Invited debate
Response to Waterall et al.

The Public Health England (PHE) paper by Waterall et al. is strong on good intentions but weak on evidence. In truth, the NHS Health Checks programme is a failure. We respond to each substantive point raised by Waterall et al.

Introduction

We agree that the burden of premature cardiovascular disease and death is enormous, inequitable and potentially preventable. We also strongly agree that population-wide measures can be powerful, rapid, equitable and cost saving. We therefore commend the PHE emphasis on policies such as salt reduction, five a day, smoke-free legislation, plain packaging, alcohol MUP and inequalities. Sadly, these aims are effectively upstaged by the continuing PHE emphasis on NHS Health Checks (NHSHC). That downstream strategy fails conceptually, scientifically, economically and practically.

The NHSHC programme was launched in 2009, yet visible gains remain absent. The Global Burden of Disease study\(^1\) clearly showed that poor diet and tobacco account for some 3/4 of the UK disease burden, and both diet and smoking can be improved far more by population-wide policies than by weaker, ‘downstream’ individual approaches like NHSHC.\(^2,3\)

Programme leadership

It is sad to see health ministers and DH officials now forcing local authorities to take responsibility for delivering an ineffective and costly strategy.

Optimizing NHS health checks

We strongly agree that major problems persist with scientific governance and programme implementation.

Even after 6 years of refinement, NHSHC are costly and difficult to implement. Registration does not itself produce benefits. Completed evaluations have all produced negative evidence. It is not clear why addition local evaluations will then help?

Promoting innovation

Waterall et al., paradoxically, assert the efficacy of a standard approach, but also piecemeal “innovation”. This approach guarantees heterogeneous implementation, higher costs and lower population impact.

Evidence for effectiveness of NHSHC

Efficacy and effectiveness of interventions can only be soundly evaluated using randomized controlled trial (RCT) designs, yet all the existing RCTs demonstrate that such programmes do not work. It is disingenuous then to dismiss this evidence as ‘not relevant’; ‘not precisely the same’ as NHS Health Checks\(^4,5\) or ‘having low uptake’.\(^4,6\)

In contrast, the cited positive evidence is observational and vulnerable to biases. The one positive European modelling study drew on the Cochrane review interventions previously rejected by PHE. Furthermore, such modelling studies are notoriously vulnerable to biases from optimistic assumptions.\(^7\)

While NHSHC are based upon interventions considered in NICE reviews, several of these are problematic, notably those on statins for low-risk adults, and obesity prevention.\(^8,9\)

Education does not necessarily translate into mortality reduction,\(^2\) particularly if starting after the age of 40.

Three crucial lessons come from a recent, large impact evaluation of the very similar Scottish ‘Keep Well’ programme:

(i) Problematic underlying theories,
(ii) Variations in implementation and
(iii) Barriers to effective assessment of impact.

Its 11 recommendations highlight systematic deficiencies in programme concept, implementation and evaluation,\(^10\) much like the English NHSHC programme.

Driving population health outcomes. PHE concede that even after 6 years, both the coverage and scale of NHSHC implementation are still poor.\(^11\) Costing \(\sim \£400\) million per annum, some \(\£2\) billion of scarce resources have already been wasted.

Individual-based interventions should not play a ‘major’ role, particularly when based on old papers.\(^12\) Population-wide prevention policies are consistently more effective than
primary prevention medications at reducing mortality. They are also cost saving and more equitable.\textsuperscript{13–15} Indeed, Waterall concedes that NHSHC risk exacerbating inequalities, even with ‘Proportionate Universalism’.\textsuperscript{16}

\section*{Conclusions}

We agree with Waterall that NHSHC are ‘not a substitute for national actions to improve the social and structural determinants of health, or tackle the regulatory environments that shape individual health behaviours and lifestyles.’ However, the NHSHC programme is fundamentally flawed in concept, science and delivery. (The House of Commons Science and Technology Committee agrees).\textsuperscript{17}

Strategies shown to be ineffective should be jettisoned before they waste further scarce resources. Scotland has decided to abandon central funding for its own health check programme.\textsuperscript{12} England should follow suit.

\section*{Editors’ note}

This article is part of an invited, non-peer-reviewed debate.

\section*{References}


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