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ARTICLE COMMENTARY

A critical commentary of the paradoxical 'success' of Making Every Contact Count (MECC)

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ABSTRACT

Initially implemented within healthcare settings but more recently expanded to the wider public and third sectors, Making Every Contact Count (MECC), an opportunistic approach to health behaviour change, has been widely adopted and implemented across the UK, Ireland, and beyond, despite little evidence to support improved health and wellbeing of service users. Drawing upon the contextual landscape of MECC implementation, this critical commentary explores the successful yet paradoxically diverse roll-out of MECC despite the lack of evidence to support its efficacy. Key drivers for MECC implementation are discussed and critiqued after distinguishing MECC from related interventions (e.g. motivational interviewing and brief interventions) and exploring the available MECC literature. The five key drivers are a need for prevention over treatment, the addressing of health inequalities, an increased drive for patient-centred care, cost-effective interventions, and key policy documents. In contrast to evidence-based practice, MECC implementation continues to be driven by an individuation tendency when attempting to address public health problems- as a form of 'lifestyle drift'. Potential solutions to improve the conceptualisation of approaches to individual-level interventions are discussed, along with recommendations for future MECC research and practice within a broader public health environment.

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Making Every Contact Count; neoliberalism; health promotion; evidence-based practice; evidence-based policy

Introduction

Making Every Contact Count (MECC) is an opportunistic approach to encouraging health behaviour change (Nichol et al., 2024b). Since it was first locally implemented in 2010 (Payne et al., 2010), MECC has become mandatory training for all staff working in health and social care (Public Health England, 2016) in England, despite sparse evidence to support its effectiveness specifically in promoting service user outcomes (Chisholm et al., 2020). Since then, MECC implementation has spread outside of England, including Wales, Ireland, Canada, South Africa, and Australia (Nichol et al., 2024b). Understanding the contextual landscape for MECC is therefore key to explaining its diverse uptake across healthcare settings in and outside of England.

Thus, this critical commentary explores the contextual landscape that determined the 'success' of MECC and its widespread and continued implementation across the English healthcare system and beyond. This commentary argues that the continued implementation of MECC is driven by ideological, institutional, and economic agendas—particularly neoliberalism, cost-efficiency priorities, and a shift towards individualised responsibility and prevention. Thus, the continued prioritisation of MECC risks obscuring structural determinants of health and widening health inequalities.

MECC: a 'successful' preventative public health intervention

MECC was introduced as an opportunistic, non-specialised, and preventative approach to engage the lower risk general population by seeking to empower individuals to undergo positive health behaviour change, resulting in improved population health and wellbeing and disease prevention, with associated economic benefits (Public Health England, 2016). MECC is not defined by the target behaviour, nor by the duration of conversations, but instead through its person-centred approach (Nichol et al., 2024b). MECC flexibly applies behaviour change principles to address needs and priorities for behaviour change identified by the individual (Nichol et al., 2024b). In this way, MECC adopts a holistic approach to health and wellbeing, and conversations could target multiple behaviours at once (Public Health England, 2016). Although the required skills for MECC,

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including active listening, asking open questions, and provision of support, resemble a motivational interviewing approach (Rollnick & Miller, 1995), MECC does not require specialist training and could potentially be delivered anywhere, to anyone, and by anyone (Nichol et al., 2024b).

The proposal of MECC outlined in the 2016 consensus statement (Public Health England, 2016) - an agreed commitment to MECC implementation between numerous partnering organisations including NHS England- drew upon the evidence base for brief interventions. However, unlike MECC, brief interventions are defined by duration (National Institute for Health and Care Excellence, 2014a), namely up to 30 minutes (Public Health England, 2016) or 40 minutes when extended support is required (National Institute for Health and Care Excellence, 2010). Also unlike MECC, brief interventions target a single behaviour, and have been demonstrated to be effective in targeting a variety of individual behaviours including smoking (Jepson et al., 2010; Stead et al., 2013), alcohol (Chisholm et al., 2018; Jepson et al., 2010), healthy eating (Jepson et al., 2010), and physical activity (Aveyard et al., 2016; Jepson et al., 2010). Indeed, a recent Delphi study to develop an updated consensus definition of MECC (Nichol et al., 2024b) confirmed that MECC is instead defined by its person-centred approach, confirming that it is insufficient to draw upon the evidence base to support brief interventions to justify MECC. Evidence to support the effectiveness of MECC specifically on service user health and wellbeing is lacking, with existing research conducted within subpopulations including pregnant women and new mothers and only supporting behaviour change for some of the measured health behaviours (Adam et al., 2020; Baird et al., 2014; Jarman et al., 2019; Lawrence, Vogel, et al., 2020). Furthermore, there still is no evidence to support the impact of MECC on mental health, alcohol, or smoking, reflecting a wider issue in England amongst other countries that despite supposed governmental values of evidence-based policy, many policy recommended interventions lack evidence of effectiveness or are indicated to be ineffective by existing evidence (Katikireddi et al., 2011).

A reasonable justification for the lack of evidence to support the effectiveness of MECC is the complexity of MECC as an intervention, meaning outcomes are difficult to both identify, measure, and attribute (Lowe & Wilson, 2017). A major source of complexity is the wide range of possible topics or health behaviours discussed, providing uncertainty around which outcomes should be measured within effectiveness studies. MECC is also opportunistic, fulfilling the more recently recognised characteristic of complexity of the interaction of the intervention with its context (Skivington et al., 2021). Others disagree that MECC is an intervention, preferring to conceptualise MECC as an approach that guides interactions (Nichol et al., 2024b), akin to recent developments in co-production/co-creation which emphasise relational approaches as the means of change (de Boer et al., 2025). In this view, the impact of MECC in and off itself is challenging to attribute despite justifying MECC using claims of effectiveness from brief intervention data, rendering claims of potential effectiveness of MECC effectively meaningless in its' own terms (Popper, 2005). Another view accepts that an individuated approach to demonstrating impact currently relies on medicalised perspectives of effectiveness. This is despite evidence to suggest the parallel value of MECC to improvements in organisational culture (Harrison et al., 2022) and increased staff capacity through higher confidence (Black et al., 2014; Chisholm et al., 2020; Lawrence, Watson, et al., 2020; Watson et al., 2020) and competence (Chisholm et al., 2020; Hollis et al., 2021; Jarman et al., 2019; Lawrence et al., 2016; Lawrence, Vogel, et al., 2020; Lawrence, Watson, et al., 2020). Such a perspective points to the need for some indication of linking individual changes within a broader longer term systemic and relational frame (French et al., 2023). This aligns with recent work which proposes an emerging framing of public health as 'universal wellbeing' as a public good (Heimburg et al., 2022), which could provide the basis of positioning MECC within a broader societal narrative thereby harnessing the widely observed localised adaption which seems to be such a key part of the achievements of MECC and embracing it in the way 'success' is evaluated (de Boer et al., 2025; Rutter et al., 2017). 'Evidencing' then could be explored in a more pluralistic, contextualised and relational way to inform learning from the individual (and group) level encounters where there is the potential for the intelligence generated through approaches like MECC to be utilised to inform broader systemic thinking (Green, 2006). Nonetheless, accepting MECC as an intervention allows the impact of MECC to be tested and possibly refuted.

Given the limited evidence of MECC's impact on population health and wellbeing, it is useful to explore the contextual background of MECC implementation (see Figure 1). The 2002 Wanless Review catalysed a shift towards prevention in UK healthcare policy (Wanless, 2002), followed by NICE's early public health guidelines recommending brief interventions for smoking in 2005 (National Institute for Health and Care Excellence, 2019), alcohol in 2010 (National Institute for Health and Care Excellence, 2010), and physical activity in 2013 (National Institute for Health and Care Excellence, 2013). In parallel, MECC emerged in 2010 in Yorkshire and Humber and was adapted regionally through initiatives such as 'Healthy Conversation Skills' in Southampton (Barker et al., 2011; Black et al., 2014), with subsequent uptake across southern England by 2014 (Devon County Council, n.d.; Wessex, n.d.). Although initially localised, MECC's reach expanded significantly following NICE's broader endorsement of brief interventions covering health and wellbeing more holistically (National Institute for Health and Care Excellence, 2014a), and the release of the national MECC consensus statement by Public Health England in 2016, which called for universal implementation across health settings (Public Health England, 2016). That same year, MECC was adopted by the Irish health service (Health Service Executive, 2016). Since then, MECC has been adapted across diverse contexts—including voluntary and community settings (Harrison et al., 2022; Nichol et al., 2024c), mental health settings (Rodrigues et al., 2023), and emergency services (Byrne-Davis et al., 2019). MECC has also been used to support public health campaigns, such as COVID-19 vaccination (Local Government Association, 2021). Clearly, nearly a decade since the publication of the consensus

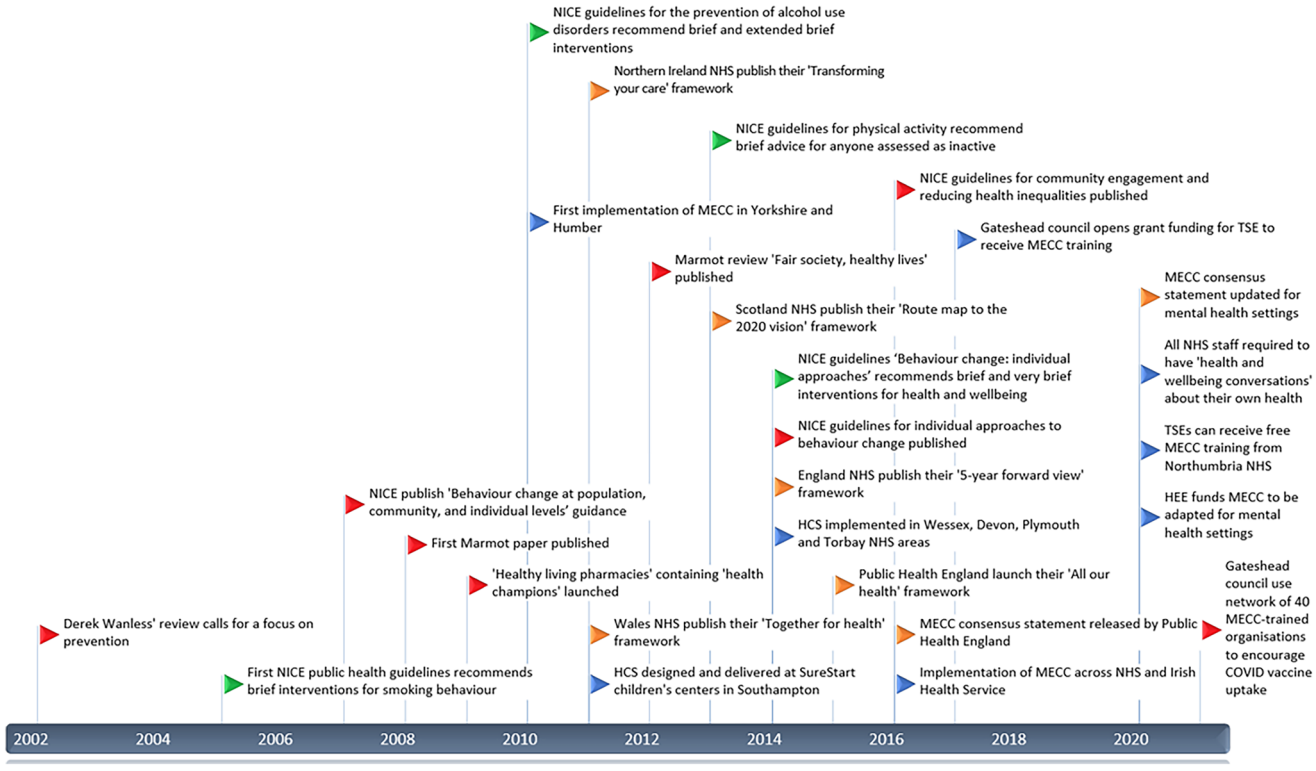

Figure 1. Key events, publications, and official documents that help to explain why brief interventions and MECC have received uptake from healthcare and TSE organisations. Code: Red = contextual events, green = NICE guidelines on brief interventions, orange = official documents, blue = implementation of MECC. The timelines are displayed separately according to each category in Supplementary Material 1.

statement, MECC implementation continues to accelerate and grow. The proposed reasons for the success of MECC- despite robust evidence of effectiveness- are discussed below.

Five key drivers for the uptake and endurance of MECC

Cost-effectiveness

Cost-effectiveness is defined as a balance between the resource cost of the intervention with the cost of not using alternate interventions with patient benefit. Cost-effectiveness is a prerequisite to the inclusion of interventions within NICE guidelines (National Institute for Health and Care Excellence, 2014b). Indeed, cost-effectiveness is so integral that it is considered as equally important as effectiveness (National Institute for Health and Care Excellence, 2014b), and NICE declares that only cost-effective interventions are recommended within NICE guidelines. Subsequently, all NICE guidelines are required to report a statement on the evidence of cost-effectiveness for the recommended interventions. NICE guidelines reflect the need of the NHS, providing universal healthcare, to be cost-effective too (National Health Service, 2014). Since NICE states that cost-effectiveness is a trade-off between costs and benefits, the more expensive an intervention is, the more certain the evidence has to be that it is cost-effective (National Institute for Health and Care Excellence, 2014b). Therefore, since brief interventions including MECC are inexpensive as they require minimal time and resources, the threshold for certainty of them being cost-effective is lower. Indeed, the first public health guideline from NICE recommended very brief interventions for smoking cessation (National Institute for Health and Care Excellence, 2019) and remains a recommendation 17 years later (National Institute for Health and Care Excellence, 2021). The sustainability of the recommendation is likely at least partly explicable by the low level of resources required to implement brief interventions. More recently, the need for cost-effectiveness is likely one of the reasons that MECC training has been delivered to volunteers, including for TSE organisations.

More broadly, prevention is more cost-effective than treatment (World Health Organization, 2021). This relates to the birth of the concept of Quality Adjusted Life Years (QALYs) in 1968, which describes the years spent ill with a disease, with the term being explicitly used first in 1976 (Zeckhauser & Shepard, 1976). This change of perspective from life or death to considering the importance of the quality of someone's remaining years alive (and the associated economic burden of morbidity) provided a strong rationale for disease prevention. Indeed, the World Health Organization highlighted interventions to target smoking, alcohol, diet, and physical activity to be the 'best buys' in addressing rise in non-communicable diseases (World Health Organization, 2021). This principle of prevention has existed for much longer than MECC and has driven a wider movement away from primary and secondary care, and towards health promotion and disease prevention.

However, whilst there is evidence to support the cost-effectiveness of brief interventions to target individual behaviours including alcohol use (Angus et al., 2014) and physical activity (Vijay et al., 2016), neither of the available studies quantifying the effects of MECC on service user outcomes performed a cost-effective analysis (Adam et al., 2020; Baird et al., 2014). As the current conceptualisation of MECC differs significantly from brief interventions in that a range of health behaviours could possibly be targeted and that the duration is determined by the needs of the individual (Nichol et al., 2024b), it is no longer sufficient to rely upon the evidence supporting brief interventions to justify the cost-effectiveness of MECC.

Prevention

Since 2000, it has become more likely for individuals to die from non-communicable diseases than from infectious diseases in developed countries such as the UK (Bíró et al., 2018; Vos et al., 2020). Now, non-communicable diseases such as cancers, cardiovascular disease, and diabetes account for 74% of deaths globally, mainly driven by increases in smoking and alcohol consumption and decreases in dietary quality and physical activity (World Health Organization, 2023). In the UK, as of 2019, noncommunicable diseases accounted for 89% of all deaths in the UK, compared to 8% from infectious diseases (Vos et al., 2020). Even during the COVID pandemic in 2020, the hypothesised relative contribution of noncommunicable diseases to mortality still dwarfed that of infectious diseases, at 79% compared to 18% (Angus, 2020). Concurrently, the Derek Wanless review (Wanless, 2002) brought focus to changing lifestyle behaviours as the key to preventing disease and reducing its burden on the NHS. Prevention of disease specifically through health promotion has arguably become the main focus of policy instead of structural changes to the environment (Ayo, 2012).

It is important to critique the role of preventative public health approaches including MECC in the reproduction of narratives of health and self-care (Ayo, 2012; Bell & Green, 2016). Inherent in the neoliberalist drive for prevention is the attribution of an individual's health to their own health behaviours, shifting the responsibility to the individual as opposed the structural, political, and social environment an individual is surrounded by (Ayo, 2012; Bell & Green, 2016; Williams & Fullagar, 2019). Neoliberalism is a broad term to describe a pro-capitalist ideology, policy, or programmes that encourage free market and decreased government spending, encouraging privatisation (Bell & Green, 2016). Although key public health bodies including the Association of Directors of Public Health (ADPH) and the UK Public Health network disregard use of the term 'lifestyle' for the undue emphasis it places on individual agency in one's health (Gruchy, 2019; Lincoln, 2015), the tendency to address prevention through individual-level interventions does exactly that, with a change in terminology insufficient to avert responsibility from individuals.

Drive for patient-centred care

Given the aims of MECC conversations are that they are shaped by the individual's needs and preferences, MECC is intended to be inherently person-centred. Person-centred care, which seeks to empower individuals to make informed decisions about their health, has become a central principle in integrated care systems globally (World Health Organization, 2015). Reflecting this shift, from 2014 NICE mandated that all guidelines align with person-centred care principles (National Institute for Health and Care Excellence, 2014b). In the same year, the NICE guideline around individual behaviour change which included brief interventions weas released (National Institute for Health and Care Excellence, 2014a). Brief interventions, and to a greater extent MECC, emphasise autonomy, informed decision-making, and personal responsibility for one's own health behaviours. Whilst person-centred care provides individuals with control and autonomy, implicit is the increased responsibility an individual has over their health, implying an expectation of self-care and engaging in health behaviours, much like the drive for prevention.

This emphasis on individual agency is particularly prominent in Western, individualistic societies, where an individual's perceptions of oneself in relation to others tend to favour independence and self-responsibility over collectivist values of interdependence (Kanagawa et al., 2001; Kitayama et al., 1997; Markus & Kitayama, 1991). Individualisation of Western cultures is intrinsically related to neoliberalism in that they both encourage individual responsibility and autonomy over other values and needs (Leme, 2023).

Health inequalities

Those of lower socioeconomic status (SES) engage in more harmful lifestyle behaviours including smoking (Martinez et al., 2018) and lower levels of physical activity (Hankonen et al., 2017) that in turn increase the likelihood of non-communicable diseases (Niessen et al., 2018). In 2007, NICE released their guidelines; 'Behaviour change at population, community and individual levels' (National Institute for Health and Care Excellence, 2007), which brought focus to the social determinants of health behaviour. Indeed, NICE guidelines on behaviour change state that any effective intervention should target multiple levels (National Institute for Health and Care Excellence, 2007). Shortly after these guidelines were published, the first review by Marmot and colleagues was published in 2008, highlighting health inequalities globally (Marmot et al., 2008). Although an individual-level approach, both the MECC consensus statement (Public Health England, 2016) and a policy position on

health inequalities from the ADPH (The Association of Directors of Public Health, 2019) claim that MECC can help to reduce health inequalities, either through engaging individuals in a conversation around their health and wellbeing that they may not have had otherwise and signposting to services to address health behaviours (Public Health England, 2016), or through providing support and facilitating access to services around the social determinants of health through the application of MECC plus (Public Health England, 2016; The Association of Directors of Public Health, 2019).

The tendency for public health approaches such as MECC to divert responsibility onto individuals is most worrying when considering issues such as health inequalities. The concept of 'lifestyle drift' describes a shift to attributing health inequalities to individual agency rather than socioecological causes and is observed to occur both on an individual and policy level. As aforementioned, the movement away from the term 'lifestyle' (Gruchy, 2019; Lincoln, 2015) does little to address the inherent consequence of individual approaches to behaviour change of placing responsibility on the individual for their own health. Whilst it may be unfair to describe health promotion as a whole as neoliberalist ideology without considering the environment of health promotion (Bell & Green, 2016), MECC relies on an individual possessing the opportunity and capability to elicit change after a MECC conversation. Thus, MECC could inadvertently align with neoliberal tendencies towards individual responsibility, particularly in contexts where individuals face reduced capability and opportunity due to socioeconomic disadvantage. Neoliberalism enforces and reinforces inequalities (Bell & Green, 2016; Peacock et al., 2014), and thus an apparent desire for MECC to reduce health inequalities seems to contradict the approach to individual-level intervention. However, claims made around the ability of MECC to reduce health inequalities are unfounded, and without an exploration of the impact of MECC on health inequalities any justification of MECC through claims in it reducing health inequalities are a tokenistic way to divert critique relating to neoliberalism. Thus, without the provision of increased resources, education, and support, or a 'safety net' (Hervik & Thurston, 2016) for those of lower socioeconomic status, the implementation of MECC may widen health inequalities as individuals of higher socioeconomic status are better able to make changes to their behaviours. For example, ethnographic work from the UK (Atkinson, 2013) found that participants were unable to consider making changes to prevent future health consequences, as their financial insecurity forced them to live day by day. Most convincingly, the disrupting review by Professor Sir Micheal Marmot and colleagues found more than 3.6 million people in the UK were living under the threshold to live a healthy life (Marmot & Bell, 2012). Thus, NICE guidelines for behavioural interventions recommend the principle of proportionate universalism (National Institute for Health and Care Excellence, 2014a), whereby intensity of an intervention should be proportionate to one's socioeconomic disadvantages.

Nonetheless, it is difficult to overlook the inherent problem with attempting to address health inequalities- which are created and reinforced by structural and political drivers enacted through governance, policy, and social and cultural norms (World Health Organization, 2010)- through individual-level intervention. Indeed, the World Health Organization states that the fundamental approach to reducing health inequalities should be through targeting the structural differences factors such as income, education, or occupation (World Health Organization, 2010). MECC attempts to addresses the need to boost self-efficacy, perceived control, and empowerment of those of low SES (Marmot & Bell, 2012; World Health Organization, 2010), but addressing individual differences in health behaviours should be a secondary to change in policy and governance (World Health Organization, 2010). Ten years after the initial Marmot review, inequalities continue to widen (Marmot, 2020).

Official frameworks

Finally, the aforementioned factors are often expressed through official national policy documents, which inform and direct future practice. Due to their high authority and far reach, policy documents including governmental reports have a strong influence on how healthcare organisations and beyond are run in the future. The timeline of publication for some of the important official documents across the UK is shown in Figure 2. Published between 2011 and 2014, NHS documents for each area of the UK all directed focus onto prevention and creating healthier societies (Department of Health, Social Services and Public Safety, 2011; National Health Service, 2014; Scotland, 2013; Wales, 2011). Plans for Northern Ireland (Department of Health, Social Services and Public Safety, 2011), Wales (Wales, 2011) and Scotland (Scotland, 2013) also included the aim of reducing health inequalities and the gap between those of the highest and SES. Whilst the '5-year forward view' for England

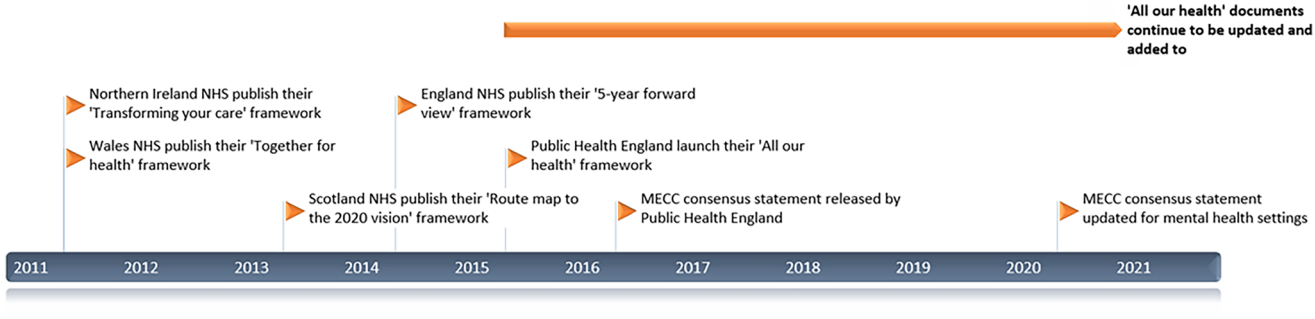

Figure 2. A timeline of the publication of official documents concerning future plans for healthcare and MECC.

acknowledged diverse communities that may require differential healthcare (National Health Service, 2014), there was a lack of awareness of the social determinants of health that link to the need for preventative healthcare. Documents for England (National Health Service, 2014), Northern Ireland (Department of Health, Social Services and Public Safety, 2011) and Scotland (Scotland, 2013) all mentioned the need for patient-centred care and enabling patients to take responsibility for their own health and wellbeing. Although MECC appears to align with the agendas set out by national policy documents in and around England, widespread implementation of MECC as the available research currently stands disregards the aims of NICE to provide evidence-based guidance.

Prognosis of MECC: navigating a course to evidence-based policy and practice

In conclusion, driven by an agenda for prevention, MECC was developed and selected as a potentially cost-effective approach to health promotion. Also, due to the favourable image of person-centred care MECC reflects and given its relatively low costs of training and implementation, evidence for the effectiveness of MECC was not a priority when considering implementation as the threshold for potential cost-effectiveness was low.

What next for MECC, then? That MECC is so adaptable and flexible likely has ensured its continued success since 2016 among changing landscapes. For example, as the landscape changed to drive the importance of mental health (Nichol et al., 2024a, 2024c), MECC diverted its focus to mental health (Health Education England, 2022) and within mental health settings (Health Education England, 2020; Rodrigues et al., 2023). When the COVID-19 pandemic hit, MECC was adapted to disseminate public health messaging related to infection prevention such as mask wearing and vaccination (Local Government Association, 2021). In accordance with drivers for integrated care, MECC implementation expanded to voluntary and community settings (Harrison et al., 2022). The ability of MECC to be applied to any topic and within any setting has hugely facilitated continued implementation. Thus, whilst there are drivers for a person-centred approach to addressing health behaviours via individual-level interventions, MECC will persist. Only last year, the independent report on the NHS released by Lord Darzi recommended that the NHS empowers patients to take as much control over their care as possible (Darzi, 2024). Subsequently, MECC continues to grow, expanding outside of healthcare settings, and outside England. Indeed, credible sources endorse MECC and recommend MECC to be applied in practice (Public Health England, 2016; Royal Society for Public Health, 2025; The Association of Directors of Public Health, 2019). A caveat is that if MECC is demonstrated to increase rather than decrease health inequalities contrary to claims by the consensus statement (Public Health England, 2016) and the ADPH, there is no longer a justification to tackling the rise of non-communicable diseases with MECC. The availability of such information is urgent to ensure resources are being spent appropriately to aid those disadvantaged most. If MECC is found to be inequitable favouring those of higher low SES, de-implementation of MECC should be considered (Helfrich et al., 2019). Namely, such evidence would justify an *unlearning* (Helfrich et al., 2018) of service providers to attributing responsibility of the health of service users onto themselves, and a *substitution* (Helfrich et al., 2018) of MECC conversations that may instead focus on active referral to services rather than promoting self-management including seeking further support (Harvey-Sullivan et al., 2024).

Accepting that MECC implementation will likely continue given the endurance of the five proposed key drivers, targeted refinements could help address the critiques raised in this commentary. Careful and tokenistic selection of language is insufficient to avoid the critique of neoliberalism- a change of approach is required which provides individuals of low SES with increased support. Also, given that it is not appropriate to draw upon the evidence base of brief interventions, one way of interpreting this paradox is that there is an urgent need to explore the impact of MECC on service users outcomes including behaviour change and health and wellbeing outcomes. Moreover, any evidence would need to reflect the current diversity of MECC implementation and delivery and explore how MECC differentially effects individuals. Whilst short term outcomes such as concrete behaviour change may be more difficult to demonstrate and attribute to MECC, it is potentially feasible to capture more nuanced outcomes including knowledge, confidence, changes in intentions, and access to further services. In sum, only through critical reflection and robust, inclusive evaluation might MECC potentially progress from a well-intentioned and superficially implementable (and low cost) policy initiative into a more meaningful equitable and evidence-based approach to disease prevention. More importantly, it is imperative that individual approaches like MECC are utilised in in tandem with, not in lieu of, structural changes for meaningful impact.

Authors contributions

All authors were involved in the conception of this article, revising it critically for intellectual content, and the final approval of the version to be published (BN, RW, AMR, and CH). Author BN was responsible for the design, analysis, interpretation of the data, and the drafting of the paper. All authors agree to be accountable for all aspects of the work.

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Data availability statement

Data sharing is not applicable to this article as no data were created or analysed in this study.

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