

**New development: The commodification of social security medical assessments—academic analysis and practitioner experience**

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**IMPACT**

This article examines an important area of public sector commodification: the medical assessments that determine eligibility for social security benefits. The commodification of this adjudication process has a significant impact on vulnerable welfare benefit claimants. The article has a particular focus on issues commonly experienced by claimants with mental health problems. Drawing on experience of working in the social welfare sector, the authors present professional reflections on the impact of commodification. Best practice guidelines for supporting claimants with social security medical assessments are presented; these make a new contribution by highlighting the approach needed by professionals to effectively navigate the privatized benefit assessment process.

## **ABSTRACT**

This article explores the issues caused by the commodification of medical assessments which determine eligibility for social security benefits in the UK, with a focus on Personal Independence Payment (PIP) and Employment and Support Allowance (ESA)/Universal Credit (UC). Commercial companies have become a mainstay in the assessment processes for welfare benefits, and yet the standard of service they provide has drawn criticism from a wide range of stakeholders. The authors contend that the current system of commodified medical assessments is fundamentally flawed and argue for an alternative approach. However, while the current system remains, it is important that vulnerable benefit claimants are supported with the process and, consequently, the academic analysis in the article is accompanied with a set of best practice guidelines developed by a welfare rights practitioner.

### **Keywords:**

Personal Independence Payment, Employment and Support Allowance, Universal Credit, Work Capability Assessment, public sector commodification, mental health, welfare rights, welfare reform

### **The use of private providers for social security medical assessments**

Medical assessments delivered by private contactors have been a feature of the UK's social security system for over two decades. The Work Capability Assessment (WCA) assesses fitness for work and determines eligibility for the Employment and Support Allowance (ESA). Currently, in England, the WCA is administered by a division of the company Maximus called the 'Centre for Health and Disability Assessments' (CHDA). The current WCA contract runs until March 2024; with a value of over £1.2 billion (Kulakiewicz et al., 2022).

Atos Healthcare, a French IT consultancy company (functioning under the name Independent Assessment Services) delivers assessments for Personal Independence Payment (PIP) in the north and south of England and Scotland. Capita, a British professional services company, carries out the assessments in central England, Wales and Northern Ireland. These current, two-year contracts are worth £566 million (Kulakiewicz et al., 2022). Atos were the original WCA contractors but were subject to much criticism and withdrew from the contract in 2014. In 2021, Atos reported an annual revenue of €10.8 billion, and Capita £3 billion.

Medical assessments for disability benefits have been delivered under commercial contracts since 1998 when the SEMA group, the predecessor to Atos, was awarded a contract by the (then)

Department for Social Security (now the Department for Work and Pensions: DWP). The rationale for the outsourcing of medical assessments was the need to improve quality standards and customer service, to expedite decision-making, and to lower costs by 25% over three years (National Audit Office, 2001).

A revised approach to social security, described as 'welfare contractualism', was introduced. This was once seen as the domain of the political right but was picked up by the Clinton administration in the USA, and subsequently by the New Labour government in the UK. It represented 'a fundamental shift in the orientation of the welfare state from the promotion of equality to the promotion of social order' (White, 2000, p. 508) with the government eager to emphasise that the new contract was based on rights and responsibilities.

### **Current knowledge base**

Aside from some notable exceptions, the academic literature tends not to focus explicitly on commodification per se. However, the authors of this article contend that the problems with social security medical assessments highlighted in the literature are intrinsically linked to commodification. We cannot separate the overall aims of welfare reform from commodification. Commodification is the vehicle through which successive governments have sought to deliver and control the objectives of welfare reform; this is central to the appointment of private companies to deliver medical assessments for ESA and PIP.

The commodification of medical assessments was long in the making. Stewart (2018) highlights the emphasis placed on a 'consumer model of care and individualism' in the 1980s—a model pursued by the then Department for Social Security.

Warren et al. (2014, p. 1322) are clear about the challenges created by commodification for people with disabilities. They argue that the market economy fundamentally fails disabled people and that we should not be surprised 'that an outsourced marketised version of state welfare is incapable of dealing with the problems the market has created'. Only two years after the introduction of the WCA, Grover and Piggott (2010) labelled it as a retrograde move for disabled welfare claimants, which promoted a medicalized model of work capability and sought to minimize costs. Commenting after Atos withdrew as the preferred provider for the WCA, Grover (2014) argued that this would not signal a change in policy direction or the commitment to the use of private companies; he has been proved correct on both points.

All the above sources highlight the negative impact of the WCA on claimant wellbeing. Griffiths and Patterson (2014) brought together many of the concerns about the WCA, which they summarised as: poor in design and application, inappropriate for people with mental health problems, and poor-quality decision-making.

The literature clearly highlights difficulties with both the WCA and PIP assessments for benefit claimants with mental health problems. Galloway et al. (2018) state that clinical evidence is key in ameliorating some of the problems experienced by claimants. Pybus et al. (2021) found that both benefit assessments overwhelmingly focus on physical health problems to the exclusion of mental health issues; analysis of administrative data shows that claimants with mental health problems are 2.4 times more likely to lose a disability benefit award following a PIP assessment than claimants with physical health problems. Research has found that Capita take a formulaic approach to PIP assessment, making it difficult for complex mental health issues to be appropriately explored and recorded (Machin and McCormack, 2023).

Boardman (2020) describes the problems faced by people with mental health problems as being trivialized by the process and claimants being caught in a repetitive cycle of assessment, benefit rejection and appeal. Shefer et al. (2016) focused specifically on claimants with mental health problems who had lost their entitlement to disability benefits and report experience of high levels of anxiety, frustration with bureaucracy and mistrust of adjudicating authorities. Hansford et al. (2019) view the WCA as damaging to mental health in a range of ways: the process can be traumatizing, can leave claimants feeling powerless as it lacks a 'real-world' assessment of need, and can promote feelings of shame and stigma.

## **Professional reflections and best practice guidelines**

This section of the article presents a critical reflection of a welfare rights officer working in the East Midlands of England for over 30 years supporting hospital and mental health patients. Except where otherwise stated, this section is based on the direct experience of the practitioner.

WCAs usually take place in urban assessment centres and home visits are extremely rare, although from the beginning of the coronavirus pandemic most have been done by phone. In practice, there has been no discernible difference between the approach to undertaking assessments taken by Atos and that taken by its successor, Maximus. Indeed, in Derby, assessments by Maximus continued to be undertaken in the same assessment centre by largely the same staff that had performed them for Atos.

When PIP was introduced in 2013, the two contracted companies outlined different approaches to undertaking assessments. Capita claimed that their services were tailored to meet the needs of disabled claimants and that they were committed to offering home visits for assessments; Atos never made such assurances. In practice, there is little to distinguish the approach of the two companies. Most claimants have been forced to attend clinic assessments, often having to travel significant distances. For example, claimants in Derby have routinely been given appointments in Nottingham (18 miles), Leicester (32 miles) and Stoke-on-Trent (34 miles).

The pandemic brought about a significant change of approach for both assessment procedures, as most took place by phone, with increasing proportions being done on paper with no direct contact with claimants at all. The trend has continued since the relaxation of Covid 19 restrictions, with providers showing little appetite to go back to mass face-to-face assessments. Capita's statistics for the year from May 2021 to April 2022, provided to an East Midlands Capita stakeholder meeting, show that 85% of assessments were performed by phone and only 4% happened face-to-face.

There have always been powerful reasons to question the appropriateness of assessments for benefit claimants. Assessments are performed by medically-trained staff (usually nurses, physiotherapists, or paramedics; occasionally occupational therapists; and only very rarely doctors) who may or may not have any prior experience of any particular benefit claimant's medical condition. Most last no more than 45 minutes and some are less than 30 minutes. Any physical 'examination' performed is limited and perfunctory, and certainly not appropriate for addressing all types of physical disability. Lung conditions, for example, cannot reasonably be assessed by the usual examination of arm and leg movements.

Assessments of claimants with mental health problems consist of talking to them about their condition and asking them about their difficulties in respect of the specific activities that make up the assessment. Based on this conversation, the assessor is effectively deciding whether or not to believe what they are being told. This can lead to claimants being awarded zero points on all activities. The reasoning given is usually either based on the assessor's own observations (typical comments include: 'he was heard to sound calm and relaxed and was able to fully engage with the assessor') or arbitrary facts about the level of input from mental health services ('although he reports that he self-harms, he has not been sectioned under the Mental Health Act and has not been referred to the crisis team'). Arguably, the move to phone interviews is itself an admission of the general inadequacy of assessments. Telephone assessments remove the opportunity for the assessor to do any kind of physical examination and make it impossible to make any of the informal observations that have always been central to the identity of the assessments.

It has now become the norm for claimants to be told by the DWP to provide their own evidence and that this is important to help the decision-maker come to the correct decision. Moreover, on appeal, decisions are most often overturned because of extra evidence: either medical or other supporting evidence from third parties or verbal evidence at the hearing. While the consensus in the social welfare law sector is to favour of other types of evidence, the approach taken by assessors in evaluating this information can also be poor and inconsistent.

For claimants with mental health problems, the introduction and increased use of assessments has been incredibly harmful. Many claimants who are on both 'incapacity for work' benefits and disability benefits (PIP) can find themselves in a constant round of assessments. As each benefit is often reviewed after two years or less, they are often subjected to a new assessment every year. Even for claimants who never actually 'fail' an assessment, the constant threat of having to experience each assessment is enough to significantly increase their symptoms and cause a deterioration in their condition.

The authors contend that the current system of commodified medicals in the UK is fundamentally flawed and argue for an alternative approach. However, while the current system remains it is important that vulnerable benefit claimants are supported with the process. This article makes an important contribution to this area is made by putting forward new best practice guidelines (see Table 1).

**Table 1. Best practice guidelines for medical assessments for welfare benefits.**

Best practice principle	Reasoning
Provide help to ensure the information-gathering form is completed appropriately.	All assessments begin with the claimant being sent an information-gathering form. A well-completed form clarifies the picture for the assessor and makes it less likely that they reject or ignore the claimant's stated needs.
Ensure that the claimant is able to participate in the assessment, whether it is face to face or by telephone, and that they have someone with them to act as support/witness.	Many claimants find it difficult to articulate their needs and difficulties and a carer, friend or family member can often explain the situation more clearly.
Consider (audio) recording or asking the assessor to record the assessment.	Claimants often dispute the veracity of the assessor's record of the meeting, and this can be a way of checking what was discussed.
Gather appropriate supporting evidence and submit this where it clearly supports the claimant's case.	Many claimants submit evidence that either fails to address relevant issues for the assessment or provides a misleading or incomplete picture.
Make sure the claimant understands the need to challenge a negative decision.	Appeals have high success rates. Claimants frequently accept decisions and, rather than appeal, submit another claim some months later. It is almost always best to pursue cases through the appeal process.
Always ensure that a claimant is represented by a specialist welfare rights worker in any appeal.	The appeal process can be very difficult for individuals to navigate and the success rates are significantly higher where claimants are appropriately represented.

### **Conclusions and recommendations**

This article has highlighted significant concerns about the impact of the commodification of medical assessments for welfare benefits. The assessment process for the predecessor to PIP, Disability Living Allowance, offers a template which we believe was simpler, more transparent and effective. A

working-age claimant submitted a claim detailing the level of their disability/health issues and the impact on their lives. They were asked to provide evidence to support this, and/or details of a health and social care professional whom the DWP could contact. Claimants were only referred for an assessment as a last resort where there was ambiguity about the level of their impairment. This process has always been in place for the Attendance Allowance—the PIP equivalent for claimants over pension age. This raises important points about the difference in administration of working and non-working age benefits, and the overall aims of welfare reform which are based on faulty notions of why people claim disability benefits. The programme of welfare reform initiated by the Conservative–Liberal Democrat coalition (2010–2015) focused almost exclusively on amending eligibility and reducing entitlement for working-age welfare benefits. What is evident is that commodification not only fits with a neoliberal agenda in broad terms, but specifically aligns with the view that greater scrutiny should be placed on working-age disability benefit claimants with a view to reducing the claimant count. The impact of the media in propagating narratives about disability benefit claimants is important.

The approach of the Scottish Government to the administration of disability benefits provides a compelling alternative to a commodified system relying on private contractors; our primary recommendation is that this approach should be adopted throughout the UK. This approach is fundamentally different in practical and ideological terms. From August 2022, the Adult Disability Payment (ADP) was introduced to replace PIP. The Scottish Government commits to not using private sector companies in assessment processes. Assessments (described as ‘consultations’) are conducted by Social Security Scotland, an Executive Agency of the Scottish Government. Consultations are not automatic and are used as a last resort in the absence of other evidence which could be ‘formal’ sources (for example a health professional known to the claimant) or ‘informal’ sources (for example a claimant’s carer or family). Consultations are carried out by professionals with a specific understanding of the claimant’s condition. The consultation is claimant-led focusing only on the information that has been recorded on the application form. There is no functional assessment as it is believed some conditions are difficult to examine in this way. A multi-channel approach to consultation is adopted; the claimant can choose a face-to-face, phone or video consultation with an advocate or supporter present. All consultations are recorded with the evidence made available to a tribunal in the event of an appeal. Research in the coming years is needed to ascertain the impact of these changes (Scottish Government, 2020).

The administration of this new benefit is based on the principles of public service and investment in people. The values and ethos of this approach are fundamentally different to the commodified assessments of PIP and the WCA. The Scottish Government have explicitly stated that they want an

assessment model which looks and feels different to the commodified practices of the rest of the UK. It is based on the principles of dignity, fairness and respect and has been developed with consultation of an Experience Panel, including claimants with lived experience.

*The Transforming support: The health and disability white paper* has proposed the abolition of Work Capability assessments in England (DWP, 2023); it is not clear how this reform would work in Scotland given the introduction of ADP. While the abolition has been welcomed by many commentators, we do not believe that it represents an acknowledgement of the problems and limitations of such assessments, especially as it puts more onus on the similarly problematic PIP assessments. It also appears to represent a worrying shift to discretionary non-appealable decisions being made with limited medical information by DWP staff. Analysis of this is, however, outside the scope of this article.

The authors contend that commodification has had a regressive impact on vulnerable and disabled claimants, is ideologically driven, and results in services which often fail to meet the most basic of customer service standards.

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## References

Boardman, J. (2020). Dismantling the social safety net: social security reforms, disability and mental health conditions. *BJPsych Bulletin*, 44(5), 208-212. doi: 10.1192/bjb.2020.79

DWP. (2023). *Transforming support: The health and disability white paper*.  
<https://www.gov.uk/government/publications/transforming-support-the-health-and-disability-white-paper>

Galloway, A., Boland, B., & Williams, G. (2018). Mental health problems, benefits and tackling discrimination. *BJPsych Bulletin*, 42(5), 200–205. <https://doi.org/10.1192/bjb.2018.43>.

Griffiths, T., & Patterson, T. (2014). Work Capability Assessment concerns. *Journal of Poverty and Social Justice*, 22(1), 59-70. <https://doi.org/10.1332/175982714X13915082967339>

Grover, C., & Piggott, L. (2010). From incapacity benefit to employment and support allowance: social sorting, sickness and impairment and social security. *Policy Studies*, 31(2), 265–282.  
doi:<https://doi.org/10.1080/01442870903429678>

Grover, C. (2014). Atos Healthcare withdraws from the Work Capability Assessment: a comment. *Disability & Society*, 29(8), 1324-1328, DOI: [10.1080/09687599.2014.948750](https://doi.org/10.1080/09687599.2014.948750)

Hansford, L., Thomas, F., & Wyatt, K. (2019). The impact of the Work Capability Assessment on mental health: claimants' lived experiences and GP perspectives in low-income communities. *Journal of Poverty and Social Justice*, 27(3), 351-368. <https://doi.org/10.1332/175982719X15637716050550>

Kulakiewicz, A., Kennedy, S., Mackley, A., & Hobson, F. (2022). Disability benefits assessments and the Government's health and disability green paper.  
<https://researchbriefings.files.parliament.uk/documents/CDP-2022-0021/CDP-2022-0021.pdf>

Machin, R., & McCormack, F. (2023). The impact of the transition to Personal Independence Payment on claimants with mental health problems. *Disability & Society*, 38(6), 1029-1052, DOI: [10.1080/09687599.2021.1972409](https://doi.org/10.1080/09687599.2021.1972409)

National Audit Office (2001). *The medical assessment of incapacity and disability benefits*.  
<https://webarchive.nationalarchives.gov.uk/ukgwa/20170207052351/https://www.nao.org.uk/wp-content/uploads/2001/03/0001280.pdf>

Pybus, K., Pickett, K. E., Lloyd, C., Prady, S., & Wilkinson, R. (2021). Functional assessments in the UK social security system: the experiences of claimants with mental health conditions. *Journal of Social Policy*, 50(2), 305-322. doi: 10.1017/S0047279420000094

Scottish Government. (2020). *Social Security policy position paper—disability benefit applications: how decisions are made*. <https://www.gov.scot/publications/decision-made-disability-benefit-application/>

Shefer, G., Henderson, C., Frost-Gaskin, M., & Pacitti, R. (2016). Only making things worse: a qualitative study of the impact of wrongly removing disability benefits from people with mental illness. *Community Mental Health Journal*, 52, 834-841, DOI: 10.1007/s10597-016-0012-8

Stewart, M. (2018). *Preventable harm and the Work Capability Assessment*. <https://citizen-network.org/uploads/attachment/618/preventableharm-and-the-work-capability-assessment.pdf>

Warren, J., Garthwaite, K., & Bambra, C. (2014). After Atos Healthcare: is the Employment and Support Allowance fit for purpose and does the Work Capability Assessment have a future? *Disability & Society*, 29(8), 1319-1323, DOI: [10.1080/09687599.2014.948746](https://doi.org/10.1080/09687599.2014.948746).

White, S. (2002). Social rights and social contract—political theory and the new welfare politics. *British Journal of Political Science*, 30(3), 507-532. doi: 10.1017/S0007123400000211