

Article

Blaming the victim, all over again: Waddell and Aylward's biopsychosocial (BPS) model of disability

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Abstract

The biopsychosocial model (BPS) of mental distress, originally conceived by American psychiatrist George Engel in the 1970s and commonly used in psychiatry and psychology, has been adapted by Gordon Waddell and Mansel Aylward to form the theoretical basis for current UK government thinking on disability. Most importantly, the Waddell and Aylward version of the BPS has played a key role as the government has sought to reform spending on out-of-work disability benefits. This article critiques Waddell and Aylward's model, examining its origins, its claims and the evidence it employs. We argue that its potential for genuine interdisciplinary cooperation and the holistic and humanistic benefits for disabled people as envisaged by Engel are not now, if they ever have been, fully

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realised. Any potential benefit it may have offered has been eclipsed by its role in Coalition/Conservative government social welfare policies that have blamed the victim and justified restriction of entitlements.

Key words

assessment, disability classification, employment, welfare benefits

Introduction

The UK government's Work Capability Assessment (WCA) has come under sustained criticism (e.g. Jolly, 2012; Franklin, 2013; O'Hara, 2014), not least for its inaccuracy, with approximately 50% of appeals being upheld (DWP, 2015b). The WCA process has also been strongly associated with increases in suicides, self-reported mental health problems and antidepressant prescribing (Barr et al., 2016). Whilst the WCA has been subject to considerable criticism, little or no attention has been paid to the theoretical model that underpins it; the Biopsychosocial Model of Health (BPS). This model, developed by Dr Gordon Waddell, an orthopaedic surgeon, and Dr Mansel Aylward, a former Chief Medical Officer for the Department for Work and Pensions, and based, albeit very loosely, on George Engel's model of mental distress, attempts to present a multi-factorial approach to disability. It has played a key role in the tightening of the criteria for access to Employment Support Allowance (ESA) and other disability benefits including the new Personal Independence Payments and Universal Credit (Parliamentary Office of Science and Technology, 2012). It may also have influenced the change from the sick note to the 'fit note' in General Practice (Hussey et al., 2015). Key to the BPS model is the idea that it is the negative attitudes of many ESA recipients that prevent them from working, rather than their impairment or health condition. In parliamentary debates around the introduction of Personal Independence Payments in 2012, the then Coalition government minister Lord Freud neatly summed up government thinking around the BPS:

I sent round a rather interesting piece of analysis to many noble Lords in the Committee, called *Models of Sickness and Disability*, which showed the differences between the models, explaining the medical model, the reaction of the social model against the pure medical model and the synthesis of the biopsychosocial model. The summary of the biopsychosocial model in the analysis is that: 'Sickness and disability are best overcome by an appropriate combination of healthcare, rehabilitation, personal effort and social/work adjustments'. There is a coherent theory behind this assessment. (Hansard, 2012)

The Waddell–Aylward BPS has remained largely unexamined within academic literature, although it has not escaped critique by disability activists (e.g. Jolly, 2012; Løstheskald, 2012; Stewart, 2013; Berger, 2014). In this article we build on these political challenges with an academic analysis of the model and the evidence used to justify it. We outline the chief features of the Waddell–Aylward BPS and argue that, contrary to Lord Freud’s comments above, there is no coherent theory or evidence behind this model. We have carefully reviewed claims in Waddell and Aylward’s publications; compared these with the accepted scientific literature; and checked their original sources, revealing a cavalier approach to scientific evidence. In conclusion, we will briefly outline the influence of the Waddell–Aylward BPS on contemporary British social policy, and the consequent effects on disabled people.

Background

Over the last 30 years, the UK, in line with many OECD countries, has seen a rise in the share of the working age population receiving disability benefits. According to the Department for Work and Pensions (DWP, 2013), the UK government spent 2.4% of its Gross Domestic Product on disability benefits, a fifth more than the European average, and significantly more than Germany, France, Italy and Spain. The numbers claiming Incapacity Benefit or Employment Support Allowance (its replacement from 2008) rose from 1.25 million in the late 1970s to just over 2.6 million in 1999. After peaking at 2.78 million in 2001/2, the rate has gradually decreased and in August 2014 stood at just over 2.5 million (DWP, 2015a). The rise in numbers in the 1970s and 80s has been partly attributed to the deindustrialisation and economic restructuring that occurred over that period (Beatty et al., 2009; Beatty and Fothergill, 2010; Berthoud, 2011). Beatty and Fothergill for example argued that many of those placed on Incapacity Benefit during this period were people who ‘could probably be expected to have been in work in a genuinely fully employed economy’ (2010: 5). Many were given a financial incentive to take incapacity benefits over Jobseeker’s Allowance as ‘The government liked incapacity benefits because they hid the true scale of joblessness’ (Beatty and Fothergill, 2010: 23). However, increased numbers have persisted, and in many areas rates of sickness benefit claims now also include large numbers of younger people, many of whom were not directly affected by the job losses of the 1980s (Beatty et al., 2009).

Governments have sought to tackle high claims levels by changing assessment and eligibility criteria to reduce on-flow, as with the introduction of the Personal Capacity Assessment in the mid 1990s. More recently, changes introduced by the 1997–2010 Labour governments and magnified

by the 2010–2015 Coalition government have sought to increase off-flows, first through the largely ineffectual Pathways to Work policy in the mid 2000s, and then through the roll out of Employment Support Allowance (ESA) (Barnes and Sissons, 2013). Launched in 2008, ESA introduced four key changes in policy (Beatty and Fothergill, 2011):

1. The introduction of a more stringent Work Capability Assessment (WCA) to replace the Personal Capacity Assessment (PCA) at three months rather than six months into the claim. The WCA uses a points-based system and examines what activities the claimant is capable of undertaking. All former Incapacity Benefit claimants have had to be retested for ESA.
2. The expectation that most of those on ESA will be fit to return to work and the establishment of a Work-Related Activity component (WRAG), on which people are expected to take part in training courses or similar activities aimed at promoting their readiness to work.
3. Introduction of sanctions against those who fail to comply with work-related activities.
4. The establishment of a Support Group comprising those who are not expected to return to work and who are exempt from work-related activities. This group also receives an additional premium on top of their ESA, thus ostensibly addressing socio-economic disadvantages (see, for example, Secretary of State for Work and Pensions, 2006).

The Coalition government's Welfare Reform Act (2012) time-limited eligibility to ESA for those in the WRAG to 12 months and considerably increased conditionality, placing much greater demands on claimants. Changes introduced in the 2015 Budget mean that from April 2017, new ESA claimants placed in the WRAG will receive the same rate as Jobseeker's Allowance recipients.

The WCA was designed to ensure that only the most 'needy' (those assessed to have the most limiting health conditions) and the most 'deserving' (those who are judged compliant) claimants can access the highest rate of ESA. Grover (2010) argues that the process of sorting initiated by reforms to ESA and the WCA was central to addressing the government belief that the gateway on to the benefit was too lax. When originally conceived, it was estimated that by 2015 one million fewer people would be on ESA than in 2004, and that roughly 10% to 12% of the on-flow would be found fit for work and ineligible (DWP, 2006). In the initial phase, 2008–2010, over 60% of claimants were found fit for work. Figures for October–December 2013 show that 27% of claimants were found fit for work (DWP, 2014). The DWP suggest that these variations are the results of changes in the assessment process introduced in response to recommendations made by the Harrington (2012) and

Litchfield (2013) reviews of WCA, which found that process improvements in the application and appeal system had been patchy.

The Work Capability Assessment

The WCA was designed to provide a functional assessment, based on the premise that eligibility for ESA should not be determined by the description of a person's disability or health condition but rather by how their ability to function is affected (Litchfield, 2013): it looks at the effects of a condition rather than the condition itself. The focus on function reflects at least nominally the WHO's International Classification of Functioning, Disability and Health (WHO, 2001). The aim of the WCA is to distinguish between those who cannot work due to health related problems and those who are fit for some work or could, with support, eventually return to employment. Importantly, rather than judging whether a person has a practical chance of being able to find a job they can do, as in the old PCA, the WCA investigates whether the person has the ability, in theory, to do some form of work, thus tightening the eligibility criteria substantially.

Applicants must first go through a 13-week 'assessment phase'. There are two separate assessments:

- *limited capability for work assessment* measures a person's ability to perform certain activities relating to physical, mental, cognitive and intellectual function and determines whether the individual qualifies for ESA;
- *limited capability for work-related activity assessment* determines the rate of ESA that will be paid after the first 13 weeks and whether the claimant will be required to undertake any work-related activity as a condition of entitlement.

Those judged via WCA as unable to work or with limited work capacity receive a higher level of benefit and are placed in the Support Group with no conditionality, i.e. they will not have to undertake work-related activities. There is now a one-year limit on contributory ESA for those in the Work-Related Activity Group (WRAG), including the 13-week assessment phase. Claimants placed in either the Support or the Work-Related Activity group receive 'main phase' ESA. This includes either the 'work-related component', which is conditional on attending work-focused interviews, or the 'support component', for those deemed unable to work. Applicants deemed fit for work are moved on to Jobseeker's Allowance (JSA), which is paid at a lower rate than ESA and means-tested after six months. From April 2017, new claimants placed in the Work-Related Activity Group will receive JSA levels of benefit from the outset.

The WCA has been heavily criticised (Kennedy, 2011). Much of the opprobrium has focused on ATOS, the French health insurance contractor who originally administered the checklist system for allocating individuals to either the WRAG or the Support Group, who were replaced in March 2015 by Maximus, an American company. However, arguably this obscures the real problem, which is the policy thinking underlying the switch from Incapacity Benefit to Employment Support Allowance and from Personal Capacity Assessment to Work Capability Assessment.

As part of this switch, the role of the General Practitioner or other physician with clinical knowledge of the individual was reduced: instead, any necessary medical examinations were conducted by healthcare professionals working directly for the company administering the tests and thus ultimately the Department for Work and Pensions. Regular NHS doctors were perceived to have been 'soft' on their patients (Grover and Piggott, 2009). Critics claim that the assessment by a DWP healthcare professional dominates decision making, ignoring the psychosocial factors that influence a person's capability for work (e.g. Grover and Piggott, 2009; National AIDS Trust, 2013). The Litchfield Review (2013) also critiqued the reliance on information from medical records, which rarely describe capability. Assumptions about capability are made on the basis of diagnoses, which may not only undermine the policy intent but also reinforce the stigma that persons with disabilities face in accessing employment. Litchfield was concerned that non-medical evidence (e.g. information from support workers, carers) which might have generated a full picture of capability was not given appropriate consideration (Litchfield, 2013).

As well as placing a heavy mental health burden on claimants (Barr et al., 2016), the WCA has also been ineffectual. An analysis by Barnes and Sissons concluded that there is 'little evidence to date that policies aimed at activating those on sickness benefits in the UK have had any beneficial effects on increasing the employment prospects of those who are workless as a result of ill health' (2013: 90).

Similarly, the OECD report on the UK's job activation programme suggested that rates of return to work for those placed in the Work-Related Activity Group were low and that there were no benefits for this group (OECD, 2014: 25). Barnes and Sissons (2013) argue that many of those placed in the WRAG are more severely impaired or are more difficult to place in the labour market, aspects that would have been captured by the older PCA. Many of those found fit for work are unable to meet the conditionality imposed by the JSA – in other words, they are unable to search online, apply for sufficient jobs, attend job interviews on time etc. ESA is failing either to improve people's work prospects or to resolve the problems it was originally intended to address (Grover and Piggott, 2010).

We argue that much of the fault with ESA lies in the underlying model used to define disability, and it is to a discussion of that model that this article now turns.

The Waddell–Aylward biopsychosocial model

The Waddell–Aylward BPS model is an attempt to shift understandings of sickness and disability. Waddell and Aylward developed their approach while working at the Centre for Psychosocial and Disability Research, Cardiff University. This Centre has worked extensively for the Department for Work and Pensions, and from 2004 to 2008 was sponsored by the US health insurance company Unum Insurance. Two key publications by this team have been *The Scientific and Conceptual Basis of Incapacity Benefits* (2005) and *Models of Sickness and Disability: Applied to Common Health Problems* (2010). This latter document represents the most recent and extensive statement of their perspective on the BPS. The model reframes employment support for disabled people within a ‘support’ discourse, arguing that ESA should be seen as a mechanism to support people who experience health- or disability-related barriers to work in accessing employment (see, for example, Secretary of State for Work and Pensions, 2006).

The original biopsychosocial model was developed by George Engel (1977, 1980) in the context of psychology. He argued against biologically reductionist accounts of mental illness, and in favour of holistic or whole systems approaches (Pilgrim, 2002; Cromby et al., 2013). Engel argued that data about psychosocial issues derived from talking to patients had as much scientific value as biological measurements. Although influential and widely cited, Engel’s biopsychosocial model was never properly defined or adequately described. The original Engel model is neither based on an underlying theory nor testable empirically: it does not explore the nature of the interaction between the biological, psychological and social levels (Cromby et al., 2013; Van Oudenhove and Cuypers, 2014).

In the 1980s, Gordon Waddell brought the term ‘biopsychosocial’ and the acronym ‘BPS’ into the field of disability (Waddell, 1987). In applying the BPS to a non-psychiatric illness, low back pain, Engel’s intention became somewhat changed, shifting from simple description to causal explanation. Waddell applied the BPS to highlight what he saw as the role of social and psychological, rather than biological factors, and to emphasise illness (a social phenomenon) rather than disease (a medical phenomenon). In the BPS, ‘physical disorder, distress and illness behaviour combine to produce disability’ (Waddell, 1987: 638). Symptoms are treated as being subjective, and iatrogenic disability is the real threat. Rather than addressing low back pain as a medical problem with a medical solution, Waddell’s recommendation is to

avoid surgical or pharmaceutical treatments, and instead to prescribe graduated exercise and, if necessary, psychological interventions. This approach to chronic back pain has resulted in the growth of terms such as 'simple back pain' and 'non-specific spinal disorder', and the suggestion that symptoms are as much psychological as biological.

In later work Waddell and Aylward argue that their approach is required because the prevailing models of disability are not sufficient. They regard the medical model of health as too reductionist, although they also state that their BPS 'does not reject or replace the medical model, but supplements and extends it' (Waddell and Aylward, 2010: 28). The economic model (i.e. government efforts to sanction and make life on benefits less attractive) is regarded as unproductive and simplistic. Waddell and Aylward also discuss the social model of disability (Finkelstein, 1980; Oliver, 1990), but only to damn it with faint praise: 'The social model represents the perspective of disabled people. Whatever its lack of "scientific" evidence, it is based on the personal experience and views of disabled people and has considerable social and political acceptance and reality' (Waddell and Aylward, 2010: 13).

They contend that whilst the social model may be relevant to those with severe conditions and permanent impairment, it is not appropriate for 'common conditions'. 'Common health problems' refers to musculo-skeletal, cardio-respiratory and mental health conditions, which together account for two-thirds of sickness absence, early retirement and incapacity benefit claims (Waddell and Aylward, 2010: 6). These common conditions, it is argued, are 'similar in nature and sometimes even in degree to the bodily and mental symptoms experienced at times by most adults of working age' (Waddell and Aylward, 2010: 6). Further, it is claimed that the associated non-specific diagnoses are 'often "nominal", existing in name only, not real or actual', although 'these symptoms are very real, justify healthcare, and may cause temporary restrictions' (Waddell and Aylward, 2010: 7). As with low back pain, so with these other common conditions, a return to work is advised: 'These people have what should be manageable health problems. Provided that they are given proper advice and support, recovery is normally to be expected and long-term incapacity is not inevitable' (Waddell and Aylward, 2010: 8).

Rather than bringing together biological, psychological and social factors in a holistic account of disability, the Waddell–Aylward BPS is in actuality a causal explanation of sickness absence, with advocacy for a particular approach to disability management.

By saying that the social model is not relevant to this population, and by differentiating 'common conditions' from 'severe conditions', advocates of the Waddell–Aylward BPS are advancing a distinction between 'real' incapacity benefit claimants, with long-term and incurable health conditions, and 'fake' benefit claimants, with short-term illness: 'Common health problems are very

different from the severe medical conditions and permanent impairments for which sickness and disability benefits were originally designed' (Waddell and Aylward, 2010: 8). Given the uses to which the Waddell–Aylward BPS has been put in recent UK government welfare reform, it seems apt to suggest that this distinction maps closely onto the historical social policy division between the deserving and the undeserving poor (Stone, 1984). It also drives media coverage and popular attitudes to disabled people (Briant et al., 2013).

Challenging the Waddell-Aylward BPS

Here we will explore the elisions and exaggerations that we believe render the Waddell–Aylward BPS approach conceptually and empirically invalid.

Conceptually, Waddell and Aylward slide from generally well-accepted statements about the role of psychological factors in health, to their BPS model, which is a specific and highly contested account of the role of psychological factors in health (Waddell and Aylward, 2010: 37). For example: 'The biopsychosocial model recognizes that biological, psychological and social factors, and the interaction between them, can influence the course and outcome of any illness' (Waddell and Aylward, 2010: 22).

Whilst most commentators would accept that disability is multi-factorial, it is a bigger and more contentious claim to state that each of these factors influences *any* disease or disability. However, by using the word 'illness', which medical sociologists have always applied to the social experience of disease (Field, 1976), Waddell and Aylward are muddling the picture. What they are actually trying to do is to emphasise psychological factors in the common health conditions that often generate incapacity benefit claims.

The leading example of a multi-level account of disability is the WHO International Classification of Functioning, Disability and Health (ICF), which offers an internationally accepted, validated schema for disability. The ICF includes different levels of explanation – health conditions, activity limitations and participation restrictions – and importantly allows the role of the environment to be included at every level. The framers of the ICF have called their approach a 'biopsychosocial model', because it integrates the medical and social models. Waddell and Aylward (2010: 34) appear to want to associate their biopsychosocial model (BPS) with the ICF, in order perhaps to give their model greater credibility. The conflation between the BPS and ICF is now evident in other public documents (e.g. Parliamentary Office of Science and Technology, 2012).

Yet the International Classification of Functioning, Disability and Health (ICF) is very different from the biopsychosocial model (BPS), not least because it is scientifically validated, peer reviewed and objective. Waddell and Aylward claim that their BPS is preferable to the ICF, presumably because the

ICF is a descriptive model designed to standardise terminology, data collection and welfare assessment. The ICF does not differentiate by condition, while the Waddell–Aylward BPS is an explanatory model with a barely concealed normative dimension of victim-blaming. Thus: '[the ICF] is still very much a model of disability rather than sickness, and applies best to people with impairments. It fails to consider adequately the personal/psychological dimensions or the interactions between the three dimensions' (Waddell and Aylward, 2010: 22ff.). Here again they reinforce the idea that many of those claiming Employment Support Allowance do not have an impairment.

It is true that the ICF failed to analyse personal factors to the same extent that it analysed environmental factors. However, it is incorrect to suggest that the interactions between dimensions are not considered. Moreover, the ICF is explicitly a universal model of disability and health that applies to all decrements in functioning, whether short term or long term. It does not apply best to people with long-term impairments: it also includes people who have illnesses and conditions (somatic or psychological) that, in interaction with contextual factors, affect their functioning (Cerniauskaite et al., 2011).

Both the ICF and the Waddell–Aylward BPS use similar terms: for example both talk about 'performance' and 'capacity'. However, in the ICF such terms have defined technical meanings: 'performance' refers to what an individual does in their everyday context whilst 'capacity' refers to their ability to execute a task or action in a uniform or standard environment. Gaps between performance and capacity highlight the role of disabling or enabling factors (Bostan et al., 2014). Because of social and environmental barriers, performance is usually lower than capacity (Almansa et al., 2011). In the Waddell–Aylward BPS, the same terminology is used, but in a misleadingly different way: 'As an oversimplification, capacity may be limited by a health condition, but performance is limited by how the person thinks and feels about their health condition' (Waddell and Aylward, 2010: 20). In other words, the difference between 'performance' and 'capacity' for the BPS is all about individual attitudes and motivation, not about environmental factors: again reinforcing the psycho over the social.

In this way, Waddell and Aylward often make elisions between widely accepted concepts and frameworks, and their own idiosyncratic accounts of disability and health. Another example is where they fail to draw a conceptual distinction between literature on medical rehabilitation, which focuses on restoration and maintenance of functioning, and literature on vocational rehabilitation, which focuses on return to work and job placement (Waddell and Aylward, 2010: 35). These slippages undermine the validity of their argument.

Most importantly, when Waddell and Aylward discuss the three common health problems associated with incapacity claims, they shift between low back pain, minor mental health problems and cardio-pulmonary health problems. First, they claim that 'the biopsychosocial model has completely

reversed the strategy of management for low back pain' (Waddell and Aylward, 2010: 31). Whilst it is correct that the clinical approach to low back pain has changed from recommending bed rest to advocacy of continued activity and gentle exercise, this has coincided with a wider change in medical practice. A 1987 paper by Waddell appears to have played a significant role in this transformation, and has been widely cited. However, it is not clear that the shift in clinical treatment of low back pain is evidence of the success of the BPS approach in general.

It is interesting to note that the American College of Physicians/American Pain Society review of acute low back pain (Chou et al., 2007) is disparaging of Waddell et al.'s 1996 recommendations to start exercise after 2 to 6 weeks, because they were based on poor quality evidence. A Cochrane Review of behavioural interventions for local back pain found moderate quality evidence that behavioural therapy is more effective than usual care for pain relief in the short term, and found that there was little or no difference between behavioural therapy and group exercises in the intermediate-to-long term (Henschke et al., 2010). In the physiotherapy field, Hancock et al. (2011) argue that the bio has been forgotten in the biopsychosocial, and call for research on the biological component.

More importantly, however, having claimed credit for their BPS model in changing approaches to back pain, Waddell and Aylward extrapolate from the changed clinical approach to lower back pain to make a different and wider assertion, that conditions such as mental health conditions and cardio-respiratory disorders can be similarly transformed with a psychologically-based approach.

Waddell and Aylward are sometimes guilty of inconsistencies. For example, they assert that conditionality and sanctions are the way forward for return to work (2010: 42), citing a report on workfare by the neo-liberal Institute of Economic Affairs. Yet on page 18 of the same document they state that benefit sanctions are unproductive. Sadly, the policy-makers must have read page 42 rather than page 18.

Waddell and Aylward seem to make misleading statements. For example, they write that: 'symptoms are subjective bodily or mental sensations' (2010: 3), from which you might infer that symptoms lack reality. Symptoms are indeed a feature of a disease which is noticed by the patient, whereas a sign is noticed or measured by other people, for example blood pressure. But this does not mean that symptoms are all in the mind. Taking a subjective history is an important part of diagnosis. Symptoms include aspects such as pulse or respiratory rate, assessed by reliable, clinical measures. The combination of symptoms, signs and laboratory tests together generates the medical diagnosis of health conditions. Subjective does not mean 'unreal'.

They also claim that 'stress is not included in the current diagnostic classifications of mental illness (DSM IV and ICD-10)' (Waddell and Aylward,

2010: 39), implying that stress is not a real health condition. Again, this is misleading: both international classifications do include various categories of stress, such as acute stress reaction, post-traumatic stress disorder, stress-response syndrome, mixed-anxiety depressive disorder etc. (López-Ibor, 2002), even though both *DSM* and *ICD* have had difficulties classifying work-related stress. Both the Health and Safety Executive and the European Commission recognise the existence of work-related stress, although no simple case description is possible because of its complex nature as an intangible, subjective and inconsistent disorder (Cox et al., 2006).

Most importantly, given that the BPS is intended as a contribution to policy formation, and that contentious claims are often made, it might be expected that a robust evidence base would be provided. Yet the authors rely on unevidenced assertions throughout their work. For example, they state ‘the more non-specific and subjective the health condition, the more important the role of personal and psychological factors’ (Waddell and Aylward, 2010: 7): this may or may not be true, but when no evidence is provided, it is hard to know either way. To take another example, work and return to work are presented as a good thing, and as being generally good for health (2010: 33). Yet evidence for positive impact of interventions that aim to encourage return to work following illness or injury on quality-of-life outcomes is weak (Franche et al., 2005).

Waddell and Aylward slide between general statements that are scientifically valid and specific statements that are matters of opinion or political prejudice. They also tend to cite their own, non-peer reviewed papers extensively. For example, they claim ‘We have the knowledge to reduce sickness absence and long-term incapacity associated with common health problems by 30–50%, and in principle by even more’ (2010: 45). They underpin this claim by reference to one of their earlier publications, *Concepts of Rehabilitation for the Management of Common Health Problems* (Waddell and Burton, 2004). However, there is no evidence cited in this 2004 work to support such a claim; in fact this publication even acknowledges the paucity of evidence in this area (Waddell and Burton, 2004: 50). The closest justification for the claim in the 2004 publication occurs where a 50% increase in return to work is evidenced by reference to a literature review of modified work and return to work following back pain conducted by Krause et al. (1998). But this misrepresents Krause et al.’s findings: the focus of their review was on changes to working practice and accommodation in working hours, not to individual programmes of rehabilitation.

In preparing this article we systematically went through the 2010 publication looking for the evidence that Waddell and Aylward used to underpin their claims and found many other examples where the citation seems to be inappropriate. For example, when Waddell and Aylward assert that the common health problems (low back pain, mental health, cardio-respiratory) are

'often "nominal", existing in name only, not real or actual, they are simply labels' (2010: 7), they cite in support a review of 'functional somatic syndromes' by Barsky and Borus (1999). Yet the original paper discusses Gulf War Syndrome, multiple chemical sensitivity, sick building syndrome, repetitive stress injury and chronic whiplash (Barsky and Borus, 1999: 910), which are mostly not the 'common health problems' under discussion.

Ostensibly, Waddell and Aylward avoid blaming welfare recipients for their situation, making statements such as: 'Many incapacity benefit recipients are not completely incapacitated ... although this does not mean they are all malingerers or scroungers' (2010: 5). Indeed, the notion of a biological-psychological-social approach implies that all levels of explanation – from the medical to the attitudinal to the social and structural – are deployed. A genuinely multi-factorial, multi-dimensional approach to disability, in line with the ICF (WHO, 2001) or the critical realist approach (Shakespeare, 2014) would be widely welcomed. However, such complex and non-reductionist explanations are lacking in the BPS, which attributes almost all the causal role to individual agency. While Waddell and Aylward do suggest 'More could work if individual, psychosocial and system barriers were removed' (2010: 24), they always concentrate on individual and psychological factors, rather than the systemic level of analysis. The BPS neglects social class and fails to make adequate space for the role of disabling barriers – both physical access barriers and discriminatory attitudes on the part of employers, who often see workers with impairments and illnesses as being too much trouble, too disruptive or too costly (Foster and Wass, 2013).

The failure to include both macro socio-economic factors, and the meso and micro disabling factors means that a BPS approach can only blame victims for their plight: 'For most people with common health problems, decisions about being (un)fit for work, taking sickness absence or claiming benefits are conscious and rational decisions, free choices with full awareness and intent, for which they must take responsibility' (Waddell and Aylward, 2010: 22). In other words, they should be perceived as scroungers.

Conclusion

In criticising the BPS model of disability, and the wider Coalition/Conservative governments' welfare reform agenda, we are not denying that there are genuine policy issues to confront. There are rising numbers of disabled people, due to widening levels of inequality, population ageing, increasing levels of mental health problems arising from pressures of modern life, obesity and lack of physical activity and the consequent increasing numbers of chronic diseases (Glozier, 2013). Research by Barnes et al. (2008) points to the social and economic pressures that underlie common health problems.

Wider structural changes in the labour market render unskilled or semi-skilled workers less eligible for jobs. Despite the paradigm shift to a disability rights perspective, efforts to reduce employment discrimination have not resulted in improved access to work for disabled people (Berthoud, 2011; Maroto and Pettinicchio, 2014).

Nor would we challenge the role of psychosocial factors in disability. For example, there is very strong evidence to suggest that back pain and other conditions can be associated with psychological problems (Bigos et al., 1991). But simply putting people back into the situation that caused their ill health in the first place is not the solution (Wang et al., 2008). The psychosocial work environment represents a potentially reversible cause of ill health (Hemingway et al., 1997). A better solution is to change working practices and provide reasonable adaptations, rather than simply to locate the problem in the individual (Krause et al., 1998). A genuine multi-factorial account of disability is required, which gives appropriate weight to the biological, to the psychological, and to the social/structural. We need to take psychological issues into account in a non-victim-blaming way.

There is much assertion and rhetoric in the Waddell–Aylward BPS, yet it has been used to underpin increasingly harsh and at times punitive measures targeted at disabled people as the state seeks to reduce the number of people in receipt of Employment Support Allowance. The effects of the BPS have been to make it harder for disabled people to qualify for ESA through redefining the concept of ‘work readiness’, which we would suggest was the underlying motivation behind the adoption of the BPS. Further, evidence suggests that many of those found fit for work and placed in the WRAG have genuine need and are not able to meet the conditionality applied to their benefits (Barnes and Sissons, 2013). This claim is further supported by the DWP’s figures for sanctions of those on ESA, which in 2014 were at an all-time high for any 12-month period of 36,808, again suggesting that many claimants are simply unable to meet the conditionality attached to their benefit (DWP, 2015b). Previous work has critiqued either the role of ATOS or WCAs (e.g. Garthwaite et al., 2014). But it is not simply the contractor, nor the test that is the problem, it is the underlying justificatory model that requires change.

These policies have directly damaged disabled people by tightening eligibility for ESA. They have also been used to drive changes in media representation of disabled people, promoting the myth that large numbers of claimants are fraudulent (Briant et al., 2013). This has increased victim-blaming, with the likely effect of creating a disincentive to people claiming the benefits to which they should be entitled. The policy comes full circle (Beatty and Fothergill, 2011). More recent changes have introduced a time limit of one year for nearly fifty thousand contributory Employment Support Allowance claimants who are placed in the Work-Related Activity Group, which makes reliance on the BPS as a means to determine work capacity even more problematic. Cited

in this policy change was Waddell and Burton (2006), a review which reflects the same victim-blaming outlook that generated the BPS model.

There are already strong social norms that prevent people taking sickness absence (Barnes et al., 2008). Rather than emphasising the supply side and blaming the victim, it is the demand side that should be targeted to ensure that employers are encouraged, supported, regulated and finally forced to give due consideration to disabled people as workers (Minton et al., 2012). It is here that the greatest success in returning disabled people to the labour market is likely to be achieved. The comparison with Australia, which uses a more barriers-focused approach, shows that there are practical alternatives to the UK emphasis on the individual (OECD, 2014).

It is also important to remember that some disabled people will not be able to work, regardless of the accommodation and provisions designed to help them into employment (Abberley, 1996). Society must accept that work is not always appropriate or possible, and that for many disabled people humane and supportive alternatives to work are needed. These must not stigmatise those who are so supported, nor should non-working disabled people have to suffer poverty and social exclusion. In conclusion, the relationship of the advocates of the Waddell–Aylward BPS to the UK government’s ‘welfare reform’ does not represent evidence-based policy. Rather, it offers a chilling example of policy-based evidence.

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