

Briefing note: Health Checks

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On the 20/8/26, the Scottish Government announced a 5-year partnership with Chest Heart and Stroke Scotland (CHSS) to “launch heart and lung checks” (1). Information from CHSS said they would operate in Dundee, Glasgow and Grampian, with a forth site in Ayrshire planned for 2027. This would focus on “communities facing the greatest barriers to good health”, aim to build on the CHSS “Health Defence Hubs” to “identify cardiovascular and respiratory risks earlier and help prevent avoidable illness”. They stated that “Checks will include blood pressure, body mass index, heart rate, cholesterol and pulse measurements, plus a lifestyle assessment. Each person will receive practical, tailored advice” and aim to reach people “less likely to use traditional services”. CHSS said that in 2025/6, staff and volunteers helped 3,184 people over 3 sites. The contract is worth 3.2 million.

There is little debate that the poorest communities in Scotland shoulder the worst health outcomes, including deaths related to drug misuse, cardiovascular disease, and prevalence and admissions to hospital for chronic obstructive airways disease and smoking - 23% of people in the poorest communities in Scotland smoke compared to 7% in the least deprived areas (2,3,4,5,6). It may therefore appear logical to offer easy to access “health checks” in the most deprived areas. First Minister John Swinney has said that it is “all part of the early intervention and prevention approach of the Scottish government...the lung and heart MOTs that we’re taking forward with CHSS are part of ensuring that services can be available within local communities, people can easily access advice to deal with the issues and the implications that arise” (7).

CHSS do not appear to have published details of their intervention or any evaluation, independent or not. Control groups do not seem to have been used in any delivery design. Their annual report from 24/25 says that their ‘Health Defence team’ has “enabled over 1,000 individuals to access our community based hubs” (8). We do not know, for example, how people are to be invited, how tests are chosen, how they are communicated to primary care, and how duplication is avoided. CHSS currently has ability for people to book a ‘health check’ on their website, which starts “Demand for the health check appointments has been extremely high”. The team have a limited amount of available appointments each week” (9). In other words, people have to book, similar to booking a GP or practice nurse appointment. The wording used by CHSS may not be optimal for people at greatest risk and who are least likely to attend.

The ability of ‘health checks’ to benefit people at highest risk of mortality and morbidity has been of concern over the last few decades. A Cochrane review from 2019 found no evidence of benefit of general health checks and postulated that this was because “primary care physicians already identify and intervene when they suspect a patient to be at high risk of developing disease when they see them for other reasons” (10). A study aimed The Keep Well programme in Scotland, similarly aiming ‘health checks’ at the poorest communities has not been associated with a rise in either preventative prescribed medications or decreases in CVD mortality and morbidity (11). The ‘healthy attender’ effect is well noted, with the people at greatest disadvantage being most likely not to attend invitations to screening (12). While ‘health checks’ can indeed identify risks, an umbrella review has found these can reach more people at higher risk when done by general practices as opportunistic screening rather than in a separately initiated, invitation-only appointment (13).

The justification for providing an additional, separate, appointment-only service which is not part of primary care, delivers screening tests outwith standardised care pathways and which does not have a clear communication strategy or ability to avoid duplication, is lacking (14). The result is likely to include duplication of testing, including lipids, and screening for atrial fibrillation, which is not recommended by the UK National Screening Programme (15). It is not clear that general practice, including practice nurses, who will be expected to deal with results, have been consulted on the optimal way to deliver preventative healthcare with the resources available. Given the tendency for programmes like this to attract the healthiest, it may result in a further shift of resources towards those already most likely to live longest, and away from the poorest. It may also result in disjointed, fragmented care, increased GP workload, with less care going to the most vulnerable.

Information about the background for this announcement was sought from Scottish Government. They told us they had commissioned the Cardiovascular Disease Direct Enhanced Service through NHS GPs, intended to support 220,000 patients. They also said that they intended the Cleaner Air Act, Warmer Homes Scotland Scheme and the Tobacco Action plan to provide wider preventative action. They said they commissioned Chest Heart and Stroke Scotland to do this work on the basis that it was 'already an established, operational delivery programme'. Information was sought about the evidence base for this programme, and evaluation. Scottish Government said that "Arrangements for monitoring and evaluation the programme will be developed as part of the ongoing partnership with CHSS". While Scottish Government said that 'The programme will work closely with local NHS services to understand demand and ensure appropriate referral pathways' and mechanisms to avoid duplication 'are being developed' it is unclear what these will be, if these will be fit for purpose, and if evaluation will be independent.

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