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Translating Prevention and Health Promotion into Action in Research, Health Care and Society

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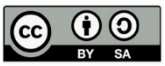

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Preliminary remarks

An increasing amount of as well as a more effective approach to, health prevention is becoming increasingly important for improving social and individual well-being, enhancing the productivity of the population, securing long-term health care provision and strengthening the economy. In view of demographic developments, growing health risks due to climate change and the skills shortage in various sectors of society, disease prevention and health promotion are becoming increasingly important for politics, the health care system, scientific research, and the economy. |[1] This is true not only for Germany, but also for the European Union (EU) and at the international level (e.g. the World Health Organization (WHO)).

The topics of prevention, health promotion and health protection necessarily encompass a broad socio-political dimension. The Science and Humanities Council (Wissenschaftsrat, WR) is aware of this responsibility. The need for a stronger focus on disease prevention and health promotion has been a key concern in health policy discourse at federal and state levels and has recently gained increasing attention. |[2] In light of these developments, a key concern for the WR is to demonstrate how science and science policy can contribute to strengthening prevention and health promotion as well as to a health-oriented cultural change that comes with this. Comprehensive scientific evidence on factors influencing health and disease prevention and their implementation in health care practice, can significantly support the systemic shift towards prevention and health promotion as core components of the health care system. While

| 1 Elsewhere, the Science and Humanities Council (Wissenschaftsrat, WR) addresses the future parameters for research and the system of research of higher education in the face of multiple challenges. See the WR (2026).

| 2 At the state level, see the Conference of Health Ministers' resolution from 2025 (Conference of Health Ministers (2025)). At the federal level, mention can be made of the networking process for a National Prevention Initiative (see German Federal Ministry of Health, 2025a). Various statements by the "Health and Resilience" Expert Council have also referred to aspects of disease prevention and health promotion, for example the "Health and Resilience" Expert Council (2025), "Health and Resilience" Expert Council (2024a), the "Health and Resilience" Expert Council (2024b), the "Health and Resilience" Expert Council (2024d) and the "Health and Resilience" Expert Council (2024e).

prevention can conserve resources in the medium to long term, it requires investment in the short term.

As in most other highly developed nations, health care in Germany currently focuses primarily on the treatment of disease. Progress and innovation are, of course, important goals, particularly in the treatment of diseases with largely unavoidable risk factors, diseases affecting children and adolescents and other vulnerable groups. These goals remain of vital importance to society as a whole. However, when it comes to dealing with the increase in the burden of disease driven by demographic developments and a changing society, health care systems in many countries, especially in Germany, are reaching their limits. Therefore, addressing issues relating to prevention, health protection and maintaining quality of life and thereby aspects that cut across various diseases, is not only desirable but urgently needed. However, these aspects are not yet reflected adequately in current German health research or health care. In addition to somatic health, this applies in particular to mental health, the relevance of which is continuing to grow in the face of overlapping social challenges – such as global crises, social inequalities, climate change, digital transformation and increasingly dense working and living environments – and which has not yet been given adequate consideration. At the individual level, disease prevention and health promotion are also fundamental to social participation, autonomous lifestyles and experiences of (self-)efficacy.

Prevention and health promotion involve different groups of actors and stakeholders, whose collaboration and networking is essential. Due to the heterogeneity and complexity, providing a comprehensive overview of all existing social and political initiatives is beyond the scope of this position paper, which therefore focuses primarily on scientific institutions and stakeholders. According to the WR, scientific actors can play a vital role in establishing disease prevention, health protection and health promotion as social paradigms (e.g. by sharing evidence from prevention research, advising on and supporting the implementation of measures, training specialists and developing and increasing health literacy). This creates important points of contact in terms of science and social policy. In this context, existing action plans and areas for development should be highlighted and examined in greater depth, without focusing on specific health areas or clinical pictures.

With the "Prävention neu denken! Brauchen wir eine nationale Initiative für Prävention?" ("Rethinking Prevention! Do we need a national initiative for prevention?") symposium |[3] held in late May 2024, the WR brought together a large number of stakeholders to create a discussion forum for a multi-perspective, interdisciplinary and interprofessional approach to prevention. Initial

| 3 See WR (2024a).

international perspectives and developments were also addressed, such as Dutch prevention policy. As a result, the WR has set itself the goal of examining how the system of research and higher education, particularly in university medicine, the health sciences and other disciplines, can be reformed to promote a more pronounced interdisciplinary and interprofessional approach to prevention and health, with an impact on politics, the economy and health care in Germany. To this end, it is essential to strengthen networks within and between scientific disciplines as well as between the economic sector and the public health sector. It is also important to consider supportive scientific policy measures and to make use of regional and international examples and developments. Furthermore, the trend of silo formation in research and health care needs to be reversed, and prevention established as a sustainable, interdisciplinary and interprofessional field of activity. This position paper aims to contribute to these goals.

In addition to the fundamental need for a stronger focus on prevention and health in research and health care, attention is also given to the effectiveness of preventive measures and how they can be implemented sustainably and effectively in everyday health care. Projects that have been successfully evaluated are often not integrated systematically into health care. There is no nationwide concept for the systematic, needs-oriented development, implementation and evaluation of prevention and health promotion measures. Further concretisation also requires political support across various departments so that prevention strategies and goals which enjoy broad support can be developed and pursued. Not least, this would place health and health promotion within a broader contextual framework that includes socio-economic factors as well as developments and measures related to education, the environment, society and living environments. This requires political action in various areas. Against this background, the WR aims to demonstrate how different scientific disciplines and research results can be incorporated into these processes and used to develop solutions in collaboration with policymakers.

The recommendations highlight the need for major developments to strengthen the focus on health in various areas, taking examples from other countries into account and, where possible and appropriate, formulating concrete measures.

In addition to members of the WR, external experts have also contributed to the preparation of this position paper. The WR is particularly grateful to them for their valuable contribution. Furthermore, the WR would like to thank the numerous experts who held discussions with the Committee on Medicine and provided extensive materials, thereby supporting the consultation process.

This position paper was adopted by the WR in Berlin on 30 January 2026.

Abstract

The German Science and Humanities Council's (Wissenschaftsrat, WR) core attention is to advocate for a stronger **health-orientation within society** and to support a health-related **cultural change**, also from within **science and the humanities and its institutions**. The aim is to create healthy living environments that enable autonomous decisions and make the healthy choice the easy choice – while simultaneously maintaining a balance between individual autonomy and collective responsibility.

An ageing population, a skills shortage, the increase in chronic diseases and environment-related health risks make it urgent to focus strongly on prevention and health promotion. Despite high health expenditures, the health status of the German population has yet not improved correspondingly. The health system is heavily focused on therapy and treatment, while preventive approaches play a subordinate role. However, these approaches can be a lever for relieving the burden on the health system, promoting social productivity, improving quality of life and well-being as well as fostering individual functional capacity and social participation.

Prevention and health promotion face the paradox that, despite thorough knowledge, sustainable implementation is still not adequately successful. A central problem is the "**knowledge-acceptance deficit**". This deficit is the result of a series of systemic obstacles within the health system itself and in the sectoral subsystems that have a particular influence on health, especially in the food and nutrition sector. Particularly problematic is the fact that those who should benefit most urgently from preventive measures are the least likely to be reached. This **inequality** aggravates health disparities and can also encourage the political exploitation of health issues. The **extreme heterogeneity** and **fragmentation** of the stakeholder landscape in Germany further complicates the systemic strengthening of prevention.

This position paper aims, based on the perspective of scientific stakeholders, to help identify interfaces where **science and the humanities** can interact synergistically **with politics, society, health care and other areas**. Scientific actors can play an essential role through prevention research, consulting and policy advice, professional training and contributions to health literacy.

Disease prevention extends far beyond medicine and health policy. From the perspective of the WR, the Health *in* All Policies concept should be further developed into a **Health *for* All Policies approach**: Health must be an integral and mandatory part of action in all policy areas (including education, labour, science, economic, agricultural, food, and environmental policy). The health implications of political actions should be measurable and taken into account in democratic negotiation processes for political measures. A cross-policy-field health approach brings **multiple benefits**, as it also serves to other societal goals – from health equity and climate protection to securing a skilled workforce (e. g. Prevention of health risks caused by heat waves, poor air quality or impacts on food systems). These **potential co-benefits** must be made more visible. This also opens up perspectives for thinking about social prosperity enabling development in terms of an "Economy of Wellbeing".

A **more consistent and binding** approach to **prevention strategies** is necessary for a health-oriented paradigm shift. In Germany, several strategic processes have been initiated at various political levels (federal, state and municipal) along with the involvement of various stakeholders. Instead of fostering cohesion among various stakeholders and interest groups, the already fragmented stakeholder landscape in prevention and health promotion has become even worse. In the federal system of competences, **close cooperation between the federal and state governments** is necessary. The WR suggests creating conditions enabling cooperation in the field of prevention by means of agreements and implementing **national health goals** in state and municipal **sub-goals**.

Strengthening evidence-based practice and enabling data use

Better **data availability** in the sense of **interoperable, standardised and reusable data provision** and more extensive and long-term **use of health data** are of utmost importance for prevention research and the development of evidence-based measures. Despite having taken important steps to standardise and harmonise health data, **interfaces** between higher education, non-university and departmental research institutions still **have untapped potential**. In addition, it is imperative to ensure that the advantages of using health data for the purpose of research are not restricted by complex access regulations and conditions. The WR reiterates its call for data access for research purposes to be facilitated in accordance with the General Data Protection Regulation (GDPR) in the interests of the general public, combined with high data security requirements. |[4] Access to **original data sets** is essential, particularly for innovative research questions, such as the use of artificial intelligence in diagnostics and therapy.

| 4 See WR (2022).

The WR recommends the development of **scientific indicator sets** by taking into account existing approaches, with the aim to make the outcome of preventive measures measurable and to be able to analyse the interaction of various risk factors (e.g. environmental, psychosocial, biological etc.). **Scientific experimental spaces** in various settings (e.g. work/business environment, schools) could be used to put new measures to the trial involving politics, science, health care and business. **Focus of studies** should be on population groups that have been less addressed to date, such as children and young people, but also specific settings such as schools, daycare centres or nurseries, and should take gender dimensions into account.

Structurally promoting health communication and literacy

The implementation of evidence-based preventive measures requires the **structural promotion of health communication and health literacy**, which must also take **cultural, behavioural and situational** aspects and influencing drivers into account. Prevention and health promotion services must not only be well known and accessible, but systematically adapted to different living environments, designed in a participatory manner and optimised in terms of their effectiveness. The WHO's **Behavioural and Cultural Insights (BCI) approach** provides a suitable framework for this. The WR recommends permanently establishing behavioural-scientific consulting, competence building, research and system integration. This requires improved interaction between higher education institutions, non-university and departmental research institutions, and public health service (Öffentlicher Gesundheitsdienst, ÖGD) institutions – for example, by establishing a national BCI network with clear mandates.

Prevention research and its translation – also in connection with health communication and information – has not yet been sufficiently networked and coordinated among scientific institutions (including departmental research) or institutions of public health promotion. In the view of the WR, this **institutional gap** should be examined.

Starting points for scientific institutions

The WR identifies **a wide range of starting points** for higher education and non-university research institutions and departmental research to address issues of prevention and health promotion more intensively – both with regard to **internal scientific potential** and in interaction with the **regional health care environment and the public health service.**

Prevention research must be **interdisciplinary and interprofessional** in nature. The establishment **of interdisciplinary prevention centres** at higher education institutions with medical, health and psychological science faculties, including their university outpatient department, can be an important lever. These centres should bring together various disciplines – from medicine and dentistry to health sciences, and psychology to social sciences, behavioural

sciences and environmental sciences – and act as interfaces with politics, non-university and departmental research, the public health service and civil society. A **national coordination office** should ensure the networking of all actors and centres involved in multidisciplinary prevention research. Academic prevention centres located at university medical centres can accompany and support **regional health development** in an evidence-based manner in line with the "fourth pillar" approach. |[5]

In addition, there is a particularly urgent need for action **to strengthen the field of implementation research**. While the effectiveness of many preventive measures is well documented under ideal conditions, there is a lack of knowledge about how these can be implemented in different living environments under real conditions. This also includes the development of methods to systematically identify ineffective measures. Additionally, more stringent causal health economic evaluation methods must be developed and programmatic funding opportunities for fostering research on prevention should be created.

The application dimension in terms **of translation and transfer** is particularly important. Not only is **enhanced intra-scientific networking** necessary, but also a strengthened **cooperation** with institutions that are actively involved in health promotion – primarily the institutions of the public health service. It is essential to establish a **multidirectional translation and transfer process** that allows for feedback mechanisms between "practice" and "theory" ("from bench to bedside and community and from community to bench"). In this regard, further scientific strengthening of the public health service must be promoted.

Particularly in medical academic qualifications, but also in **academic qualifications** for **other health and therapy-related professions**, a prevention- and health-oriented attitude and action must be taught in addition to as disease and cure-oriented attitude and action. In the **education and further training** of doctors, psychologists and other health professionals, targeted training modules should be developed to broaden their competencies in preventive measures. In all formats, it is essential **to extend the teaching content** on **health promotion and health communication**.

Harnessing profession-related potential

Prevention should be understood as **a team sport** and as **an opportunity for professionals**. New job profiles and prospects can be developed for doctors and other university-educated professionals in health care and public health-related fields. Examples from other European countries demonstrate the conducive to

| 5 Building on the range of activities and services in the classic triad of research, teaching and healthcare, the WR sees an opportunity for university medicine to take on systemic and future tasks (keyword: 'fourth pillar') in (regional) healthcare and to help shape its strategic development. Systemic and future tasks of university medicine include, for example, measures relating to the coordination, networking and control of the health system, quality assurance, political consulting and science communication. See WR (2021).

good health effects of **systematic interprofessional cooperation**. Interprofessional approaches are particularly effective when they are established as a systemic component and are not dependent on projects. In Germany, there is a need to change course and obtain a differentiated overview of the possibilities for impact and sustainability by systematically strengthening implementation research. Prevention centres at higher education institutions could contribute to interprofessional cooperation as well.

Redesigning incentives and creating resources

In a system geared towards "repair" and in which resources are becoming increasingly scarce, questions about the allocation of funds inevitably arise when thinking about a greater systemic promotion of prevention. The key is to reverse the logic of the argument: The financing of prevention can hardly be justified by an immediate savings potential. In order to support interdepartmental health orientation, diverse **potential added value** – individual, intangible, social, economic – should be made more visible and an **investment narrative rather than a savings narrative** must be established. This requires rigorous scientific measures and impact assessments.

To enable greater systemic equality of opportunity, further incentives for **approaches sensitive to settings and cultures** are required to improve the systematic prerequisites. **New sources of funding** for **prevention research**, such as through a public fund or a prevention foundation, should be considered.

A. Reason, objectives and focus areas

A.I STARTING POINT

The ageing population, a growing skills shortage – particularly in health care – and an increase in chronic non-communicable diseases, multimorbidity and environmental health risks (e.g. due to heat or vector-borne diseases) make focusing on disease prevention and health promotion more urgent than ever. However, Germany and its health care system are rather strongly oriented towards the **therapy and treatment of diseases** and much less towards health maintenance and prevention. Chapter D presents detailed data that confirms these assumptions and shows that the **costs** in the German health care system are relatively high by international standards. This contrasts with a **comparatively low life expectancy**. **Non-communicable**, **chronic physical and mental diseases** also place a significant burden on the population in Germany, as in other industrialised nations. Furthermore, there is a clear social inequality in the distribution of health and disease risks. Access to health care as well as health and health status are also influenced by factors such as gender (both biological and social), language barriers, adverse childhood experiences and global crises such as climate change. Demographic changes in the population are increasing the need for nursing care while exacerbating the existing **skills shortage** – both of which are putting the health care system under increasing pressure. This could lead to restrictions in medical, psychotherapeutic and nursing care becoming increasingly noticeable across the population and could encourage the political exploitation of health issues.

A change in health policy orientation that addresses activating and person-centred care and is based on the principles of **prevention and health promotion** (including increasing the health literacy of the population) can be a decisive lever for counteracting these developments. |[6] This paper aims to identify

|[6] In a statement, the German Medical Association (BÄK) also advocates for the long-term systemic strengthening of prevention and health promotion as well as the development of a comprehensive scientific

possible courses of action in this regard. Health should not be understood as a static, individual condition. Rather, from the perspective of the WR, health is defined as the ability to cope with everyday circumstances and ailments in a self-regulating manner without experiencing prolonged stress as well as to experience self-efficacy and social participation. In addition to basic physical and mental constitution, health in this sense is also shaped, in particular, by characteristics and influences associated with living environments (including environmental influences and socio-economic factors). The WR therefore considers it essential, when dealing with issues of maintaining health through prevention (from primary to quaternary prevention, see definition in chapter D.II) and health protection, to integrate the **individual physical and mental constitution with behavioural and lifestyle aspects**, rather than considering these aspects separately (see also chapter D.II). Such an **expanded concept of health** necessitates not only individual preventive and behavioural issues and interventions, but also interdisciplinary and interprofessional strategies regarding aspects of structural prevention and its interaction with behaviour.

In the view of the WR, the figures and findings presented in chapter D.I illustrate the need for a more interdisciplinary and interprofessional approach to prevention and health promotion. Prevention, health protection and promotion are central topics in numerous scientific disciplines (see chapter D.IV). These topics are also of concern to the Public Health Service (ÖGD), health insurance funds and other social insurance providers, the economy (including the health sector) and the general public (see chapter D.III.1). This diversity of actors and areas illustrates two important points: firstly, the heterogeneity of the target groups of this position paper and, secondly, the extraordinary complexity of the field of prevention, in particular with regard to evidence generation, implementation, evaluation and control of measures. In the opinion of the WR, this requires significantly more impetus from various scientific disciplines and research, for example in the form of implementation support and the measurement of the success or failure of prevention measures.

Since 2024, the WR has often noted at numerous events and expert discussions that the stakeholder landscape in the field of prevention and health promotion is fragmented throughout Germany |[7] – both in terms of health care and, in particular, in terms of exchange between health care and scientific institutions as well as within scientific disciplines themselves.

public health strategy. The statement addresses various aspects that also form the core of this position paper, including the need for interdepartmental collaboration, the strengthening of structural prevention, and the prioritisation of prevention over cure as well as aspects of data use and evidence generation. See German Medical Association (BÄK) (2025).

|[7] See, among others, WR (2024a).

Against this background, it is important to examine how existing initiatives and different actors from research, politics, society, and the economic sector can be networked to create synergies in their prevention and health promotion activities, enabling mutual knowledge and experience sharing as well as faster implementation. This does not mean that individual actors should not continue to have their own focus and perspective. However, consideration must be given to how, where necessary, **opportunities for exchange and networking** can be stimulated and intensified to improve the management of individual measures, increase their effectiveness and potentially generate savings. Prevention and health promotion must be addressed not only within the health system, but also within the science system and **other policy areas**, such as education, labour, social affairs, the economy, nutrition and the environment – and be set as cross-departmental targets for political action.

The WR is therefore advocating for a future in which **prevention and health promotion** – in the sense of health protection as well – form **central pillars of the health system** and are taken into account and shared responsibly in **other policy areas** (under the heading of: Health for All Policies). This will enable **co-benefit potential** to be leveraged not only in health care, but also in other areas, including educational attainment, work ability, (mental) resilience and environmental developments. The scenario of "Prevention and health promotion take centre stage", developed in chapter D.I, takes up this vision. The WR's objective is to help shape this scenario with its recommendations.

A.II OBJECTIVES AND PRIORITIES OF THE WR

The WR wishes to emphasise that **extensive knowledge** on disease-related risk factors is already available. For instance, there is information on nutritional risks and malnutrition, such as the consumption of energy-dense, highly processed foods and a high proportion of animal-based foods, combined with insufficient consumption of minimally processed plant-based foods, such as whole grains, fruit, vegetables, legumes, nuts and seeds. |[8] Other risk factors include tobacco and alcohol consumption, lack of exercise, psychological stress and being overweight or underweight. Individual programmes, such as health insurance bonus programmes, may be successful in some cases. However, significant successes across society as a whole have yet to be achieved and progress is being overtaken by other developments (e.g. vaping and smoking). |[9] These **implementation deficits** point to insufficient institutional anchoring (Who provides information? Who makes proposals for regulation?), a lack of systematic distribution of low-threshold information (e.g. about new health risks) and a lack of

| [8] See the German Medical Association (BÄK) (11 July 2023).

| [9] See Deutsches Ärzteblatt (6 August 2025).

systematic design of healthy consumption environments. Not least, data from the WHO show that commercial determinants of non-communicable chronic diseases pose significant health risks, particularly for socially disadvantaged population groups. Stricter regulation of the industries primarily responsible for this (alcohol, tobacco, highly processed foods and fossil fuels) is urgently needed (see chapter D.III.2.a). Currently, information about, interest in and acceptance of health-promoting measures are left up to the individual. Consequently, vulnerable groups remain particularly at risk. There is also hesitation and a lack of systematic approach to the adoption of innovative care concepts and measures into standard care. | [10] To achieve the necessary change, it is important to consider what can be learned from existing good practices, for example in the field of dental health (see chapter D.I) or from other countries and to apply these to other areas. There are **numerous promising regional and thematic approaches** which are, however, neither widely known nor promoted as role models. This position paper presents concrete examples. Preventive measures are not examined in detail according to specific health areas or clinical pictures. Instead, the aim is to provide an overview of existing approaches and networking potential. For the WR – especially in view of its genuine institutional mandate – it is important to highlight what **scientific disciplines** and **health research in particular**, can contribute to a stronger focus on prevention and health:

This position paper offers a specific focus on **scientific disciplines and higher education institutions** in the fields of **university medicine**, **the life sciences and health sciences** (including medicine, public health, health services research, psychology, including health and prevention psychology and communication, midwifery and nursing science and therapy sciences). It also considers their **potential for networking** with other scientific fields, especially the **educational, social and behavioural sciences**, including economics. | [11] Germany has also signed up to the WHO's Resolution on Behavioural Sciences for Better Health | [12] on the use of social and behavioural scientific evidence to improve health for all. | [13] This demonstrates the relevance of research in these areas and underlines the need to promote basic, applied and implementation research in

| [10] See Lindemann et al. (2024).

| [11] With regard to the implementation of prevention and health-promotion measures, the WR considers scientific disciplines that deal with human behaviour as well as social, political and economic developments in society, and systemic structural conditions, to be particularly important. The WR also considers this to include all disciplines classified by the German Research Foundation (DFG) as social and behavioural sciences. These include educational sciences, psychology, empirical social research, journalism and communication science, economic policy and applied economics, and economic theory. See German Research Foundation (2025).

| [12] See WHO (30 May 2023).

| [13] These so-called "behavioural and cultural insights" (see definition in chapter D.II) aim to identify and break down barriers in individuals and the environment through culturally tailored interventions.

the field of health-related social and behavioural sciences as well as making systematic use of its findings.

In addition to higher education institutions, the WR also considers **research institutions** to be key actors. These include the German Centres for Health Research (DZG), non-university research institutions such as the health-related Centres of the Helmholtz Association, institutes of the Fraunhofer Gesellschaft, Leibniz and Max Planck Institutes and federal departmental research institutions, in particular the subordinate authorities of the Federal Ministry of Health (BMG) and the ÖGD. **Professional associations and specialist groups** must also be taken into account, as they deal not only with research but also with **subject-related teaching, training and practical issues**.

Funding bodies (including foundations) also play an important role in the system. They create incentives to include health promotion, health protection and prevention to a greater extent in scientific areas that are not genuinely health-related and to address them in an interdisciplinary manner. Options for action in the area of funding portfolios and the design of scientific incentives are also examined.

With regard to **specific implementation issues** relating to prevention and health promotion/protection measures, the WR also considers **the transfer and translation of knowledge** to be essential areas of action. **Evidence-based measures**, **communication**, **cost-effectiveness analyses and implementation research** are starting points for this, but there is still **room for improvement** in Germany, particularly regarding the field of **implementation science**. | [14] In addition, **the transfer of skills and the promotion of participation and communication** in all areas of society are essential elements of **knowledge** transfer that are of particular importance in the field of prevention and health promotion, and which are also addressed in this paper. This applies at both an individual, personalised level and with regard to specific population groups (e.g. in terms of education, language, political views, cultural background or age) from a societal perspective. All of this must be considered and evaluated against the backdrop of the extent to which **political action** at the various federal, state and local levels can be supported in taking up these recommendations. It is also important to ensure that the incentives for different actors in the various systems interact constructively. The WR also recognises considerable **potential for innovation and value creation** in research on prevention and health promotion. This applies in particular to collaborations between science, civil society, the industrial

| [14] See Weishaar et al. (2025), pp. 718–727. Implementation science examines how evidence-based interventions can be successfully transferred into practice. It addresses the gap between knowledge and action – in other words, the question of why scientifically proven measures are often not implemented or only partially implemented.

sector and local authorities, enabling reciprocal interaction and knowledge flows ("from bedside to bench and community, and from community to bench") | [15] and promotes the transfer of successful measures into standard care.

As the WR sees it, the ways in which scientific and science policy contributions can strengthen prevention and health promotion must also be considered and reflected upon against the backdrop of the systemic context of impact. Consequently, this paper also addresses questions such as how fundamental health-oriented cultural change can be achieved and what contribution scientific disciplines and science policy can make to this. A central concern of this position paper is therefore to stimulate discussion on systemic change in this sense, thereby building on and reinforcing current lines of discussion in health policy, both at the federal and state level: **prevention and health promotion** should be recognised and designed as **integral components** of health care and health policy. This is particularly important in conjunction with other policy areas for the further development of the Health in All Policies concept | [16], i.e. the idea of pursuing cross-departmental and cross-policy collaboration that views health as a task for society as a whole. | [17] It is also clear that short-term successes are not to be expected, meaning a long-term planning horizon is necessary for the broad, cross-departmental strengthening of prevention and health promotion.

To establish **prevention and health-oriented measures** broadly and sustainably, various policy areas must be considered comprehensively. This applies to different focal points, such as scientific, economic, social, educational, and environmental aspects as well as to the levels of responsibility ranging from local authorities to the federal and state governments (see chapter D.III). With regard to **communication and implementation aspects**, other actors must also be involved, such as public health institutions, at the federal and state level, too, as well as patient representatives at all levels. In this context, it is also important to consider opportunities for contributing to, and networking with, the spheres of scientific actors and science policy.

The practical implementation of prevention measures raises questions of **governance and strategic control** between the various stakeholders and levels of responsibility (see chapter D.III.1 and D.III.2). **Clear**, **evidence-based**, **transparent and binding goals** as well as **incentive**, **feedback and monitoring systems** geared towards achieving these goals and providing **relevant feedback for**

| [15] The objective would be to enable multidirectional translation that allows feedback between "practitioners" and "theorists", while also explicitly including health actions and evidence from the civilian population and the municipal level. This would facilitate the derivation of new scientific knowledge interests from practical implementation experiences.

| [16] See also Köckler; Greene (2022).

| [17] On the current systemic gap, see also Hurrelmann et al. (2024), p. 31 f.

planning purposes, are crucial for success. Appropriate health objectives that form a strategic framework can serve as a starting point, with sub-goals taking into account different levels of action (national, regional and local). The levels of influence, objectives and opportunities for interaction with scientific disciplines and research must also be reflected upon and optimised in order to better manage and shape prevention and health strategies in Germany.

B. Strengthening prevention and health promotion – in science, politics, health care and society

From the WR's perspective, the (added) value of prevention and health promotion applies at various interconnected levels, both individually and socially.

The health of individuals as well as the protection and preservation of individual health for as long as possible, is of fundamental importance in terms of social participation, autonomous lifestyles and the (self-)efficacy of every individual. Good health and well-being are the foundations that enable individuals to participate in society and in various areas of life, including family life, work life and social interactions. To achieve this, equal access to health care and the personal determination to make decisions that promote good health are essential prerequisites.

Furthermore, various value aspects emerge at the level of society as a whole. These are reflected in a more efficient use of funds and resources within the health care system, in increased productivity and work capacity as well as in an economic market potential itself (see chapter B.VI). Thus, prevention and health protection can contribute to both individual resilience and economic resilience, securing both individual and social capacity and performance.

Good health is a core value for every individual as well as for society as a whole. Therefore, a health-oriented cultural shift aimed at increasing the number of healthy years in the lives of individuals should be considered a self-evident goal. The following recommendations are intended to contribute to, and support, this shift. From the point of view of the WR, this appears all the more urgent given that the main causes of non-communicable chronic diseases (e.g. alcohol, tobacco and sugar) can be effectively controlled through political action and regulation. Although Germany has introduced certain measures in recent years,

including tobacco control, the country lags far behind others in Europe in terms of stronger regulation, despite the evidence for it (see chapter D.III.2.a). | [18]

At the same time, the WR emphasises that control measures implemented by the government must respect individual freedoms and rights of choice and maintain an appropriate balance (see chapter B.I). It is also important to weigh up in which areas stronger regulatory intervention, such as bans or certain behavioural obligations, can be expected to yield health benefits that justify regulation (e.g. smoking bans in public spaces). | [19] Before regulatory intervention takes place, there needs to be comprehensive reflection on the intended and unintended effects of the issues in question as well as ethical considerations differentiated according to situational contexts and the specific needs of the respective target groups. Only on the basis of such a systematic analysis can well-founded decisions be made that do justice to both the complexity of the matter and the requirements for preventive measures.

B.I SHAPING HEALTH ACROSS POLICY AREAS AND MAKING CO-BENEFITS VISIBLE

I.1 The Problem

Disease prevention extends **far beyond medicine, health care, health research and health policy**. Prevention work is central to various fields in terms of subsystems from different areas of society, such as exercise and sports, education, the environment, the economy and nutrition. Nevertheless, prevention is often defined too narrowly, both in political and in technical terms. The focus tends to be predominantly on preventing addiction to, and consumption of, alcohol and tobacco. While there is clearly a need for action in these areas (e.g. with regard to advertising bans) (see chapter D.III.2.a), other important areas of action are neglected. These include mental health, the design of living spaces, mobility, and social participation. With regard to specific groups of people, measures tend to focus primarily on older sections of the population, with less attention given to children and adolescents. The WR recognises an urgent need for action to include these groups as well.

| [18] See also the results of the Public Health Index (PHI) developed by the AOK Federal Association and the German Cancer Research Centre (DKFZ) in collaboration with an interdisciplinary research team. See AOK Federal Association eGbR (ed.); German Cancer Research Centre (ed.) (2025).

| [19] Looking at the tobacco prevention measures of recent decades, such as smoking bans in public places, raising the minimum age for purchasing tobacco and broader awareness of health risks, successes are evident. However, more far-reaching measures could be taken in Germany and smoking prevalence is still above the EU average (see Mons (2024), p. 156).

A **broad political commitment** is needed to make health and health promotion a guiding principle for interdepartmental action. The current German government's coalition agreement |[20] offers a starting point for this by formulating the intention to overcome departmental silo thinking and to reinterpret the departmental principle through a "whole-of-government" approach. When doing so, it is particularly important **to take care in weighing up** the objectives and benefits of **government control measures**. Interventions in individual freedoms and the associated ethical implications require careful consideration, for which scientific policy advice can also be helpful. A **balance** between individual autonomy and collective responsibility is essential and must be developed through a process involving society as a whole.

Both individual and collective health are closely linked to **psychosocial** and **environmental influences**, such as environmental factors or the social environment. A stronger **political and systemic focus** on health-promoting measures and environmental design can bring multiple benefits: It can promote both individual and collective health while also contributing to other societal goals, e.g. in the context of health equity (including reducing the potential for social polarisation), climate protection and sustainability |[21] , increasing the population's sense of self-efficacy, and securing a skilled workforce. These **potential co-benefits** of disease prevention and health promotion must be highlighted and made more widely known, in the interests of health protection, too. In the view of the WR, a cross-sectoral prevention and health policy could provide beneficial impetus for social development in and for various policy areas. Additionally, this opens up prospects for Germany to further reflect on the prerequisites and premises of social prosperity in line with the concept of the "Economy of Wellbeing" |[22] already adopted in various other countries. |[23] This enables social prosperity development to be related not only to economic growth, but also to quality of life, health, and ecological sustainability as essential benchmarks for

|[20] See Christian Democratic Union of Germany/Christian Social Union in Bavaria; Social Democratic Party of Germany (eds.) (2025), p. 57.

|[21] The link between health and sustainability is also evident in the fact that health is mentioned in all 17 of the United Nations' Sustainable Development Goals (SDGs). See WR (2024b), p. 13.

|[22] See Llena-Nozal; Martin; Murtin (2019), pp. 8, 12 ff. This concept places individual well-being and long-term economic growth in a positive and mutually reinforcing cycle. "Economies of Wellbeing" take into account not only the gross domestic product (GDP) but also other indicators such as health and life satisfaction, equality and social justice, environmental protection and resource conservation, and community spirit and social participation.

|[23] Finland is an example of a country that places this approach at the heart of its health policy decision-making processes and its design of measures. See Ministry of Social Affairs (n.d.).

a prosperous society. Points of contact already exist thanks to the Federal Ministry of Economics' expanded reporting since 2022. | [24]

Against this backdrop, it is clear that prevention and health promotion are **tasks that concern the whole of society** and that their (added) value extends far beyond the scientific and health care systems. These topics must be **integrated into various policy sectors**, including education, the environment, the economy, agriculture, food production, and urban development.

A successful prevention policy requires **clear objectives**, **defined responsibilities and concrete implementation options** at the federal, state and local levels. In recent decades, strategic processes have already been initiated, and a legislative framework has been established (see chapter D.III). However, the results do not align with the original intentions and expectations yet. Rather than bringing together the various actors and stakeholders, the already fragmented stakeholder landscape in the field of prevention and health promotion has become further entrenched. **Prevention legislation** (see chapter D.III.2.a) and the process of **developing national health goals** (see chapter D.III.2.c) illustrate this development in an exemplary fashion. Both represent progress and provide fundamental motivation for cross-sectoral action in the area of prevention. In their current form, however, they **do not sufficiently** promote **strategic collaboration**. This is partly due to the **system of legislative responsibilities**. With the Prevention Act (PrävG), the federal government could only oblige social insurance providers to collaborate; it could not oblige the federal states, local authorities or any other actors outside the social insurance system. Furthermore, both the structures created by the PrävG, such as the National Disease Prevention Conference (NPK), and the process of developing health goals are not sufficiently known beyond a narrow circle of actors. In particular, the **integration and connection with scientific actors** as well as with initiatives and the scientific departments themselves, is not sufficiently developed. Furthermore, responsibilities within the existing association and network structures are unclear and some functions are duplicated. This applies, for example, to the coexistence of the NPK, the Federal Association for Prevention and Health Promotion (BVPG) and the gesundheitsziele.de collaborative network (see chapter D.III.1). For outsiders, the respective responsibilities are not easy to understand. This is particularly problematic in terms of developing and implementing health goals and supporting their implementation.

| [24] Since 2022, the annual economic report of the Federal Ministry of Economics has included a chapter on aspects of prosperity and sustainability that are particularly important for the overall assessment of economic and financial policy. See OECD (29 August 2024) and Federal Ministry for Economic Affairs and Climate Protection (ed.) (2024), p. 121 ff.

Germany faces a **fundamental problem**: due to the various levels of political responsibility (federal, state and local), it is impossible to pursue and achieve a common goal. While the federal government sets general strategic guidelines (PrävG, SGB, German Infection Protection Act), the states and local authorities are responsible for the concrete implementation of preventive measures and health promotion among the population. The current goal-based management system, as set out in the PrävG, and the monitoring carried out mainly by social insurance agencies, have resulted in the national health goals being overlooked and undervalued by politics, scientific actors and wider society – which has an impact on their consistent implementation. The federal structure exacerbates these difficulties further: national and state-specific goals and strategies run in parallel to each other, are not politically binding, and create additional structures that are only partially aligned (see chapter D.III.2.c).

Developing a **sustainable and effective prevention strategy** requires a large number of different actors and collaboration at all political levels (federal, state and local). This is the only way to achieve broad implementation across various groups. Different age groups, social classes, and social groups (e.g. people with a migrant background) must be consistently included and specifically addressed. This requires appropriate coordination, which is not currently being considered. Proposals from various scientific disciplines on suitable measures for different target groups should also be taken into account here.

I.2 Recommendations

_ **Involving scientific actors and science policy:** So far, **scientific actors and science policy** have barely been structurally integrated in terms of prevention and health promotion. This should be rectified. For instance, the **Federal Ministry of Research, Technology and Space (BMFTR)** could contribute to other departments' initiatives and strategies relating to health and prevention. At the state level, **science ministries** should also participate in state health conferences. At the local level, including within universities, it is essential to **integrate scientific institutions more effectively** to develop effective health and prevention networks. This could be achieved by involving prevention centres (see chapter B.IV.2).

_ **Combining structural and behavioural prevention: Structural and behavioural prevention** must be considered in closer conjunction. According to the WR, relational changes must be linked to individual behavioural analyses and the evaluation of personal health risks. This is the only way to improve the health of the population sustainably and for the long term. Health research can contribute significantly to this (see chapter B.IV).

_ **Establishing Health for All Policies as a principle:** Effective health orientation in political action requires collaboration between different departments. The WR recommends further developing the Health *in* All Policies concept in

the sense of a **"Health *for* All Policies" concept**, thereby emphasising that health must be an integral part of, and a binding goal in, all policy areas, and must be negotiated democratically when designing measures, not only within the health sector itself, but also in areas such as urban development, education, labour, science, economics, agriculture, food and environmental policy. |[25] To this end, scientifically based key performance indicators should be developed to systematically record and track the success of preventive measures in different areas of society in a comparable manner (see chapter B.II.2). As an additional political control instrument, the **introduction of a health impact assessment (HIA)** in all policy areas could be considered, similar to environmental impact assessments. Such a systematic assessment of the health effects of political measures would provide important impetus across all policy areas. It should be implemented with the least possible bureaucratic effort and without slowing down processes.

_ **Bringing together health goals and strategies**: Health goals should contribute to an overarching national strategy for prevention and health promotion. To this end, they should be designed **using a cascading approach** that translates a few overarching national visionary goals (e.g. increasing the population's average healthy life expectancy) into state and municipal sub-goals that interlink **national and state or local strategies**.

_ **Reviewing the development and achievement of health goals systematically**: For all levels of health goals, **evidence-based indicators** (see also chapter B.II.2) that continuously measure the goal achievement, or the extent to which goals have been met or missed in various areas of society, should be documented more thoroughly than before. Any need for adjustment or critical developments should be identified through **systematic monitoring and reporting**. This could also be linked to the federal government's health reporting.

_ **Making health goals binding – both politically and socially**: Concrete **health goals** can serve as a strategic lever for prioritising various areas of individual and social importance where a stronger focus on health is desirable, for identifying particular areas of action and measures, and for stratifying the responsibilities of different actors and departments. However, they should not only be known to insiders; they should also be accepted as **guidelines** for interdepartmental political action, including in interaction with various societal, business, scientific and health care actors, and should create binding commitments.

_ **Designing effective top-down and bottom-up approaches**: Effective governance requires a balanced **interaction** between **bottom-up processes at the**

| [25] For the areas of agriculture and nutrition, the WR has formulated a target vision for sustainable and health-promoting agricultural and food systems in society, science and politics for 2024, see WR (2024b), p. 12 ff.

local level and top-down coordination at the federal/state levels. Bottom-up processes must be employed to identify local challenges and develop accepted solutions. At the same time, top-down coordination is needed to implement measures in a binding manner, clarify responsibilities, and ensure political coherence.

_ **Expanding federal-state collaboration:** A sustainable and nationally effective prevention strategy requires **close collaboration between the federal and state governments** within the federal system of competencies. The WR suggests creating the **constitutional conditions** that would enable the federal and state governments to work together in the field of prevention and health promotion through agreements.

_ **Developing the Prevention Act (PrävG) further:** The WR supports **the further development of the Prevention Act**, as also called for by the Conference of Health Ministers (GMK). | [26] The aim should be to anchor structural transformation in prevention across all areas of society, ensuring legal binding force, science-backed practical implementation, and sustainable financing.

B.II MAKING BETTER USE OF HEALTH DATA AND EVIDENCE

II.1 The Problem

Structural requirements and framework conditions

The WR considers comprehensive **data storage and use** to be essential for measuring, testing and controlling health status and behaviour of the population at both the individual and collective levels. In recent years, legislative measures such as the Health Data Usage Act (GDNG) and the Medical Research Act (MFG) were important steps to significantly improve the conditions, standards, harmonisation requirements, and potential uses of health data for research purposes. Specifically in the context of university medicine, a joint national research data infrastructure has been established at all German university hospitals through the Medical Informatics Initiative (MII) and its data integration centres (DIZ) as well as the Network of University Medicine (NUM). Researchers can apply to use data and biosamples from German university hospitals via the MII's German Portal for Medical Research Data (FDPG). The NUM transfer office gives researchers access to the NUM's study data. | [27] This has created a promising collaborative structure between the leading medical universities in Germany. The Coordination Group for Health Research Data Infrastructures (GFDI) as well as key actors

| 26 See the Conference of Health Ministers (GMK) (2025).

| 27 For example, the NAPKON cohorts (National Pandemic Cohort Network), Cross-Sectoral Platform (SÜP), High-Resolution Platform (HAP) and Population-Based Platform (POP).

from research and ministries are working together to promote the use of health data for research. |[28] In addition to the NUM and MII, members include the German Centres for Health Research, the National Centre for Tumour Diseases (NCT), the NAKO Health Study, the cancer registries, the Robert Koch Institute (RKI) with its Centre for Artificial Intelligence in Public Health Research (ZKI-PH) as well as the medical consortium NFDI4Health of the National Research Data Infrastructure (NFDI) as key cross-location data infrastructures. |[29] Nevertheless, there is still room for improvement in terms of **interfaces and links** within these networks, within the university and non-university sectors, and between departmental research and the National Digital Health Agency (gematik). Sufficient digitisation of processes is a prerequisite for this.

Due to the nature of the tasks involved, the datasets are at the same time limited to a somewhat selective spectrum of the population. For example, they may only include patients at university hospitals. However, particularly regarding prevention-related research questions, more comprehensive population data is required that encompasses not only patients or individuals with illnesses, but also healthy population groups. The **Health Data Lab (FDZ Gesundheit**), which is based at the Federal Institute for Drugs and Medical Devices (BfArM), is an important addition to this. |[30] There, on the basis of federal law (SGB V), the billing data of all 94 statutory health insurance funds are first collated and made available for evaluation in a "trusted research environment" on the basis of research applications. In a subsequent expansion stage, the FDZ Gesundheit will also be able to link personal data from cancer registries with statutory health insurance (GKV) data. Furthermore, the FDZ is part of a uniform national health data space, which is being implemented as part of the **European Health Data Space (EHDS)** regulation. The EHDS aims to create a shared data usage ecosystem involving various stakeholders from science, industry, ÖGD, and politics across Europe. While these processes are extremely complex in terms of their structural alignment, they offer great potential for health research, including prevention research, if structured prudently and efficiently.

Biobanks are another important type of research infrastructure that is significant for health research in general and for prevention research in particular. Quality assurance and standardisation are essential prerequisites for comprehensive scientific usability across locations and institutions. The WR therefore welcomes the German federal government's commitment to its coalition

| 28 See the Medical Information Initiative (n.d.).

| 29 NFDI4Health contributes to standardising and harmonising medical research data for secure, GDPR-compliant use, while the RatSWD makes social and economic data accessible and ensures its quality, integrity and data protection.

| 30 The FDZ provides access to pseudonymised billing data from all statutory health insurance companies for research purposes for health research institutions and relevant federal organisations.

agreement to establish a national biobank supporting preventive, precision and personalised medicine. |[31] The WR considers sensible the coordinated network and structural development between the NUM and the German Biobank Node (GBN) as well as the concept for a "Biobank Platform Germany" developed by a broad scientific and industrial network. At the same time, links to large health studies such as the NAKO Health Study must also be established.

The WR considers it necessary to **improve data standardisation and harmonisation** based on international standards. Not only must data be systematically collected, it must also be made available for use by the relevant stakeholders. Electronic patient records (ePA) offer considerable potential in this regard, and this must be exploited. While the latest legislative measures, e.g. the GDNG and the Register Act, which is currently being considered by associations, offer important steps in the right direction, they are not yet sufficient to make Germany's research competitive at an international level. Further efforts are needed to reduce the burden of meeting data protection requirements and ethical reviews while maintaining a high level of personal data protection. The WR reiterates its call for data access for research purposes to be facilitated in accordance with data protection legislation for the benefit of society, alongside high data security standards. |[32]

Evidence generation and data use for prevention research

As in many other areas in Germany, the **data situation regarding health factors** and **effective prevention measures** is rather difficult. As early as in 2022, the WR identified the lack of availability, networking and integration of high-quality, care-related data as the biggest and most persistent deficit in the use of health data. This relates to the data-based networking of various actors and institutions in the science and health system as well as across sector boundaries. |[33] Prevention is further complicated by the fact that, in principle, little data is routinely collected from the general population. Although data is collected during the standard developmental "U examinations" for children up to the age of five throughout Germany |[34], it is not stored in a central way. This means that it cannot be used for population-wide health monitoring or, for example, for setting up a malformation register. |[35] The medical determination of causes of death should also be more differentiated and standardised to expand

| 31 See the Christian Democratic Union of Germany/Christian Social Union in Bavaria; Social Democratic Party of Germany (eds.) (2025), p. 78.

| 32 See WR (2022).

| 33 See WR (2022), p. 10.

| 34 See "Health and Resilience" Expert Council (2024e).

| 35 See the German Medical Association (BÄK) (2022).

the scope for analysis. Data from check-ups, including the health check-up for ages 30 and 35 and data from maternity logbooks, is collected but not collated nationwide, so it cannot be analysed across the board. Data from other nationwide examinations, such as school-age health screenings, should also be made more accessible and usable. |[36] The same applies to the digital documentation of vaccinations enabled by the electronic patient file (ePA), which should comply with international standards.

From the point of view of the WR, it is also crucial, in line with the interdisciplinary concept of prevention, for health data to also be linked to other data (e.g. environmental or social data) for **research** in the field of prevention. In addition to the relevant legal and technical foundations (e.g. unique identifiers), **interoperability** between data from research institutions, health care sectors and other areas of society must therefore also be ensured. This is particularly relevant for access to datasets from private companies that originate from wearables. |[37] These are also of great interest in anonymised or pseudonymised form with regard to movement/behavioural data as well as motivational issues. Links and evaluations that are both deeper and more detailed (e.g. at the level of postcode districts) must also be permitted. It should be made clear that this data is not collected as an end in itself, but rather to generate evidence and strengthen prevention and preventive measures. Technological developments in the field of artificial intelligence (AI) also offer great potential, particularly with regard to primary prevention, for identifying impending diseases and deriving appropriate preventive measures. |[38] These developments are especially important when it comes to personalised prevention approaches.

Based on an interdisciplinary prevention concept, the WR believes that **scientific indicator sets** should ideally be developed to measure the outcome of preventive measures at the behavioural and relational levels, while also identifying **various risk factors** (environmental, psychosocial, biological etc.) and their interactions. Existing approaches should be taken into account. |[39] Consideration must also be given to which **monitoring instruments** are required to create a

| 36 See ibid.

| 37 Wearables are small computer systems designed to be worn directly on the body. They can be used to measure various factors such as heart rate, blood pressure, blood sugar levels, sleep and calorie consumption, and the results can be evaluated via applications (apps). The most widely used wearables are fitness or activity trackers. See the Federal Office for Information Security (27 February 2025).

| 38 See Mossavarali et al. (2025).

| 39 The prevention indicators developed by a working group on health reporting (UAG Präventionsindikatoren) can be cited as an example. See Röding; Gerlich; Walter (2024). Another example is the prevention indicator system of the federal states, which has enabled them to develop a harmonised set of indicators for prevention reporting. See the National Prevention Conference (2023), p. 80.

valid, standardised database, and which structures can ensure cross-sectoral use. |[40] One example is the RKI's Burden of Disease Study (BURDEN 2020), which ran from 2018 to 2021. |[41]

A **regional focus** can provide a relevant reference and test area for implementing, monitoring and gathering evidence of prevention measures and projects, which could be established as model regions. This could include the efficacy and effectiveness of health-related measures and new financing mechanisms (see chapter B.VI).

A key challenge in implementing and measuring the long-term success of prevention measures is the **large number of project-based initiatives**, which tend to be short-term in nature. There is a need for greater long-term planning and consistent options for continuing and communicating findings.

For prevention to remain **agile and responsive** – for example, in the event of heat waves, pandemics or other crises – real-time evidence on prevention and risk factors and behaviour is needed. |[42] Adaptive qualitative public health sentinel cohorts |[43] and quantitative monitoring provide context-sensitive signals for developing an understanding of a population's situation. These must be in place well in advance of crises arising. In conjunction with established health

|[40] See the German Medical Association (BÄK) (2021).

|[41] The RKI conducted a national Burden of Disease study (BURDEN 2020), developing a Burden of Disease analysis of the German population, both nationally and including regional aspects, in order to determine lost years of life, taking morbidity and mortality factors into account. The project aimed to create a data-based information foundation for decision-makers in the health care sector, supporting the needs-based, appropriate and economical planning of preventive measures for specific clinical cases. For the study's results, see Wengler et al. (2023). In addition to regional data, the results can be diversified by gender and age cohort for various clinical conditions (e.g. diabetes mellitus, cancer or cardiovascular disease). See the Robert Koch Institute (2021).

|[42] See Daube; Jenny; Pelull (2025) and Zintel et al. (2025).

|[43] The term "adaptive qualitative public health sentinel cohorts" refers to a new form of population study being developed in public health research. These studies monitor health developments in real time and enable a rapid response to crises. These cohorts are called "adaptive" because they can adapt dynamically to changing conditions, such as heatwaves, pandemics or the movements of refugeed people. They are based on continuous, primarily app-supported data collection that can be expanded to fit the situation. "Qualitative" refers to the use of focus groups and surveys to capture participants' attitudes, perceptions and social contexts. Participants act as public health sentinels, providing information on new risks, stresses, and mood changes in everyday life. One example is the PULS study (Population-Based Survey on Living Conditions and Social Health), which is conducted by the Centre for Preventive Medicine and Digital Health at Heidelberg University. The study aims to capture social and health situations in times of crisis in a context-sensitive manner and almost in real time. This will enable faster and more evidence-based political decisions and preventive measures.

monitoring instruments, for example those of the RKI or the Federal Institute for Public Health (BIÖG), needs can be identified, target groups defined and the barriers to, and drivers of, health behaviour recorded. Evidence-based interventions can then be developed, tested, implemented and evaluated.

II.2 Recommendations

_ **Ensuring data harmonisation and connectivity: Strategy development and harmonisation** of various types of data and datasets should be based on **existing processes and projects**. The process adopted by the BMG in developing a data strategy for the BIÖG is to be explicitly welcomed. Furthermore, **connectivity to the planned EHDS** must be ensured. This is expressly provided for in the current Register Act. To this end, it is also necessary for other departments, such as the BMFTR and suitable GFDI, to be involved in designing the implementation of the EU regulation, in addition to the BMG.

_ **Exploiting health data**: From the WR's perspective, it is considered positive that the use of health data for and in research is an end in itself, as set out in the GDNG and the EHDS Regulation. For these advantages over institution-related use and access rights to be realised in full, access to health data from the population, for example via the FDZ Gesundheit, must **not be hindered** for scientific institutions **by complex access regulations** and conditions. For innovative research questions, particularly those in diagnostics involving AI, it is important to ensure not only analysis options in trusted research environments, but also **direct access to original datasets**. Consideration should be given to making use as legally secure and research-friendly as possible. A ban with reservation of permission means that every legitimate request for use must first undergo a lengthy review before permission is granted. It would certainly be helpful to consider other possible solutions here, in particular a **permission principle with the possibility of sanctions/prohibitions**. Additionally, the WR reiterates its recommendation for a **national FDPG** that builds on existing solutions and considers the future EHDS, providing information on decentralised datasets, especially those held by the public sector, and supporting researchers in accessing these datasets. | [44]

_ **Enabling interoperable, standardised and reusable data provision**: The opportunities offered by **digitalisation** for use and analysis of prevention-related data must be exploited more effectively in relation to the population. All data holders, including health professionals, service providers and hospital information systems, must be required to **provide interoperable, standardised, and reusable data** to fully exploit the research potential of digital health data. Scandinavian countries can serve as role models in this respect, with the key concept being "unique identifiers" for research and health care data. From

| [44] See WR (2022), p. 48 f.

the perspective of the WR, it would also be desirable for private providers to make anonymised or pseudonymised datasets, e.g. from wearables, available for research purposes via data donations. This is particularly relevant for motivational and behavioural research.

_ **Harnessing the potential of the ePA:** The German government's intention to expand the standard U examinations for children in its coalition agreement is a positive step. Similar to **data from routine check-ups** (e.g. health check-ups at ages 30/35 or data from maternity logbooks), this data should definitely be made available for **research purposes**, too. This requires standardisation and centralised documentation. | [45] In this regard, the **ePA** and the FDZ Gesundheit at the BfArM offer opportunities that should be consistently exploited and accelerated in their implementation.

_ **Standardising biobanks and expanding sample stocks:** From the WR's perspective, the development of a centralised **national biobank platform**, along with the associated opportunities for access and collaboration for research purposes, is to be welcomed. At the same time, particularly with regard to the needs of prevention research, it is important not only to collect samples from sick people, as is customary for biobanks at university hospitals, for example, but to establish or open **biobank stocks of samples from healthy people, too**. The NAKO health study has already obtained some 30 million biosamples from approximately 200,000 participants. A comprehensive characterisation of these samples is currently being developed. | [46] The Lifelines population study from the Netherlands (see chapter D.III.2.c) and its biobank structures, processes and materials implemented here are considered role models by the WR.

_ **Making application processes for data use simple, reliable, and fast:** For prevention research to achieve its full potential, **application processes and the availability** of datasets must be **guaranteed** to be **simple, reliable and fast,** not only for health studies, but also for disease-related registries (e.g. the cancer registry), biobanks and other relevant research infrastructures for health data generation. In this respect, too, Dutch counterparts such as the Lifelines study are exemplary.

_ **Providing datasets with the necessary level of detail:** Prevention research questions often require a **more in-depth and detailed analysis**, for example regarding sports facilities and school equipment. In some cases, this conflicts with data protection regulations. In such cases, the **scope of data provision and analysis granularity** should be decided with a sense of proportion, provided that the scientific question justifies it, so as not to restrict research

| [45] See also "Health and Resilience" Expert Council (2024c).

| [46] See, among others, Wichmann et al. (2016).

processes. However, it is also important to state that the right to impose sanctions in cases of scientific misconduct is reserved.

_ **Defining key performance indicators (KPIs):** Evidence-based **KPIs** can provide a useful basis for steering and evaluating prevention measures, as they enable the success of prevention and health promotion to be systematically recorded and tracked at a population level in **various areas of society**. Examples include reducing the incidence of stroke, increasing life expectancy in certain population groups and climate protection-related indicators in public spaces. These should also be linked to cross-policy health goals. KPIs for measurement should ideally be negotiated and defined across departments (see chapter B.I.2). KPIs should also be simple, sensitive to change and easily measurable.

_ **Establishing real-time evidence and early warning systems**: A permanent, adaptive **surveillance infrastructure** can provide context-sensitive signals for prevention as well as for crisis and climate risks, and these can be fed systematically into political decision-making and programme processes. Existing infrastructures, such as the RKI Panel Health in Germany, should be expanded further to specifically promote healthy behaviour.

_ **Conducting broader health studies: Large-scale studies** such as the German NAKO Health Study often focus on older population groups, while young people and specific settings, such as schools or kindergartens, have been underrepresented to date. From the WR's point of view, the **broader inclusion** of such settings can help to monitor and record behavioural changes in greater depth as well as promote competence development across the board. Data from these studies should be linked not only to **routine data**, but also to other **datasets** (e.g. environmental data, socio-economic data and motivational data). The NAKO should also collaborate more closely with the RKI Health Panel and other cohorts in Germany where appropriate.

_ **Creating interdisciplinary experimental spaces: Environmental/climatic factors** (including urban planning, noise pollution, heat protection and air pollutants etc.), **socio-economic aspects** (including individual financial circumstances, poverty and education) and **social conditions** (including living conditions and opportunities for participation) as well as **motivational, psychosocial and gender-sensitive factors**, all play a central role in health. This significantly increases the complexity of dealing with prevention. Where reliable data and findings already exist on the influence of these factors on prevention and health promotion measures, suitable **experimental spaces** should be established. These spaces should be scientifically monitored and integrated

into various areas of life, such as workplaces, schools |[47] and daycare centres, to create an open innovation environment for testing new, evidence-based approaches and measures between various actors, including politics, scientific disciplines, health care, business and society. Where data, evidence and scientific expertise for the development and monitoring of measures are lacking, these should be provided or developed.

_ **Examining the potential for cohort studies to become permanent**: With regard to the sustainability and systematic monitoring of health development, the phased project financing of large-scale projects such as NAKO could potentially be obstructive. The WR therefore advocates for the examination of **options for continuing such cohort studies or permanently usable sub-aspects**. Where appropriate in terms of subject matter and responsibility, the health department should be involved in the considerations alongside the science department.

B.III HEALTH COMMUNICATION, HEALTH LITERACY AND ITS GOVERNANCE

III.1 The Problem

Health communication |[48] as well as **competence building** |[49] **and the transfer of knowledge** also play an important role in terms of evidence and quality assurance. The different living environments and realities of various target groups (e.g. different age groups, cultural backgrounds and educational levels) must be recognised, considered in a differentiated manner and addressed accordingly. Contrary to previous trends, studies on health literacy show a slight improvement in Germany in recent years. However, this improvement is primarily evident in more affluent population groups. Additionally, difficulties persist in connection with a challenging information environment in the field of

|[47] One example is the Mental Health Coaches programme, which has been run as a pilot by the Federal Ministry of Education, Family, Seniors, Women and Youth (BMBFSFJ) since autumn 2023. The programme aims to improve the mental health of schoolchildren by providing them with access to mental health coaches in schools. The programme is being monitored and evaluated by scientists. Further information can be found on the website of the BMBFSFJ (23 January 2025).

|[48] Health communication is the field of research and practice that describes, studies and influences communication about health and illness – whether interpersonal, via the mass media or digitally – in order to promote health and prevent illness. See Schäfer and Reifegerste (2025).

|[49] Health literacy refers to people's knowledge, motivation and ability to find, understand, evaluate and apply relevant health information in order to make informed decisions about care, prevention and health promotion in everyday life. See Jordan (2023).

health. |[50] From the WR's point of view, **society as a whole** needs to make **a concerted effort to communicate** with various actors from politics, public health institutions and academia and involve patient and stakeholder representatives as well as other experts. This will enable informed health decisions and promote the acceptance and use of scientific findings through health communication that is sensitive to target groups and contexts.

In order to **provide reliable information**, it is advisable to improve collaboration between higher education institutions, non-university and departmental research institutions and the ÖGD. Scientific institutions are essential for gaining insight into the factors that influence the development of certain clinical presentations, as well as those that hinder preventive behaviour. These findings need to be linked more closely with regional and local authorities, such as health authorities or the BIÖG, which acts as a nationwide health communicator, in order to communicate them effectively to the public and develop evidence-based interventions.

To strengthen the focus on prevention and health, services must be well-known, accessible and practical, but also systematically adapted to various living environments. They must also be optimised in terms of their effectiveness at being participatory, barrier-free and fair.

The WHO's **Behavioural and Cultural Insights (BCI) approach** provides a suitable framework for this. |[51] The aim is to understand human behaviour in order to promote the health of all. Combining behavioural and cultural sciences, the approach tailors health policy, services and communication to improve outcomes and reduce inequalities. The methodological core consists of four phases – **situation analysis, research, intervention design as well as implementation and evaluation** – which are similar to the Public Health Action Cycle. |[52] The approach is complemented by the development of programme theories that enable a systematic understanding of the mechanisms of action of interventions and their implementation. |[53] These theories describe how an intervention is

| 50 One example is the multi-year study "Health Literacy in Germany (HLS-GER)", conducted by Bielefeld University. This study showed that health literacy initially deteriorated between the first study cycle in 2014 and the second cycle in 2020. The study revealed social gradients in health literacy distribution and showed that dealing with navigation-relevant information, i.e. the ability to orientate oneself and find one's way around the health system, was particularly difficult, particularly with regard to digital health literacy. See Schäfer; Berens; Hurrelmann (2023). The results of the HLS-GER study, published in 2025, show a slight improvement, but only among population groups that are better off socially and financially. Finding one's way around the health system remains difficult. See Bielefeld University (n.d.).

| 51 See Snijders et al. (2025).

| 52 See Ewert (2025).

| 53 See Skivington et al. (30 September 2021) and Chen et al. (2018).

expected to produce its effects and under what conditions, thereby linking the Theory of Change and the Action and Change Model (which describe how interventions are implemented and why they work). Such a theoretical foundation supports both the planning and evaluation of complex implementation processes and interventions.

The BCI approach is politically supported by the WHO's global resolution on Behavioural Sciences for Better Health (WHO76.7, 2023), in which member states agreed, among other things, to mainstream behavioural science approaches, establish relevant units and functions and build evidence, expertise and capacity. At the European level, the regional resolution (EUR/RC72/R1, 2022) sets out a five-year action framework comprising strategic commitments, national contact points and regular reporting. This means that **target group orientation, impact orientation and participation** are operationalised in a binding manner, for example through evidence gathering, co-design, pre-testing and evaluation prior to broad implementation and scaling.

Health communication and health literacy reinforce each other by translating local insights regarding factors that promote or inhibit health-related behaviour into understandable, accessible and culturally sensitive messages, thereby facilitating the navigation of the health care system. This approach is particularly effective in combination with structural adjustments, such as simplified access, price and advertising regulation as well as improved service pathways. The BCI approach explicitly emphasises the **shared responsibility** of individuals, governments and health systems. For programmes, this means adopting a **package logic instead of individual measures**. |[54] Therefore, communication components should be linked to structural measures, and behavioural and structural prevention should be planned and implemented jointly.

Current evidence from Germany shows, for example, how nutrition can perpetuate social inequalities in behaviour. |[55] Strategies that combine regulatory and behavioural instruments with target-group-specific communication are effective. Measures to reduce inequalities require **disaggregated data**, as aggregated data often masks inequalities. |[56] Only with personalised, high-resolution data can particularly disadvantaged subgroups be specifically identified and taken into account appropriately.

Internationally, **institutionalised models** such as the Behavioural Science Unit at Public Health Wales are proving successful. |[57] There, behavioural science

| 54 See Snijders et al. (2025), Ewert (2025) and WHO (20 April 2023).

| 55 See Pedrós Barnils et al. (2025).

| 56 See Snijders et al. (2025).

| 57 See Gould (2025).

consulting, competence building, research/evaluation and system integration are permanently anchored. Their working methods include: (1) collecting, analysing and evaluating motivation and behaviour; (2) providing practical recommendations to decision-makers; (3) offering rapid feedback on materials, measures and products during development and implementation; (4) system-wide competence-building in behavioural science; (5) advocacy, engagement and awareness-raising to embed the approach; and (6) offering technical and methodological support to implementation teams in their day-to-day work. The aim is to improve **the efficiency**, **effectiveness and fairness** of measures within the health care system. The WR recommends that Germany should adopt similar institutionalised structures.

Regarding the institutional **networking of prevention research and the translation of its results**, even beyond health communication and information, there is currently a **gap in Germany**: scientific institutions (including departmental research) are not sufficiently networked with public health institutions. Unlike in other countries, Germany does not have a single institution, such as a national public health institute, that links the various activities. The two main institutions, each with their own specific tasks and responsibilities, are the RKI and, with a particular focus on health communication, the BIÖG (formerly: Federal Centre for Health Education – BZgA). There are also other departmental research institutions and institutes that deal with aspects of public health. |[58]

III.2 Recommendations

_ **Combine networking competencies and responsibilities in a national coordination centre:** Unlike in other countries, Germany does not yet have an institution mandated to link prevention research and its translation across various scientific institutions and with public health institutions. In the view of the WR, consideration should be given to how this **institutional gap** can be **filled** in order to **network and coordinate research and translation as well as health communication and information** on prevention and health promotion in the sense of a national public health institute. |[59] An **external evaluation** could be helpful in this regard.

_ **Pooling data and translation**: In the opinion of the WR, higher education institutions, non-university and departmental research (especially the BIÖG and

| 58 These include the BfArM, the Paul Ehrlich Institute (PEI) and the Institute for Quality Assurance and Transparency in Health care (IQTIW), see Scientific Services of the German Bundestag (2023).

| 59 In general, national public health institutes serve as central bodies through which countries can organise and network activities in the field of public health, thereby improving opportunities for collaboration and, thanks to their scientific orientation, the efficiency and effectiveness of measures. See CDC (3 September 2025).

the RKI) as well as federal states and public health services should collaborate within a **national BCI network** with clear mandates. This would enable the establishment of uniform, interoperable data and interface standards; joint, comprehensible health and behaviour reporting for the public and decision-makers; and structured feedback loops between local practice and national governance.

_ **Addressing living environments in an evidence-based manner:** Different living environments and realities must be systematically surveyed and translated into measures within co-design processes together with the relevant target groups. **Children and young people** should be given appropriate consideration throughout their lives. Particular attention must be paid to the spectrum of adverse childhood experiences, their effects on mental and physical health in adulthood and intersectoral preventive measures, e.g. in education and child and youth protection. |[60] At the same time, **targeted (secondary) prevention and health promotion** for **older people**, and **disadvantaged subgroups** in particular, should also be strengthened.

_ **Linking communication with structure:** According to the WR, health communication must be consistently linked to structural and environmental adjustments (e.g. the food environment, advertising, price and availability signals as well as service paths |[61]). This will help to achieve the goal of reducing social **inequalities** by combining regulatory, service-related and behavioural instruments.

_ **Applying package logic instead of individual measures:** Incentives, target-group-oriented communication and the promotion of health, media, information and data literacy should be implemented as an integrated package alongside structural measures (e.g. availability, price/advertising regulation and service access). These measures must be designed using a theory of change such as **capability, opportunity and motivation (COM-B)** and tested in relevant subgroups before implementation.

_ **Ensuring competence development for BCI and knowledge transfer:** The WHO's BCI approach enables health policy, services and communication to be tailored to different target groups, taking socio-cultural conditions into account by using findings from behavioural and cultural sciences. For ÖGD, care providers and practitioners, **binding continuing education pathways** should be created for the **qualified consideration of the BCI approach** in practical work and the socially and culturally sensitive orientation of health

| 60 See Bellis et al. (2023).

| 61 Service pathways, also known as care pathways, are structured, coordinated routes that guide people through the health care system. They describe the physical and organisational routes through which people access health care services. This also includes digital information pathways and channels.

programmes. The WHO's Tailoring Health Programmes (THP) guide can be helpful for this purpose. | [62]

_ **Establishing risk communication as dialogue**: Risk education must be **understandable, low-threshold and dialogue-based**, e.g. involving patient representatives and citizen panels. The **ÖGD** should act as a **multiplier** in people's everyday lives and as a feedback channel, while scientific institutions should provide evidence and evaluations. Real-time monitoring such as sentinel panels/cohorts, quantitative and representative monitoring, and the pre-testing of communication measures can enable rapid adjustments. As the WR sees it, this also requires a consistent equity perspective and transparency about existing uncertainties.

_ **Aligning data visualisation with behavioural relevance**: Reporting systems and dashboard formats (at the federal and state levels) should integrate **behaviour-related indicators and equity sections** for the appropriate categorisation and breakdown of reports by subpopulations and **evaluation feedback**. Content must be tailored **to specific user groups** (e.g. the public, practitioners and politicians) and reviewed and updated regularly. The potential applications of generative AI models in supporting visualisation and reporting formats should be examined.

B.IV STRENGTHENING PREVENTION AND HEALTH PROMOTION IN RESEARCH, HIGHER EDUCATION, KNOWLEDGE TRANSFER AND INNOVATION

IV.1 The Problem

From the WR's perspective, health research also needs to undergo a paradigm shift, focusing more strongly on prevention and health promotion rather than highly subspecialised "repair medicine". This requires a clear **commitment to interdisciplinary collaboration in research and higher education** as well as a **multidimensional understanding of knowledge transfer**.

The **German research landscape** on prevention and health promotion (see chapter D.IV) reveals a complex picture: various leading institutions – both university and non-university – are already addressing these issues. The focus is primarily on **medical research** that investigates **personalised or personalisable parameters** of disease progression and health maintenance, for example in molecular and genetic research. These institutions include Helmholtz Association (HGF) research institutions in the Task Force on Prevention, thematic research networks such as the DZG and institutional and cross-organisational institutions of university medicine. Currently, an interdisciplinary and interprofessional

| [62] See WHO (20 April 2023).

concept of prevention plays a largely subordinate role for these institutions and networks (see also chapters D.IV.1 and D.IV.2).

Research areas such as **public health and prevention research** as well as the increasingly important development of real-world data methodologies – but also **health, social and behavioural sciences**, which focus on holistic aspects of the status and development of population health rather than personalised individual health parameters – all currently stand disconnected from each other. An important actor is **health services research**, which examines the function and quality of health-related public services at the system level, the institutional and organisational levels and the patient level (see chapter D.IV.1). |[63] To exploit the full potential of prevention and health promotion, there needs to be **greater collaboration** between actors conducting research into molecular prevention and those conducting research into health and health development of the population as a whole. Only through the systematic exchange of knowledge and methods can personalised approaches and population-based perspectives be integrated. The aim is to develop effective, evidence-based strategies for health promotion at the individual and societal levels and to support their implementation. According to the WR, this requires the **interaction of various scientific disciplines**. Alongside epidemiology, biometrics, statistics and health services research, the following disciplines play an important role in both prevention itself and the implementation and evaluation of prevention projects: psychology (including health and prevention psychology); health sciences (midwifery, nursing and therapy sciences); sociology; and other social, economic, behavioural and communication science disciplines. These disciplines help to identify factors that either promote or hinder the implementation of prevention projects at individual and societal levels. According to the WR, there is currently an **insufficient connection** between social, behavioural and communication science disciplines and clinical medical disciplines in research and teaching. The same applies to interfaces with health sciences (midwifery, nursing and therapy sciences) and to public health and health care research within medicine.

According to the WR, **medicine and health sciences** (midwifery, nursing and therapy sciences) in particular must also become more aware of **non-medical influencing factors**, such as environmental factors, loneliness and social factors such as poverty etc. and take a more consistent biopsychosocial approach. This requires intensive interdisciplinary collaboration to improve knowledge transfer in disease prevention and health promotion. Furthermore, there is a lack of interdisciplinary expertise in communicating evidence-based prevention in all medical disciplines, and this area of **competence-building** should be strengthened from higher education onwards. Even in **dentistry**, a field that has seen widespread implementation and use of preventive measures, particularly in caries

| [63] Health sciences (midwifery, nursing and therapy sciences) also address issues of health service research.

prophylaxis, in recent decades, there is a need for more interdisciplinary research into the link between cardiovascular disease, periodontitis and tooth loss. |[64]

In addition to placing a stronger focus on prevention and health promotion in research and teaching, direct implementation in specific **areas of application** must also be considered. This requires closer collaboration with public health institutions of the ÖGD and departmental research as well as better internal scientific networking. The aim is **multidirectional translation** with feedback mechanisms between practice and theory ("from bench to bedside and community and from community to bench" |[65]). Practical implementation experience gives rise to new scientific questions and innovative approaches to obtaining evidence.

Scientific guidance and support are required for the development of evidence-based indicators and measures for effective disease prevention and for their subsequent application, measurement and review. Ultimately, the aim must be to establish an evidence base by systematically recording the effects of various prevention measures and approaches empirically, and to identify the characteristics of successful prevention. |[66] According to the WR, great potential therefore exists in the field of **implementation research** that is not yet being sufficiently exploited: while the transfer of basic research into guidelines already works well in many areas, strategies for transferring it into everyday care and for systematically learning from successes and failures ("learning health system") are lacking (see also chapter B.II). **Systematic implementation research and support** for the implementation of preventive measures should be a regular part of the measures and should also include processes, including de-implementation processes for measures that are not promising.

The tasks and institutional structure of **the ÖGD** in Germany are highly diverse and require review in terms of roles and functions. The infrastructural, financial and personnel strengthening enabled by the Pact for the ÖGD |[67] and the increased public awareness during the COVID-19 pandemic represent an opportunity here, provided the resulting improvements can be anchored for the long term. The ÖGD's strengths lie in its regional and local networking and expertise, and it can play a supporting role in addressing target groups in this area. In its current institutional constitution, the ÖGD is not yet broadly compatible as a

| 64 See the National Association of Statutory Health Insurance Dentists; the German Dental Association (17 March 2025).

| 65 See also: Ogilvie et al. (2009).

| 66 See also the German Medical Association (BÄK) (2025), p. 44 f.

| 67 See the Federal Ministry of Health (2023).

scientific collaboration and implementation partner, especially at the local level. | [68] Its fundamental orientation should be **more science-based**. This must be accompanied by extensive training in applying scientific knowledge and a strengthened culture of transfer and translation. The steps already initiated by the Pact for the ÖGD, such as the creation of ÖGD bridge professorships at universities, are helpful in this regard. There have been some initial successes, but further efforts are needed.

IV.2 Recommendations with a focus on research

_ **Broadening the concept of prevention in health research:** The WR welcomes the efforts evident in both higher education institutions and non-university research to address aspects of disease prevention in the sense of precision prevention (see chapter D.IV). A systematic approach to prevention and consideration of which subjects should be included has not yet been adopted in **higher education or non-university institutions** or only in a few isolated cases. The WR therefore encourages institutions to catch up in this regard. In particular, **scientific institutions engaged in cutting-edge research** should broaden the concept of prevention and create opportunities for collaboration with the fields of public health research, health services research and other health science disciplines.

_ **Expanding public health research:** In the view of the WR, **public health research** is a key driver of prevention research. The establishment of additional professorships and institutes for public health at higher education institutions could bolster this **scientific discipline** in Germany in terms of both concept and personnel.

_ **Pooling interdisciplinary research collaboration in prevention centres**: To make greater use of the potential for scientific collaboration for disease prevention and health promotion, and to combine it synergistically, the creation of **prevention centres** should be considered at **higher education institutions with medical, health science and psychology departments** (including their university outpatient clinics). The WR identifies the following potential for research and research-based care in this regard:

  _ **Promoting interdisciplinary collaboration:** Prevention centres can facilitate and strengthen **regular interdisciplinary scientific exchange** between relevant disciplines, including medicine, dentistry, health sciences (midwifery, nursing and therapy sciences), sports science, psychology, social and

| [68] The BÄK also sees the ÖGD and its institutions, in particular the medical staff, as key actors in strengthening public health. In this context, the overall decline in the number of specialists is perceived as worrying, and recruiting young talent in this area is seen as crucial. See German Medical Association (BÄK) (2025), p. 34.

behavioural sciences, social work, education and environmental sciences on a wide range of prevention research issues.

_ **Sharpening regional research profiles and priorities**: Depending on the respective university profile and non-university environment, prevention centres offer opportunities for integrating prevention research more closely into the research and clinical priorities of the respective locations, or for combining it through an interdisciplinary approach. For example, this could be achieved through scientific collaboration under the "One Health" approach (see chapter D.IV.1) or even the "Planetary Health" concept. |[69] This would mean that **regionally focused research priorities** could also emerge in prevention research which could also have links to the non-university research environment wherever possible. The National Cancer Prevention Centre (NCPC) in Heidelberg, initiated by the German Cancer Research Centre (DKFZ) and German Cancer Aid, could serve as a model for this. The University of Greifswald's (UG) profile in the field of One Health, in conjunction with the Helmholtz Institute for One Health (HIOH), which is currently being established, is also a significant example.

_ **Providing impetus for new therapeutic approaches**: Taking a more interdisciplinary approach to prevention research can also provide **new insights into therapeutic approaches and disease-, organ- and gender-specific research aspects**. For example, prevention centres could specifically investigate the positive effects of changing a health risk factor (e.g. lack of exercise, obesity) on patients. The example of smoking |[70] has already shown that quitting smoking has a positive effect on the treatment of lung diseases at any stage of therapy. This could also be scientifically investigated in other areas.

_ **Supporting regional developments in public health**: New findings on therapeutic approaches mean that prevention centres at university medical centres in particular can now directly influence **regional health care practices**. This allows them **to support** and promote the **health of the**

| 69 Planetary health is a scientific concept that describes the dependence of human health on the health of ecosystems. The aim is therefore to examine how different ecosystems are interconnected and the factors that threaten them, such as species extinction and air pollution. Classifying these complex interactions and tipping points requires collaboration between various scientific disciplines, including health sciences, social sciences, natural sciences and behavioural sciences. See the KLUG German Alliance on Climate Change and Health (no date provided).

| 70 See El-Haddad et al. (2025).

population in an evidence-based manner, in line with the "fourth pillar". |[71] However, these incentives should also be reflected in the list of services and tasks performed by university hospitals. Against this background, it is important to review the existing incentive and financing mechanisms of the health system with regard to their incentive effect on prevention and health promotion (see chapter B.VI).

- **Ensuring coordination and networking**: Valuable insights can be gained from both effective and ineffective prevention measures alike. These insights should be used to further develop best practices and provide them with a scientific basis. It is crucial **to network all actors systematically** in prevention research, regardless of their regional location, and to break down silo structures within the field. This includes networking universities with non-university institutions and research networks such as the DZG. The WR recommends that prevention centres in Germany be networked with existing structures (see chapter B.III).
- **Ensuring links between prevention centres and practitioners and committees**: Strengthening the collaboration between academic theory and practice is also important, for example with **the ÖGD**. To this end, prevention centres should participate in **health conferences of the federal states**, where they exist. In addition, regular networking and information events, as already planned in some federal states, are a good idea. |[72]

- **Structurally developing and expanding implementation research**: In Germany, the field of implementation research is underdeveloped. According to the WR, systematic implementation research and support for the implementation of prevention measures must be an integral part of the development, implementation and monitoring of prevention and health promotion measures. This should also include processes enabling less promising measures to be redesigned or discontinued. To this end, the field of research must be strengthened and developed further, both structurally and in terms of personnel. This includes the targeted expansion of chairs and research structures in the field of implementation research, as well as the systematic development and theoretical underpinning of interventions, including the planning of outcomes, mechanisms of action and contextual conditions. It is also necessary to

| 71 The WR sees an opportunity for university medicine to take on systemic and future tasks ("fourth pillar") in regional health care and help shape its strategic development, building on the range of activities and services in the classic triad of research, teaching and patient care. These systemic and future tasks include measures for health system coordination, networking, control, quality assurance, political consultancy and science communication, for example. See WR (2021), p. 66.

| 72 In Bavaria, for example, the "Master Plan for Prevention" published in autumn 2025 plans to organise an annual prevention day.

investigate factors that **promote or inhibit** implementation as well as to conduct feasibility studies prior to large-scale efficacy studies. **Participatory research approaches** are of central importance here, involving all relevant stakeholder groups across age groups (especially children and young people), genders and social situations from the outset and throughout all phases of research, in order to consider needs, requirements and contexts appropriately.

_ **Developing a causal methodology for the health economics evaluation of prevention measures and create comparability:** When researching the effectiveness of prevention and health promotion measures, the economic aspects of cost development and efficiency should also be considered. Stringent **causal health economics methods** for evaluating prevention and health promotion measures need to be developed. Specifically, health economics evaluations should also be an integral part of all prevention projects so as to track effects, build evidence and demonstrate the economic and financial co-benefits of prevention measures. In future, the development, implementation and monitoring of measures could, for example, be staggered across **countries and different regional settings** to generate opportunities for comparison.

_ **Strengthening the scientific status of prevention research:** A longer time horizon is required to demonstrate effective results in prevention research. This can conflict with the reputation logic of the scientific system. To increase the **visibility and status of prevention research**, **professional associations** should devote more attention to this topic. For example, they could do this through awards, scientific publication series, statements or by making it a focus at specialist conferences and in related communication and public relations work. The topic should also be given greater consideration in the medical guidelines of the Association of Scientific Medical Societies (AWMF).

_ **Strengthening support for prevention research:** Currently, there is a gap in Germany in terms of **programmatic funding opportunities** for prevention research and research on health promotion measures. Respective programmes and funding guidelines should also incentivise various scientific institutions to collaborate with public health institutions to strengthen the implementation of measures and the associated impact assessment. In addition to **public third-party funding providers** (the federal government, federal states or funding organisations), **privately financed funding formats** (including foundations) should also be encouraged, not least because of the economic and societal implications of a stronger focus on prevention and health. With a particular view to innovative care and treatment concepts, the **scope of funding provided by the Innovation Fund** should also be expanded to include the topic and field of action of prevention (see chapter B.VI).

_ **Strengthening the scientific orientation and resources of the ÖGD:** The public health service institutions are also of great importance for science and research. Their networking with higher education prevention research appears

to be just as expandable as the **scientific orientation of public health services** (especially state and health authorities) **itself**. Institutions of the ÖGD have specific access to vulnerable groups, enabling prevention research to target specific groups more effectively. Greater involvement of the ÖGD would also ensure the application of research results in practice (see also chapter B.IV.4). Therefore, it is important to **expand research capacities within the ÖGD** and to recruit more staff for research-related activities. The WR expressly supports the efforts to this end set out in the Pact for the ÖGD and the relevant demands of the Advisory Board of the Pact for the ÖGD. |[73]

IV.3 Recommendations focusing on higher education studies and teaching, as well as on vocational training and continuing education

_ **Designing interdisciplinary curricula: Curricula** in medical and health science degree programmes should have stronger interdisciplinary links to relevant fields such as education, health psychology, health communication, therapy as well as sports/movement and nutrition sciences. Individual medical departments and higher education institutions should examine appropriate options, taking into account and utilising the **department's profile**, **research priorities** and the **teaching and qualification spectrum of the entire higher education institution** when determining their respective orientation and focus. This is particularly relevant with regard to the interfaces between medicine and the health sciences (midwifery, nursing and therapy sciences), as it opens up new options for achieving individual therapy goals for patients on a collaborative basis (see chapter B.V) and establishing them in practice. This would enable the necessary mutual basic knowledge and awareness of treatment and intervention potential in health promotion to be anchored within different professional groups in future specialists from an early stage in their studies, and to sensitise them to this.

_ **Strengthening a prevention-oriented attitude during higher education degree courses**: Furthermore, the current integration of prevention aspects into the **learning objectives of medical and health professional study programmes**, as well as psychology programmes, should be reviewed. Here, the focus should shift from measurable treatment aspects, such as rehabilitation measures, to **strengthening a prevention-oriented attitude in professional practice**, including by deepening the teaching content on health promotion and communication. Department heads at universities, interdisciplinary dean

| 73 In its third report on the key topic of "Science and research in and for a sustainable ÖGD", the advisory board to the ÖGD Pact called for the ÖGD to be given a stronger internal scientific position (e.g. by expanding health authorities to include teaching and research responsibilities) and for collaboration with universities and non-university institutions to be intensified (e.g. through professorships, bridge professorships and cross-disciplinary calls for applications). See Advisory Board to the ÖGD Pact (ed.) (2023).

conferences and the Medizinische Fakultätentag (MFT), should actively support this.

_ **Integrating prevention skills as a building block in education and training**: Later stages of training and continuing education for medical professionals or scientists in other medical-related disciplines, psychologists and health professionals should include modules to broaden their competence in preventive measures, e.g. through certified **continuing education and training courses**. This should also include addressing issues of health promotion and communication. The German Medical Association (BÄK) and the Chambers of Physicians in the various states, as well as other relevant professional associations should consider offering such courses.

_ **Creating interdisciplinary courses**: Degree programmes for **therapeutic** or **social professions** should teach profession-specific knowledge on prevention issues and their own approaches to health promotion. Depending on their classification, the **curricula** of these degree programmes should combine knowledge and learning objectives with medicine for specific clinical pictures, either within the department or across departments, where appropriate. Organising relevant lecture series or, if necessary, interdisciplinary and interprofessional teaching teams should be considered.

_ **Establishing higher education institutions as actors in health promotion**: Students, in particular, but also other interest groups of higher education institutions, are increasingly exposed to **psychosocial stress**. As employers and in terms of providing the structure of studies and teaching, higher education institutions can influence the development of a **work and teaching/learning culture conducive to good health**. Higher education institutions should be aware of this area of action. Existing approaches should be strengthened, for example by offering more flexible study programmes and teaching and learning formats that better adapt to students' different needs, as well as integrating physical activity interventions into teaching. |[74]

IV.4 Recommendations focusing on transfer and translation

_ **Strengthening collaboration between scientific institutions and the ÖGD**: Existing structures such as the DZG, non-university and departmental research institutions as well as higher education institutions should be used as **collaboration partners of the ÖGD**, and contacts should be expanded. This is particularly important in health communication as well as in science-based policy advice (see chapter B.III).

| 74 The WR reserves the right to address these issues elsewhere, including with regard to the (psychosocial) situation of students.

_ **Establishing multidirectional transfer and translation pathways:** Studies and research conducted by scientific institutions should focus more on providing direct links to the ÖGD so as to enable **multidirectional transfer and translation activities**. Not only should the **ÖGD** be involved in primary prevention projects, but it should also strive for broader, **networked collaboration with scientific actors**. For example, the ÖGD could be included in controlled intervention studies. From the perspective of the WR, the reverse translation of findings from the practical work of the ÖGD back into science could contribute to the development of new research approaches, strengthening prevention research in the long term and promoting the translation ("bench to bedside and community") of scientific findings into areas of application (e.g. medicine or nursing). This requires the development of structured feedback processes and collaboration structures. Broad competence building in the application of scientific findings and a strengthened transfer and translation culture are also required.

_ **Expanding ÖGD bridge professorships:** The WR considers the **ÖGD bridge professorships** established by the federal states with federal funds from the ÖGD Pact to be an important and welcome step towards strengthening the exchange and collaboration between the ÖGD and scientific institutions. However, there are not enough of these professorships; further expansion at medical universities would be desirable.

_ **Promoting institutional networking and multidirectionality:** Institutions such as the existing **BIÖG** could provide an opportunity to promote **networking and multidirectionality**. For this purpose, the structure and remit of the BIÖG must be well designed and further developed for this purpose (see chapter B.III).

_ **Exploiting the innovation potential of health data science:** According to the WR, **health data science** and the processing and analysis of various medical data carried out in this field, including in connection with machine learning practices – from clinical data and ePA databases to motivational data from wearables – also holds **considerable innovation potential** for answering scientific questions related to prevention. In the field of health data science, prevention aspects should be considered in research and translation projects.

B.V STRENGTHENING PREVENTION AND HEALTH PROMOTION IN INTERPROFESSIONAL AND INTERSECTORAL CARE

V.1 The Problem

The WR views prevention as a **cross-sectional task** that can only be successfully addressed through the collaboration of various actors. From the WR's point of view, **interdisciplinary** and **interprofessional networking** is of particular

importance. This strengthens the long-term application of scientific findings and their transfer into practice, e.g. into care measures and political, social or educational interventions. Systematic implementation support, which provides an overview of successes and areas requiring adjustment, as well as interprofessional and interdisciplinary exchange, are essential for achieving **learning effects from practice**. The planned prevention centres (see chapter B.IV.2) could provide a suitable structure for promoting this, both within the scientific community and as a central point of contact for regional actors, such as those from the ÖGD.

Prevention should also be understood as **a team sport** in professional practice and seen as **an opportunity for specialists**. |[75] New job profiles and prospects can be developed for medical professionals, but also for other areas related to health care and public health. These involve all health care professions and other professions outside the health care sector, such as social work or education. |[76] The academisation of the therapeutic professions and nursing offers considerable opportunities that should be widely exploited. |[77]

For **academically qualified health care professionals** in particular, tasks in the area of prevention and health promotion offer academically qualified health care professionals the opportunity to establish independent professional fields that complement the health care system in a meaningful way thanks to their specific skills. One example is the role of **the community health nurses (CHN)**, who act as a key point of local contact for health and nursing matters. One main focus of their work is on health promotion and prevention. CHNs help to identify and address gaps in preventive care and treatment at an early stage. Many health problems are caused not by acute illnesses or chronic conditions, but by structural or preventative deficits, e.g. medication management. This is where CHNs come in, developing patient-oriented approaches, strengthening health literacy and thereby contributing to a sustainable improvement in care. |[78]

Public Health Nurses in Finland

The profession of public health nurse (PHN), similar to the CHN profession developing in German-speaking countries, has existed in Finland for over 100 years. Until 1970, the profession was known as “health sister”. |[79] The role is

| 75 This is evident, for example, in the case of interprofessional specialists working in the field of preventive home visits in over 40 cities, municipalities and local authorities in Germany.

| 76 See also the statement by the German Nursing Council from autumn 2025. See German Nursing Council (2025).

| 77 See WR (2023c).

| 78 See Kozisnik; Edtmayer; Rappold (2021) and Gasperini et al. (2023).

| 79 See Saastamoinen; Putkuri (2024).

especially well-established in Finland, even compared to other Nordic countries. This is particularly evident in the areas in which PHNs work. While PHNs in other countries are often assigned to specific target groups, in Finland they support the population throughout their lives, from birth to elder care. They work in maternity and children's clinics, occupational medicine, home care, educational institutions, health centres and other health care organisations. |[80] This interdisciplinary work is already reflected in their training: relevant subjects include health promotion, family medicine, occupational therapy, community health, paediatrics, adolescent medicine, obstetrics and practical clinical placements. |[81] Finnish PHN training provides professionals with a broad range of expertise and offers a wide variety of career opportunities.

In Finland, PHNs are also known as "experts in promotion and prevention" reflecting their high status. |[82] Since 1972, the employment of PHNs in health care facilities has been required by law. For instance, PHNs may accompany children from birth until they start school or from the start of school until the age of 16, providing them with personalised health-promoting care throughout this period. Through their dedication and proximity to patients, PHNs contribute to both individual and general health promotion. In addition, life-stage-related care helps to minimise non-communicable diseases and increase health literacy, among other things, thereby reducing the burden on the entire health system. |[83]

In addition, there is also potential in medical professions |[84] and within the medical and social sectors (including psychology, therapy and sports) that has not yet been sufficiently exploited in Germany. The draft bill on the further development of pharmacy care (ApoVWG) presented in autumn 2025 |[85], and the approaches it contains for explicitly transferring preventive tasks to pharmacies – such as providing counselling and measuring cardiovascular risk factors and

| 80 See Alstveit et al. (2021), p. 272.

| 81 See ibid., p. 274.

| 82 See Saastamoinen; Putkuri (2024) and Hussein et al. (2024).

| 83 See Grym; Borgermans (2018).

| 84 See also the German Medical Association (BÄK) (2025), p. 44 f. Among other things, the German Medical Association (BÄK) advocates providing better support to the medical profession in its existing tasks, e.g. in occupational health and safety, but also in facilities for children and adolescents, and removing barriers.

| 85 See the Federal Ministry of Health (20 October 2025): Draft bill ApoVWS, URL: https://www.bundesgesundheitsministerium.de/service/gesetze-und-verordnungen/detail/apovwg.html, last accessed on 14 November 2025.

administering vaccinations (except live vaccines) – should also be mentioned as an example of interdisciplinary collaboration in the field of prevention.

The role of general practice in the health care system in the Netherlands

General medicine plays a central role in the country's health care system. General practitioners are responsible for coordinating care and promoting interprofessional collaboration, as well as identifying health risks. While secondary and tertiary prevention clearly fall within their remit, primary prevention is more closely associated with public health and politics. A key area of action is the early detection of health risks, e.g. in children at risk of obesity. However, there is a shortage of qualified personnel to implement prevention services across the board. Pilot projects are attempting to achieve targeted patient referral through the use of guides.

In the Netherlands, general practice is structurally anchored in various policy areas and regulatory systems that extend beyond health care, including the Health Insurance Act (Zorgverzekeringswet), the Long-Term Care Act (Wet langdurige zorg), the Social Support Act (Wet maatschappelijke ondersteuning), and the Youth Act (Jeugdwet). |[86] These legal foundations define responsibilities within the health care system and the role of general practitioners, who act as gatekeepers for access to specialist or inpatient care, forming a cornerstone of the Dutch health care system. At the same time, there is a significant shortage of general practitioners, particularly in rural areas, which makes it difficult to maintain continuity of care and regional ties.

Primary care and research

In the Netherlands, integrating general practice with scientific research and teaching is essential for providing high-quality primary care. The Department of Primary and Community Care at the University Medical Centre Groningen (UMCG) in Groningen exemplifies this approach by closely integrating practice and science. This allows research results to be directly incorporated into patient care, new care models to be tested and innovative prevention projects to be implemented. One example of this successful networking is the Vitaal Groningen network, |[87] which brings together various stakeholders, including general

|[86] Together with the Public Health Act (Wet Publieke Gezondheit), these four pillars form the structure of the Dutch health care system. Although this act is not one of the four central legal pillars of general medicine, it is nevertheless considered one of the five so-called "Stelselwetten" (system laws that structure the health care system). See Wessels et al. (2018), p. 79.

|[87] The Vitaal Groningen network forms part of the second task area, "More prevention, well-being and community", and aims to promote a healthy working population in Groningen to boost the region's economy. To achieve this, two types of needs assessment are prioritised: area-specific experiments involving community

practitioners, nursing professionals, researchers, local authorities and citizens' initiatives, and promotes exchange between scientific research, practical care and prevention projects. Another example is the Aletta Jacobs School of Public Health at the University of Groningen, which acts as a bridge between researchers, teachers, citizens and professionals within and outside the health system. The school focuses on citizen science and various formats of science communication.

The concept of research nurses also illustrates the close interconnection between primary care and science. These nursing professionals have advanced research skills and contribute to research projects by incorporating nursing science issues, designing and conducting studies with interprofessional teams. They integrate scientific and methodological findings into clinical practice, making a significant contribution to the systematic transfer and further development of nursing science evidence in everyday primary care. General practices range from individual practices to larger care units with several doctors and multidisciplinary teams. These structures enable the differentiated implementation of innovative care and research approaches, benefiting both scientific development and patient-oriented care.

Regarding specific care services, developments towards **a tiered approach to care** should also be mentioned. These should start as early as possible so that certain symptoms do not occur in patients or so that they may be addressed through different, interlinked treatment pathways that respond to specific requirements and needs. The demands of *the Mental Health Alliance* |[88] illustrate this approach, as they aim to transform mental health care, especially for young people, by creating a tiered care system based on an integrative, preventive care chain. The objective is to differentiate between various levels of mental illness prevention and to treat and manage them in a manner tailored to the individual situation. |[89]

participation and ownership, and experiments targeting specific groups at municipal and provincial levels. Individual measures are developed based on the specific assessment. See the Netwerk Gezond Groningen (2023).

|[88] The Mental Health Alliance is a civil society-led coordinating network. The network's goal is to contribute to the structural development of Germany's mental health system, particularly with regard to prevention, equitable care, and cross-sectoral collaboration. See Lobby Register (08/09/2025): Mental Health Alliance, in: German Bundestag. URL: https://www.lobbyregister.bundestag.de/suche/R007579/63710, last accessed on 13 November 2025.

|[89] This includes universal prevention (e.g. resilience training and destigmatisation of mental illness for all people), selective prevention (e.g. for risk groups such as children of stressed parents) and indicated prevention (e.g. through digital services) at the first signs of illness, as well as inpatient, outpatient or hybrid treatment and aftercare. See Mental Health Alliance (2025).

_ **Involving private practices in research:** With regard to private medical practices, primary care specialists such as general practitioners, internists and paediatricians in Germany should be **more involved in research and the implementation of preventive measures**, e.g. through **functional research practice networks**. The German Research Practice Networks Initiative DEGAM-ForNet |[90], which connects general medical university locations with research practices across locations and networks, is an example of a network approach with great potential for the field of prevention research. Where possible and appropriate, this should **also** be extended **to other non-medical professional groups**, particularly psychologists and health science professionals (midwifery, nursing and therapy sciences).

_ **Systematising interdisciplinary exchange:** To develop **collaborative therapy goals** and achieve a holistic understanding of health, different professional groups should regularly participate in **joint case discussions and care structures** and learn from each other. This can have positive health effects, particularly when targeting vulnerable groups specifically, e.g. through health centres |[91], or across society, e.g. Finnish family centres, Neuvola |[92] . From the perspective of the WR, greater **interprofessional collaboration** would also prioritise health orientation and promote a cultural shift in this direction. Scientific prevention centres at universities can also contribute to networking.

_ **Examining the institutionalisation of innovative interprofessional care models:** Examples from other European countries demonstrate the health-promoting effects of **systematic interprofessional collaboration**. One example is Finland's family centres (Neuvola) for child and adolescent health. These centres demonstrate that such measures are particularly effective when they are established as **systemic components** of society, rather than as **project-dependent initiatives**. In Germany, a change of direction is necessary in this sense, with a focus on **strengthening supporting implementation research in a**

| 90 See Initiative Deutscher Forschungspraxennetze (German Research Practice Networks Initiative), URL: https://www.degam-fornet.de/initiative/ueber-uns, last accessed on 7 January 2026.

| 91 See, for example, the health centres in Hamburg (https://www.hamburg.de/politik-und-verwaltung/behoerden/sozialbehoerde/themen/gesundheit/stadtteil-gesundheitszentren), last accessed on 7 February 2026.

| 92 Family centres (Neuvola) form part of the general health care system in Finland. The centres focus on giving all children in Finland a healthy start in life. They support, accompany and advise families from the moment of pregnancy through all stages of early childhood and into adolescence, regardless of socio-economic status. This concept has existed since 1922, and infant and maternal mortality rates have decreased in Finland (e.g. the average infant mortality rate was 29.7 infant deaths per 1,000 live births in 1955, compared to 1.8 in 2021). See De Carvalho (2022).

systematic way to gain a more detailed understanding of the potential impact and consolidation of new interprofessional approaches and care models.

_ **Making more systematic use of lessons learned from Innovation Fund projects:** From the WR's perspective, temporary model projects, such as those made possible by the Innovation Fund of the Joint Federal Committee (G-BA), are to be welcomed as a means of testing new care approaches over a limited period of time. Nevertheless, **learning effects from the successes and failures** of such projects must **be used** far **more systematically** to inform the consolidation of proven structures and approaches or the readjustment or dissolution of such projects (de-implementation) (see also chapter B.III). The "Communities that Care" platform is an example of this. |[93]

B.VI CHANGING SYSTEMIC FINANCING AND INCENTIVE MECHANISMS AND CREATING RESOURCES

VI.1 The Problem

At the societal level, health is influenced by framework conditions, regulations and incentives from various sectoral subsystems. While health and social systems are central, other sectors such as agriculture and food, education, the environment, transport and mobility should also be considered. In line with the Health for All Policies concept (see chapter B.I), a genuine focus on health requires different efforts related to everyday life, such as in transport policy, urban development and planning as well as the provision of educational facilities. In particular, commercial health determinants, which are also key drivers of non-communicable chronic diseases, must be addressed through the regulation of various sectoral subsystems. Germany still has considerable ground to make up in this area (see chapter D.III.2.a). However, action is also needed in terms of incentive design and resource management within the health system.

In terms of the **business case** for **prevention and health promotion**, Germany is facing a structural problem: there are currently insufficient economic incentives or structures to encourage a stronger focus on these areas. For instance, clinics do not yet have a viable business model for preventive measures. Therefore, consideration should also be given to what appropriate **financial incentives** might look like, and how these could be reflected in the relevant social security codes – particularly SGB V (statutory health insurance), VII (statutory accident insurance) and XI (statutory nursing care insurance). According to estimates by the German Psychotherapists Association (DPtV), preventive measures

| [93] See Communities That Care, URL: https://communities-that-care.de/

in the field of psychotherapy are also not yet being used sufficiently, in both individual therapy and workplace health promotion, for example. |[94]

In addition, fundamental questions arise regarding the **financing and burden sharing** between the various actors. Health-promoting financial services are currently regulated and mandatory under the SGB for health and nursing care insurance funds as well as for statutory pension and accident insurance funds. Nevertheless, private health insurance companies voluntarily contribute 22 million Euro annually to prevention and health promotion measures, thus fulfilling the legal requirements for participation in the NPK. However, these benefits can only contribute to a limited extent to creating healthy living environments and situations (e.g. through nutrition programmes, daycare and school programmes to promote physical activity as well as workplace health promotion), partly because social insurance providers and private health insurance companies are dependent on the participation of those responsible for the living environments.

The health care system is optimised to provide support when treatment is needed, with economic implications taken into account. Despite numerous initiatives, however, the prevention landscape in Germany remains highly fragmented. Responsibilities, and the associated distribution of funds and resources, are divided between the federal government, states, local authorities, health insurance funds, professional associations and ministries. As the WR sees it, this fragmentation leads to an inefficient use of funds, unclear responsibilities and an absence of sustainability in preventive programmes. A nationwide, public-interest **foundation for prevention**, which could flank a possible national public health institution (see chapter B.III), could act as an independent, science-based coordination centre, linking research, politics, business and practice and pooling resources. In this context, it is also important to change the argumentative logic that the financing of prevention is difficult to justify based on immediate savings potential. Rather, **financing disease prevention and health promotion** should be viewed as **an investment model** that generates long-term social value. In other countries, such as the Netherlands, some argue that investments in prevention measures do not need to be justified any more than investments in other health care services. The same principles, methods and guidelines should be applied to the economic evaluation of investments in prevention as to other health care investments, such as curative care. |[95]

| 94 From the DPtV's perspective, preventive measures such as health examinations for registered psychotherapists should be cost-effective and straightforward to implement. The DPtV believes that psychotherapeutic expertise is not yet firmly anchored in occupational health and safety legislation. See the German Psychoanalysts Association (2025), p. 19.

| 95 See Rotteveel et al. (2025).

The WR also highlights the following three aspects as areas in which greater investment in disease prevention could prove worthwhile:

_ Firstly, **demographic changes and increases in the burden of disease** are putting pressure on the health care system and the professionals working in it (see chapter D.I). A stronger focus on disease prevention could provide significant relief while also achieving a **more effective use of funds and resources** within the health care system. Various examples, such as caries prophylaxis in dentistry |[96] or dementia prevention |[97], also demonstrate actual savings.

_ Secondly, disease prevention **increases work capacity**, thus boosting **overall social** productivity |[98] – with positive effects on the economy and social systems. |[99]

_ Thirdly, prevention and health promotion themselves offer **economic market potential** in the form of health-related services, products or programmes that are developing in response to changing consumer demands. Developing health-promoting product lines, such as reduced-sugar foods, nutrition programmes or health-oriented services, and collaborations in the health care sector also

|[96] The results of the 6th German Oral Health Study, conducted by the National Association of Statutory Health Insurance Dentists (KZBV), the German Dental Association (BZÄK), and the Institute of German Dentists (IDZ), show a significant decline in the prevalence of tooth decay among the population. 78 percent of 12-year-olds have no caries; among younger adults (aged 35 to 44), the number of people with caries has halved since 1989. This is due to the widespread use of dental prophylaxis. According to the KZBV, the proportion of statutory health insurance expenditure on contracted dental services has fallen by more than 30 percent in recent years. See the National Association of Statutory Health Insurance Physicians and the German Dental Association (17 March 2025).

|[97] For findings on cost savings through reducing risk factors and the associated reduction in dementia incidence, see Michalowsky, Kaczynski & Hoffmann (2019), and Blotenberg, Hoffmann & Thyrian (2023). For evidence of the potential to positively influence risk factors for dementia in Germany, see Claus et al. (2024) and Yau et al. (2025). For information on the cost-effectiveness of dementia prevention, see Michalowsky et al. (2024) and Michalowsky et al. (2019)

|[98] See Mierau et al. (2024).

|[99] A Prognos study, to be published in autumn 2025, estimates the gross value added at around 360 Euro per healthy working day and employed person. With an estimated 45.9 million people in employment and an average of 15.2 sick days taken in 2023, the cost per average sick day is around 16.4 billion Euro. According to the study, this illustrates the immense potential of prevention and effective health care. See the Federation of German Industries (03 November 2025). In their jointly published Public Health Index, the AOK Federal Association and the DKFZ also highlight the significant financial burdens on the health care system and the economy caused by various disease drivers, such as alcohol and tobacco. In the case of alcohol, the indirect costs to the economy are estimated at around 40 billion Euro, including loss of productivity, early retirement and incapacity to work. A further 17 billion Euro is directly attributable to the health care system. See AOK-Bundesverband eGbR (ed.); German Cancer Research Centre (ed.) (2025), p. 39.

create additional revenue opportunities for companies. Until now, however, these companies have contributed to the prevalence of non-communicable chronic diseases with certain products (e.g. highly processed foods) (see chapter D.III.2.a). | [100] In this way, new markets can be opened up, brand image strengthened and long-term competitive advantages achieved.

Scientists should closely monitor the effects and developments that may result from greater investment in disease prevention. The Netherlands' "Investment Model for Prevention" is a similar approach that could serve as a model.

Innovative programmes and operational implementation in the Netherlands: Investment Model for Prevention

Despite its ambitious goals, Dutch prevention policy faces structural challenges in its practical implementation. These include the lack of a binding legal framework for preventive goals, and insufficient or unsustainable funding for preventive measures, which makes long-term planning difficult. Furthermore, prevention only tends to receive political attention when short-term results become visible, which hinders sustainable planning.

A key instrument for overcoming these challenges is the Investment Model for Prevention, which is currently being promoted in the Netherlands. This model treats preventive measures as long-term investments, making the benefits and costs of strategic interventions more transparent and comprehensible. Developed with the close involvement of scientific experts, the model is supported by a scientific advisory committee that provides technical advice, methodological assessments and evidence-based recommendations. | [101] Although it is not yet possible to calculate the exact benefits, the model nevertheless helps to illustrate the relationship between the input used and the output.

The implementation process comprises the following steps:

_Definition of measures to increase efficiency (Advisory Committee)

_Development of an assessment framework, implemented by the National Institute for Public Health and the Environment (RIVM)

_Financial decisions made by the national government or other competent institutions

_Continuous monitoring and systematic evaluation as crucial steps for ensuring effectiveness and sustainability

| [100] See WHO (2025e).

| [101] The initial recommendations of the scientific advisory board are already available. See Leden van de Adviescommissie passend bewijs voor preventie (2025).

Germany also lags significantly behind other European countries in terms of various **regulatory approaches**. This is evident in the absence of **specific taxes on sugar or alcohol**, for example (see chapter D.III.2.a), which are designed to discourage unhealthy behaviour and reduce the associated burden of disease. The revenue from these taxes could be used to strengthen prevention and health promotion measures. Furthermore, even in a prosperous country such as Germany, health and life expectancy are closely linked to an individual's level of education, as well as their **social and economic situation** (see also chapter D.I). Currently, a so-called "inverse care law" applies: | [102] those who need the most health support receive the least. According to the WR, this demonstrates that the existing **market mechanisms within the health care system** must be modified to eliminate or at least mitigate health inequalities.

VI.2 Recommendations

_ **Examining incentive mechanisms scientifically:** A fundamental scientific examination of **incentives in the German health care system and their possible counterproductive effects** on a stronger systemic focus on health is necessary. This issue should be addressed more intensively from a health economics perspective in particular and include a cost-efficiency analysis of existing early detection and screening programmes, which are often very costly (see chapter B.IV.2). In line with the Health for All Policies concept, health-promoting incentive structures should also be pursued in other sectoral subsystems.

_ **Highlighting potential added value:** To strengthen an interdepartmental focus on health, **the potential added value** must be made more visible, including individual intangible, social and economic benefits. An investment narrative must be established, rather than a narrative based on savings. This requires rigorous scientific evaluation of measures and their effects.

_ **Putting commercial health determinants to the test:** Various industries contribute significantly to the development of non-communicable chronic diseases through their products and business models. Examples include alcohol, tobacco and highly processed foods (see chapter D.III.2.a). These commercial drivers of disease must be tackled decisively using various regulatory mechanisms, such as price increases, higher taxation and stricter advertising bans. It is necessary to systematically gather evidence on the health-promoting effects of such regulatory measures.

_ **Tapping into new funds for prevention research:** With a view to the interaction between **regulatory and financing approaches**, consideration should also

| [102] The term "inverse care law" was coined by general practitioner Julian Tudor Hart, who published a thesis in the 1970s arguing that while disadvantaged population groups need more health care than privileged population groups, they actually receive less. See Haines; Floss (2021).

be given to **modified taxation models**, for example for disease drivers such as sugary foods, alcohol or tobacco as well as the transfer of additional funds to a **public fund**, for example, to strengthen research and implementation projects for prevention and health promotion. The GMK's demand in this regard is also to be welcomed from the WR's point of view. | [103] A **prevention foundation** could also be a viable option in the context of considerations to bundle national competencies for prevention and public health.

_ **Ensuring appropriate remuneration for prevention in the health care system**: With regard to **service remuneration** specifically, it should be examined which preventive approaches could have a real impact on positive health development in relation to various individual goals. For example, in the case of dementia, this could include measures to enable patients to remain independent for as long as possible, while for joint diseases, weight reduction approaches could already achieve significant relief. Such measures should be **prioritised over therapeutic measures**, in line with quaternary prevention. Health insurance funds should provide appropriate remuneration for services.

_ **Focussing on prehabilitation**: Scientific studies should be conducted to determine the extent to which **prehabilitation programmes** | [104] can specifically prepare patients for the physical strain of major surgical procedures, such as liver, pancreatic or gastrointestinal surgery. It is recommended that this be implemented as part of **multimodal programmes**, incorporating physical training to enhance cardiorespiratory fitness, alongside nutritional and nursing guidance as well as psychological support. Clinical data show that such interventions can significantly reduce the rate of postoperative complications. To systematically exploit these effects, programme content should be standardised, appropriate success indicators defined and the long-term effects on mortality, disease progression and cost-effectiveness investigated.

_ **Acting in a setting- and culture-sensitive manner**: To **achieve** greater **systemic equality of opportunity** with regard to health, the WR believes that further **incentives for** such **setting- and culture-sensitive approaches** must be created (see also chapter B.III). Binding interprofessional collaboration mechanisms coupled with central coordination and allocation via the primary care physician model envisaged in the coalition agreement, as well as greater use of professional groups such as the CHN, can provide important support here, too.

| [103] See the Conference of Health Ministers (GMK) (2025).

| [104] Prehabilitation addresses the key objectives of the "quadruple aim", which is to improve patient health and treatment experience, working conditions in the health care sector and economic efficiency simultaneously. The economic factor is particularly evident in reduced complication rates and shorter hospital stays, enabling cost savings in the health care sector.

C. Immediate scopes of action for science and science policy

This position paper focuses on strengthening the structure of prevention and health promotion from a scientific and policy perspective.

The following is an extract of the recommendations from the previous chapters that directly concern **scientific and science-policy issues and areas for action**. This is also intended to illustrate what could and should be addressed as quickly as possible from a **scientific and science-policy** point of view to bring about **health-oriented change** in science, health care, the economy and society at large.

The WR considers the **additional analyses and recommendations** made in **chapter B** , some of which have a broader **social and health policy dimension**, to be **equally urgent.** They should be addressed by the relevant groups of actors and stakeholders (federal, state and local politics, ÖGD, service providers etc.).

The WR reserves the right to review the implementation status of its recommendations after ten years as part of a systematic follow-up and to issue further recommendations if necessary. In doing so, the WR aims to facilitate contact and interaction between all stakeholder groups in the system, to contribute to networking and to strengthen prevention in Germany.

Excerpt from scientific and science policy-related recommendations from chapter B.I

_ **Involving scientific actors and science policy:**

- _ **Science departments** should be involved in initiatives and strategic alliances for the national and regional coordination of prevention and health-promotion measures. This includes, for example, the BMFTR's participation in the National Prevention Initiative, but also to the regular participation of the state ministries of science in state health conferences.
- _ State health conferences should also ensure **the better involvement and integration of scientific institutions** so as to develop effective health and

prevention networks. This could be achieved by involving prevention centres.

_ **Combining structural and behavioural prevention:** Structural changes must be linked to individual behavioural analyses and personalised health risk assessments. This is the only way to improve the health of the population sustainably and for the long term. To this end, **relational and behavioural prevention** must **also** be **more closely integrated in scientific terms**. Health research can contribute significantly to this.

_ **Establishing Health *for* All Policies as a principle:** Effective health orientation in political action requires collaboration between different departments. The WR recommends further developing the Health *in* All Policies concept in the sense of a **"Health *for* All Policies" concept**, thereby emphasising that health must be an integral part of, and a binding target in, all policy areas, and must be negotiated democratically when designing measures, not only within the health sector itself, but also in areas such as urban development, education, labour, science, economics, agriculture, food and environmental policy. To this end, scientifically based key performance indicators should be developed to systematically record and track the success of preventive measures in different areas of society in a comparable manner (see chapter B.II.2). As an additional political control instrument, the **introduction of a health impact assessment (HIA)** in all policy areas could be considered as a complementary instrument of political control. This should be implemented with the least possible bureaucratic effort and without slowing down processes.

Excerpt from scientific and science policy-related recommendations from chapter B.II

_ **Exploiting health data stocks:** All data holders should make access to **original health data records** available for research purposes. The legal and research-friendly use of this data should be examined. One sensible approach could be a **permission principle with the possibility of sanctions or prohibitions**. It is also essential to ensure the binding provision of interoperable, standardised and reusable data. Private health data providers should make anonymised or pseudonymised datasets, e.g. from wearables, available for research purposes via data donations.

_ **Broadening the scope of health studies:** Wherever possible and appropriate, large-scale health studies such as NAKO should consider **broader settings and population groups**, and be linked to routine data as well as **other datasets** (e.g. environmental data, socio-economic data or motivational data).

_ **Creating interdisciplinary experimental spaces:** Such spaces should be created that are scientifically supported and integrated into different **areas of life**, e.g. the work/business environment, schools and daycare centres. They should also take **various aspects** into account, including environmental and climate

factors, socio-economic aspects, social conditions and psychosocial and gender-sensitive factors. These spaces should foster an **open innovation environment** that enables various actors (including politics, scientific disciplines, health care, business and society) to test new approaches and measures for prevention and health promotion.

Excerpt from scientific and science policy-related recommendations from chapter B.III

_ **Combining networking competencies and responsibilities in a national coordination centre:** Unlike in other countries, Germany does not yet have an institution mandated to link prevention research and its translation across various scientific institutions and with public health institutions. In the view of the WR, consideration should be given to how this **institutional gap** can be **filled** in order to **network and coordinate research and translation as well as health communication and information** on prevention and health promotion in the sense of a national public health institute. | [105] An **external evaluation** could be helpful in this regard.

_ **Pooling data and translation:** Higher education institutions, non-university and departmental research (especially the BIÖG and the RKI) as well as federal states and ÖGD should collaborate in a national **BCI network** with clear mandates. This would enable the establishment of **uniform data and interface standards**, **common, comprehensible health and behaviour reporting** for the public and decision-makers as well as **structured feedback loops** between local practice and national governance.

_ **Addressing living environments in an evidence-based manner:** Different **living environments** and realities must be **systematically** surveyed **focusing on the life course**, and the results must be translated into measures in co-design processes with the target groups. **Children and adolescents** should be given appropriate consideration, with particular attention paid to the spectrum of adverse childhood experiences and their effects on mental and physical health in adulthood as well as intersectoral preventive measures, e.g. in education and child and youth protection. At the same time, **targeted (secondary) prevention and health promotion** for the elderly and particularly disadvantaged subgroups should also be strengthened.

_ **Aligning data visualisation with behavioural relevance:** Reporting systems and dashboard formats (at the federal and state level) should integrate **behavioural indicators and equity cuts** in the sense of appropriate categorisation

| [105] In general, national public health institutes serve as central bodies which enable countries to organise and network public health activities under one roof, thereby improving opportunities for collaboration and, through their scientific focus, the efficiency and effectiveness of measures. See CDC (3 September 2025).

and breakdown of reports by sub-populations and **evaluation feedback**. Content must be tailored to specific user groups (e.g. the public, practitioners and politicians) and reviewed and updated regularly. The potential applications of **generative AI models** in supporting visualisation and reporting formats should be examined.

Excerpt from scientific and science policy-related chapter B.IV

_ **Broadening the concept of prevention in health research:** In particular, **leading research institutions** should define the concept of prevention more broadly, creating opportunities for **collaboration** with the field of public health research or other health researchers and other health science disciplines. A future-oriented research approach must consider personalised prevention in the sense of **precision prevention as well as aspects of behavioural and structural prevention**.

_ **Pooling interdisciplinary research collaboration in prevention centres: Medical and health-related higher education institutions** should consider establishing such **prevention centres** to make greater use of the potential for scientific collaboration in disease prevention and health promotion. This would enable synergies to be pooled and regular interdisciplinary scientific exchange to be established on a wide range of prevention research issues between relevant disciplines. This would also enable further **scientific and regional specialisation and focus** (e.g. in the areas of One Health or Planetary Health), as well as provide new **opportunities for gaining insights into therapeutic approaches** and disease- and organ-related as well as gender-sensitive research. In this context, care must be taken to ensure that **supra-regional networking** is based on existing structures, in order to prevent silo formation and enable learning effects, as well as adequately involving the non-university environment (including non-university and departmental research institutions and ÖGD), in both research and in translation. The WR recommends linking and networking prevention centres in Germany with existing structures.

_ **Structurally establishing and expanding implementation research:** The field of implementation research in Germany needs to be strengthened and further expanded **in terms of** both **structure** and personnel. This includes the targeted expansion of professorships and research structures in this field as well as the systematic development of interventions and their theoretical foundation, from the planning of outcomes to mechanisms of action and contextual conditions. It is also necessary to **investigate factors** that **promote or inhibit** implementation as well as to conduct feasibility studies prior to large-scale efficacy studies. **Participatory research approaches** are of central importance here, involving all relevant stakeholder groups, including children and young people, across all age groups, genders and social situations, from the outset and throughout all phases of research, in order to appropriately consider

needs, requirements and contexts. In connection with research questions on the effectiveness of prevention and health promotion measures, more stringent **causal and health economics evaluation methods** are needed than have been used to date.

_ **Strengthening a prevention-oriented attitude in higher education degree courses as well as in vocational training and continuing education:** Furthermore, the quality of the current integration of prevention aspects in study programme-related **learning objective catalogues** for medicine and other health-related subjects – including psychology – should be reviewed. The focus here should shift from directly measurable treatment aspects (such as rehabilitation measures) to **strengthening a prevention-oriented approach in professional practice**. This includes, in particular, deepening the teaching content on **health promotion and health-related communication**. Later **stages** of **training and continuing education** for doctors, scientists in other medical-related disciplines, and psychologists and health care professionals should also include modules to develop competence in preventive measures (e.g. through more certified further training courses). This should also address issues of health promotion and communication.

_ **Establishing multidirectional transfer and translation pathways:** Studies and research conducted by scientific institutions should focus more on providing direct links to the ÖGD in order to enable **multidirectional transfer and translation activities**. The ÖGD should be involved not only in primary prevention projects, but should also strive for broader, **networked collaboration with scientific actors**. For example, the ÖGD could be included in controlled intervention studies. From the perspective of the WR, reverse translation of findings from the practical work of the ÖGD back into science could contribute to the development of new research approaches, strengthening prevention research in the long term and promoting the translation ("bench to bedside and community") of scientific findings into areas of application (e.g. medicine or nursing). This requires the development of structured feedback processes and collaboration structures. Broad competence-building in the application of scientific findings and a strengthened transfer and translation culture are also required.

Excerpt from scientific and science policy-related recommendations from chapter B.V

_ **Involving private practices in research:** With regard to private medical practices, primary care specialists such as general practitioners, internists and paediatricians in Germany should be **more involved in research and the implementation of preventive measures**, e.g. through **functional research practice networks**. The German Research Practice Networks Initiative DEGAM-ForNet, which connects general medical university locations with research practices

across locations and networks, is an example of a network approach with great potential for the field of prevention research. Where possible and appropriate, this should **also** be extended **to other non-medical professional groups**, particularly psychologists and health science professionals (midwifery, nursing and therapy sciences).

_ **Examining the institutionalisation of innovative interprofessional care models:** Examples from other European countries demonstrate the health-promoting effects of **systematic interprofessional collaboration**. One example is Finland's family centres (Neuvola) for child and adolescent health. These centres demonstrate that such measures are particularly effective when they are established as **systemic components** of society, rather than as **project-dependent initiatives**. In Germany, a change of direction is necessary in this sense, with a focus on **strengthening supporting implementation research systematically** to gain a more detailed understanding of the potential impact and consolidation of new interprofessional approaches and care models.

_ **Making more systematic use of lessons learned from Innovation Fund projects:** From the WR's perspective, temporary model projects, such as those made possible by the Innovation Fund of the Joint Federal Committee (G-BA), are to be welcomed as a means of testing new care approaches over a limited period of time. Nevertheless, **learning effects from the successes and failures** of such projects must **be used** much **more systematically** to inform the consolidation of proven structures and approaches or the readjustment or dissolution of such projects (de-implementation).

Excerpt from scientific and science policy-related recommendations from chapter B.VI

_ **Examining incentive mechanisms scientifically:** A fundamental **scientific examination of incentives in the German health care system** and their possible counterproductive effects on a stronger systemic focus on health is necessary. This issue should be addressed more intensively from a health economics perspective in particular and include a cost-efficiency analysis of existing early detection and screening programmes, which are often very costly. In line with the Health for All Policies concept, health-promoting incentive structures should also be pursued in other sectoral subsystems.

_ **Highlighting potential added value:** To strengthen an interdepartmental focus on health, **the potential added value** must be made more visible, including individual intangible, social and economic benefits. An investment narrative must be established, rather than a narrative based on savings. This requires rigorous **scientific evaluation of measures and their effects**.

_ **Putting commercial health determinants to the test:** Various industries contribute significantly to the development of non-communicable chronic diseases through their products and business models. Examples include alcohol,

tobacco and highly processed foods (see chapter D.III.2.a). These commercial drivers of disease must be tackled decisively using **various regulatory mechanisms**, such as price increases, higher taxation and stricter advertising bans. It is necessary to systematically gather evidence on the health-promoting effects of such regulatory measures.

_ **Tapping into new funds for prevention research:** With a view to the interaction between **regulatory and financing approaches**, consideration should also be given to **modified taxation models**, for example for disease drivers such as sugary foods, alcohol or tobacco as well as the transfer of additional funds to a **public fund**, e.g. to strengthen research and implementation projects for prevention and health promotion. A **prevention foundation** could also be a viable option in the context of considerations to bundle national competencies for prevention and public health.

Appendix

D. Prevention and health promotion in science and politics: an attempt at inventory

D.I HEALTH IN GERMANY – (SYSTEMATIC) CHALLENGES

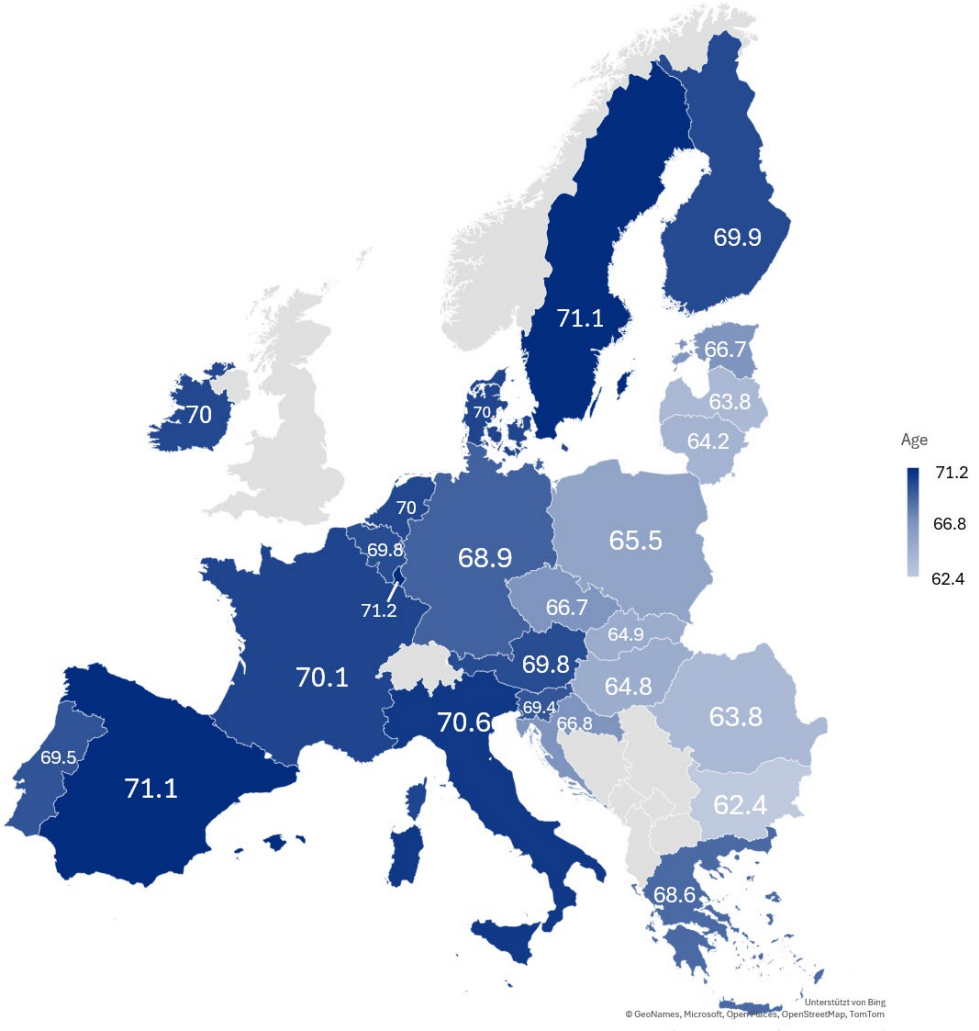
In view of an ageing population, an increasingly apparent skills shortage – especially within the health care system – and an increase in chronic non-communicable diseases | [106] and multimorbidity, as well as mounting environmental health risks (e.g. due to heat or vector-borne diseases), changes towards a stronger focus on disease prevention and health promotion are more urgent than ever. This is particularly true of Germany, where health expenditure across all sectors and cost types is relatively high compared to other EU countries, while the average number of years lived without significant health restrictions is too low. With an average of 68.9 healthy years from birth (HALE indicator) | [107], Germany is only slightly above the EU average of 68.2 years and behind countries

| 106 In its health reports, the RKI refers to chronic non-communicable diseases, listing them as some of the most common and significant health problems in industrialised countries in terms of health economics. These include cardiovascular diseases, cancer, chronic lung diseases, musculoskeletal disorders, mental health conditions and diabetes mellitus. See Robert Koch Institute (1 September 2025). The WHO endorses this terminology and the associated clinical presentations. The WHO's monitoring of non-communicable diseases in Germany provides further details on the associated disease burdens and forecasts. See WHO (2018), p. 94.

| 107 The WHO's HALE indicator shows the average number of years a person of a certain age can expect to live in "full health", taking into account years lived with illness and/or injury. This data is based on a combination of mortality rates and national health data on the prevalence of diseases, injuries, and disabilities. Unlike the EU's Healthy Life Years indicator, which relies primarily on surveys and self-assessments, HALE is based on various statistical data. This means it should be viewed with a degree of caution, not least because of differences in how health data is collected and stored in different countries. For more information on the challenges of generating evidence on "healthy life years", see OECD; European Union (2024), p. 62 ff.

such as the Netherlands (70 years), Finland (69.9 years) and the frontrunners Luxembourg and Sweden with around 71 years (see Figure 1 and Table A.1).

Figure 1: Healthy life expectancy (HALE) at birth in EU countries



Source: WHO: Healthy life expectancy (HALE) at birth (2021)

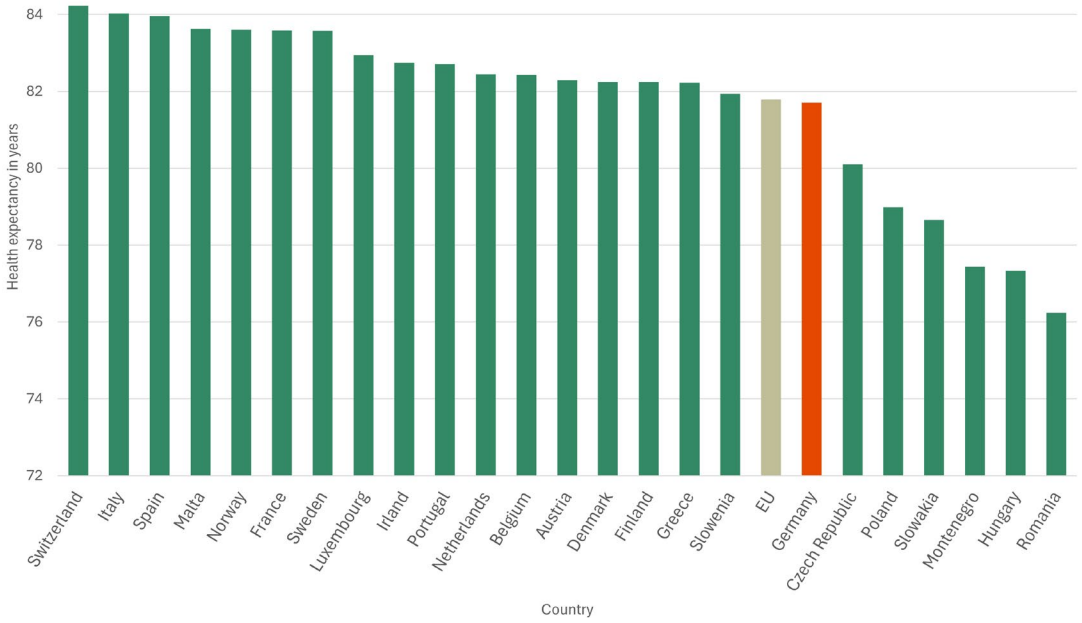
In terms of overall life expectancy, Germany ranks just below the EU average of 81.8 years with an average of 81.7 years, placing it near the bottom of the list (see Figure 2 and Table A.2).

In terms of communicable and non-communicable diseases, most years of life lost in Germany are attributable to cancer, cardiovascular diseases |[108], chronic

|[108] Cardiovascular disease also poses a significant challenge at a European level. In December 2025, the European Commission presented a plan to address the health challenges posed by this disease in the EU. The Safe Hearts Plan includes targeted measures to improve the prevention, detection and treatment of cardiovascular diseases. It contains a flagship initiative to close research and innovation gaps, for example for a better understanding of the mechanisms of disease onset and progression, and the biological mechanisms underlying various cardiovascular diseases. See the European Commission (2025a). The plan forms part of a

obstructive pulmonary disease, alcohol-related disorders and suicide. |[109] In addition, 27.8 percent of adults in Germany are affected by mental illness each year. Mental illness is not only the second most common cause of sick days at work |[110], it is also the most common reason for early retirement.

Figure 2: Life expectancy in European countries



Source: United Nations; Population Division (2024); WR representation.

The direct and indirect costs associated with this are also expected to increase further in future. |[111] Children and young people are particularly affected by mental illness, which places a significant burden on them. |[112] Between 2007

broader context of EU strategies and initiatives to combat non-communicable diseases, including Europe's Beating Cancer Plan (2021) (see European Commission, 2025b) and the "Healthier Together – NCDs Initiative" (see European Commission, n.d.)

| [109] See the German Council of Experts for the Assessment of Developments in the Health Care System and Long-Term Care (2024), p. 120. SVR Gesundheit refers to the findings of the BURDEN 2020 project, which was carried out by the RKI and analysed the burden of disease in Germany and its regions over a period of three years. See Robert Koch Institute (2021).

| [110] The Techniker Krankenkasse (TK) health report recorded 10.39 million cases of incapacity to work and 117.75 million days of absence among TK members in 2024. Mental disorders also ranked second among illness-related absences here. See Techniker Krankenkasse (2025).

| [111] The German Society for Psychiatry and Psychotherapy, Psychosomatics and Neurology (2025).

| [112] Current figures from the RKI show that young people between the ages of 18 and 29 are most affected by low mental well-being. See Robert Koch Institute (02.07.2025).

and 2022, mental illness in this population group almost doubled, while mental well-being halved over the same period. | [113] On a global level, mental disorders account for almost 45 percent of the disease burden in 10- to 24-year-olds. | [114] In addition, adverse childhood experiences (such as neglect, loss, abuse and violence) are a major cause of chronic physical and mental illness in adulthood. | [115]

According to the RKI, non-communicable, chronic physical and mental illnesses | [116] and an increase in heat-related deaths | [117] also have a significant impact on mortality in Germany. The WHO has reached similar conclusions regarding Germany and Europe as a whole. The WHO estimates that 1.8 million preventable deaths occur in Europe each year due to non-communicable chronic diseases. | [118] The organisation also estimates that these deaths result in economic productivity losses of around 514 billion US Dollar for Europe each year. | [119] According to the WHO, commercial determinants such as tobacco, alcohol, highly processed foods and fossil fuels also significantly impact non-communicable chronic diseases and related deaths in Europe. | [120]

Current figures for 2024 from the RKI's "Health in Germany" study | [121] show that, of the adults surveyed, more than half report having a chronic disease or long-term health problem. Increasing chronic non-communicable diseases particularly affect the age cohort aged 45 and above.

| 113 See McGorry et al. (2024), pp. 731–774.

| 114 See Patton et al. (2016).

| 115 Bellis et al. (2023), p. 19 ff.

| 116 Suicide is the most common cause of death among 10- to 25-year-olds in Germany (see Federal Statistical Office (2024)).

| 117 See Heiden et al. (2025).

| 118 Sixty percent of these deaths are attributable to preventable causes or factors that can be influenced by preventive health policies, such as tobacco and alcohol consumption, high blood pressure, an unhealthy diet, obesity, and a lack of exercise. According to the WHO, the remaining 40 percent are due to treatable causes that could at least be delayed, if not prevented, with timely diagnosis and access to care. See WHO (2025a).

| 119 See WHO (2025b), p. 6 f.

| 120 According to the WHO, around 7,500 deaths per day are related to commercial determinants.

| 121 With the "Health in Germany" study, the RKI has launched a large-scale study on behalf of the Federal Ministry of Health to obtain an overview of the health status of the German population. The RKI randomly invited around 47,000 citizens aged 16 and over who are registered in Germany to participate in the study. Topics covered include questions on physical and mental health, social environment and living conditions, health behaviour and health risks and health care. The results will also be incorporated into the federal government's health reporting. See Robert Koch Institute (03.11.2025).

Looking at the different educational backgrounds reveals that people from less educated groups are significantly more likely to suffer from chronic illness (61.9 percent) compared to those from middle (51 percent) and highly educated groups (46.7 percent). | [122] In Germany, an extreme example of this is that individuals from socioeconomically disadvantaged backgrounds (e.g. in terms of educational attainment, occupational status, income or regional deprivation) have a lower life expectancy. | [123] Socioeconomic status can therefore be seen as a key factor influencing morbidity and mortality in Germany; worldwide, it is also decisive for health status and health care provision at both the individual and country levels. | [124]

In addition to significant social and educational differences, there are also regional differences in Germany. In regions ahead of the nationwide demographic trend of an ageing population, the burden of chronic non-communicable diseases is increasing more rapidly. This results in figures above the national average of 53.7 percent of the regional population affected by a chronic disease or ongoing health problem. | [125]

Overall, the proportion of people in the population affected by a chronic non-communicable disease or a long-term health issue has increased across all age groups in Germany since the first RKI surveys on this topic in 2014 up to the current results of the "Health in Germany" study in 2024 (see Figure 3).

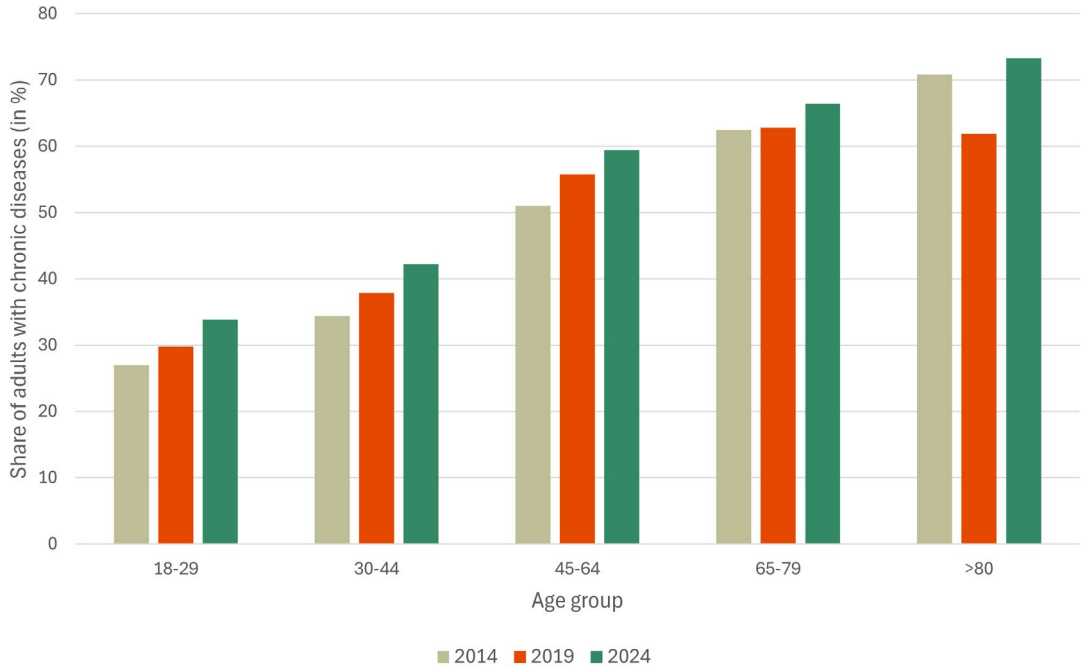
| [122] See the Robert Koch Institute (2025a).

| [123] This is illustrated by data from recent decades, including data from the RKI, which examine regional deprivation as a factor influencing life expectancy. See Hoebel et al. (2025).

| [124] See the German Council of Experts for the Assessment of Developments in the Health Care System and Long-Term Care (2023), p. 68. Globally, this is evident in the unequal distribution of vaccines during the Coronavirus pandemic, for example. Rich countries had privileged access to vaccines, while poorer countries found it difficult to procure them. See ibid., p. 69 f.

| [125] See the Robert Koch Institute (2 July 2025).

Figure 3: Proportion of adults with chronic diseases by age group in 2014, 2019, 2024 (in %), in Germany

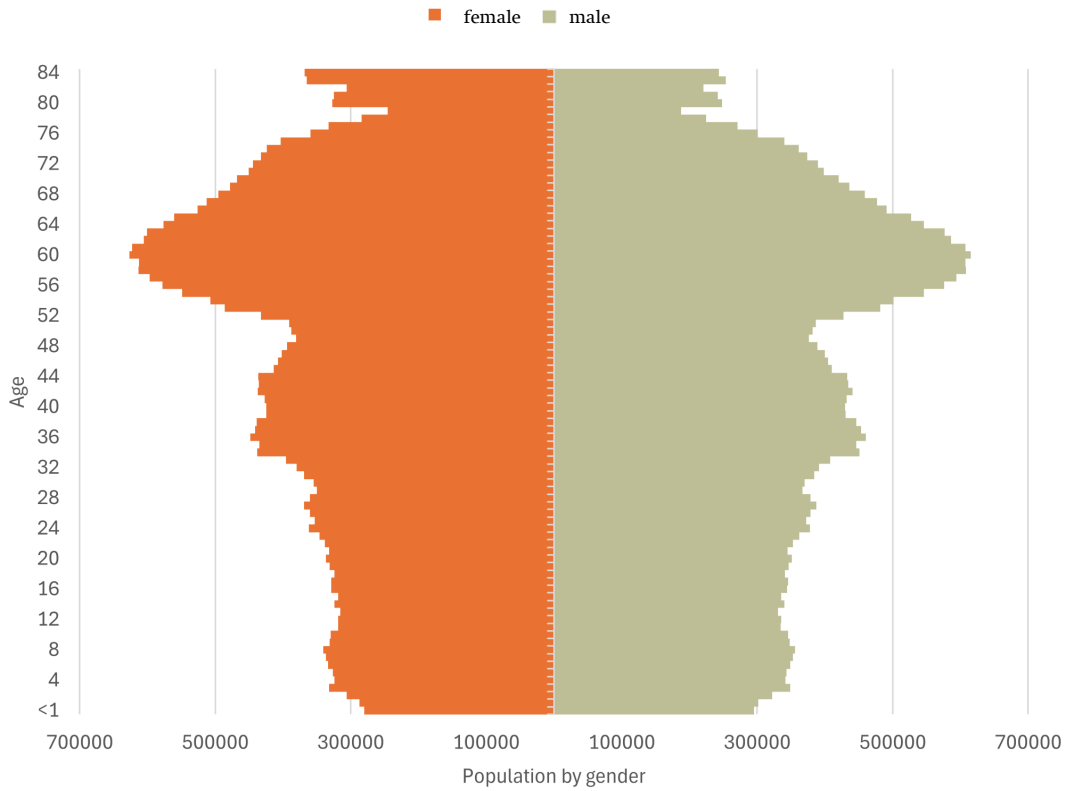


Source: Robert Koch Institute (2025b): Gesundheitsberichterstattung – Daten zu nichtübertragbaren Erkrankungen (2025); WR represenattion.

An examination of the age structure of the German population in 2024 (see Figure 4) reveals that Germany's population is ageing rapidly. The primary impact is visible both among women and men of the baby boomer generation (those born in the 1960s). In addition to the burden of chronic disease – which according to RKI data has increased significantly from that generation onwards – this age structure has further significant implications for the economy and society, such as future changes in employment. Over the next 10 to 15 years, the largest cohorts will retire. At the same time, labour force potential in terms of labour force participation in various age groups up to 64 years of age is already being exploited to a high degree, making it difficult to expand it to the extent required to compensate for demographic effects. | [126]

| [126] According to the Federal Statistical Office, more than two out of three people aged 60 to 64 were in employment in 2023. See Federal Statistical Office (2023).

Figure 4: Age structure in Germany (as of 31 December 2024)



Source: Statistisches Bundesamt (2025): Fortschreibung des Bevölkerungsstandes; WR representation.

In addition to socioeconomic and age-related factors, **gender-related factors** also significantly influence health. This applies to health-related behaviour and individual health status alike. The term "gender-sensitive medicine" encompasses sociocultural gender, biological sex and the interactions between the two in terms of their influence on health development and disease progression. It is a fact that individuals react differently to preventive measures depending on their gender, and that disease progression, diagnosis and treatment differ between individuals. |[127] In Germany, no gender-sensitive health promotion and prevention landscape has yet emerged. Currently, very few projects and approaches include gender-specific dimensions (one example is the male-equitable occupational health management programme offered by the Techniker Krankenkasse).

| [127] See WR (2023b), p. 77. Common examples of the different ways in which men and women are affected include heart disease and cancer, but gender-sensitive considerations are needed in all areas of disease. One example of this is the recent finding that gender-sensitive treatment improves the outcomes for dialysis patients (see Lösment and Kuhlmann, 2024)

| [128] In health research (including medicine, as well as the health and nursing sciences), there is still room for improvement in considering gender aspects. | [129]

In terms of the health care system, major challenges exist in two areas: first, in the development of skilled workers in the workforce and second, in rising costs due to greater demand and a greater need for care services. Regarding the share of health care expenditure as a percentage of gross domestic product (GDP), the German health care system is already the largest in the EU. Health care expenditure in Germany is expected to reach 12.6 percent of GDP in 2024 (EU average: 10.37 percent). | [130] Germany also leads the way in Europe in terms of the number of inpatient hospital stays and the number of hospital beds. | [131] Funds for prevention and health protection in Germany account for around 7.9 percent (2022) | [132] of total health expenditure | [133]. In a European comparison, Germany is also above the EU average (5.49 percent in 2022) (see Table A.3). | [134] However, this higher level of expenditure in Germany | [135] has not yet had an equivalent effect on the health status of the population.

All of this supports the thesis that Germany and its health care system remain very strongly focused on diagnosing and treating diseases | [136], rather than on preventing them and maintaining health through primary prevention before disease onset. One notable exception is dental health, where decades of focus on prevention and prophylaxis have led to significant progress. However, this is still a rare example.

A brief digression on dental health: the decline in caries as a partial success story

According to Strippel (2024, pp. 241–248), the decline in caries among the population can be described as a success story in the field of dental health. Yet, this example also illustrates the importance of health policy goals being addressed through a cross-policy approach and implemented through a multi-stakeholder

| [128] See Altgeld; Klärs (2024).

| [129] See WR (2023b), p. 78 f.

[130] See the Federal Statistical Office (2022).

| [131] See also Karagiannidis; Augurzky; Alscher (2025), p. 26 f.

| [132] See Eurostat (2025a).

| [133] The largest share of health expenditure in 2022, at 42.8 percent, was accounted for by curative care. See Eurostat (2025b).

| [134] See ibid.

| [135] According to the RKI, the proportion of funds allocated to prevention and health protection in Germany remained relatively constant between 1992 and 2020 (1992: 3.7 percent; 2020: 3.6 percent). Following the outbreak of the Coronavirus pandemic, there was a sharp increase of 6.6 percent; however, this proportion of total health expenditure is still considered relatively low. See the Robert Koch Institute (2024).

| [136] See Hurrelmann et al. (2024), p. 29.

process involving science, the health care system and the economy. In addition to product launches such as fluoride toothpaste, the interaction of health, education, labour, family, agricultural and social policies was also a decisive factor in this success. In industrialised countries, a 96 percent decline in caries cases among 9-year-olds was observed between 1973 and 2021. However, despite this success, social inequality factors continue to impact oral health. For instance, younger adults with a low level of education have 2.2 times more teeth affected by caries than those with a higher level of education, and severe periodontitis is found in 13.6 percent of the former group, compared to only 4.8 percent of the latter.

The massive rise in the burden of chronic disease and the resulting demand for care, coupled with demographic changes and ageing populations, will undoubtedly put immense pressure on the health care system. In short, the lack of success in prevention cannot be compensated for by expanding curative medicine alone.

Another significant factor in health care is the foreseeable shortage of medical, nursing, therapeutic and midwifery staff. In the medical field, bottlenecks in general practitioner care are one of the issues to be addressed. The shortage of nursing staff is even more acute, exacerbated by the demographic structure of this group and the increasing needs of an ageing population. | [137] There is also a shortage of specialist psychotherapists.

The German government's "Health and Resilience" Expert Council estimates that around 30 percent of currently active health care professionals will retire within the next ten years. Neither immigration nor more flexible procedures for recognising foreign qualifications are likely to be able to fill these gaps completely, especially since lengthy recognition procedures | [138], discrimination experiences in everyday working life and right-wing tendencies act as an additional deterrent. | [139] As a result, there is a threat of a massive skills shortage, both in quantity and quality.

In addition, the "Health and Care" Expert Council considers reliable medical and nursing care to be a basic prerequisite for social trust in state institutions and actors. The development of skilled workers among the general population could also lead to restrictions in medical, psychotherapeutic and nursing care becoming noticeable. This could undermine the functioning of public services, social

| [137] See Karagiannidis; Augurzky; Alscher (2025), p. 40 ff.

| [138] See Loss et al. (2020).

| [139] See Yolci et al. (2022).

cohesion and trust in state institutions in Germany. | [140] Against this backdrop, there is an increased urgency for systemic reflection and decisive change.

A shift in health policy orientation towards engaging and patient-centred care, based on the principles of prevention and health promotion — including increasing the population's health literacy — can be a decisive factor in meeting current challenges. Various model calculations show that even small changes aimed at increasing healthy life expectancy could significantly reduce age-related public expenditure in the coming decades. This would not only prevent health care costs from continuing to rise, but also support the functioning of the health care system and its skilled workforce, while having a positive impact on other areas of social security and the labour. | [141]

Future scenarios for Germany

According to Zeeb and Busse (2024), **various scenarios are conceivable for the future** of prevention and health promotion in Germany. | [142] Based on this, the WR has reflected on development opportunities and urgent actions for Germany, elaborating these in two adapted scenarios.

Scenario 1: Business as usual until the system becomes overloaded

In this scenario, prevention and health promotion in Germany continues to operate on many unconnected levels in an unsystematic manner. There is no overall strategy and insufficient evidence-based practice. The approach is strongly project-oriented with little impact. It also remains closely aligned with an individual medical paradigm (focused primarily on secondary and tertiary prevention and cure). Consequently, resource flows remain largely unchanged, and fundamental successes in preventing significant health challenges, such as chronic non-communicable diseases, remain elusive.

A key reason for this is the ongoing lack of collaboration between research and practice in all areas of prevention. This hinders the implementation of well-evaluated measures and the sustainable, equitable design of prevention and health promotion, particularly with regard to fair access. Furthermore, there is still a lack of sustainable networks between different stakeholders and interdepartmental, health-oriented policy approaches. Instead, federal and sectoral fragmentation hinders the necessary integrated, cross-system approach.

| [140] See the German Council of Experts for the Assessment of Developments in the Health Care System and Long-Term Care (2024), p. 92.

| [141] See the Federal Ministry of Finance (2024), p. 74 ff. See also the WHO's Quick Win Interventions and their implementation in countries such as Sweden, Belgium and Luxembourg. See WHO (2025c), p. 14 f.

| [142] Zeeb and Busse (2024, p. 563 f.) refer to a scenario analysis for the US system according to Patrick (2008).

In an extreme scenario influenced by a more neoliberal economy, various recessions and crisis dynamics, the progression of climate change and demographic change, competition for resources intensifies both nationally and internationally. This also applies to the distribution of funds between political departments. Systemic pressure resulting from the disproportionate treatment of chronic conditions leads Germany to move away from its solidarity-based system, increasing social inequality in the provision of preventive services. In this scenario, preventive services are no longer part of the standard range of services due to the high cost to health insurance funds, further increasing the privatisation of health care. This results in growing socio-economic inequality within the health care system. Low-income groups find it very difficult, if not impossible, to access health promotion and prevention services. This further erodes trust in state institutions and health care.

Scenario 2: Focus on prevention and health promotion

In this alternative scenario, the principles of prevention and health promotion are central to medical and health science research and teaching, as well as to health care. They are also specifically addressed in various policy areas, scientific disciplines and professions. There is a consensus that prevention and health promotion involve factors beyond medicine, including environmental changes, socio-economic aspects, educational issues and gender dimensions, and that cross-sectoral action is necessary to create health-promoting living conditions. Evidence-based measures for prevention and health promotion are adopted quickly and systematically, including within the standard health care system. In this area, prevention and health promotion measures work on an interprofessional basis, rather than in accordance with the market mechanisms of curative medicine. Therefore, it is essential for all other medical and therapeutic professions to be involved, including nursing professionals, community health nurses (CHNs), physiotherapists, speech and language therapists, occupational therapists, midwives, obstetric nurses, psychologists, pharmacists, social workers, sports scientists and nutritionists. A coordinated approach geared towards care objectives allows for better control of health care costs. This also enables the development of more targeted measures for vulnerable groups, with the aim of improving health and quality of life for all. At the same time, start-ups and companies that are newly developing in this area are creating an industry that combines modern technical possibilities, such as personalised medicine and digitally supported health solutions (e.g. apps, wearables and miniaturised sensor technology), with improvements in individual health.

Consequently, the health status of the population improves continuously in the medium to long term. In an OECD comparison, Germany's health status in this scenario is above average for EU and OECD countries, particularly in terms of life expectancy and healthy life years. Furthermore, the increase in healthy life expectancy reduces age-related public expenditure. A stronger focus on health

also has other benefits for society as a whole, including educational success, the ability to work, social participation, mental resilience and ecological developments.

With these recommendations, the WR is attempting to help shape scenario 2, with a focus on prevention and health promotion.

D.II PREVENTION AND HEALTH PROMOTION – CLARIFICATION OF TERMS

The task of preventing illness and promoting health falls to political institutions and various scientific disciplines, including medicine, social sciences and health sciences. However, it is also the responsibility of society as a whole.

According to the WR, it is essential to consider **individual behavioural and social relationship aspects** together, rather than in isolation. | [143] This is based on a **concept of health** that encompasses not only basic physical constitution and condition, but also psychological and lifestyle-related characteristics and influencing factors. In line with the **BCI approach**, this includes environmental, economic, gender-sensitive and biopsychosocial dimensions of health, as well as molecular biological aspects. Such an expanded concept of health necessitates behavioural issues and interventions as well as interdisciplinary and interprofessional strategies regarding structural prevention and its interaction with behaviour. In its considerations, the WR focuses primarily on somatic and mental human health. Nevertheless, the WR considers approaches that take a more holistic view of human, animal and environmental health (see chapter D.IV.1 on the One Health concept) to concepts of planetary health | [144] to be equally important and forward-looking – not only for society and health care, but also for interdisciplinary scientific issues.

In the general understanding of the term | [145] disease prevention, it is important to distinguish between **primary, secondary, tertiary and, in more recent differentiation, quaternary prevention** measures. While primary prevention measures at the population level are expected to have the greatest medium- to long-term effect on health, questions about how to better deal with conditions that manifest early in life — such as hereditary disorders — or how to cope with existing clinical presentations, also play an important role (secondary and tertiary prevention). Finally, in particular from a medical perspective, the use of

| [143] See also Loss; Saß; Betsch (2025), pp. 969–970.

| [144] The concept of planetary health views human health as inextricably linked to the health of ecosystems. See KLUG German Alliance on Climate Change and Health (n.d.).

| [145] The understanding of prevention by social insurance schemes (including health, long-term care and pension insurance) differs depending on their respective systemic tasks.

medication and therapy must always be carefully considered to avoid incorrect and excessive treatment (quaternary prevention). In addition to primary prevention, which the WR considers a particularly relevant starting point, secondary, tertiary and quaternary prevention measures are also important at the individual and collective levels.

Below is a compilation of relevant definitions of primary, secondary, tertiary and quaternary prevention; the difference between behavioural and structural prevention; health promotion and health protection; and the BCI approach.

Definitions of primary, secondary, tertiary and quaternary prevention

Primary prevention | [146]

This refers to measures aimed at preventing diseases or health problems before they arise. It focuses on reducing risk factors and promoting a healthy lifestyle to prevent disease development. Examples include vaccinations to control pathogens and their long-term effects, programmes to promote healthy eating and physical activity as well as initiatives to reduce tobacco and alcohol consumption. Awareness campaigns and environmental and occupational safety measures also fall into this category. The ultimate goal is to prevent diseases from developing in the first place. Primary prevention is mainly aimed at healthy individuals or population groups. The respective services in the area of primary prevention and health promotion for health insurance funds are defined in SGB V §20.

Secondary prevention | [147]

Secondary prevention involves taking measures to detect diseases at an early stage, enabling early treatment and slowing or stopping the progression of the disease. This form of prevention focuses on the early detection of diseases in people who are not yet showing any symptoms, but who are in the preliminary stages of a disease. Examples include regular screening examinations such as mammograms for the early detection of breast cancer, organised screening programmes for colon and cervical cancer as well as urological preventive examination for the early detection of prostate cancer. It also includes blood pressure and blood sugar measurements to detect hypertension and diabetes, respectively. The aim of early diagnosis is to prevent complications and the disease from worsening, and to improve treatment success.

| 146 See Hurrelmann et al. (2024), p. 48.

| 147 See ibid.

Tertiary prevention | [148]

Tertiary prevention comprises measures aimed at minimising the effects of an existing disease, improving the quality of life of those affected and preventing complications. It comes into effect after the onset of a disease and focuses on preventing secondary diseases or serious impairments, as well as supporting the competent and self-determined management of the disease. This includes rehabilitation programmes and intensive aftercare for chronic diseases. It covers both physical and mental illnesses as well as any combination of the two.

Quaternary prevention | [149]

Alongside the classic triad of primary, secondary and tertiary prevention, quaternary prevention is a newer differentiation that describes the avoidance of harm through medical and (psycho)therapeutic measures. These measures include incorrect or excessive treatment, such as excessive diagnostics (in particular imaging, laboratory medicine and technical examinations without therapeutic consequences), repeating examinations already carried out as well as invasive procedures (e.g. surgical treatment before conservative measures have been exhausted). They also include continuing medication without regular checks to ensure that the indication still exists. In case of doubt, the focus should be on ruling out preventable dangerous developments so as to avoid potential harm and "low-value care" (e.g. continuing maximum therapy for advanced cancer requires prior information, consideration and a joint decision with the patient). A sustainable doctor-patient relationship, regular critical review of all measures taken, and restraint with regard to maximum medication or therapy are paramount. In nursing, quaternary prevention involves critically questioning standardised routines that provide no individual benefit and may cause stress. Examples include unnecessary restraints, routine indwelling catheterisation and rigid repositioning intervals. In therapeutic contexts such as physiotherapy, occupational therapy and psychotherapy, it is also important to avoid over-treatment, for example through long-term therapies or measures without proven additional benefits.

The shared goal of medicine, nursing and therapy is to protect patients and those in need of care from over-treatment and harm, ensuring quality of life and promoting needs-based, person-centred care.

| [148] See Franzkowiak (2025) and Robert Koch Institute (14 December 2023).

| [149] See Klimm; Peters-Klimm (2019).

Definition of behavioural and structural prevention

Behavioural prevention | [150]

Behavioural prevention refers to measures aimed at changing individuals' or groups' behaviour in order to reduce the risk of health problems. It focuses on promoting behaviours that benefit health and reduce the risk of disease. Examples of such initiatives include those by health insurance companies that aim to reduce unhealthy behaviours, such as smoking, excessive alcohol consumption, physical inactivity and an unhealthy diet, while promoting healthy alternatives, such as physical activity and a healthy diet.

Structural prevention | [151]

Structural prevention refers to measures aimed at improving social, economic and environmental conditions that negatively impact health behaviour. It focuses on changing the external conditions and structures that influence the health behaviour and quality of life of individuals and population groups. Examples of such measures include improving working conditions, creating healthy living environments, promoting access to healthy food and improving air quality. Structural prevention takes into account the social and structural dimensions of health, and is often aimed at society as a whole.

Health promotion | [152]

The term health promotion was first defined in the WHO's 1986 Ottawa Charter (see chapter D.IV.1) as a process that enables people to take greater control of their health and strengthens their ability to maintain it. Health promotion follows a salutogenic approach, focusing on health and well-being as well as the resources and skills required to achieve them. It concentrates on the development and maintenance of health.

Health protection | [153]

Health protection encompasses all legally established measures aimed at averting dangers to human life and health. In contrast to health promotion, it is generally mandatory. The aim is to avoid health risks and eliminate existing hazards. The central principles of health protection are the precautionary principle, the polluter pays principle and the collaboration principle, which structure government action. Health protection is applied in many areas of life, such as occupational safety and infection control, disaster and consumer protection, and the monitoring of food, medicines and environmental factors. In

| 150 See Franzkowiak (2025), Geene; Köckler; Trojan (2022) and Robert Koch Institute (14 December 2023).

| 151 See ibid.

| 152 See Niederberger; Finne (2021), p. 6 f. and Kaba-Schönstein (2018).

| 153 See Kuhn; Böhm (2024).

Germany, the state's responsibility for health protection is derived from the constitutional Basic Law (Art. 2 (2) Basic Law (GG)).

Behavioural and cultural insights (BCI) approach | [154]

The BCI approach is based on empirical evidence from a variety of scientific disciplines, including psychology, sociology, ethnology, economics, communication, sports science, nutrition and political science. These findings demonstrate how people make health-related decisions in their everyday lives, as well as the factors that influence their health-related behaviour, including motivational ones. Both contextual and individual barriers and facilitating factors are identified and compiled. Based on this evidence, the aim is to develop interventions that are as tailored and effective as possible, pursuing the goal of achieving better health and equal health opportunities at the population level. In addition to evaluating the effectiveness of the developed health-related measures, a key element is the participatory involvement of the target groups and potential multipliers in their development.

D.III HEALTH POLICY AND LEGISLATIVE FRAMEWORK FOR PREVENTION AND HEALTH PROMOTION

The strategic and legislative framework conditions for prevention and health promotion are currently strongly dependent on health policy at the federal, state and local levels.

Considerations regarding the restructuring of everyday health care provision with a focus on prevention directly affect university medicine, as it plays a special role in the health and health care system. Through its research and training activities, it contributes significantly to the further development of health care provision and health research. | [155] At the same time, systemic changes and shifts in focus regarding health policy and legislation always impact university medical institutions and other scientific institutions involved in health research.

III.1 Actors in prevention and health promotion in German health policy

The German health care system can be described as a complex multi-level control system based on the interaction between state political regulations and the delegation of (executive) powers to various actors within the system, including associations, the medical profession, service providers and reimbursers. | [156]

| 154 See Loss et al. (2025).

| 155 See WR (2021), S. 19.

| 156 See Gerlinger; Rosenbrock (2024), p. 21 f.

Essentially, the federal and state governments set the legal parameters for the health care system, limiting themselves otherwise to individual tasks (e.g. hospital planning or the ÖGD, with health administration institutions at the federal, state and local levels). The operational management of care processes and structures, including key remuneration issues, is the responsibility of the system's joint self-administration, comprising associations, cost bearers and service providers. | [157]

In the field of prevention and health promotion in particular, additional actors and interest groups exist. Alongside government institutions, public-law corporations and independent organisations also operate at the federal, state and/or local levels. These institutions are located in both the health sector itself (e.g. health authorities) and other areas of society (e.g. occupational safety, environmental protection and food safety). At the local level in particular, measures aimed at creating healthy living conditions for citizens and providing access to health-promoting services are included in public services. Statutory health insurance funds can support local authorities in this regard and promote appropriate measures. | [158] In addition, the federal states, social insurance institutions and private employers in Germany play an important role in occupational safety, accident prevention, health protection and workplace health promotion.

Almost all federal states have coordination structures in the form of "health conferences" to jointly sponsor health promotion and prevention measures. Many federal states have been holding such health conferences since the 2000s. These are partnerships between various institutions and stakeholders in the health care system at local and municipal levels, which are provided with an institutionalised forum for information, networking and exchange through the respective conferences. | [159] University medicine is also involved in some state health conferences, for example in Baden-Württemberg. | [160] The exchange is mainly informal and topic-related. However, the participation of university medicine in state health conferences has not yet been systematically or structurally developed. There is considerable potential here with regard to the translation and implementation of preventive and health-promoting interventions at the population level.

In addition to state-wide health conferences, some states also hold municipal health conferences. These aim to stimulate improvements in specific regions that require particular control and action in relation to local health and health

| [157] See WR (2021), p. 31.

| [158] See the GKV Alliance for Health (2025).

| [159] See Hollederer; Trojan (2025).

| [160] See, among others, the Ministry of Social Affairs, Health and Integration Baden-Württemberg (n.d.).

care. In some cases, these are also linked to model regional health initiatives. Examples can be found in Bavaria, North Rhine-Westphalia. | [161]

The ÖGD also plays a special role among the actors involved in and prevention and health promotion at the federal, state and local levels. | [162] Overall, the ÖGD takes a population-based approach to its work. This complements the individual medical care approaches of medical professionals and, in some cases, acts as an additional resource for them. It applies when special needs make it necessary to ensure comprehensive vaccination or counselling services, for example. Beyond tasks relating to health protection and management, the ÖGD is responsible for general health promotion, health education and information. The ÖGD is particularly important in its function as a municipal-regional multiplier and through its knowledge of the respective local health situation. | [163] Recently, there have been increased efforts towards strengthening the scientific position of the ÖGD, including through bridge professorships (e.g. in Baden-Württemberg, Bavaria, Saxony, Hesse and North Rhine-Westphalia) and the promotion of academic multi-professionalism. Examples include the academic positions created as part of the Pact for the ÖGD | [164] and the possibility of completing the mandatory practical year (PJ) for physicians in training in ÖGD institutions. | [165]

In a 2024 statement | [166] , the "Advisory Board for Sustainable Structures in the Public Health Service in Implementation of the Pact for the ÖGD" stated that the health system alone cannot provide regional prevention, health promotion and care from a single source. Instead, it requires coordinated collaboration between

| 161 See Hollederer and Trojan (2025). In Bavaria, the three regional health conferences (in the city and district of Bamberg and the district of Weißenburg-Gunzenhausen in south-east Bavaria) were initially tested as pilot projects and then evaluated by the Bavarian State Office for Health and Food Safety (LGL). The conferences were deemed a success in terms of improving coordination, collaboration and exchange between various regional and municipal health stakeholders. Consequently, it was decided to expand their regional scope and transform them into a health region. See the Bavarian State Office for Health and Food Safety (ed.) (2015).

| 162 The lowest level, and the level closest to citizens, is that of the health authorities or departments of the districts and cities. The next level up, in larger states, comprises health departments in district administrations of district governments, which often take on technical supervision of municipal institutions as well. Above these are the state health ministries, some of which are supported by state health authorities or higher authorities. At the federal level, institutions of departmental research, particularly the BMG, also perform public health service tasks and are assigned to this area. Hurrelmann et al. (2024), p. 398 f.

| 163 See ibid., pp. 402–406.

| 164 See the Federal Ministry of Health (12 November 2024).

| 165 See the Advisory Board Pact ÖGD (ed.) (2023), p. 24 f.

| 166 See the Advisory Board Pact ÖGD (ed.) (2024).

actors from public health, social affairs, labour, planning, transport and security.

III.2 Legislative framework and health policy strategies for prevention and health promotion

Currently, German health policy continues to focus strongly on aspects of disease care, including early detection and rehabilitation measures. Prevention, particularly primary prevention, health promotion and the associated measures to change individual behaviour and contextual conditions in terms of living environments, plays a subordinate role. | [167] This may be partly due to the fact that, although the 2015 "Act to Strengthen Health Promotion and Prevention (PrävG)" represented an important legislative step towards more binding and coordinated prevention measures between service providers in the health system, the processes of strategy development, goal setting and control are largely left to the service providers themselves. For example, social insurance providers were obliged to coordinate their specific prevention mandates and services more effectively in the National Disease Prevention Conference (NPK, see chapter D.III.2.b) to improve the collaboration in, as well as quality and effectiveness of, their service provision. Implementing national health goals in Germany is also primarily the responsibility of the service providers (see chapter D.III.2.c).

Overall, the political shaping of health-promoting parameters in Germany continues to face difficulties. This is illustrated by the sometimes difficult path to the PrävG | [168], but also by the lack of policy development in areas such as nutrition (see chapter D.III.2.a). A major factor here is that responsibility for health promotion and prevention, particularly of non-communicable diseases, lies with the federal states (see Article 74 (19) of the Basic Law (GG)). The federal government can essentially make use of its concurrent competence to regulate social insurance institutions (see Art. 74 (1) No. 12 Basic Law (GG)). For this reason, the federal government has also addressed health insurance funds and social insurance institutions in the (Federal) PrävG.

In addition, certain decisions at the international level indirectly affect the area of (public) health, such as in the area of climate protection. In a recent statement on climate protection | [169], the International Court of Justice (ICJ) opined that a clean, healthy and sustainable environment is a human right and that this implies an obligation under international law for states to prevent significant environmental damage. Western industrialised countries such as Germany in particular are called upon to take action.

| [167] See Gerlinger; Rosenbrock (2024), p. 61 f.

| [168] See Meierjürgen; Becker; Warnke (2016).

| [169] See the International Court of Justice (2025).

The adoption of the PrävG ("Act to Strengthen Health Promotion and Prevention") which primarily affects Social Code V (SGB V), in particular Sections 20–26 | [170], was a significant step forward for prevention and health promotion in 2015. | [171] For the first time, the PrävG addresses the regulatory aspects of health promotion according to living environments (e.g. including the private sphere, companies and care facilities) and thus represents the starting point for addressing relational aspects as well. The Act obliges social insurance institutions to take structural and strategic measures to prevent and promote health in living environments. This includes the NPK established by the PrävG, comprising the binding collaboration between health insurance funds and other social insurance institutions, as well as the development and implementation of a joint prevention strategy (see chapter D.III.2.b). Only health and long-term care insurance funds, as well as statutory pension and accident insurance funds, are obliged to provide financial benefits that specifically promote health; private funds are not. However, the latter voluntarily contribute 22 million Euro annually to prevention and health promotion measures. While this has facilitated communication, the selection and control of measures remain the responsibility of the respective service providers. Some prevention and health promotion services appear to be designed more as a means for health insurance funds to compete for insured persons. In their GKV Alliance for Health, the health insurance funds promote local authorities' implementation of health promotion projects for vulnerable target groups in particular. Preventive changes, such as those relating to transport policy or urban planning, fall outside the remit of health insurance funds and therefore cannot, as a rule, be financed by the PrävG.

Critics emphasise that transferring essential tasks to social insurance providers, particularly statutory health insurance funds, does not allow for a holistic, systemic approach to prevention and health promotion. | [172] Key stakeholders in health promotion and prevention, such as scientific institutions, municipal

| 170 SGB V contains provisions governing statutory health insurance. Furthermore, the PrävG is not a standalone law, but rather an omnibus bill, as it amends existing legislation. See Wanek; Schreiner-Kürten (2021), p. 8.

| 171 The process leading up to the adoption of the PrävG was extremely difficult and spanned three legislative periods and various drafts. It started with basic ideas in the 1980s, continued with a concrete declaration of intent in the coalition agreement of the red-green federal government in 2002, and ended in 2015. Some drafts failed in the Bundesrat, while others failed within the various government coalitions. The main stages in the development of the PrävG can be found in more detail in the table in Gerlinger and Rosenbrock (2024), p. 89 f.

| 172 See also the guest article by Geene (30 June 2025) on the 10th anniversary of the PrävG.

authorities, civil society organisations and ÖGD, remain underrepresented. | [173] The PrävG's mandate for statutory health insurance funds to design measures and support living environments complements the responsibility of federal states, local authorities and companies to create healthy living, learning and working conditions. However, the fragmented stakeholder landscape and their different areas of responsibility make coordination both costly and extremely difficult.

The adoption of the PrävG as such, together with the explicit requirements it sets out for comprehensive collaboration between the various actors in the NPK, represent important steps in German health policy. | [174] However, exactly ten years after the law was passed, voices calling for its reform are now growing louder in public discourse. | [175] In the summer of 2025, for example, the GMK published a resolution urging the federal government to amend the law to firmly establish health promotion as an overall societal responsibility. | [176] At the same time, it should be noted that, although the federal states have legislative competence for health promotion, none have passed regulations at the state level in line with the Prevention Act. Nevertheless, some states have developed their own state-specific strategies based on the PrävG provisions (see D.III.2.b).

Beyond the PrävG, there are various consumer-related areas in which legislative regulations could be introduced to promote health. These include changes to the taxation of consumer goods proven to be harmful to health, such as alcohol, tobacco and foods high in sugar, including implicit and explicit advertising practices. These are all important drivers of chronic, non-communicable diseases. As a measure that can demonstrably impact population health within one year, the WHO lists increasing the price and taxation of these products. | [177]

Although some measures have been taken in Germany, particularly with regard to tobacco control and reducing tobacco consumption, these efforts fall far short of what is actually possible. This is evident from the lengthy process of restricting tobacco product advertising, which has only been gradually addressed since 2020. | [178] It is also evident from Germany's ranking as 67th out of 90 countries

| [173] See Gerlinger; Rosenbrock (2024), p. 93 ff.

| [174] See Wanek; Schreiner-Kürten (2021), p. 10 f.

| [175] See the Association of Private Health Insurers (2025) and Geene (30 June 2025).

| [176] See Conference of Health Ministers (GMK) (2025).

| [177] See WHO (2025d).

| [178] See Gerlinger; Rosenbrock (2024), p. 123 ff.

(as of 2023) in the Global Tobacco Index, which places it firmly in the bottom third. | [179]

In other areas, such as taxation and price increases for unhealthy foods (e.g. fast food and sugary soft drinks), Germany also lags far behind countries such as Ireland | [180] and the United Kingdom | [181] in a European comparison. This is confirmed by the 2025 update of the Nanny State Index, which was compiled by the Institute of Economic Affairs (IEA), a British think tank that promotes free-market policies. The index ranks European countries according to the extent to which regulatory interventions restrict the population's lifestyle habits, e.g. the taxation of alcohol, tobacco and certain foods. The current ranking shows that Germany has the most liberal market policy and the fewest regulatory restrictions on alcohol, cigarettes/e-cigarettes and food/soft drinks for the fourth consecutive time, compared to 28 other European countries (including Türkiye) (see Table A.4). | [182] Data from the WHO | [183] also show that the commercial drivers of non-communicable chronic diseases pose significant health risks, especially for socially disadvantaged population groups. According to the WHO, stricter regulations of the four industries primarily responsible for this (alcohol, tobacco, highly processed foods and fossil fuels) are urgently needed to protect public health. The results of the Public Health Index (PHI), published for the first time in autumn 2025 by the AOK Federal Association and the DKFZ, also highlight Germany's considerable regulatory backlog. | [184]

III.2.b National Prevention Conference (NPK) and National Prevention Strategy

One of the PrävG's key health policy instruments is the establishment of **the NPK**. This is a working group comprised of the leading organisations of all social

| [179] The Global Tobacco Index provides information on the extent to which the tobacco industry's commercial interests influence health policy-making in countries. The most recent report is available for 2023. See Assunta (2023).

| [180] See Revenue. Irish Tax and Customs (14 May 2025).

| [181] The United Kingdom introduced a tax on soft drinks in 2018, levied according to the amount of added sugar. See Sasse and Metcalfe (14 November 2022).

| [182] For example, Germany currently has no sugar tax, no display bans for cigarettes or e-cigarettes in retail outlets, and no legal closing time for bars. Taxes on beer, alcohol and cigarettes are among the lowest in Europe. Only three of the sixteen countries have a comprehensive smoking ban. See the 2025 Nanny State Index (n.d.).

| [183] See WHO. Regional Office for Europe (2024).

| [184] AOK and DKFZ, together with an interdisciplinary research team, compared regulatory measures in 18 European countries in the areas of tobacco, alcohol, nutrition and exercise. German-speaking countries in particular lag behind in all areas – often very significantly – in a European comparison. For further details, see AOK-Bundesverband eGbR (ed.); German Cancer Research Centre (ed.) (2025).

insurance schemes (health, pension, accident and social care insurance). These organisations have voting rights and take turns chairing the NPK. | [185] Since 2017, the Association of Private Health Insurance (PKV) has also been involved as a voting member, voluntarily contributing to the funding of prevention in everyday life. The federal and state governments along with other civil society actors, municipal umbrella organisations, social partners and patient representatives, are involved in the NPK as **advisory members**. The federal government is represented by four ministries (Health; Labour and Social Affairs; Agriculture, Food and Rural Affairs; and Education and Family Affairs), while the federal states are represented by the GMK and the Federal States Committee on Occupational Safety and Safety Engineering of the Conference of Ministers of Labour and Social Affairs (ASMK). Organisationally, the NPK is supported by an office based at the BIÖG. | [186]

In accordance with Section 20e of the German Social Code, Book V (SGB V), the NPK is responsible for developing a **national prevention strategy** to promote prevention and health promotion in Germany. This involves formulating federal framework recommendations (BRE) and documenting the resulting developments in the form of a **prevention report**, | [187] to be submitted every four years. The BRE contain overarching strategic goals and resulting fields of action that cover all age groups, with the aim of addressing all aspects of prevention and health protection related to everyday life. | [188] The BRE are voluntary guidelines for action that instruct the providers of statutory health, accident and pension insurance, social care insurance and private health insurance to contribute to the respective areas. The three overarching goals are:

_ Growing up healthy

_ Healthy living and working

_ Healthy in old age

The implementation of the prevention strategy and the specification of the objectives are at the state level and are set out in **state framework agreements (LVR)**, which are made by the state associations of health and substitute insurance funds, including for long-term care insurance funds, with the statutory pension insurance providers, the state associations of statutory accident insurance and the states (see Section 20f SGB V). The BRE and the overarching goals and scope of action serve as a guide, but can be supplemented by regional

| [185] See the Social Security Code V, Section 20e, URL: https://www.gesetze-im-internet.de/sgb_5/

| [186] See the National Prevention Conference (n.d.).

| [187] Two reports have been published to date, in 2019 and 2023. See the National Prevention Conference (2019) and the National Prevention Conference (2023).

| [188] See the National Prevention Conference (2018).

priorities specific to each state. | [189] All 16 states have concluded state-level framework agreements with the social insurance providers. | [190] To monitor these objectives, a prevention indicator system has also been developed at the national level | [191], which forms the basis for the NPK's prevention reports. Some federal states have developed their own state-specific strategies for prevention and health promotion based on the provisions of the PrävG, launching strategic programmes and action alliances that aim to support and implement the LVR's objectives and measures. | [192]

Once a year, the NPK organises a prevention forum where various organisations and associations can exchange information and experiences from the field of prevention and health promotion. The forum's objective is to engage the invited groups in the development of the national prevention strategy and generate ideas for the BRE's further development. The NPK commissions the BVPG to organise this specialist forum.

In addition to the BRE and its overarching objectives, Germany also has what are known as **National Health Goals** (see chapter D.III.2.c). However, these should be considered separately from the NPK regarding their development and responsibility processes. They also differ in terms of category, history, involvement of stakeholders, significance for the various system actors and the coverage they achieve.

In addition, Section 20g of the SGB V enables service providers and the relevant associations to develop **model projects** for achieving the objectives set out in the framework recommendations and associated measures. These projects must also be scientifically monitored and are generally designed to run for five years. | [193] One example of this is the "Healthy Working in Thuringia" collaboration project | [194] by the BARMER health insurance and the German Society for Occupational and Environmental Medicine (DGAUM), conducted under the auspices of

| 189 See the National Prevention Conference (2018).

| 190 This includes state and regional associations of health insurance funds (usually AOK, BKK; IKK; miners' social insurance fund, social insurance for agriculture, forestry and horticulture, and substitute and nursing care funds), the Association of Substitute Funds, pension insurance providers (regional and federal as well as miners' social insurance fund for rail and sea) and accident insurance providers (German statutory accident insurance and social insurance for agriculture, forestry and horticulture). An overview of all LRVs can be found here: National Prevention Conference (n.d.).

| 191 See the Prevention Indicators Sub-Working Group (ed.) (2021).

| 192 For example, in Hamburg: The state of Hamburg concluded a "Pact for Prevention" in 2008. In addition to the LRV, this serves as a strategic framework for developing and implementing various measures in different fields of action, resulting from the national PrävG. See the Hamburg Working Group for Health e.V. (n.d.).

| 193 See the Social Act V, Section 20g, Paragraph 2, URL: https://www.gesetze-im-internet.de/sgb_5/

| 194 See the German Society for Occupational Medicine and Environmental Medicine; BARMER (2017).

the Thuringian Ministry of Health. Running from 2017 to 2021, the project aimed to improve health promotion and prevention in the workplace in Thuringia. The DGAUM was responsible for the scientific monitoring and evaluation of the project. A key outcome of the project is a modular toolkit containing guidelines and checklists for intercompany networking of micro, small and medium-sized enterprises (MSMEs), intended to serve as a nationwide resource for MSMEs. The final report has been available since 2025. | [195]

In 2024, the BMG launched the National Prevention Initiative (NPI) to further develop existing strategic approaches with the NPK members, examining the interaction between various actors and expanding networking potential. | [196]

In addition, separate movements are emerging at the state level with a view to broader prevention strategies and alliances. In **Baden-Württemberg**, the establishment of a **prevention alliance** | [197] was announced in autumn 2025, with the aim of achieving a more prevention-oriented focus in state health policy. To this end, stakeholders from science and research as well as the business community will be explicitly involved in strengthening innovation in the field of prevention and health promotion, ensuring a better evidence base, and ultimately improving the effectiveness of health-promoting measures and increasing health literacy, especially among vulnerable groups. At almost the same time, the **state of Bavaria** announced the publication of a **Bavarian Prevention Master Plan** | [198], which aims to anchor prevention and health promotion structurally in the state and for the long term. To this end, a distinction is made between structural and health objectives. The structural goals represent the systemic framework, for which the state is responsible and which is to be designed with a stronger focus on prevention and health (e.g. through the expansion of prevention reporting, a statewide prevention day, the establishment of prevention conferences and a statewide overview of services). The health objectives cover individual health aspects, such as improving health literacy, strengthening mental health, reducing obesity and preventing or delaying the need for long-term care. To achieve these goals, collaboration with various stakeholders and partners (including those from university medicine) is planned. The master plan is designed as a holistic life-stage strategy. In both states, explicit efforts are being made to achieve interdepartmental collaboration.

| [195] See Drexler et al. (2025).

| [196] See the Federal Ministry of Health (2025a).

| [197] See the Baden-Württemberg State Ministry (24 September 2025).

| [198] See the Bavarian State Ministry of Health, Care and Prevention (2025).

Health goals are a tool for enabling various social stakeholders to identify different objectives in the field of health, consider possible courses of action and demonstrate a commitment to achieving these objectives. In principle, these goals can focus on specific areas or groups or address structural conditions within health care systems. |[199] The concept of health goals as a steering instrument has its origins in decisions made by the WHO, which has promoted the development of global health goals for the international community since the 1970s. |[200]

These international developments have led to various country-specific approaches to formulating health goals at the national level, including in Germany. Against this backdrop, in the 2000s, the Federal Ministry of Health (BMG) collaborated with the federal states to significantly advance the development of national health goals for Germany. In 2007, the BMG launched the health goals collaboration network gesundheitsziele.de |[201], which currently brings together over 140 different health-policy stakeholders and associations from the social and health sectors. |[202] This network has developed ten national health goals for Germany for the current period (as of 2025) through an iterative processes:

_ Goal 1: Type 2 diabetes mellitus: reduce the risk of disease, detect and treat patients early *(a national health goal since 2003)*

| 199 See Gerlich; Schwarz; Walter (2023).

| 200 Based on the WHO Declaration of Almaty (until 2003: Alma Ata) in 1978, the WHO presented its first global health target programme, “Health for All”, which has been updated and further developed several times over the years. For Europe, the European Regional Office of the WHO and the 53 member states of the European Region adopted the European “Health 2020” health framework concept in 2012, which has also been incorporated into the implementation of the 2030 Agenda for Sustainable Development. See ibid.

| 201 Gesundheitsziele.de is a follow-up association that emerged as a BMG-funded project from the original GVG committee “Medical Orientation in the Health Care System” and was transferred in 2006 to the sponsorship of various health care and social insurance organisations. See Gesellschaft für Versicherungswissenschaft und -gestaltung e. V. (n.d. a).

| 202 Members of the collaboration network include various federal ministries (including the Federal Ministry of Health (BMG), the Federal Ministry for Economic Affairs and Energy (BMWE) and the Federal Ministry of Food and Rural Affairs (BMLEH)), state and local authorities, federal agencies, including departmental research institutions, professional associations, patient and self-help organisations, trade unions, welfare organisations, industry and science. The network is supported by the GVG, 12 federal states (not participating: Berlin, Hamburg, Saxony and Schleswig-Holstein), medical associations and societies, the PKV Association, health insurance funds and associations, and the German Hospital Federation. (See Gesellschaft für Versicherungswissenschaft und -gestaltung e. V. (undated b)).

_ Goal 2: Breast cancer: Reduce mortality and improve quality of life *(a national health goal since 2003, updated in 2010 and 2014)*

_ Goal 3: Reduce tobacco consumption *(a national health goal since 2003, updated in 2015)*

_ Goal 4: Growing up healthy: life skills, exercise and nutrition *(a national health goal since 2003, updated in 2010)*

_ Goal 5: Increase health literacy and strengthen patient autonomy *(a national health goal since 2003, updated in 2011)*

_ Goal 6: Depressive disorders: prevention, early detection and long-term treatment *(a national health goal since 2006)*

_ Goal 7: Healthy in old age *(a national health goal since 2012)*

_ Goal 8: Reduce alcohol consumption *(a national health goal since 2015)*

_ Goal 9: Health around childbirth *(a national health goal since 2017)*

_ Goal 10: Patient safety *(a national health goal since 2022)*

The aim is to make these goals as diverse as possible and to take the Health *in* All Policies concept into account. In line with this approach, specific measures are proposed for each goal. These include formats for promoting social participation (sub-goal 1 of health goal 7), lifelong learning and the expansion, continuation and establishment of flexible partial retirement models (sub-goal 2 of health goal 7). The goal audience includes relevant stakeholders from various policy areas at the federal, state and local levels, as well as from academia, civil society and the private sector. The health goals are selected, defined and reviewed via a multi-stage scientific process, the responsibility of the Evaluation Advisory Board of the gesundheitsziele.de network. | [203]

Various measures and, in some cases, evaluation processes have been implemented over the years to achieve the goals. However, systematic monitoring and evaluation of the health goals has only taken place to a limited extent so far, and communication on this subject is fragmented. Although the Evaluation Advisory Board has developed evaluation concepts for assessing goals, sub-goals and measures, these have only been applied to three goals thus far. | [204] Existing data (e.g. from the RKI) is used for evaluation purposes. There is no regular monitoring of the objectives using clearly defined indicators. Some of the objectives have been

| [203] See the Gesellschaft für Versicherungswissenschaft und -gestaltung e. V. (2018).

| [204] Evaluation concepts have been developed for the goals of "reducing tobacco consumption", "depressive disorders" and "increasing health literacy, strengthening patient sovereignty" and have been evaluated for the health goal of "reducing tobacco consumption". This was done in close collaboration with the health survey/monitoring of the RKI and BIÖG. The BMG publishes the results of gesundheitsziele.de developed by itself and its two specialist authorities, the RKI and BIÖG, in its publications. See Hess (2012), p. 19.

updated over the years and, in the process, the current health situation has also been considered for each goal. However, the specific processes are difficult to understand. Furthermore, their integration into an overall national strategy is not guaranteed, and there is no follow-up to ensure that the goals are achieved.

The first eight of the existing national health goals were incorporated into the PrävG |[205] (Prevention Act), which was enacted in 2015. One consequence of this is that, when defining uniform fields of action and criteria for health insurance funds' primary prevention and health promotion services, the GKV-Spitzenverband (National Association of Statutory Health Insurance Funds) must take into account the content of the health goals relevant to these services. |[206] Some federal states have also developed their own health goals. |[207]

A brief digression: Health goals and prevention policy in the Netherlands – a look across the border

The Netherlands is considered to have one of the most systematic prevention policies in Europe. There, health is understood not only as an individual matter, but as a societal responsibility, too. The strategy aims to link prevention and health promotion closely with research, policy and practice, and to strengthen health equality among the population. Legal framework conditions, institutional structures, innovative programmes, the use of comprehensive health data and the integration of regional networks all play a central role in this. Despite these promising approaches, challenges remain, such as ensuring comprehensive care, the long-term financing of preventive measures as well as the long-term implementation of strategies – all of which are also important aspects of German prevention policy.

National goals and strategic programmes

One example of a comprehensive prevention strategy is the National Prevention Agreement |[208] initiated in the Netherlands in 2018. This multilateral agreement involves the government, businesses, local authorities, civil society organisations and scientific institutions, including the RIVM, various Dutch

| 205 See PrävG, URL: https://www.bundesgesundheitsministerium.de/service/gesetze-und-verordnungen/detail/praevg.html

| 206 See the Federal Ministry of Health (2024) .

| 207 Baden-Württemberg can also be cited as an example here. The health targets in Baden-Württemberg are: 1. Reduce the risk of type 2 diabetes mellitus and mitigate its consequences; 2. Grow up healthy; 3. Reduce depressive disorders and the consequences of chronicity; 4. Age healthily and actively; 5. Reduce the consumption of legal addictive substances; 6. Detect and combat breast cancer earlier; 7. Increase health literacy, strengthen patient autonomy; 8. Health of the unemployed. See Ministry of Social Affairs, Health and Integration Baden-Württemberg (n.d.).

| 208 See the Ministry of Health, Welfare and Sport (2019).

universities, the Netherlands Institute for Health Services Research (NIVEL) and the Scientific Council for Government Policy (WRR). These institutions support the agreement through research, data analysis and the development of evidence-based measures.

The agreement sets specific goals for reducing tobacco consumption, obesity and alcohol abuse, and promotes programmes to encourage healthy eating and exercise, particularly in schools. Specific measures are geared towards vulnerable groups, such as providing breast cancer screening for women with a migration background and offering low-threshold health services to people in socioeconomically disadvantaged situations. However, evaluations by the RIVM have shown that the goals set out in the agreement have not yet been achieved and that more needs to be done.

In addition, the Dutch Health in All Policies agenda pursues health as a cross-cutting task. It takes an interdepartmental approach, focusing on four central areas of action:

_ Social security and labour market participation

_ Healthy childhood and youth

_ Health-promoting environmental conditions

_ Transformation of the health system towards greater participation and self-determination

The aim is to systematically integrate health issues into various policy areas, moving beyond the traditional care perspective. Health in All Policies thus supplements the National Prevention Agreement by adding a structural, intersectoral dimension that aims to promote long-term health equality.

Science, evidence-based approach and regional networks

The implementation of the Dutch prevention strategy relies heavily on close collaboration between research, politics, business and health care. Scientific expertise is combined with municipal structures and engagement from civil society in order to translate research findings into locally adapted prevention measures.

This process is underpinned by the continuous provision of health and social data, enabling evidence-based policymaking. Of particular importance is the Lifelines Study |[209], a population-based cohort study with over 167,000 participants from the north of the Netherlands. Since 2006, medical, social, psychological and biological data have been collected at regular intervals across three generations and processed in a high-quality database. This gives researchers access to comprehensive information on lifestyle habits, health parameters and

|[209] See Lifelines (2025), URL: https://www.lifelines.nl/

socio-demographic characteristics. At the same time, Lifelines contributes to the systematic inclusion of rural populations and supports the development of learning health systems, in which research and practice are continuously linked.

As part of the Dutch prevention strategy, regional initiatives serve as practical implementation platforms. The Ems-Dollart region, for instance, operates as a cross-border real-world laboratory where the Cross-Border Institute of Health care Systems and Prevention (CBI) devises and trials participatory, needs-based care concepts. These approaches help to transfer research results directly into regional care, establishing permanent structures for education, knowledge transfer and health management in the process.

At the same time, the GezondGroningen |[210] network is implementing the Health in All Policies approach at the regional level. This involves systematically linking health issues with the areas of education, the economy and civil society in order to design effective preventive measures, promote health equality and strengthen social participation.

The success of these networks hinges on reliable funding and the continuous evaluation of their effectiveness. This is the only way in which strategies can be adapted and innovative approaches permanently established, ensuring the effective implementation of the prevention strategy as a whole.

Conclusion and implications for German prevention policy

Although Dutch prevention policy aims to promote health in an integrated, cross-departmental way, it faces several challenges: limited political attention to prevention, especially given volatile political majorities; complex structures of responsibility; insufficient participation; and uncertainties regarding long-term funding. The difficulty of translating ambitious goals into concrete, binding implementation commitments is particularly evident.

Nevertheless, the Dutch approach offers valuable insights, such as stronger links between research and practice, the institutionalised integration of health into all policies, and targeted support for disadvantaged groups. These elements could help to make prevention more sustainable, increase social acceptance and ensure the long-term implementation of binding measures. Rather than relying solely on bans, it is important to emphasise the benefits of prevention and

| 210 The Gezond Groningen network promotes collaboration between the medical and social sectors with the aim of improving the health of the population of Groningen. Regional and city-specific plans are being implemented to promote health and prevent illness in the areas of mental health, physical activity and general health. Further information can be found at Gezond Groningen (2025), URL: https://gezondgroningen.nl/netwerk/

encourage the acceptance of health-promoting measures without triggering defensive reactions.

D.IV KEY ACTORS AND FOCAL POINTS IN SCIENTIFIC DISCIPLINES AND RESEARCH

IV.1 Prevention and health promotion in higher education and research institutions

Scientific research into health promotion and prevention is predominantly carried out in larger subject groups within the **medical and natural sciences** disciplines, such as medicine, public health, health services research, health sciences (including midwifery, nursing and therapy sciences), psychiatry, nutrition and sports sciences as well as in **educational**, **social and behavioural** sciences such as education, psychology, (health) communication and different areas of economics and sociology. However, disease prevention is not a modern concept – indeed, it is deeply rooted in the origins of medicine. In fact, it can be traced back to Hippocrates as a field of medical activity. Additional health science disciplines, such as nursing and other health and therapy sciences, also have historical roots that have influenced the field of medicine.

The emergence of **hygiene and disinfection measures** in the 19th century is one example of a development in medical history with clear health-promoting and preventive effects related to findings from other health professions. In 1847, Austrian physician Ignaz Semmelweis demonstrated that handwashing in obstetrics led to a significant reduction in maternal mortality. Semmelweis reached this conclusion by systematically examining the different mortality rates in maternity wards staffed by either doctors or midwives within the same hospital. He recognised the crucial difference in that doctors did not wash their hands after performing autopsies, thereby transmitting infections to women in labour. |[211] This finding was subsequently corroborated by the emerging field of bacteriology and the discoveries of Robert Koch and Louis Pasteur. Today, hygiene is a standard preventive measure in all medical facilities, not only in obstetrics. |[212]

Although prevention is not a new field for medicine and medical research, but rather a core component, it is currently perceived and promoted in Germany as being of little importance independent of and alongside curative medicine.

| 211 See Goddemeier (2011).

| 212 See Porter (2006a).

Indeed, it is often overshadowed by the latter. |[213] This biomedical orientation has several historical roots, including changes to the health system after 1945, such as the establishment and expansion of outpatient and inpatient sectors as well as medical advances in pharmacology, molecular biology, diagnostics and therapy. |[214] At the same time, these developments have significantly undermined the ÖGD and its institutions. The misuse of population health control in Nazi Germany also contributed to the neglect of the ÖGD in the decades following the war, a situation that continues to this day. This has led to a trend of focusing almost exclusively on shifting health issues to the field of curative medicine. |[215]

It should be noted here that developments in Germany differed between West Germany (the Federal Republic of Germany) and East Germany (the former German Democratic Republic). In East Germany, a more preventive approach to medicine was adopted. |[216] In West Germany, on the other hand, prevention was subordinated to a therapeutically oriented medicine. |[217] It was not until the 1970s that counter-movements emerged, calling for a stronger focus on the connection between living conditions and health and a shift away from a purely biomedical, curative focus. The continued rise in chronic degenerative and mental health conditions also highlighted the limitations of curative medicine.

Internationally, the realisation also gained ground that health cannot be defined solely in biomedical terms, but instead must be viewed in biopsychosocial terms and as a balance between individual resources and health and social requirements. |[218] The WHO's Ottawa Charter of 1986 marked a decisive turning point in this regard, laying the foundation for the expansion of prevention and the related focus on health promotion as a separate field and discipline. |[219]

| 213 Differences in approach between public health and biomedical research can be traced back to the early days of microbiology. One example of this is the contrasting approaches of Robert Koch and Rudolf Virchow: While Robert Koch, the co-founder of bacteriology, focused on bacterial causes of disease, Rudolf Virchow, a proponent of social medicine, emphasised the importance of social and environmental factors. See Porter (2006b).

| 214 See also Ruckstuhl (2021), p. 36.

| 215 See Kießling (2023), p. 47 f. and see Gerlinger; Rosenbrock (2024), p. 37.

| 216 Examples include the wide range of preventive and screening services and counselling centres, which primarily provide care for pregnant women and mothers, but also offer early screening programmes for children, as well as vaccination programmes, counselling and education on healthy lifestyles and nutrition. See, for example, Böttcher (14 March 2022).

| 217 See Schleiermacher (2005).

| 218 See Gerlinger; Rosenbrock (2024), p. 38 and Engel (1977).

| 219 See Ruckstuhl (2021), p. 38 ff.

The **Ottawa Charter** |[220] is the first resolution of the inaugural International Conference on Health Promotion, which was held by the WHO in Ottawa, Canada, in 1986. The conference aimed to develop action strategies for the overarching Health for All goal. The Charter, signed by 38 countries, sets out the following areas of action: developing a comprehensive health promotion policy (incorporating health promotion into policy and appointing those responsible for its implementation); creating health-promoting environments (taking environmental conditions into account and determining the interactive influence between human health and the environment); supporting health-related community actions (promoting self-help and regional activities in the community); developing personal skills (strengthening health skills and disseminating health promotion teaching); and reorienting health services (reorganising health care so that health promotion plays an important role). These scopes of action are to be implemented using three strategies: advocate (create stable policies and environments to secure basic requirements); empower and enable (ensure equal opportunities); and connect and network (create networks that bring together all industries and people from all areas of life). Following the first conference in 1986, subsequent conferences have incorporated new scopes of action and specifications. Since the eighth conference, which took place in Helsinki in 2013, the Health in All Policies concept has emerged.

For **academic research and qualification** in general, it can be said that prevention and health promotion play a role in various disciplines and that new fields of study have developed, including from interdisciplinary approaches. This has also led to the emergence of new scientific focal points, with an increasing number of studies focusing on the health of the entire population alongside those focusing on disease prevention and health promotion for individuals. This development has been evident since the 1990s, as can be seen from the development of **public health research** in Germany. |[221] Public health is typically a sub-field within medical departments, also when compared with other European countries. This has sometimes hindered the expansion of health-related issues beyond biomedical and clinical health. The US is a counterexample, as the field of public health tends to constitute a separate department there. |[222]

|[220] See WHO (1986) and Kaba-Schönstein (2018).

|[221] See Kuhn (2013), p. 26 and Ruckstuhl (2021), p. 45. Public health research primarily addresses the question of how the health of the population or specific population groups can be improved in the best possible way. It takes a holistic view of health, addressing the promotion of physical and mental health, disease prevention, health behaviour, the influence of living conditions and environments, and systemic requirements for health care (including the care situation in the event of illness). See Federal Ministry of Research, Technology and Space (15 July 2020).

|[222] See Paccaud; Nocera (2011), p. 69.

In contrast to the health sciences, public health research focuses on the conceptual and systemic aspects of public health. The **health sciences**, on the other hand, are characterised by a more interdisciplinary orientation and methodology as well as collaboration on everyday problems with partners from practice. |[223] In this context, midwifery, nursing and therapy sciences have also become independent fields of research, each making specific contributions. Nursing science has introduced preventive approaches in all phases of life, including patient education and health literacy promotion, the early detection of risks relating to infection, falls and pressure ulcers along with community-based concepts in the sense of community health nursing. Therapeutic sciences, such as physiotherapy, occupational therapy as well as speech and language therapy, offer preventive perspectives on exercise, language development, ergonomic working and functional participation in everyday life. Finally, midwifery science focusses on prevention and health promotion from pregnancy to early childhood, thereby strengthening the healthy development of families. Together, these disciplines significantly broaden the perspective on prevention and care by incorporating patient- and life-world-oriented approaches into scientific discourse.

The focus of **health services research** also differs from that of public health research. Health services research addresses the actors, structures, quality, effectiveness and efficiency of health care from a scientific point of view and has developed independently in recent years. |[224] Unlike public health research, it focuses particularly on the planning, organisation, regulation and evaluation of medical care in relation to affected patient groups, rather than on the health development of the population as a whole. |[225] Nevertheless, health services research sees itself explicitly as part of public health. |[226]

Health sciences, including midwifery, nursing and therapy sciences, as well as public health and health services research, have now established themselves as independent disciplines at German higher education institutions and in science. |[227] This is evident not least in the scientific umbrella and professional associations |[228] that exist in these disciplines as well as in the growing number

| 223 See Nowak; Kolip; Razum (2022).

| 224 See Hoffmann et al. (2025).

| 225 See, among others, German Research Foundation (2010).

| 226 See Hoffmann et al. (2025).

| 227 See Gerlinger (2024), pp. 7–14.

| 228 Notable examples include the German Network for Health Service Research (DNVF), the German Society for Public Health (DGPH) and the German Society for Social Medicine and Prevention (DGSMP). The WR considers organisation in professional associations to be one of the essential characteristics for the establishment and differentiation of scientific disciplines, see WR (2020), pp. 13 ff. and WR (2025).

of departments, institutes and degree programmes in Germany. |[229] With these developments, particularly the expansion to include social as well as medical, nursing and therapeutic interventions, the topics of disease prevention and health promotion have consequently become scientifically differentiated beyond the narrow field of medicine. |[230]

A brief digression: Science-based prevention in Germany – Impulses from Greifswald for an integrated public health strategy

The prevention landscape in Greifswald and Western Pomerania is characterised by the specific demographic and structural conditions of a rural region with low population density. Mecklenburg-Western Pomerania has a dynamically ageing population, a high burden of disease and a lower life expectancy than the national average. Key health indicators such as diabetes prevalence and mental morbidity are stagnating or showing negative trends in some areas – especially in socially disadvantaged and rural regions. Access to medical care is hampered by problems in filling vacancies in general practitioners' and specialists' practices. The skills shortage is jeopardising outpatient and inpatient nursing care and the existence of some care facilities in rural regions. At the same time, health is a high priority in state politics and is increasingly understood as a task for society as a whole. The focus is on medical care as well as municipal and civil society initiatives. Community medicine, health services research and prevention are key areas of research and teaching at Greifswald University and the Greifswald University Hospital (UMG).

Key issues concern ensuring comprehensive care, the sustainable implementation of evidence-based strategies and the long-term financing of preventive measures.

Prevention as a focus in science and research

The community health approach forms the central strategic framework for the further development of preventive care. This approach does not view health in isolation as a medical and nursing problem, but in the context of social, ecological and individual factors. The aim is to transfer evidence-based prevention strategies directly into people's lives and thus promote health at the population level. Scientific evidence is closely interlinked with municipal practice, participatory formats and interdisciplinary research so as to implement measures in a tailored and effective manner.

| [229] See Nowak; Kolip; Razum (2022).

| [230] See Gerlinger (2024), p. 11.

Health as a cross-cutting task in research and higher education policy

In Greifswald, health is not viewed as a mere medical topic, but rather as an interdisciplinary task spanning multiple science departments, teaching and municipal practice. Topics such as mental health, healthy ageing, environmental influences and social participation are addressed in a transdisciplinary manner – in innovative care interventions by nursing professionals in the community in the spirit of AGnES (doctor-relieving, community-based, e-health-supported systemic intervention) and dementia care management, in telemedicine networks and cross-sectorial regional medical records. Programmes such as Health AI Pomerania |[231] or T!Raum One Health |[232], are joint initiatives of Greifswald University (GU) and the Greifswald University Hospital (UMG). The latter is being implemented in close collaboration with the Helmholtz Institut for One Health (HIOH), which is supported by a broad alliance. Alongside the GU and the UMG, these include the Helmholtz Centre for Infection Research (HZI), the Friedrich Loeffler Institute (FLI), and numerous other stakeholders from the fields of research, business, politics and civil society. These initiatives combine technologies such as AI, omics and digital health data with participatory formats and municipal implementation practices. Through the close integration of research, teaching and practice, prevention in Greifswald is studied theoretically and implemented actively in health care, preventive programmes and measures in collaboration with regional and local stakeholders. Greifswald thus serves as a model region, demonstrating how scientific institutions can embrace health as an overarching responsibility and promote effective prevention and health research in practice.

New roles for research, teaching and knowledge transfer

The UG and the UMG integrate teaching, research and social responsibility within a single model. Students are involved in regional health projects from an early stage, and many research approaches are strongly application-oriented and participatory. Thanks to their long-standing collaboration with schools, social welfare organisations and municipal institutions, they can set up intervention and observational studies effectively and practically, facilitating reciprocal knowledge transfer. The UG and the UMG consider themselves as active members of the local community.

| 231 The UMG-led project is investigating the potential applications of AI in medicine. For example, the AI tool EVE (Evolutionary Model of Variant Effect) can identify gene mutations in the orthologous genes of 140,000 different animal species. (See Greifswald University, 17 July 2024).

| 232 The establishment of T!Raum One-Health-Region Western Pomerania seeks to transform the entire Western Pomerania region through a paradigm shift, turning it into a One-Health region. The collaboration between science, industry and politics seeks to improve health in the region. This includes promoting the health of people, animals, and the environment. Further information can be found at: https://onehealth-region.de/

Western Pomerania also functions as a real-world laboratory in which new preventive concepts are developed scientifically, tested practically and evaluated systematically, including in terms of implementation support. Community medicine plays a particularly important role here, aiming to link research, care and health promotion systematically, involve local actors and take regional characteristics into account. The focus is on developing regional networks and cross-sector collaboration. One example is the tandem practice model in Mecklenburg-Western Pomerania, where paediatricians hold regular consultation hours at general practitioners' surgeries. Telemedical consultations are used to supplement this approach, e.g. in paediatric surgery or epilepsy, to ensure specialist care is available even in structurally weak regions.

Particular attention is paid to the functional participation of children and adolescents, for example through advisory boards or participation formats in childcare and educational settings. In many projects, non-medical professional groups, such as teachers and social workers, are also systematically integrated into multidisciplinary prevention structures.

Greifswald is a prime example of a model in which prevention is recognised as a core aspect of university research, both theoretically and through active engagement with health care, education, politics, and civil society. Despite the conceptual strength of these approaches, their impact on the population has so far been limited. Key health indicators such as life expectancy, mortality, diabetes prevalence and mental morbidity are stagnating or showing unfavourable trends, particularly in socially disadvantaged and rural areas of Mecklenburg-Western Pomerania. This could indicate that prevention can only be effective if it is embedded permanently, systematically and structurally in a "learning health system".

Experience from other countries, such as the 1970s North Karelia Project in Finland |[233], shows that health policy measures often only translate into measurable health improvements after decades. In North Karelia, long-term programmes to reduce smoking, promote healthy eating and improve cardiovascular health led to a significant reduction in mortality and an increase in life expectancy. Therefore, patience and long-term continuity are essential for

|[233] The North Karelia Project was launched in 1972 in an attempt to reduce the high mortality rate among men in the Finnish region of North Karelia. The region had a mortality rate of 700 per 100,000 men due to excessive salt and animal fat consumption and low fruit and vegetable intake. Through collaboration with NGOs, local authorities, and educational institutions in the region, the following three goals were achieved: 1. Lowering cholesterol through a low-fat diet, 2. Lowering blood pressure through reduced sodium intake, 3. Weaning people off tobacco smoking. Improvements in the mortality rate were quickly apparent. By 2010, the mortality rate had fallen to 100 per 100,000 people. See Puska; Jaini (2020).

scientifically based prevention strategies to be effective at the level of the population.

The limitations of the curative health care system are becoming increasingly apparent. For this reason, there are growing calls from the medical and medical research communities for a shift in focus towards prevention and health promotion. This change is reflected scientifically in both universities and non-university research measures and initiatives, such as the National Cancer Prevention Centre (NCPC) of the German Cancer Research Centre (DKFZ) and German Cancer Aid, as well as other networks (see chapter D.IV.2). New structures – at various stages of implementation – are emerging at state universities in Germany that offer medical degrees, including interdisciplinary and interprofessional research centres |[234], specialised research buildings |[235] and joint projects such as the ImmunoPreCept cluster of excellence at Berlin Charité University Medicine, which was newly selected for funding in 2025 as part of the German Excellence Strategy. |[236] The Berlin Institute of Health at Charité |[237] is also noteworthy, particularly in the context of precision medicine and translational issues. In the broader context of translation, studies such as the HANSE Lung Study conducted by Hannover Medical School (MHH), Schleswig-Holstein University Hospital (UKSH) and LungenClinic Grosshansdorf in the field of lung cancer screening, with a focus on individual early detection and examination of heart and lung health, are also noteworthy. |[238] Another example is the joint MARTHA study of the Ludwig Maximilian University (LMU) and the Helmholtz Centre in Munich, which focuses on identifying risk factors for asthma development in children. |[239] These developments demonstrate that, alongside issues of cure, detection and treatment of disease, questions of health itself, its protection and

| 234 Examples include the Friede Springer Cardiovascular Prevention Centre at Charité Berlin, the Centre for Health and Society (chs) at Heinrich Heine University Düsseldorf and the Centre for Health and Medical Prevention (CHaMP) at Otto von Guericke University Magdeburg.

| 235 Examples of this include the planned William B. Kannel Centre for Community Medicine research building at UMG, and the current Berlin Centre for the Biology of Health at Charité and FU Berlin. This centre brings together various scientific disciplines to investigate what keeps people healthy (see Charité – Universitatsmedizin Berlin, 21 April 2023). The WR recommended funding for these projects in 2021 and 2023 respectively (see WR (2023a), pp. 53–54). Within the framework of funding for research buildings at universities, including large-scale equipment, on the basis of Article 91b of the German Basic Law, the WR regularly considers applications from federal states for research building funding in accordance with the GWK agreement implementation scheme.

| 236 See Charité Universitätsmedizin Berlin (22 May 2025).

| 237 See the Berlin Institute of Health, URL: https://www.bihealth.org/

| 238 See HANSE study, URL: https://www.hanse-lungencheck.de/

| 239 See the Federal Institute for Drugs and Medical Devices (n.d.).

promotion, including indicators of success, are becoming increasingly important in university medicine. However, the university centres mentioned above have a clear focus on the application of modern biomedical methods (e.g. omics, AI) and personalised approaches.

Issues of health and, associated with this, disease prevention and health promotion also play a role in **many other scientific disciplines**. While these certainly include psychology, health/prevention psychology and psychotherapy |[240], sports science, nutrition science and rehabilitation science, the health sciences (midwifery, nursing and therapy sciences) as well as social and behavioural science disciplines such as communication sciences and sociology are to be considered. The latter is particularly evident in Germany, where health inequalities have been increasingly addressed and studied scientifically since the 2000s, opening up to social science topics and even socioeconomic topics. |[241] Health issues are also becoming increasingly important in the fields of agricultural, food, nutritional and environmental sciences as well as education and training. |[242] This is exemplified by interdisciplinary fields of research such as **"One Health"**.

The **One Health approach** takes a holistic view of health and is based on the understanding that human, animal and environmental health are closely linked and interdependent. Through an interdisciplinary analysis of the complex causes and interrelationships of disease outbreaks, the approach aims to promote health and to achieve sustainable health risk management. |[243] The health of humans, animals and ecosystems should be brought into sustainable balance and optimised. The approach covers the entire spectrum from prevention and health promotion to the detection, prevention, response to, and management of, health crises. It also considers the collective need for healthy food, water, energy and air, incorporates measures against climate change and aims to contribute to sustainable development. |[244]

This approach is fundamentally interdisciplinary, building on collaboration between various scientific disciplines such as human medicine, veterinary

| 240 One example of this is the Wald|Gesund project run by UG. The project aims to develop low-threshold forest therapy programmes to promote health for various patient groups and the ageing general population, and to evaluate the short- and long-term effects of the project in terms of psychosocial and physiological parameters and behaviour-based risk factors. See Greifswald University (2025).

| 241 See Gerlinger (2024), p. 12.

| 242 The WR considers agricultural, food and nutritional sciences to be of particular importance for contributions to disease prevention due to their close links to medicine. See WR (2024b), p. 73.

| 243 See FAO; UNEP WHO; WOAH (2023), p. 4.

| 244 See One Health High-Level Expert Panel et al. (2022). Further information on the panel can be found here: WHO One Health High-Level Expert Panel (OHHLEP), URL: https://www.who.int/groups/one-health-high-level-expert-panel, last accessed on 18 September 2025.

medicine, environmental sciences and social sciences. It mobilises not only different sectors and disciplines, but also communities in different living environments and at different societal levels, ranging from the local to the global. |[245] The approach was developed in the context of international collaboration and has since been further developed in significant ways by four international organisations: the WHO, the World Organisation for Animal Health (WOAH), the Food and Agriculture Organisation of the United Nations (FAO) and the United Nations Environment Programme (UNEP). The approach received increased attention in response to the SARS and H5N1 outbreaks in the 2000s. |[246]

IV.2 Prevention and health promotion in non-university and departmental research

Scientific research into prevention is playing an important and increasingly significant role in non-university research and various federal departmental research institutions. To gain an initial overview of the institutional importance, research and translation activities and challenges in this field, the WR asked selected institutions for their assessments. |[247] The key findings from this survey are summarised in the following.

IV.2.a German Centres for Health Research (DZG)

The **German Centres for Health Research (DZG) prioritise** prevention in its institutes for the major widespread diseases it studies. In this context, the future German Centre for Child and Adolescent Health (DZKJ) plays an important role, focusing specifically on the prevention, diagnosis and treatment of diseases in the paediatric population, without limiting itself to a specific clinical picture or common disease (community medicine). With regard to prevention-related scientific activities, the DZG are researching the fundamental molecular mechanisms and various influencing factors (e.g. genetic predispositions and environmental pollution) that contribute to the development of common diseases. These issues are addressed in clinical studies conducted by the DZG, which are sometimes supported by technological approaches to promote insights into personalised prevention strategies and to gain a broader understanding of the causes of disease long before symptoms appear. Based on these research findings, the DZG's main objective is to contribute to new diagnostic and therapeutic approaches in health care practice, as well as to disease prevention, e.g. through vaccine development. Furthermore, the DZG aim to raise public awareness of the

| [245] See ibid.

| [246] See FAO; UNEP WHO; WOAH (2023), p. 1.

| [247] In addition to non-university and departmental research institutions, the DZG and public health institutions were also addressed.

diseases they study through various information channels, thereby contributing to the growth of knowledge about these diseases.

With regard to **translational successes** in the field of prevention, the DZG primarily refer to the development of disease-related therapeutics or diagnostics for the various clinical cases studied by the DZG. Examples include contributions to drug and vaccine development, the further development of care guidelines and various prevention and screening programmes.

Although all DZG attach great importance to disease prevention, they encounter various **difficulties in the scientific approach** to prevention, particularly with regard to its sustainable implementation and application in everyday care and beyond. They identify individual causes (e.g. lack of health knowledge and patients' unwillingness to change their behaviour) and systemic-structural barriers (e.g. the easy and excessive availability and visibility of unhealthy foods in supermarkets and public spaces) as the reasons for this. These systemic and structural challenges include regulatory hurdles, such as bureaucratic hurdles in the development and approval of new prevention approaches (e.g. in relation to animal testing), as well as economic hurdles, such as high costs combined with low financial incentives in vaccine development and lower profit prospects compared to therapeutics. There is also a lack of political support at the local level.

The availability and validity of health data are essential for prevention-related research, particularly in the context of personalised prevention. However, federal responsibilities and data protection regulations make collecting and using high-quality health data difficult. According to the DZG, without representative data, the impact of prevention on general recommendations will be limited. Comprehensive access to valid data is necessary to create tailored approaches for different risk groups.

Several DZG organisations believe that the situation is further complicated by the fact that health risks are sometimes misjudged or completely denied (e.g. vaccine scepticism). A good example of this is obesity, which is generally assumed to be merely a consequence of an unhealthy lifestyle that can be controlled by willpower alone. However, genetic, neurophysiological and environmental factors also play a significant role. According to some DZG members, reducing the issue to individual behaviour can prevent the development of effective, cause-oriented, patient-centred prevention strategies.

IV.2.b Prevention and health promotion at non-university research institutions

Among the non-university research institutions of **the Helmholtz Association (HGF)**, the **Leibniz Association (WGL)**, as well as the **Fraunhofer-Gesellschaft (FhG)** and the **Max Planck Society (MPG)**, there are institutions with links to prevention and health promotion.

Among the **HGF** institutions, the centres of the Helmholtz Health Network are particularly noteworthy. |[248] The Helmholtz Health institutions are also involved in the NAKO health study.

The **NAKO Health Study** is Germany's largest long-term study on the research of common diseases. |[249] The NAKO e.V. association is conducting the study with its 26 member institutions. It is being funded by the BMFTR, the HGF and participating states. When the study began in 2013, over 205,000 people were randomly selected by 18 study centres, underwent medical examinations and were asked about their lifestyle habits. These were followed by repeated surveys and examinations. The examination is standardised in all study centres and is subject to strict quality assurance. To date, over 27 million biological samples have been collected from NAKO participants and are available for research. NAKO's aim is to identify the causes and risk factors of common diseases. One of its objectives is to create an evidence base for future prevention strategies.

In April 2025, the HGF announced plans to establish a prevention research task force comprising all institutions within the Helmholtz Health Network and the NAKO health study. According to the HGF, the task force will combine cross-institutional research on the prevention of various diseases. The focus will be on chronic and infectious diseases. Another goal is to promote more systematic networking and use of health data. Findings from increased prevention research will also be used to develop recommendations for prevention strategies and political action. Helmholtz Munich and the DKFZ will jointly chair this task force. |[250] In addition, the Helmholtz Association has established the National Cancer Prevention Center (NCPC) |[251], a prominent structure dedicated to nationwide research, education, public relations and policy counselling in the field of cancer prevention. Technology and AI play an important role in the research conducted by Helmholtz Health institutions, enabling them to identify biomarkers and molecular mechanisms for specific disease risks, among other things.

In terms of prevention research, the Leibniz Institute for Prevention Research and Epidemiology (BIPS) is a key institution for the Leibniz Association (WGL)

| 248 Helmholtz Health encompasses the Helmholtz Association's health-related research activities. Centres assigned to this area include the German Cancer Research Centre (DKFZ), the German Centre for Neurodegenerative Diseases (DZNE), the Max Delbrück Centre for Molecular Medicine, Helmholtz Munich, the Helmholtz Centre Dresden-Rossendorf and the HZI. See Helmholtz Health (n.d.).

| 249 See NAKO Health Study, URL: https://nako.de/

| 250 See the Helmholtz Health Prevention Task Force (2025).

| 251 The NCPC was founded in Heidelberg in 2019 by the DKFZ and the German Cancer Aid. It is an interdisciplinary centre that combines research, education, training, public relations and policy advice. Its overarching goal is to provide personalised prevention advice to the entire population and enable participation in studies through prevention clinics. See National Cancer Prevention Centre (n.d.).

facilities. Prevention also plays a role in other institutes, however, such as the German Centre for Diabetes Research (DZD), the Leibniz Institute for Resilience Research (LIR), the Bernhard Nocht Institute for Tropical Medicine (BNITM) and the German Institute of Human Nutrition (DIfE).

Among other non-university institutions, the **Fraunhofer-Gesellschaft (FhG)** and **Max Planck Society (MPG)** institutions have interfaces with topics related to prevention and health research. In line with its translation- and transfer-oriented approach, the (FhG) strives to develop innovative solutions for affordable health care. The Fraunhofer Institute for Translational Medicine (ITMP) is a prime example of the FhG's innovative health research. Among the MPG institutions, the Max Planck Institute for Demographic Research (MPIDR), for example, deals with the health development of the population.

With regard to the **successful transfer and translation** of disease prevention, some of the institutions surveyed by the WR – similar to the DZG – referred to developments in innovative therapy and diagnostics (e.g. early detection and guideline development). In addition, technological innovations for monitoring and information purposes (e.g. apps and information portals), as well as counselling and workshop offerings, also form part of the non-university institutions' portfolios.

With regard to **obstacles and barriers in the field of prevention**, institutions active in health research also identified structural and individual challenges and barriers to the WR. Similar to the DZG, structural challenges included the lack of access to medical data or biomaterials for molecular technology analyses or AI training. In addition, insufficient remuneration, a lack of research funding opportunities and the difficulty of proving the cost-effectiveness of prevention measures were cited as obstacles. The high cost of high-tech procedures was also cited as an issue.

Furthermore, various non-university research institutions consider it a hindrance that prevention is not prioritised in society or politics. This means that priorities should be shifted, which could be achieved through regulatory measures, such as different taxation on sugar or further incentives for health-promoting behaviour. The "repair orientation" of the health care system and the lack of specificity for target groups in health communication and competence building have also been described as obstacles.

Beyond these aspects, some non-university research institutions noted a lack of interdisciplinary collaboration within health research, which is crucial for a holistic approach to prevention issues. The work of basic biomedical research and public health research needs to be more closely connected to translate laboratory findings into concrete, applicable population strategies (bench to bedside and community) and vice versa (bedside to bench and community). According to some non-university institutions, focusing solely on specific risk factors without

considering the interactions between genetic, social, and environmental factors is counterproductive. Against this background, some non-university research institutions are also questioning the formation of a central structure in Germany (a prevention centre), which would integrate and connect departmental research institutions with other scientific actors. The subject area must also become more attractive to early-career researchers. Long study periods and the difficulty of demonstrating rapid success act as deterrents and are also counterproductive to the reputation logic of the scientific system. Furthermore, the long-term economic effects are difficult to investigate within the confines of temporary funding projects.

IV.2.c Prevention and health promotion in federal departmental research institutions

Federal departmental research institutions, which primarily focus on prevention and health promotion, fall within the remit of the German Federal Ministry of Health (BMG). However, issues of prevention and health promotion also fall under the remit of other departments. These include, among others, the Departments of Labour, the Environment, Agriculture and Food as well as of Family Affairs.

Key institutions within the remit of the BMG's downstream authorities include the Institute of Public Health (BIÖG; formerly BZgA |[252]) and the RKI. The Paul Ehrlich Institute (PEI) and the Federal Institute for Drugs and Medical Devices (BfArM) also fall within the BMG's remit. |[253] The BIÖG, RKI and PEI, with their respective portfolios of tasks, also form part of Germany's federal-level ÖGD. In this capacity, they interact closely with public health institutions at state and municipal levels. The BIÖG and the RKI, in particular, have explicit priorities in areas relevant to prevention within their respective fields.
The WR also asked the BMG's departmental research institutions about their institutional involvement in prevention and health maintenance. Responses were also received from other departments, including the Federal Institute for Occupational Safety and Health (BAuA) and the Federal Institute for Risk Assessment (BfR).

According to the **RKI**, the institute attaches great importance to prevention and sees itself as the federal government's central institution in the field of application- and action-oriented biomedical research (the "National Public Health Institute" |[254]). The **RKI** is responsible for the federal government's health reporting and also monitors the health status and health-related behaviour of the

| 252 See the Federal Institute for Public Health (9 May 2022).

| 253 See the Federal Ministry of Health (2025b).

| 254 See the Robert Koch Institute (2016).

population. In addition, the RKI's core tasks include the prevention and control of infectious diseases and the preparation of epidemiological analyses. The RKI advises the BMG, expert groups and the public. Through infection surveillance, it fulfils a central "antenna function" in the sense of an early warning system and conducts health studies on non-communicable diseases in adults and children. In doing so, it analyses health trends, calculates the burden of disease and examines risk factors such as poverty and social inequalities. The RKI also identifies knowledge and care gaps and provides politicians, the ÖGD and other actors with information and data for prevention measures and research.

The **BIÖG**, which was developed from the BZgA in 2024, sees itself as the central institution for health literacy in Germany. As a federal authority under the jurisdiction of the BMG, it is responsible for planning and implementing evidence-based prevention strategies. Its goal is to minimise health risks and encourage healthy lifestyles. This is achieved through targeted information campaigns and programmes that promote health literacy and personal responsibility. The BIÖG also collaborates with various national and international partners to promote health at all levels (federal, state and local). According to the BIÖG, its preventive measures target a broad audience and take a holistic approach that encompasses individual and structural changes for the benefit of health.

The **PEI's** primary focus in prevention research is the approval, research, quality assurance and efficacy testing of vaccines for the prevention of serious infectious diseases.

With regard to **translation and transfer activities**, the BMG's departmental research institutions primarily cited information and advisory services, alongside monitoring and reporting activities which inform evidence-based policymaking.

Similar aspects to those mentioned by other research institutions were considered to be **challenges and obstacles** in the field of prevention. In terms of research, the main difficulties are data availability and evidence generation, particularly with regard to population-based measures and efficacy studies. The surveyed departmental research institutions also consider interdisciplinary scientific approaches to be important, but note that these are not yet being pursued on a broad scale. Specific implementation hurdles cited include a lack of target group orientation, misinformation and false information about health topics as well as the difficulty of securing long-term funding for prevention projects, coupled with institutions' high dependence on third-party funding.

Furthermore, the fragmented responsibility across different departments within the federal system is proving to be a critical problem. According to various departmental research institutions, departments other than the health department must also take responsibility for prevention and health promotion at the population level. Similarly, cross-sectoral collaboration on prevention and health promotion should be strengthened and the complexities of collaboration

(e.g. between various social insurance providers) should be reduced. This is intended, not least, to bring about changes in living conditions and structural framework conditions, also because focusing solely on individual health-promoting behaviour is not scientifically sound.

IV.3 Research funding for prevention and health promotion

Currently, there is no systematic funding for research into prevention and health promotion in Germany. At the federal level, national **programme-based research funding** in health research primarily falls within the remit of the science and health ministries. Since 2004, the **BMFTR** (formerly the Federal Ministry of Education and Research BMBF) has continuously funded prevention research as part of its funding priorities. |[255] This programme aims to strengthen knowledge transfer by fostering collaboration between research and practice, as well as promoting evidence-based and implementation research. The funding measures address various population groups and topics, strengthen structural prevention in living environments and address socially determined health inequalities. Particular focus was placed on nutrition research, among other things. Additionally, sustainable collaboration structures have been established between various research institutes and disciplines as well as between research and practice. Another important consequence of this funding priority is the continuous increase in the international visibility of German prevention research. The funding of the Lausitz Centre for Digital Public Health (LauZeDiPH) enables the needs of the population and public health to be monitored and evaluated continuously in a model region using comprehensive data collection. Based on this data, tailor-made public health interventions are to be developed. |[256] From 2004 to 2024, the BMFTR's funding priority for prevention research received a total of approximately 191 million Euro in funding. As of 1 December 2024, the BMFTR states that it funds projects in the field of health promotion and prevention through various funding measures, even if these funding offers are not explicitly focused on this topic (see Table A.5). As part of the European "Fostering a European Research Area for Health" (ERA4Health) partnership, the BMFTR funds research projects with international partners. This partnership aims to coordinate the activities of funding organisations in the European research area for health and wellbeing in a flexible and effective manner. Within this framework, transnational collaborative research in Europe is promoted through joint programme planning that addresses priority areas of public health. Regarding disease-specific research on prevention, the BMFTR refers not only to the establishment and expansion of the future DZKJ and the future German Centre for Mental Health (DZPG), but also to existing organisations such as the DZG, non-university

| 255 See Ruckstuhl (2021), p. 44 and the Federal Ministry of Research, Technology and Space (3 June 2025).

| 256 See the Federal Ministry of Research, Technology and Space (19 July 2023).

research institutes and the Leibniz Institute for Prevention Research and Epidemiology – BIPS, as well as the HGF (e.g. the Cancer Prevention Centre). Through the activities of the DZG, the HGF in the field of health research, and the BIPS, the BMFTR and the participating federal states provide significant institutional funding for prevention-related research. During the National Decade Against Cancer, the BMFTR and its partners are focusing on prevention. Additionally, the BMFTR is organising a Science Year on the topic of "Medicine of the Future" for 2026, in collaboration with various partners. The medicine of the future is explicitly described as "preventive", one of the four core themes of the Science Year. This includes considerations on digitally supported prevention in connection with low-threshold, target-group-adapted health technologies. | [257]

According to the **BMG**, it calls for the submission of project descriptions in accordance with individual thematic funding guidelines. There are currently no open research funding announcements from the BMG on disease prevention (as of 1 December 2024). However, the BMG does fund research activities on various key topics in the field of "health promotion and prevention" (seeTable A.6). | [258] Additionally, cancer prevention is a priority for the BMG in its reorientation of the National Cancer Plan 2024. | [259]

With regard to nationally funded projects in the field **of open-topic basic research**, the **German Research Foundation (DFG)** is the main primary funding organisation in Germany. As of 1 December 2024, an analysis of DFG-funded projects in sub-areas of medicine and the social and behavioural sciences revealed a total of 393 projects related to disease prevention (out of a total of 7,682 projects funded in these fields). | [260] The majority of the prevention-related projects are funded under individual funding programmes (286 projects), 240 of which are material grants. A total of 105 projects are funded as sub-projects in coordinated programmes: 62 in research groups and 29 in collaborative research centres.

| [257] See the German Aerospace Centre (2025).

| [258] The main areas of focus include strengthening suicide prevention, exercise and the promotion of physical activity as well as strengthening collaboration between public health services and public health research. See the Federal Ministry of Health (2025c).

| [259] See the Federal Ministry of Health (26 February 2025).

| [260] Projects on the topic of "disease prevention" were identified by means of a keyword search (e.g. prevention, preventive, early detection, health promotion etc.) based on project titles, abstracts and keywords. the results of which were then subjected to manual content validation. This search identified projects with a connection to the topic of prevention that is potentially very broad. The evaluation based on this search relies on data generated during the DFG's application processing and is subject to updates. The dynamic nature of changes to applications or ongoing projects can lead to minor fluctuations in the reported values, which may therefore not correspond to previous information or representations in all cases. The search term logic used here may also be adjusted and refined over time, which may result in future reclassifications.

Two projects are funded in the area of infrastructure funding. The majority of funded prevention-related projects are in medicine (279), neuroscience (68), and psychology (35).

Prevention and health promotion have not yet played a prominent role in the **German foundation landscape**. Currently, there are no structural, programme-based funding approaches or priorities in this area.

At **the European level**, health and health promotion have become increasingly important in recent decades. This is partly because, in its economic and competitive orientation, the EU has identified population health as a fundamental pillar of prosperity and economic growth, addressing prevention and health promotion in the context of a social investment strategy. Similar to the German discourse, key arguments include the dangers of an increase in chronic diseases and the resulting need for care, which could lead to a significant rise in health care expenditure, as well as the threat to economic growth coupled with a demographic decline in the working population. |[261]

Against this backdrop, various health action programmes have been launched at the European level since the 1990s, addressing aspects of disease prevention as well as improved care and health information. The latest and currently ongoing **action programme**, **EU4Health** (2021–2027), which was strongly influenced by the experiences of the 2020 coronavirus pandemic, focuses on improving the coordination of EU Member States in the fight against infectious diseases. |[262] The programme's core objectives are to improve and promote health in the Union, combat cross-border health threats, implement the European medicines strategy and strengthen the resilience of national health systems. EU4Health primarily implements EU health policy objectives and has a budget of 4.4 billion Euro for the current term, which is mainly allocated through grants and contracts. |[263]

In addition to the EU4Health programme, there are significant funding opportunities for health research in the EU's **research framework programmes** (especially Pillar 2/Cluster Health), particularly with regard to research and innovation. Areas of intervention include research on health across the life course, environmental and social determinants of health as well as rare, non-communicable and infectious diseases. |[264] The European Commission's proposal for the next Research Framework Programme (2028–2034), published in July 2025, also

| 261 For more details, see: Gerlinger; Rosenbrock (2024), pp. 535–558, specifically on prevention and public health.

| 262 See the Federal Ministry of Health (2021).

| 263 See ibid.

| 264 See the European Commission (2024).

includes health under Pillar 2. Unlike in previous programmes, health is no longer a separate cluster, but is instead linked to biotech, agriculture and the bioeconomy. |[265]

The **Safe Hearts Plan** published by the European Commission in December 2025 proposes a roadmap for research and innovation specifically in the field of cardiovascular disease. The aim is to accelerate the implementation of research results and innovation. |[266]

IV.4 Business activities related to prevention and health promotion

In addition to government actors, there are also many **private-sector research activities** in the field of prevention and health promotion. The most prominent example of private sector research investment into prevention and health promotion products is **vaccine development**. However, there is also a very large market heavily focused on maintaining health and fitness that is only based to a limited extent on scientific findings or collaborates with science. This **lifestyle market** includes books, magazines and blogs on healthy living, digital applications (apps), fitness trackers and smartwatches as well as self-tests and dietary supplements and is considered a billion-dollar growth market. |[267] Health-conscious consumers are attracted by food manufacturers offering reduced-sugar drinks, snacks and ready-made meals as well products marketed as "superfoods". |[268]

In **the digital sector**, private-sector products and services offer many opportunities to expand and integrate care and prevention services into everyday life. In this area, the **Digital Health Applications Regulation** (DiGAV) incentivises companies to develop apps that meet medical device standards and have a scientifically proven positive effect on care, contributing to the detection, monitoring, treatment or alleviation of diseases. |[269] There are various digital health applications (DiGAs) that focus more strongly on prevention, such as those for treating stress, addiction, obesity and sleep disorders. |[270] However, the market impact of this intervention has been limited so far, as only a relatively small number of digital companies have been able to meet the requirements for their apps. |[271]

| 265 See the European Commission (2025c).

| 266 See the European Commission (2025a), pp. 26 ff.

| 267 See Ludwig (9 April 2025).

| 268 See Zentgraf (13 July 2022).

| 269 See the Federal Institute for Drugs and Medical Devices (2025).

| 270 See the Federal Institute for Drugs and Medical Devices (2024a, 2024b, 2024c, 2024d, 2024e, 2024f).

| 271 See Janßen; Reif; Schubert (2025).

Another market gap exists with regard to **medical wearables**. The FhG is conducting research on this topic at several institutes. |[272]

There are also **collaboration projects** between **science and industry**, such as the Newlife project, which is funded by the EU's Horizon Europe programme. This project focuses on developing smart textiles for the prevention and monitoring of health issues during pregnancy and for newborns. It is an ongoing collaboration between Philips Electronics Nederland, Fraunhofer Institutes, other companies, and universities. |[273]

| 272 E.g. the Fraunhofer Institute for Electronic Microsystems and Solid State Technologies EMFT, see Fraunhofer (28 August 2025), or the Fraunhofer Institute for Integrated Circuits IIS with offerings in mobile sensor data analysis, see Fraunhofer (15 September 2025), or smart textiles, see Fraunhofer (23 October 2025).

| 273 See the Newlife Project, URL: https://www.newlife-kdt.eu/

Annex

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Table A.1: Healthy life expectancy at birth in EU countries

Country	Healthy life expctancy in years
Luxembourg	71.2
Sweden	71.1
Spain	71.1
Malta	70.7
Cyprus	70.7
Italy	70.6
Denmark	70.1
France	70.1
Ireland	70.0
Netherlands	70.0
Finland	69.9
Belgium	69.8
Austria	69.8
Portugal	69.5
Slovenia	69.4
Germany	68.9
Greece	68.6
EU	68.9
Croatia	66.8
Estonia	66.7
Czech Republic	66.7
Poland	65.5
Slovakia	64.9
Hungary	64.8
Lithuania	64.2
Latvia	63.8
Romania	63.8
Bulgaria	62.4

Source: WHO: Healthy life expectancy (HALE) at birth (2021); WR representation.

Table A.2: Life expectancy in European countries

Country	Life expectancy in years
Switzerland	84.2
Italy	84.0
Spain	84.0
Malta	83.6
Norway	83.6
France	83.6
Sweden	82.6
Luxembourg	82.9
Ireland	82.7
Portugal	82.7
Netherlands	82.4
Belgium	82.4
Austria	82.3
Denmark	82.2
Finland	82.2
Greece	82.2
Slovenia	81.9
EU	81.8
Germany	81.7
Czech Republic	80.1
Poland	79.0
Slovakia	78.7
Montenegro	77.4
Hungary	77.3
Romania	76.2

Source: United Nation: Population Division (2024); WR representation.

Table A.3: Preventive health expenditure in EU countries (2023)

Country	Share of total health expenditure (in %)	Expenses per capita (in Euro)
Germany	7.85	457.7
Austria	7.44	410.6
Netherlands	5.70	311.5
Denmark	4.98	304.2
Luxembourg	4.56	300.3
Finland	6.38	297.6
Ireland	4.66	279.5
Sweden	3.61	203.3
EU	5.49	202.2
France	4.04	186.0
Italy	6.04	180.0
Belgium	2.50	127.6
Slovenia	4.73	122.6
Czech Republic	5.21	118.6
Estonia	5.66	106.1
Spain	3.79	104.2
Lithuania	4.69	80.8
Portugal	3.24	78.9
Greece	4.51	75.8
Cyprus	2.54	68.5
Croatia	5.29	67.7
Latvia	2.80	43.7
Malta	1.18	36.9
Hungary	2.90	33.9
Slovakia	2.04	31.9
Bulgaria	3.09	30.6
Romania	2.84	24.3
Poland	1.90	21.6

Source: Eurostat: Preventive health care expenditures statistics (2025); WR representation.

Table A.4: Nanny State Index 2025

Influence	Country	Alcohol	Safer nicotine	Food / Soft Drinks	Smoking
Least free	Türkiye	21.7	13.8	1.7	10
	Lithuania	18.8	10.9	3	10.1
	Finland	15.2	8.9	1.6	12.1
	Hungary	4.5	9.8	9.6	13.5
	Ireland	17.7	2.2	4.5	12.5
	Latvia	10.5	9.2	4.1	10.4
	UK	7	2.3	7.4	15
	Poland	9.1	5.2	7.7	8.5
	Estland	12	7.2	0	9.4
	Sweden	15.8	4.6	1	6.4
Less free	France	8.3	2.9	3.2	12.3
	Netherlands	5	8.8	0	12
	Slovenia	7.4	7.3	1.3	9.7
	Croatia	7.1	4.6	2	9.6
	Romania	5.3	5.1	0	12.2
	Greece	4.6	6.1	0	10.7
	Slovakia	3.5	5	3.6	9
	Belgium	1.8	7.1	1.2	10.4
	Portugal	5.2	5.1	2.4	7.7
Freest	Cyprus	4.7	6.5	0	7.9
	Denmark	1.9	5.7	2.7	8.8
	Bulgaria	4.1	3.3	0	10.2
	Austria	6	4.8	0	6.6
	Malta	5.8	3.3	0	7.9
	Czechia	2.7	3.2	0	8.6
	Italy	3	2	0.7	7
	Luxembourg	3.7	4	0	4.7
	Germany	2.4	4.1	0	5.2

Quelle: Snowdon (2025). Nanny State Index ’25. European Policy Information Center.

Note: The Nanny State Index ranks European countries according to the extent to which the state influences consumption. The higher the index, the greater the state’s influence on freedom of consumption. The ranking includes four categories: alcohol (weighting: 33.3 percent); e-cigarettes (weighting: 16.7 percent); food and non-alcoholic beverages (weighting: 33.3 percent); and smoking (weighting: 16.7 percent). Factors influencing freedom of consumption, and thus the result, include: price increases (e.g. through taxation); social stigmatisation of consumers; restriction of choice (e.g. ban on menthol cigarettes); inconvenience for consumers (e.g. restricted opening hours or smoke-free/alcohol-free zones); restriction of information (e.g. advertising bans); reduction in product quality. See Nanny State Index, URL: https://nannystateindex.org/

Table A.5: Prevention-related support measures of the BMFTR (as of 1 December 2024)

Name of support measure	Duration	Funding amount (in Euro)	Number of projects funded
Guideline for promoting equal health opportunity through healthy eating and exercise as part of the framework of the European Partnership (ERA4Health)	04/24–04/27	1.8 million	5 transnational consortia, each with a German consortium partner
Guideline for promoting intervention studies to encourage healthy and sustainable living conditions and lifestyles	02/25–02/28	8.3 million	6 collaborative projects
Guideline for the funding of transdisciplinary and interdisciplinary research consortia on the topic of "Pandemic prevention and response within the framework of a One Health approach"	Plan: 11/25–10/30	Total 25 million	Plan: 7 networks Not yet approved
Guideline for the funding of scientific "Junior Research Groups Global Change: Climate, Environment and Health" within the framework of the BMBF strategy "Research for Sustainability" (FONA)	2022–2027	Up to 3.4 million	1 consortium, 1 individual project
Guideline for the funding of a systems medicine research network for the early detection and prevention of liver cancer (LiSyM-Krebs) as part of the National Decade Against Cancer, Phase 2 Federal Gazette of 7 January 2020	2024–2027	18.6 million	29 projects (4 consortia)
Guideline for the funding of collaborative research projects on risk-adapted early detection of cancer – National Decade Against Cancer – Federal Gazette of 13 February 2023	2024–2027	Up to 10.0 million	13 projects (4 consortia)
Guideline for promoting research networks for the prevention of colorectal cancer in younger and future generations – National Decade Against Cancer – Federal Gazette of 10 September 2020	2022–2026	up to 13.9 million	22 projects (4 networks)
Guideline for promoting research networks for knowledge-generating networking of research and care in model regions – National Decade Against Cancer – Federal Gazette of 23 January 2023	2024–2027	Up to 8.9 million	12 projects (4 consortia)
Guideline for promoting research networks on the molecular causes and tertiary prevention of long-term and late effects in long-term survivors of cancer – National Decade Against Cancer – Federal Gazette of 28 August 2024	2026–2029	Approx. 10 million	5
Guideline for promoting projects on interactive technologies for cardio-oncological aftercare – National Decade Against Cancer – dated 13 November 2024	2025–2029	Approx. 10 million	5 consortia with a total of 27 projects

LauZeDiPH – Lusatian Centre for Digital Public Health – for health and needs-based health care in Lusatia*	05/23–12/32	Approx. 4.2 million	Centre with 3 locations
Funding for the establishment and expansion of the future German Centre for Mental Health (DZPG)*	2023–2030	149.5 million	33
NAKO health study	2013– at least 2028	Up to 383 million, financed by the federal government, participating states and HGF	Joint project (26 university and non-university research institutions)
Start-up funding for future German Centre for Child and Youth Health (DZKJ)*	2024–2027	48 million	30

* This figure covers all measures – it is not possible to provide a breakdown of individual sub-projects that focus specifically on prevention.

Source: The information shown is based on statements made by the BMFTR at the request of the WR; WR representation.

Table A.6: Ongoing research projects of the BMG in the field of health promotion and prevention (as of 1 December 2024)

Project title	Duration	Project management	Objective/description
Tactilography Evidence Analysis Mamma: Prospective study on tactilography as a building block for improving women's health (TEAM)	09/24–12/26	PD Dr Hannah Woopen, Charité	The main objective of the TEAM study is to scientifically investigate the diagnostic reliability of tactile breast examinations performed by visually impaired MTUs. Three key objectives are to promote diagnostic reliability, health literacy and participation in mammography screening. The background to this is the high number of women with breast cancer and the associated high mortality rate due to neglected preventive care and early screening.
SuiLearning – Development, testing and evaluation of an e-learning programme called "Basic Course in Suicide Prevention in Health Care"	12/24–05/28	Professor Dr Reinhard Lindner, German Academy for Suicide Prevention (DASP)	The aim of the consortium is to develop, evaluate and implement an online e-learning programme called "Basic Course in Suicide Prevention in Health Care" for all professional groups in the health care sector. These include doctors, psychotherapists, social workers, pharmacists, health care and nursing professionals, nursing scientists, physiotherapists, occupational therapists, speech therapists, pastoral carers, counsellors, psychologists and other professions.
Networking of municipalities, municipal institutions and districts for heat protection (Hitzeservice.interaktiv)	03/24–03/26	Dr Jürgen Ritterhoff, ecolo GmbH & Co. KG, Agency for Ecology and Communication	The overarching goal of the "Hitzeservice.interaktiv" project is to research municipal needs with regard to heat protection for the population. A major aspect of this is the networking of municipalities with each other. This gives municipalities the opportunity to exchange ideas and learn from each other. Various networking formats are offered, addressing both municipalities of different sizes and districts.
Requests for assisted suicide among older people in inpatient and outpatient long-term care – professional care and suicide prevention (Attention)	09/24–08/27	Professor Annette Riedel, Professor Thomas Heidenreich, Esslingen University of Applied Sciences	Based on the results of a systematic literature review and findings from group surveys with nursing professionals in inpatient and outpatient long-term care, two practical and two ethical guidelines will be developed, coordinated and implemented.
Behavioural data for effective heat communication (HEATCOM)	11/23–12/26	Dr Mirjam Jenny, University of Erfurt	The aim of the HEATCOM project is to systematically close existing research gaps with regard to heat-adapted behaviour and to promote further theoretical development. The aim is to identify the factors that influence the behaviour of certain target groups in heat situations in order to enable behavioural changes.
Model projects for mental health action weeks	03/24–08/26	Professr Dr Arno Deister,	The overarching goal of the MASE2024 joint project is to scientifically investigate the

Project title	Duration	Project management	Objective/description
and their evaluation (MASE2024)		Action Alliance for Mental Health (ABSG) represented by the German Society for Psychiatry and Psychotherapy, Psychosomatics and Neurology e. V. (DGPPN)	effectiveness of the AWSG. To this end, all AWSG events in 2024 and 2025 in two model regions (Leipzig and Hamburg) will be recorded and evaluated, an evidence-based strategy for stigma-free reporting will be developed and implemented and anti-stigma interventions for different target groups will be developed.
CANJUStop – CAN Stop group training against problematic cannabis use in youth welfare	07/23–03/26	Professor Dr med. Rainer Thomasius, University Medical Centre Hamburg-Eppendorf, Centre for Psychosocial Medicine German Centre for Addiction Issues in Childhood and Adolescence (DZSKJ)	The main objective of the project is to transfer the “CAN Stop” group training programme against problematic cannabis use to Inpatient youth welfare services in a scientifically supported and participatory process.
Intervention study to increase the HPV vaccination rate in Germany (InveSt HPV)	01/23–06/26	Dr Anja Takla, MPH M.Sc., Robert Koch Institute	The project aims to test and scientifically monitor two approaches to increasing HPV vaccination rates in practice. Module 1 of the project focuses on so-called recall systems, which can help to support timely contact with doctors.
Syphilis testing, resistance determination of Mycoplasma genitalium and LGV subtyping as part of the MSM Screening Study 2.0 (MSM)	01/22–06/26	Dr Klaus Jansen, Robert Koch Institute	The overall objective is to measure the prevalence of urogenital, pharyngeal and rectal infections with Chlamydia trachomatis, Mycoplasma genitalium, Neisseria gonorrhoeae and Treponema pallidum in the group of men who have sex with men (MSM). Among other things, risk factors for acquiring STIs will be analysed and evidence-based measures for the prevention, diagnosis and treatment of STIs in MSM will be implemented or adapted.
Design, programming and testing of an AI-based chatbot for addiction	10/24 – 09/26	Fabian Leuschner, delphi-Gesellschaft für Forschung, Beratung und	With this funding measure, the Federal Ministry of Health (BMG) intends to support a project that develops, tests and evaluates the use of AI in the field of addiction prevention. The project aims to highlight the opportunities and benefits, but also the risks, of using AI in

Project title	Duration	Project management	Objective/description
questions (SuchtGPT) | [274]		Projektentwicklung mbH	the field of addiction prevention. The goal is to offer people a low-threshold opportunity to obtain individual information.

Source: The information shown is based on statements made by the BMG at the request of the WR; own representation.

| [274] See the Federal Ministry of Health (2025).

AI	Artificial intelligence
BCI	Behavioural and Cultural Insights
BfArM	Bundesinstitut für Arzneimittel und Medizinprodukte Federal Institute for Drugs and Medical Devices
BIÖG	Bundesinstitut für Öffentliche Gesundheit Federal Institute of Public Health
BIPS	Leibniz-Institut für Präventionsforschung und Epidemiologie Leibniz Institute for Prevention Research and Epidemiology
BMBF	Bundesministerium für Bildung und Forschung Federal Ministry of Education and Research
BMFTR	Bundesministerium für Forschung, Technologie und Raumfahrt Federal Ministry of Research, Technology and Space
BMG	Bundesministerium für Gesundheit Federal Ministry of Health
BRE	Bundesrahmenempfehlung Federal Framework Recommendation
BVPG	Bundesvereinigung für Prävention und Gesundheitsförderung Federal Association for Prevention and Health Promotion
BZGA	Bundeszentrale für gesundheitliche Aufklärung Federal Centre for Health Education
CHN	Community health nurses
DFG	Deutsche Forschungsgemeinschaft German Research Foundation
DGAUM	Deutschen Gesellschaft für Arbeitsmedizin und Umweltmedizin German Society for Occupational and Environmental Medicine
DKFZ	Deutsches Krebsforschungszentrum German Cancer Research Center

DZG	Deutsche Zentren der Gesundheitsforschung German Centres for Health Research
DZKJ	Deutsches Zentrum für Kinder- und Jugendgesundheit German Center for Child and Adolescent Health
EHDS	European Health Data Space
ePA	Electronic patient file
EU	European Union
FDZ	Research data centre
FhG	Fraunhofer-Gesellschaft
GDNG	Gesundheitsdatennutzungsgesetz Health Data Usage Act
GDP	Gross domestic product
GFDI	Health Research Data Infrastructures
GG	Grundgesetz Basic Law (Constitution of the Federal Republic of Germany)
GKV	Gesetzliche Krankenversicherung State-mandated health insurance
GMK	Gesundheitsministerkonferenz Conference of Health Ministers
GVP	Health impact assessment
HGF	Helmholtz-Gemeinschaft Helmholtz Association
HIOH	Helmholtz Institute for One Health
KPI	Key performance indicator
LVR	Landesrahmenvereinbarung State Framework Agreement

MFT	Medizinischer Fakultätentag Medical Faculty Association
MII	Medizininformatik-Initiative Medical Information Initiative
MPG	Max-Planck-Gesellschaft Max Planck Society
MPI	Max Planck Institute
MSME	Micro, small and medium-sized enterprises
NCPC	Nationales Krebspräventionszentrum National Cancer Prevention Center
NPK	Nationale Präventionskonferenz National Disease Prevention Conference
NUM	Netzwerk Universitätsmedizin The Network of University Medicine
OECD	Organisation for Economic Co-operation and Development
ÖGD	Öffentlicher Gesundheitsdienst Public health service
PEI	Paul Ehrlich Institute
PHN	Public health nurses
PKV	Private Krankenversicherung Private health insurance
PrävG	Präventionsgesetz Prevention Act
RIVM	Rijksinstituut voor Volksgezondheid en Milieu (Dutch) National Institute for Public Health and the Environment
RKI	Robert Koch Institute

SGB	Sozialgesetzbuch German Social Act
UG	Universität Greifswald Greifswald University
UMG	Universitätsmedizin Greifswald Greifswald University Hospital
WGL	Leibniz-Gemeinschaft Leibniz Association
WHO	Weltgesundheitsorganisation World Health Organisation

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The following is a list of the people involved in the deliberations of the German Science and Humanities Council (WR) and the Committee on Medicine as well as the staff of the Head Office involved in the development process.

In a one-step process, the drafts prepared by the working groups and committees are discussed in the commissions of the WR and can also be changed if necessary. As a result, the WR is considered the author of the published recommendations, statements and position papers.

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