alternative to narrowly care-focused approaches. Above and beyond questions of individual responsibility, it is essential to face up to our collective responsibility and the impact, both positive and negative, that our ecosystems may have on our health capital. **As such, the foundation's mission was expanded and reaffirmed in 2023, with a new focus on how to make lasting change and convert intention into action in health matters, at both the individual and the societal levels.**

"Because changing attitudes towards our own health capital is a central priority, our goal is to capitalise on the important contributions made by the behavioural sciences (neuroscience, positive psychology, cognitive sciences, anthropology etc.), adopting a proactive approach to promote good health for all. We are convinced that we find ourselves at a turning point: because health issues are at the forefront of public debate, because the general public are simultaneously inundated with information and seeking answers to their own challenges, because our healthcare system is tired.. We have an opportunity to help change the narrative, to make the collective and individual leap from 'cure' to 'care'.

As an action-oriented foundation, we aim to operate as a catalyst for change, focusing on four major priorities: understanding, acting, evaluating and enlightening."

Sophie Ferreira Le Morvan,
Delegate General of the APRIL Foundation



TWO CONCRETE EXAMPLE OF FIELDS OF RESEARCH AND EXPERIMENTATION WHICH THE APRIL FOUNDATION IS KEEN TO EXPLORE:

How do young people aged 18-25 feel about their health?

- Surveys, focus groups and the like can allow us to learn much about the way young people perceive their exposure to health risks, their understanding of the healthcare system, their engagement with prevention tools and particularly their use of e-health applications and social media tools. Such consultations would also shed light on the factors which encourage/ discourage 18-25 year-olds to take control of their own health.
- Further experiments could help us to design and deploy new tools, "equipping" this group to autonomously manage their own health and prevention pathways.

The world of work is changing rapidly: where do health promotion and preventive efforts fit in? Which actors for which roles?

- 360° studies, interviews, etc. can help us to compare and contrast different perspectives, reinvent roles and imagine new organisational solutions with a view to nurturing a culture of health at work.
- Concrete, targeted actions could also be taken, such as introducing active design to the workplace in order to combat sedentary habits, varying mobility options, food practices, opportunities for exercise etc.

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True to our comprehensive, federating philosophy, we spoke to an array of prominent experts in order to benefit from their wisdom, compare points of view and inform our own reflections.

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- Philippe Korda
- Laura Litvine
- Alima Marie-Malikite
- Pauline Martinot
- Dr. Jean-Christophe Masseron
- Stéphanie Mazza
- Laure Millet
- Clémence Montagne
- Frédérique Pain
- Benjamin Rohaut
- Nicolas Rousset
- Rebecca Shankland

- Members of the Board of Directors of the APRIL Foundation in its previous incarnation.
- APRIL colleagues who took part in the discussion workshops

Interviews conducted by Elisabeth Bonnet Katz, journalist,
and Sophie Ferreira Le Morvan, Delegate General of the APRIL Foundation.