A medical degree can open all sorts of doors. One is the brown and tinted glass entrance of the Atos Healthcare offices in Glasgow, where I checked that my name was on the list held by the security guard at the desk. This recruitment evening was for doctors, nurses, and physiotherapists interested in working with this French information technology firm, which is subcontracted to the Department for Work and Pensions to provide work capability assessments.

In November last year Atos announced a three year extension to its contract with the department, worth £300m (€350m; $480m), to “support the UK government’s welfare reform agenda.”

Atos is the sole contractor, and the medical reports it generates are used to make decisions about eligibility for Employment and Support Allowance. This benefit, which has been replacing incapacity benefit and income support since 2008, is paid to people who are medically unfit to work because of illness or disability. The weekly allowance, once the claim has been verified with an assessment of capability, is worth up to £96.85. The government estimates that 2.5 million UK citizens receive sickness benefits at an annual cost of around £12.6bn to the taxpayer.

A quick glance at internet discussion forums suggests widespread dissatisfaction from people who have been assessed. The adverts for Atos, however, consist of smiling, badged professionals saying, “Getting home on time has become part of my daily routine.” The lack of on-call duties and the 9.5 office hours were also the major advantage plugged at the evening, where nurses and doctors working for Atos helped to promote joining the company.

Isolated view

But what are the ethical issues in performing disability assessments in this way, separate from the NHS and without access to patients’ full medical records? Atos was awarded the assessment contract in 2005 and claims that its reports are “evidence based, clearly presented, legible and fully justified.” Are medical assessments accurate enough to make major decisions about people’s ability to work? And is Atos the best company to do them?

The message from the recruitment evening was quite clear. We were told: “You are not in a typical caring role. This isn’t about diagnosing.” And: “We don’t call them patients . . . We call them claimants.” Training is provided for each type of benefit examination. Its length, we were told, depends on experience but is generally up to five days of classroom training, followed by sessions accompanied by a trainer that are audited afterwards.

Full time doctors can earn £54 000 as basic salary plus various benefits including private healthcare. Sessional doctors work a minimum of four sessions a week and are paid “per item”—£35.16 for an incapacity benefit examination and £51.37 for non-domiciliary disability living allowance (DLA) examination, for example. The application forms for sessional doctors state that “10 DLA domiciliary visits cases per week would earn £60 211.60 per annum. Five LCWRA/ LCW [limited capacity for work related activity/limited capacity for work] cases per session, for six sessions per week, would earn £62 883.60 per annum.”

Throughput is a clear focus. The average morning or afternoon session should consist of five assessments, and it was made clear at the recruitment evening that clinicians who did not achieve this regularly would be picked up quickly on audit trails and speed of work addressed.

Nurses and physiotherapists do effectively the same job as doctors in the centres, but do not see people with neurological conditions such as stroke or multiple sclerosis. Otherwise people are seen on a first come, first served basis. One nurse in the audience asked about training in mental health, as she had had little training in this area and would not feel competent to assess it in a fitness for work setting. The reply was that health professionals were “very thoroughly assessed” at interview for their abilities; however, general nurses were often taken on and given training. Is a relatively short training course thereafter enough to ensure the assessments are medically accurate and fair?

Duty of care

Atos chose not to be interviewed by the BMJ, although the Department for Work and Pensions referred me to the organisation for questions
about recruitment, training, and audit that it couldn’t answer.

However, from the recruitment evening it was clear that the medical examination consisted of a computerised form to be filled in by choosing drop down statements and justifying them. For example, you could say “able to walk with ease” if you witnessed this or the patient told you this.

The professional role of the doctor is very different from that in the typical NHS. Paul Nicholson, chair of the BMA Occupational Medicine Committee, says that working in this environment brings specific difficulties. “Notwithstanding a contractual obligation to provide a report to a government department, I still have a professional duty of care to the patient and to make the care of the patient my first concern.”

The Faculty of Occupational Medicine publication Good Occupational Medical Practice reinforces the General Medical Council’s position that, good medical care “must include adequately assessing the patient’s conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient’s views, and where necessary examining the patient; providing or arranging advice, investigations or treatment where necessary; referring a patient to another practitioner, when this is in the patient’s best interests.”

In other words, it expects doctors to adhere to the same professional conduct as they would in any other role.

Does it work?

So is the current method of assessment fit for purpose? There is a queue of people who think not. The Citizens Advice Bureau Scotland, in a report last year, noted “the vast majority of complaints and advice queries stem from the Work Capability Assessment.” This includes both the result of the assessment as well as the manner in which it was carried out, it said. “Citizens Advice Scotland (CAS) is extremely concerned that many clients are being found fit for work in their Work Capability Assessment despite often having severe illnesses and/or disabilities. Our evidence has highlighted the cases of many clients with serious health conditions who have been found fit for work, including those with Parkinson’s disease, multiple sclerosis, terminal cancer, bipolar disorder, heart failure, strokes, severe depression, and agoraphobia.”

“One assessment, which initially reported a woman was fit to work, reported as evidence that her mental health was reasonable that she “did not appear to be trembling . . . sweating . . . or make rocking movements.”

Other countries rely more on general practitioner assessments of fitness to work. For example, in the Republic of Ireland, general practitioners mainly certify patients and a doctor acting for the Department of Social Protection reviews around 12% of cases as a control mechanism. In Sweden, a certificate from your general practitioner does not automatically entitle you to sickness pay. However, the certificate asks for a description of how illness affects work capacity and a time frame. Just 3.5% of claims are turned down, and about 10% of these are overturned at appeal.

So what is the optimal system? Malcolm Harrington, emeritus professor of occupational health at the University of Birmingham, reviewed the work capability assessment system last year and is currently writing a second review. He wrote: “The pathway for the claimant through Jobcentre Plus is impersonal, mechanical and lacking in clarity. The assessment of work capability undertaken for the DWP by Atos Healthcare suffers from similar procedural problems. In addition, some conditions are more subjective and evidently more difficult to assess. As a result some of the descriptors may not adequately reflect the full impact of such conditions on the individual’s capability for work. The final decision on assigning the claimant to one of the three categories theoretically rests with the Decision Maker at Jobcentre Plus but, in practice, the Atos assessment dominates the whole procedure. This imbalance needs correcting.”

His view is that “the Jobcentre Plus Decision Makers do not in practice make decisions, but instead they typically ‘rubber stamp’ the advice provided through the Atos assessment.” The Citizens Advice Bureau shares this view and says it wants “better accuracy” in reports. But how can this be achieved when funding is devolved to Atos with no routine access to detailed specialist or general practice based information and opinion? Professor Harrington says this “results in the Atos assessment driving the whole process, rather than being seen in its proper context as part of the process.” And so, as things stand, how sure can Atos doctors be that they doing their professional duty?

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DOES POOR HEALTH JUSTIFY NHS REFORM?

Andrew Lansley claims radical NHS reform is necessary to drive up the UK’s poor health outcomes compared with the rest of Europe. But is our record really so bad, questions health economist John Appleby?

On the basis that if it ain’t broke don’t fix it, UK health secretary Andrew Lansley has said that his reforms for the NHS are needed because the country’s health outcomes are among the poorest in Europe. But are they?

The official ministerial briefing for the Health and Social Care Bill states that despite spending the same on healthcare, our rate of death from heart disease is double that in France. Although statistics from the Organisation for Economic Cooperation and Development (OECD) confirm that in 2006 the age standardised death rate for acute myocardial infarction was around 19/100,000 in France and 41/100,000 in the UK,

39 comparing just one year—and with a country with the lowest death rate for myocardial infarction in Europe—reveals only part of the story. Not only has the UK had the largest fall in death rates from myocardial infarction between 1980 and 2006 of any European country, if trends over the past 30 years continue, it will have a lower death rate than France as soon as 2012.

These trends have been achieved with a slower rate of growth in healthcare spending in the UK compared with France and at lower levels of spending every year for the past half century. The most recent OECD spending comparisons show that in 2008, the UK spent 8.7% of its gross domestic product on health compared with 11.2% for France—29% more. The epidemiology of the downward trend in deaths from myocardial infarction is of course more complicated than a simple
function of increased NHS spending—just as comparing countries’ population health outcomes needs to be approached with caution. The trajectory for many causes of death swoops up and down over decades—often linked to changes in lifestyle behaviours rather than spending on healthcare.

Our apparently poor comparison with other countries on cancer deaths has also been a key argument for reforming the NHS. However, comparisons are not straightforward and depend where you look. Death rates for lung cancer in men, for instance, rose steadily to a peak in the UK in 1979. But since then they have steadily fallen, mirroring long term changes in smoking patterns, and are now lower than for French men, where the peak death rate occurred over a decade later in the 1990s.2 Similar long term trends are evident for breast cancer mortality. Since 1989, age standardised death rates per 100 000 in the UK have fallen by 40% (from 37.8 to 24.4) to virtually close the gap with France, where they have fallen by just 10% (from 25.5 to 22.0).3 Again, if trends continue, it is likely that the UK will have lower death rates than France by 2012.

Mortality is one thing, survival another. The most comprehensive ongoing study of cancer survival across Europe is the Eurocare study.4 As Cancer Research UK has pointed out, although the Eurocare data often feed headlines that the UK is the “sick man of Europe” for many cancers, trends from Eurocare actually show improvements in survival rates for the UK.4 These are confirmed by the Office for National Statistics, which last year reported improvements in five year survival rates between 2001-6 and 2003-7 for nearly all cancers.5 But Eurocare is problematic; the latest study includes diagnoses only up to 2002, and coverage is patchy (French data cover around 10-15% of people with cancer, the UK, 100%).4 Furthermore, differences in survival rates may reflect variations in how early diagnoses are made, not the state of healthcare in different countries.

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3 Eurocare-4. EUROCARE-4 database on cancer survival. 2002, and coverage is patchy (French data cover around 10-15% of people with cancer, the UK, 100%).

