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RAPPORT

# SWEDISH SOCIAL INSURANCE OFFICIALS STRUGGLING WITH THE VAGUENESS OF THE WORK ABILITY CONCEPT

THE CASE OF SICKNESS COMPENSATION<sup>1</sup>

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<sup>1</sup>*Sickness compensation refers to financial compensation for people permanently unable to work because of either illness or injury.*



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## Abstract

In a research project – *Practices of Frontline Interactions in the Swedish Social Insurance Agency (SSIA)* – we are studying how goals and rules are shaped and handled in conversations between officials and clients. A central aim is to develop knowledge about what kind of room these officials have to develop policy in practice and how they make use of it. This is done by a multi-level research approach combining analyses on an institutional and interactional level (Bruhn & Ekström 2017). Data are collected via mixed methods: recorded interactions (official–client), qualitative interviews, and documents. In this paper, except for some minor changes identical with a paper originally presented at the 2nd Conference on Street-level Bureaucracy in Copenhagen 2017, we discuss officials’ room for and use of discretion when assessing *work ability* in investigations about sickness compensation (previously called sickness pension). To get sickness compensation the individual’s *work ability* must be permanently reduced (i.e. he/she shall not be able to take part in working life anymore).

Work (dis-)ability is a diffuse and contested concept. It is a core concept not only for officials here in focus, but for several other organisational actors in the field of labour market and health insurance issues as well. Many actors with different missions and interests are recurrently involved in negotiations about how to interpret and take actions on the basis of this concept. The diffuseness of the concept often puts the investigating official – the Street Level Bureaucrat – in a position of having quite lot of room to assess and affect the outcome of the investigations at hand. Internal SSIA statistics also point to quite wide variations in outcome of investigations between different units in the organisation. At the same time there is also internal pressure on the investigators to “keep figures down”. The magnitude of such pressure is related to changes in pressure upon the authorities on the political level. This leads to fluctuations between different fiscal years. Last year (2016), 70% of the applications for this benefit were rejected. This is an increase from earlier years, and a hint of a growing restrictiveness in assessments of what is seen as permanently reduced *work ability*. In this paper, we discuss the *work ability concept* in relation to the room for assessment – the discretion – of these sickness compensation investigating officials. It is based on earlier research, official documents, qualitative interviews and speech recordings.



## Introduction

To obtain sickness compensation, the individual's *work ability* must be permanently reduced to such a degree that the person is assessed not to be able to fully (or to a certain degree) take part in working life any more. An application for sickness compensation is normally set up when the individual has been on sick leave for a long time and different rehabilitative efforts has been made without any permanent positive effects. Responsible for investigating and taking decisions about this type of measure is a special department in the SSIA. The investigations are taken care of by specialized investigators – officials that can be characterized as typical Street Level Bureaucrats (Lipsky 1980).

The concept of work ability is quite a complicated and diffuse one not regulated by law to a very high level of detail. Assessments of work ability are done not only in connection with the type of measure we discuss here – sickness compensation – but also when it comes to sickness cash benefits and other types of measures (Lindqvist & Lundälv 2017). To study interpretations and use of this concept in relation to the case of sickness compensation therefore has implications for other groups of Street Level Bureaucrats (SLB) as well, i.e., both in relation to other SSIA officials and their measures, and in relation to measures taken by officials at the employment authority, medical doctors and so forth.

How to define and assess work ability has long been contested terrain among several actors in this arena – authorities as well as different experts and professional groups. Several researchers have pointed to a growing medicalization when assessing people that have problems gaining a foothold in the labour market. How are individual abilities to be judged – on the basis of medical diagnoses, or do these have to be complemented with assessments of labour market abilities, social relations, family situation and social context as a whole? This contested terrain with different, competing interpretations of and approaches to this concept also contains sensitivity towards political level changes, and an interesting but complicated space for collaboration and negotiation between different institutional actors. The lack of clarity embedded in the regulatory system together with differences in knowledge, approaches and interests among actors, not least between different professional groups involved, may be pivotal for what kind of discretion SSIA officials have in suggesting measures on the basis of their investigations. The nature of this space and how it is used by the investigator, and the results in the form of practical policy towards clients, are the themes of this paper.

*The aim is to, on the basis of views of the officials in focus, outline an analysis of their discretion when assessing work ability, and the result when official policy and regulations are transformed into practice in the interaction between themselves and clients.*

*– How do officials reflect upon their abilities to help clients towards the “best” solutions, and if so which are the “best solutions”?*

*– How do they experience the dilemma between macro-level responsibility – a fair system, strictly rule-following guaranteeing same treatment for all – and a responsibility towards clients and the wholeness of their unique life circumstances?*

*– Are there common views among officials about issues like these – an informal praxis shaping limits for discretion inside the group setting?*

*– How sensitive are officials towards political level fluctuations?*

The paper is disposed in the following way: After a brief presentation of sickness compensation as a social insurance measure and some words about data and analysis we will present the theoretical framework that has guided us into this study, a framework developed in an earlier quite similar project but in another authority. After this we discuss the concept of work (dis-)ability – its history and development, different interpretations and applications, and its relationship to different domains of public activities. The next section contains analysis of some data. The project is based on a multi-method approach. Data consist of documents, qualitative interviews, recorded conversations (official–client) and completed investigations. In this paper the analysis rests primarily upon documents and interviews (and a few recorded conversations). It is important to stress that this paper only points out some aspects of a coming deeper analysis to be completed when all data are gathered.

### **The case: Sickness compensation as a social insurance measure**

This measure, previously called sickness pension, is intended for people with such permanently reduced work ability that they cannot function in regular work, at least not full-time (there is a possibility to get part-time compensation). The loss of, or reduction in, work ability should be assessed as permanent, i.e., not expected to change in the future. However, a follow-up assessment is required every third year. If circumstances have changed – if the individual has regained work ability – efforts are made to re-introduce him/her on the labour market.

Normally, sickness compensation becomes an option for those who have been on sick leave and receiving sickness cash benefits for a long time, and where several measures from different actors in the labour market field, i.e., the employment agency, SSIA, and social and health authorities, have been made for rehabilitation and return-to-work without any progress being made (in accordance with the so called rehabilitation chain used in relation to people on long term sick leave). Some cases, though, may be “new” to the SSIA because people coming from, e.g., the social welfare bureau have not been working and are not registered for taxation and therefore have not been connected to the Swedish social insurance system (e.g. immigrants).

An application for this measure is made by the client. However, the allowance associated with sickness compensation is lower than the sickness cash benefit. The motivation for such an application may therefore often be the result of the systemic pressure connected to different stages and control intervals the person has passed while on long term sick leave, e.g., an increasing threat of losing further sickness cash benefits.

The application is handled by a special department in SSIA, with officials specialized for investigating these cases. Obligatory, and the main basis for the investigator’s assessment, is the medical certificate where a physician examines the applicant and certifies his/her status in relation to work ability (see below). Other types of information collected and assessed in the investigation process are reasons for sickness cash benefit, what kind of rehabilitative efforts have been made by different medical health instances, the employment agency and so forth during sick leave, or during the time the individual has been “outside” the labour market. Facts are also collected about different allowances received, e.g., unemployment benefits and social security benefits, and further social living conditions, leisure activities and engagements. The investigator’s work ends up in a proposal, a recommendation for a certain kind of



decision. In particular difficult cases, the investigator may turn to an SSIA specialist in this field to get advice before developing a final recommendation. The investigator also has the opportunity to turn to a special medical adviser (contracted by the agency) if there is anything unclear in the medical certificate report. Finally, the decision about the case is made by a special decision maker at the agency. The applicant has the right to appeal if he/she is not satisfied with the decision.

### **Data and steps in the analysis**

As mentioned, the project rests upon a multi-method approach. However, it was written before all types of data had been analyzed. The discussion below is based first and foremost on interviews and documents. Some speech recordings have also been scrutinized. However the lion's share of the interactional data remains to be analyzed, and this goes for the analysis of ready-made investigations too.

### **Tentative theoretical framework**

#### *Research traditions*

An increasing number of studies have explored how policy implementations are shaped by encounters between frontline professionals and citizens. In analyzing adult social care in the UK, Ellis (2011) identifies different forms of discretion in frontline practices shaped in encounters in concrete settings. Jewell and Glaser (2006: 335) argue that organisational context “mediates between policy goals and frontline behavior” and they suggest a framework of five organisational aspects (authority, workload, client contact, knowledge/expertise and incentives). Prior and Barnes (2011) show how social policy outcomes can be understood as contingent consequences of face-to-face interactions in which the agencies of the service staff and the users are negotiated. They also highlight the “agencies of resistance” that in different ways may subvert management policy (p. 269). This may be done by officials who adopt practices that differ from official policy, or by the clients who use resources to reach personal goals in the interactions.

The attempts to relate frontline interaction and institutional realities are of particular relevance for our study. Rice (2013) outlines a micro-institutionalist approach in which welfare institutions and interactions are considered fundamentally interrelated. Social welfare systems are manifest in institutional realities such as legal texts and formal organisations, which enable and restrict frontline interactions. At the same time, the welfare institutions become “real” in the ways they are “constantly (re-)enacted in these interactions” (Rice 2013: 1043).

As stated in Bruhn & Ekström (2017), although a number of studies clearly show the importance of studying the realm of frontline encounters, the dynamics of real-time interactions are rarely analyzed as such, i.e., analyses of unfiltered speech data. Ethnographic methods and interviews provide important insights into frontline encounters (Dubois 2009, 2010; Ellis 2011; Garrow and Grusky 2012; Maynard-Moody and Mushenos 2012). They often show that the policy space of front-line work cannot be simply deduced from official policies and organisational structures. Maynard-Moody and Mushenos (2012) illustrates this in the observations of unexpected orientations to rules and the nuanced pragmatic judgments of social equity in concrete situations. To catch such phenomena in this project we will turn to Conversation Analyses (CA). As mentioned in the method section above, this type of

analysis represents a further step compared to what is presented in this paper, which is first and foremost based on interview data.

### *The character of discretion – tools for interpretation*

Lipsky's (1980) theory about SLBs is here a natural take-off point. The concept of SLBs denotes civil servants responsible for mediating between the state's programmatic policy-making and its citizens. This implies certain autonomy and discretion to act – rules and regulations must be interpreted and translated from their programmatic format to unique situations and applied with consideration for human factors (Lipsky 1980, p. 15). On the basis of this discretion they develop practical policy for how formal rules should be applied in real situations.

Now, what kind of discretion do the officials have? Where are the limits, and how do the officials develop practice in relation to such a vague concept as work (dis-)ability? To work in the SSIA is to work in a highly regulated business. In part because this is a social insurance authority with by nature quite precise and detailed regulation about who is entitled to get a benefit and on what premises, in part also increasingly regulated because of today's systems of governance (New Public Management, NPM). In this context: what views do officials have about how to act in accordance with what is valued by them as professionalism and high quality in work?

We cannot presuppose that a highly regulated business automatically means weak discretion (Evans & Harris 2004, see also Bruhn 2015). Paradoxically it may sometimes create more of it. The wording of rules is always open-textured. They are by necessity vague. There are always ambiguities and borderline cases, alternative fields of application, and so forth (ibid.). The situations the rule is meant to cover are never identical. Different rules may often end up in conflict with each other, leading to a need for adjustment, balance, and prioritization. Taylor and Kelly (2006) discern three different forms of discretion which may serve as entrance to the analysis:

1. Value discretion: the ability to act upon norms about professional practice anchored in knowledge, experience, and training.
2. Rule discretion: the ability to interpret and prioritize between vague and contradicting rules and rule systems.
3. Task discretion: the ability and skill to execute prescribed tasks. Even if these are increasingly exposed to control and steering measures, they may be complex and demand discretion on street level.

The authors conclude that a key characteristic of service delivery under NPM systems in the UK has been the encouragement of SLBs to use their discretion to reduce the costs and improve the quality of service, “arguably increasing task discretion for professionals and helping to create an increased awareness of the cost of services” (Taylor & Kelly 2006, p. 633). This process toward a more task-oriented service also implies more skill-based training at the expense of knowledge-based education of some professionals. Taylor (2007, p. 560) sees a trend of teachers becoming technicians occupied with teaching skills measured against “social efficiency” while their “developmentalist position” as professionals is in-

creasingly being repressed. Ellis (2011) shows how some groups of social workers adjust to the management logic of governance (e.g. the pragmatic approach, the organisational professional). The discretionary scope for developing informal practice is severely reduced because of rules being increasingly detailed in combination with new ICT systems of control. Rules become tools for self-discipline, and the worker becomes a practitioner saluting professionalism in rule-performance, in mastering the rule-system in a technical way (cf. Liljegren 2012). Barton (2008) concludes that performance indicators in social work create an “isomorphic approach” that makes professional innovation, assessment, and autonomy disappear.

Finally, it is important to stress that discretion is neither good nor bad *per se*. Discretion always exists within a political and ideological context in which the professional group and other social forces operate, and it must be analyzed in relation to that context (Evans & Harris 2004). In our case, the terrain is highly contested between different political forces. Official policy seem to change quite often. This will become obvious in the next section when we turn to the concept of work (dis-)ability and how it is understood by different actors on the scene.

### **The concept of work (dis-)ability – hints from a debate that seems to be permanently ongoing**

SSIA’s formal regulation concerning sickness compensation contains several rules and directives. The official at SSIA handling applications often takes contact with, and references from representatives of several authorities as well as occupational groups (e.g. officials at the employment office, social workers, psychologists, occupational therapists etc.). Of special importance here are assessments from the applicant’s physician (or psychiatrist), because of the decisive role of the medical certificate.

At the core of the whole investigation process is how to interpret the quite vague and diffuse concept of work ability. According to which prerequisites should work ability then be assessed? And, in comparison with what – general physical and psychological assets and abilities in relation to some sort of hypothetic job, or in relation to the actual supply on the labour market? Further, how can work ability be estimated in relation to the individual’s occupational background or to the labour market in general? Work (dis-)ability is a core concept also in relation to sickness cash benefits, and is therefore a basic concept concerning the core of SSIA’s activities. It has been a focus for debates between researchers as well as different stakeholders for a long time and on several layers. Moreover, policy level changes in signals and directives regarding how to interpret work ability have made clear imprints on its practical application longitudinally. The number of applications approved (for sickness compensation as well as sickness cash benefits) varies notably over time. This is a clear indication of quite large changes in how the concept has been applied on the authority level as well as of strong pressure from political level fluctuations in social politics. At the same time, the vagueness of the concept seem to open the process up for quite severe variations in approval rates between different regional and organisational units (Schierenbeck 2009), and maybe also between different individual officials in local units.

How, then, is work ability defined and regulated? In the following sections we will describe the central themes in the debate about this concept and how it is regulated in law and implemented in practice by different authorities. To structure this description, domain theory is

helpful (see. e.g. Kouzev & Micko 1979, Blom & Morén 2015). According to this theory, public enterprises analytically can be divided into three domains – the *political* domain, because they are politically governed; the *administrative* domain, which contains the different managing levels responsible for implementing political-level decisions; and the *professional* domain, i.e., those who in daily work have to practice the policy. Necessary to add here is that all such enterprises must be related to the conditions of the social context in which they operate – to clients, other authorities and actors.

### *The political domain – official policy changes and developments*

Labour market policy and the question of how to keep unemployment down is one of the big issues in the struggle between different welfare ideologies and regimes. And, in relation to this so are the questions about social insurance – here the obligations to contribute to society by providing for yourself via labour, but also the right to get protection if one cannot for one reason or another function under the normal conditions of working life. In relation to work life and social insurance, the question of obligations vs. rights is heavily contaminated by political ideology. And, it spills over to how concepts such as illness and work (dis-)ability are interpreted. Schierenbeck (2009) states in a comparison between the 1970s and the 1990s that several notable changes have taken place here in Swedish welfare policy. One important one when it comes to illness is that a number of new diagnoses, mostly concerning psychiatric diseases and conditions often related to stress and other psychosocial factors, have become increasingly common alongside diagnoses related to problems with a bad back, the latter type heavily dominating in the earlier period. At the same time, the view of work ability is related to a medically oriented principle, i.e., the idea

that illness (irrelevant of the work being performed) is the cause of work sickness, and that non-medical factors motivate work sickness (such as work-related problems, family life, life situations etc.) (ibid. p. 244).

The insurance perspective, on the other hand, takes a stringent connection between illness and work as a point of departure; here, illness is seen as “due to work and to a certain work task at work” (ibid 247). The author means that the new diagnoses go hand-in-hand with the priority of searching for medical causes of health problems; a medicalization has taken place, a medicalization of both personal and social problems. Others mean that this signifies a general development in society. Lindqvist & Lundälv (2017) states that medical certifications and (medically based) functional assessments have become “the core administrative mechanism” for a number of redistribute policies in modern welfare states. “Medicalization became part of a larger therapeutic culture (Furedi 2003) that also tended to change the culture of welfare administration so that not only long-term sickness but also unemployment tended to be interpreted in medicalized terms” (p. 3, see also Eriksson et al 2008). While Schierenbeck shows how an increasing number of non-medical conditions such as family and workplace situations together with the growing number of psychiatric diagnoses came to the fore as criteria for sick cash benefits and sickness compensation during the nineties, Lindqvist & Lundälv claim that policy development of today is aimed at circumscribing the action radius of medicalization by means of sharpening entitlement criteria to increase activation and return-to-work. This means an increased focus on individual obligations and duties, and restrictions in entitlement to social insurance if the individual does not try “hard enough”. “Sweden has developed into an incentive-strengthening work-first activation approach”

(ibid. 4), and issues about labour market development have become less relevant for policy makers while “the individual’s shortcomings and lack of work motivation, flexibility and employability have become the central aspects”. The problem of not being able to work is handed over to the individual to take responsibility for, finding new ways to return to work life, “from ‘welfare’ to ‘workfare’” (Nyberg 2012).

*The administrative domain – SSIA implementation and sensitivity towards the political domain*

The above described changes of signals from the political level seem to have a clear impact on the fluctuations in the number of approved applications for sickness compensation (as well as sickness cash benefits). Such policy fluctuations are in this case to a great extent made possible also because of the ambiguity with which the concept of work (dis-)ability is treated in Swedish legislation. Laws have to be general and on an abstract level. They have to contain judicial terms and concepts that are all-embracing and flexible. However, this level of abstraction has to be within reason. Legislation with too much arbitrariness and room for assessment is at risk of creating uncertainty (Mannelqvist 2017:59).

An official social insurance investigation concludes that the judicial construction of this insurance means that the insured cannot count on being treated equally, and that chance and individual circumstances gives such room for considerations that it cannot be consistent with a judicial security use of this insurance (SOU 2006:86, p. 55). Another type of critique closely connected with this is, according to Mannelqvist (2017), that the SSIA by developing, and from time to time changing, a great number of codes of practice, rules about exceptions, time and assessment limits and so forth changes the way the law is applied in practice. On top of this, the regulations developed by the authority contain a number of in legislation undefined or loosely defined concepts. This means that the regulations applied by the authority may or may not be much more restrictive towards applicants than what is actually supported by the law. And, in what direction this discrepancy leads has to do with sensitivity towards policy changes at political level. A third interesting factor in the case of work ability is that this according to the law (1998) should be tested in relation to all kinds of possible jobs. This was later on altered (in the law) to “normally occurring jobs”. However, in the case of sickness compensation, the SSIA today uses the old rule. Swedish sickness insurance on the whole is different from that in most countries, because it is related to work in general rather than occupation (Ståhl et al 2009).

All in all, we may conclude that regulation in this field seems to open up quite a lot of room for changes and fluctuations around how the very central concept of work ability should be applied, and that this is a public sector branch quite sensitive to political currents in society. On top of this, it seems that SSIA also has quite a lot of authority to decide how to interpret and apply this legislation. However, through the development of more direct government guidance in recent years with concrete yearly aims and objectives (“Regleringsbrev”), fluctuations seem to be caused by quite rapid changes on the policy level that the SSIA is forced to adjust to. All in all, changes in welfare policy in recent years have been in the direction of a more restrictive policy when it comes to sickness benefits as well as sickness compensation (see e.g. Lidwall 2013 about effects of changes in sickness insurance in 2008). This goes together with “medicalization”. What were previously defined as non-medical

problems (for example, unemployment) have become defined and treated as medical ones, i.e., as illnesses and disorders (Schierenbeck 2009).

*An important actor on the professional domain – physicians and psychiatrists*

The other key figure besides the investigating official in the process of sickness compensation assessment is the medical doctor. The medical certificate is the main document (and proof) attesting that a person should be seen as qualified for sickness compensation. The most important parts of this are the medical status, i.e., diagnosis/impairment, and activity reduction, i.e., disability in relation to specific types of work and work tasks. SSIA recurrently reviews the quality of these medical certificates. In one of those reviews (in 2012, of all cases and not only sickness compensation), the result was that only about 54% of certificates were rated as having acceptable quality (variations between regions were quite large). The part on which most certificates failed was that concerning how the illness limits the patient's ability for activities (work ability) (ibid p. 9). This points to an important problem: doctors are expected to assess whether a patient with a certain kind of disease is able to work, and in that case how much. Not all doctors (maybe very few) have enough knowledge about what kind of jobs there are in today's working life, and what kind of demands these involve. And as mentioned above, in the case of sickness compensation, such ability for activity should be assessed in relation to all kinds of jobs in the market, not only those the patient is trained for and experienced with. Assessments will therefore be quite vague and general (hypothetical jobs). According to Mannelqvist et al. (2016), these jobs being referred to are in most cases not existing regular jobs in the market, as in accordance with the law, *but rather jobs already adjusted to people with disabilities* (p. 54).

Another aspect of medical assessments is brought to the fore by Ståhl et al (2009). This is the conflict between the reductionist approach of SSIA claiming a specific medical diagnosis from doctors and that of most health professionals in their study, who take a holistic approach towards a patient's work ability. SSIA's emphasis on medical diagnosis means a close link between work ability and the original disorder, "which implies a risk that psycho-social or work related factors of work disability are neglected in the assessments" (p. 271). The results of Ståhl et al (also supported by other earlier studies) show "that physicians often take non-medical aspects into account when assessing work ability" (p. 266), considering a variety of factors as contributing to an individual's work ability. Because of this, physicians often have problems being forced to state a specific and strict diagnosis causing work disability.

Several studies about sickness compensation have also shown – pointing to SSIA's own investigation processes, i.e., the ones done by its own officials – that "other factors" than strict medical diagnoses play a role in the assessment of work ability. Ydreborg & Ekberg (2004), for example, show that clients younger than 50 years, unemployed and living in the central municipalities had a higher risk of being rejected for disability pension (sickness compensation) than those over 50 who were employed and lived in rural areas (p. 1085). This is in line with what is mentioned above, i.e., big differences in the rate of approved applications between different SSIA units. Of special importance here, also, is the tension between SSIA's medicalized and individualized criteria for work ability and what the labour market really has to offer. When it comes to sick listing (sickness cash benefits), the clash between SSIA's disease-centered definition of work ability and the employment authority's anchoring in employability and the needs of the labour market is well known (see e.g.

Eriksson et al 2008). This may also spill over in several ways on both the medical certificates of physicians and officials assessments in the SSIA when it comes to sickness compensation. The former may as indicated above relate their judgments to what they experience as the reality of labour market demands – the latter, by knowing that if a sickness compensation application is turned down, the client will end up last in the queue of those in the favour of the employment agency.

### *Summary*

The regulations regarding how to define and assess work (dis-)ability are in places quite vague and open to interpretation and to variation in how they are applied. The relationship between formal regulation and directives and what actually happens in practice seems not to be a very direct one. Differences in standards between different authorities and stakeholders as well as between occupational identities of different professionals are not bringing any clarity, either. Such a situation may be seen as a threat to the judicial security of the client. On the other hand, it may be seen as necessary vagueness, allowing for professional holistic assessments anchored in the reality of the often very complex situations of clients. The latter is obviously not something that is striven for at the political level and top management of the SSIA, though. Rather, by medicalization and standardization, and strong emphasis on transparency via diagnoses as a basis for decisions, they try to make professional conduct knowable and manageable, in this way decreasing the discretion of not least the officials here in focus (cf. Nyberg 2012). How then do they succeed in this? Before turning to this issue and other questions formulated above, a closer look at the composition of the group of officials in focus is needed.

### **This group of officials**

This group of investigators (heavily female dominated) can be seen as a group of typical street level bureaucrats. Several of them have been officials in the authority for a long time, starting by working with sickness cash benefits or other functions, while others have come directly from the outside, this being their first position in the SSIA. The work is pure investigation of client cases. In contrast with, e.g., working with sickness cash benefits, where one and the same official may develop a relationship with a client for years, the contact with clients here is limited to the period of investigation (normally 2–4 months). What kind of people are recruited for such a job then? SSIA has a standard nowadays only to recruit people with some sort of academic degree. However, it is not defined what kind of degree and on what level. It seems that the group therefore contains quite a broad spectrum of educational backgrounds. Among those interviewed here, two are social workers (in Sweden a 3.5 year university education), two bachelor's in public health, one bachelor in law, one in German language and one is an archeologist but with some courses in political science. How recruitment is handled on the regional office level seems mainly to be a result of local manager reflection. The following statement by a first line manager interviewed is interesting:

Yes, then we had much staff coming from sickness cash benefits, they automatically were transferred, and then some that applied and got employed. And, there were very many social workers then. Some occupational therapists and social science but mostly social workers. But now when recruiting, we do not now have very big staff turnover here, but we have got a few more resources, and then when recruiting I try to get some staff with competence in jurisprudence.

Because of this recruitment policy, one may expect that their interpretation of the occupational role, the role-identity they develop (Turner 2002), and how they try to develop their work practice differ to a certain degree. The degree of standardization, regulation, and control significant of this authority may be counteracted by in-service training and team-based dialogues. About the latter: it seems that such team-based activities are up to local initiatives. How are newly recruited staff introduced then? How the introduction is organized in practice is related to local organisation and something that is developed first and foremost at the regional office level. Three of those interviewed were employed at the same time in one office. They were introduced together and had regular team meetings from the beginning discussing how to handle investigations and different types of cases. The others (at least three at another office) seem to have had very little of such things. The collegial discourse and control of the individual's performance then seem to be weak, and something that may vary a lot between different units and offices. Several of those interviewed say that if they want to discuss how to solve a problematic issue they talk to a trusted colleague in private. Workplace meetings where tricky questions in different cases, policy and so forth are discussed in an organized way do not seem to be a standard in the organisation, although that does occur in some units. So far we have not seen any signs of a strong internal culture among these officials.

Unlike some other groups of SLBs this group of officials does not have a common background platform in competence, nor common professional expertise. They have not been socialized into some kind of professional identity. In relation to the above-discussed vagueness in core concepts, not least the concept of work ability, the question that arises here is the effect of this when it comes to practical policy-making in daily work. Working with these types of investigations seem to be a job of quite individualistic character. Of course, there are specialists to take advice from, and the formal decision whether to accept the client's application is made by a special decision maker. There are also a great many directives and instructions produced internally at the agency, as well as, as discussed above, influences from the policy level and other actors about how to handle and decide about these cases. Paradoxically, though, it is not certain that the latter leads to decreased discretion. A lot of rules, sometimes in parallel but sometimes even in contradiction to each other, may open up a space for acting on an individual level.

Even if the investigator does not make the formal decision about the client, we may expect that he/she has a decisive influence over the outcome via the investigation and the proposal about how the matter should be decided. As an example:

And then, I used almost a whole day writing down reasons why this person should have sickness compensation because I felt that 'this will not be accepted by the decision maker if I don't really motivate it'. It went through because I used an awful lot of time on it. And, the reason for doing this was that I did talk very much with this client and really discovered something that could not be seen in all the papers, so to speak (resp 1).

### ***The investigation process***

When we started recording telephone calls in this project there were a lot of phone calls where the official had to make an excuse to the client because of the extreme delay of the investigation. This situation in which there are a large number of delays the authority now has dealt with by employing extra staff temporarily. Some of these staff members have now



been hired full-time. Staff resources for handling sickness compensation have thus expanded. There are some internal divisions of work tasks between local officials when it comes to types of cases on the basis of interest and individual competence. Such divisions can be about, e.g., cases where the client want to lower the compensation trying to start working again part-time, it can be about a certain kind of disability problem and so forth.

The investigation process can be divided into the following steps (more about these steps can be found in the authority's different documents and guidelines):

- All investigations start with a phone call as soon as the application has been received, to let the client know who's going to investigate, explain the process, inform the client about whether there are any documents and facts missing from the application, etc. If the client cannot be reached this way, a letter is sent with a request for contact. Face-to-face meetings are extremely rare.
- Collecting and investigating all case documents, especially the medical certificate – is it complete and understandable?
- Collecting further information – contact with other actors (e.g. rehabilitation staff, employment office)
- In parallel: further phone contacts with client – completing information about physical and social-psychological conditions, scrutinizing living circumstances, family situation and other social circumstances. The number of phone contacts may vary a lot. It depends on the individual case and information already at hand, and the magnitude of the client's worries and needs to talk about or mediate his/hers situation.
- Next step: the investigation goes to a decision maker (randomly chosen) for a decision.
- When the decision is finally made, officials normally phones the client to inform them that they will get a letter of communication soon telling them that a decision is suggested and approved by quality control (the decision maker). The client now has two weeks to submit more information to strengthen his/hers case if he/she think it is needed.
- If nothing has happened during this time the final decision is made. This is communicated with a new letter together with information about the right to appeal and how this is done if the client wants to do it. Such appeals go to a special board for reconsideration (a SSIA unit but in another geographical location). They are intended to be resolved within eight weeks. Currently, however, they take about 25 weeks. Many applicants tries to appeal, but very few win their case.
- As mentioned, to get sickness compensation work ability must be permanently reduced (for life). However, a follow up evaluation should be done every third year. In many cases, it is obvious that no changes have taken place. But sometimes a real investigation is opened up and work ability is assessed again; this time it is done by a different SSIA official than the original one. The latter specialized in these follow ups.

## ***Officials' views, experiences and strategies – Qualitative steps and elements in the investigation process***

### *The core concept – work (dis-)ability*

This I should say, and all men are so unlike you know, so you cannot ever be clear about this concept, you can arrive at a view, but then ..., every person is unique, and depending on what kind of diagnosis the person has, and depending on what kind of jobs that have been tested, and what kind of job the person has – it always become an individualized assessment, and it is very hard to get it right each time.

(Resp 1)

All respondents confirm that they experience the concept of work ability as a very diffuse one, hard to manage. However, this is experienced as necessary because it opens up space for what the quote above is about – the need to make assessments in the complexity of unique cases. The medical certificate no doubt is a point of departure and pivotal for what sort of decision the investigation will result in. At the same time, officials seem to be perfectly aware that doctors are fallible and often write quite ill-founded certificates (see below). A dilemma here is that the official has to take doctors' words seriously but at the same time investigate the whole picture (they may also send it back to the doctor for reconsideration). And, as we will see, doing so can change the outcome. Still, a proposal from the official will not be accepted if it does not have support in the medical certificate; thus, the latter is a necessary but not sufficient condition.

There is a lot more, though, to these investigations. The aim is to examine the whole situation. To do this the official first and foremost has to make sure that the medical certificate covers all what is needed in relation to two main parts, the medical diagnosis of the disease – the medical problem – and the doctor's assessment of whether the person is able to do some sort of work in relation to the medical problem, and if so what kind and to what extent. As mentioned above, the latter should be related to all kinds of "possible" jobs. This boils down to an investigation of the person's ability to perform some sort of activity, and if this can be related to some sort of job. The official has to check whether this really is fully covered in the certificate, i.e., whether all necessary rehabilitative steps have been taken on the one hand and on the other, the individual's social situation and living conditions. The latter concerns whether he/she is doing some sort of activities in their free time – such as hobbies, having assignments in associations and so forth that points to some abilities to work if work is adjusted to such abilities. Last but not least, the person's family situation, way of life, etc. has to be mapped out. All respondents confirm that they often find weaknesses in the certificates that forces them to take a lot of contacts, gathering a lot of information from different actors, to be able to establish the full picture of the applicant. The official thus has to take several initiatives based upon his/her own judgment and skill analyzing the situation. A central question here is where the limit is for such initiatives: what and how much is the official obliged to do? This is quite unclear and heavily concerns the discretion of officials. An application can be turned down because documents about different rehabilitation steps are lacking, but the official may also take a lot of contacts with different institutions responsible for rehabilitation for receiving such documents.

The medicalized view of work ability that establishes the foundation for SSIA's decisions comes becomes problematic when collaboration with employment offices in rehabilitative measures gets actuality:

R. Yes, but most of all how you look at it like here we are so "it is only the medical we don't care about anything else" but that is not the mission of the employment office. They look at it from many different perspectives – what kind of competence the person has, what he is interested in, they have very many other parts and there it becomes a big crash because then we think that "yes but they haven't tried something that is adjusted after these medical problems, they have tested before what they can do, what they are interested in and that didn't go well, but that is not enough in our view".

I. And on top of that doing assessments of the labour market and its possibilities.

R. Exactly and that we do not care about either. (Resp 2)

That no sickness compensation can be granted unless work disability is assessed to be permanently reduced is also a complicated rule to handle. It demands an extremely thorough investigation to be able to make such a decision, and be sure that the person's health and abilities will not improve sometime in future. On the other hand, there is the rule that the decision will be followed up every third year. The rule therefore sounds more dramatic than it actually is (but it heavily affects the decision in the investigation phase). Some respondents say that it is hard to tell a young person that they will be outside the labour market for the rest of their life, but this three-year-rule contrasts this in a positive way – positive things can happen – a new medicine, a new type of job possibility because of technical advancements in aids for the disabled, and so forth.

At the same time I think that it is nice that one can say to the person that "it is not over, you can have inactive compensation in the future", it becomes like doomsday otherwise, I mean "you will have pension all your life" and the benefit is not that high either. That does give some hope to the person. (Resp 3)

There is of course also a question of authorities preventing misuse of the system:

We often hear from those officials handling the follow up that they have talked to some person and "yeah but now this person has two new sidelines, he has started a business," this is pretty possible, and then it becomes more of investigation, and this may actually lead to withdrawal of the pension (Resp 2).

However, of special interest here is that the rule about "being permanently disabled" puts quite a heavy responsibility upon the initial investigating official:

And the thing is, everything, every possibility to work must be scrutinized, before you being able to assess that somebody will not be able to work again, ever. Thus, yes, no but it is complicated (Resp 4).

It seems reasonable to assume that such a rule indirectly works towards denials of compensation in single cases. Even the slightest doubt – "maybe this person could be tested for ..." – in the head of the investigator may trigger an application being turned down.

### *The medical certificate*

I. You are not completely tied up (by the certificate, our remark)?

R. Nor exactly. It is hard you know, doctors' differ in writing skills, one single badly written sentence may destroy the whole possibility for the person almost. (Resp 1)

As mentioned, the certificate is pivotal, and it contains two parts: the medical diagnosis and the doctor's assessment of the client's ability for activities. And, as mentioned above, it is

first and foremost in relation to the latter that the medical certificates often are of inferior quality. That this is the case is not very surprising – the doctor may for obvious reasons not be very oriented to the very broad spectrum of jobs existing on today's labour market, and especially not to the content of these jobs, what kind of abilities they demand. There may be other reasons, too. The following quote reveals other reasons:

R. No, some are very good, others seem to have no orientation at all it feels

I. No

R. ...and sometimes one wonders if they write badly because they actually do not think that the person should have sickness compensation...

I. \*Laughs\*

R. but sometimes they do like that, because they don't have the energy to say no when the person comes and begs for it...

I. They may write badly because they are unsure on their own decision also maybe?

R. Yes, just because that they write a statement does not mean that they want the person to have compensation (Resp 1).

R. Yes, it is common that doctors copy certificates and written assessments, so that, I mean if we for example, if we have a person that got compensation granted in 2013 and now applies for increased compensation and so it is the same, copied, statements from the old certificate and then you can't let the increased compensation be granted because it is the same things that were already there, it must be described why things have gotten worse (Resp 4)

All respondents affirms that there are great variations between medical certificates when it comes to quality. It is common that the certificate states that all kinds of treatment have been administered when this in reality is not the case. If, for instance, it is stated that the patient has psychiatric problems, questions arises about "what kind", "have these been evaluated", "has the patient met a psychiatrist", and they may not because the certificate has been written by a general practitioner at the health center.

R. Yeah, some, it is very different how they express themselves of course. But it happens now and then, that they write "no there are definitely no work ability here whatever kind of job", ... but then we say "but you haven't tested ..." then it naturally becomes "but the doctor said this" and we have to discuss it (with the client, our remark) (Resp 2)

This raises the question of what can be expected of rehabilitative efforts, and who decides when it is enough, when the client is at the end of the road.

### *Rehabilitative measures*

As is obvious, to get sickness compensation "all necessary" rehabilitative measures have to be taken. But when is that? Who decides? The official in focus is an investigator, and do not have regular contact with different rehabilitative instances (medical care, employment office etc.). He/she does control if such efforts have been made, maybe sometimes by collecting more information about what did take place, results and so forth. Of centrality here is whether the working capacity of the client really has been properly assessed. This is done in collaboration with the employment agency. It means a rigorous mapping out in a context of adjusted optimal working conditions for the person – with a supervisor, possibilities to take a break and rest when needed, and only containing work tasks that the client, on the basis of the

medical diagnosis, should be able to perform. If the person is not able to perform ten hours a week under such optimal circumstances. he/she is qualified for sickness compensation if otherwise he/she is referred to the employment agency to apply for a job there. If the person (or for that matter the employment officer) questions this and asks “Where do I find such an optimal job?” the answer is:

R. “We check for work ability, we cannot consider the problem of finding you a suitable job, I understand that with your 30 years as a surgeon (an example, our remark) makes it hard to go to the employment office and find another type of job” but they have to register there because they will not get compensation from us. (Resp 3)

### *The social inquiry*

R. And in the social inquiry then a lot of information emerges. One may even ask questions about alcohol consumption, smoking and weight (resp 3).

The investigator has to make inquiries about the applicant’s total life. Respondents mean that they have to catch the wholeness of the picture. Doctors cannot always be expected to know so much about a patient’s life when they assess the ability for activities. An important question here is however what kind of impact such social inquiries have on the investigations and their outcomes. Why ask questions about this when the medical diagnosis is said to be so decisive and superior? Respondents motivate this along two lines. First if the person has a certain types of spare time activities, such as, e.g., commissions of trust in associations, certain hobbies and so forth, this may raise questions about ability to be active also in regular work.

R. Then I was forced to talk to the applicant about this and ask “how is your ordinary day”, it says here that you play computer games eight hours a day (Resp 4).

The other line is about finding out how much the person's lack of work ability is affected by responsibilities at home, demanding relatives (maybe taking extra care of someone), active drug abuse, phobias and so forth. Maybe the main hindrance to work in fact lies in the total situation and not primarily in the medical diagnosis? Maybe the applicant could function in work if other measures were taken? If drug abuse seem to be a more important factor than a physical disease. the person should get treatment instead of sickness compensation. On the other hand, maybe some factors in social life, some responsibilities towards other family members, for instance, multiply the effects of a diagnosis that points to work disability? It is important, though, that a problematic social life in itself cannot not be seen as a cause for receiving sickness compensation. Fundamental is that the medical certificate must declare permanent disability to work.

### *The decisional stage*

Formally, the decision made on the basis of the investigation done by an official is made by a special decision maker. There are a small group of such decision makers in every region of the SSIA. Which decision maker becomes the one to decide a single case is randomly chosen. The investigator makes a proposal on the basis of his/her investigation. In the vast majority of cases the investigator and the decision maker agree on what decision should be made. In practice, this seems to function as quality control because all information and argumentation, the choice of facts to present, what kinds of factors are most important, etc., are produced by the investigator. Sometimes, as mentioned, the investigator turns to a specialist, or sometimes

to the SSIA's medical advisor when some exceptionally tricky problem to interpret arises, but typically the investigation and the proposed decision rest on the investigator's own information and judgment.

It happens now and then that the investigator and the decision maker disagree. Several respondents confirm that one over time learns that (and how) different decision makers think slightly differently, and therefore they, when they have a complicated case, often "know" what the decision will be when they see which decision maker is going to take the stand.

R. But you can think "yes, now this case ends up with that person and because of this it won't go through, but if it had ended up with that other person it would have" (resp 4).

If they disagree with the decision made, officials always have the possibility to make a note in the journal indicating that they are of a different opinion than the decision maker. It is not uncommon that investigators make use of that possibility.

***Concluding remarks: Officials' discretion and occupational role  
– some fragments from an ongoing analysis***

The officials at SSIA are typical Street Level Bureaucrats (SLB). Like so many other types of occupations in the public sector, at the core of their occupational role is translating, adjusting and transforming state laws and regulations into practice handling unique clients (patients, users etc.) in unique situations and contexts. No matter how detailed regulations tend to be, there is always a distance between formal written rules and all these unique situations where they are applied. This gives the SLB room, a certain discretion, to assess and decide how rules should be interpreted, used, and what priority they should be given in relation to other applicable rules in the same situation. This makes them policymakers in practice – they develop a certain practice in how to use the rules and regulation at hand in day-to-day business. If the distance between formal rules and how they are applied in such practice is too great, clients and citizens will experience arbitrariness and lack of judicial security; if it is too little – rules are applied in too standardized a way, with no consideration of the client's right to have his/her personal conditions considered – they will experience lack of trust and the authority and its representatives as insensitive. This dilemma between two principles and how they are balanced is fundamental for the mission of SSIA, and it puts the SLB as translator of policy into practice in the center. To understand the outcomes of investigations and decisions, and how the authority fulfills its mission, we must understand what is happening in practice. How strict and detailed are the rules to follow, and how tight is management control of SLB's performance? What characterizes the relation between the official and the client, and what are the abilities for the SLB to consider different facts and use personal judgment? What room for interpretation of such central concepts as work ability do the officials have?

In this paper the focus has been to analyze the discretion of officials with the key concept of work ability as a point of departure. To understand what is going on in the investigations and communication between officials and clients in the case of sickness compensation is, as hopefully has become clear above, absolutely central.

I: Or is it maybe a little okay that this concept (work ability, our remark) is diffuse because it gives you a bit bigger space when to take a decision?

R: I should say so, and all people are so unlike so you can never be good with this concept if one says so, you can have an opinion, but then every individual is unique and depending on the type of

diagnosis, and on what has been tested, or what kind of job the person has. It becomes an individual assessment every time. It is very hard to get it right every time. And it depends so much upon what the doctor writes, because they describe the limitations of activity ...//... and this can be everything possible. Then you have to put this in relation to what has been tested before or what should be possible to test, and then in relation how it is adjusted, ...// (more examples, our remark) (Resp 1)

This quote is quite representative of how our respondents experience their discretion to act in accordance with their own view about what it means to be professional in this job. They are obviously torn between what they experience as a stiff regulative framework and their experiences of all the deserving cases they meet but cannot support. At the same time they say that they have a lot of room for steering investigations in “the right direction” when they are convinced that it is needed but when the outcome from the beginning seems unclear.

The findings described in this paper can be summarized in four points:

1. The concept of work (dis-)ability is vague and disputed, and ideas about how it should be applied come from many societal actors representing different interests. The meaning ascribed to it by the authority has also changed from time to time, and in relation to changes in the political context. The regulatory claim in the case of sickness compensation that work disability shall be permanent also makes the assessments extremely complicated. The facts mentioned open up a lot of room for interpretation and investigative efforts searching for arguments supporting (or denying) an application. On the other hand, they also allow for the possibility of being very strict and narrow in judgment. SSIA is already an authority with an extensive regulatory regime. To enhance the level of regulatory detail and control even further to guarantee sameness in assessments in these cases will probably not help as long as the core concept is as vague as it is.
2. An obvious complication in relation to the first point is that so many different actors are involved with the same clients but on behalf of different authorities and organisations and inside different institutional frameworks. These actors often act on the basis of a different understanding of the concept. It is also a complication that differences in how the concept should be applied exist even inside the SSIA – between at least sickness compensation as one type of insurance, and sickness cash benefit as another.
3. Not all doctors manage to live up to the authority given both to make a diagnosis and to assess the client’s ability for activity (in prolongation work ability). The formal status of, but at the same time quite large variation in quality when it comes to medical certificates, creates a need for officials to search for and acquire information from several other actors and instances involved in rehabilitative work with these types of clients. It is often possible to choose between holding on to the information given in the certificate or to acquire more information, and therefore there is obviously room for the official to take a stand building up argumentation for succeeding in getting the “right” decision.

4. The officials in the SLB group are quite heterogeneous when it comes to experiences and academic background. We can therefore also expect that important differences exists between different officials in how they interpret their occupational role. We may expect differences between individual officials in where they feel they have their primary loyalty – towards the authority or towards the client. Do they experience their work as first of all social work helping people in need, or being authority representatives upholding formal regulation and judicial security?

No, but there is some discretion, but there is also a non-discretion and I think that this is the reason why, I knew many colleagues that have quit because of that, you work so much with customers (authority language for client) ...//... to be torn between the authority and all the frames, and “I see how bad this person feel but I can’t grant this because this isn’t ...” here it points to that all possible options haven’t been tested, and I know many that have quit who maybe have felt this was the biggest problem (Resp 3)

Many people working as officials in the SSIA have a professional background working with social problems, helping people. They have core values about what is humane treatment, and what is the best way of helping people in the long term. Many of them have academic degrees in social work, behavioral sciences, health and so forth. They have solid knowledge and firm views about what it means to be professional when working with people. If they do not feel that they have the room and possibility to negotiate and develop their occupational role in accordance with that, they may leave the business. What is interesting is that many of them also actually experience such flexibility, something confirmed by our analysis so far.

There also seem to be another group of officials that have a more “authority-adjusted” view of their occupational role. One hypothesis here is that those that have such views more often have a background in, e.g., political science, law and economics. They experience themselves as authority-representatives not there primarily for taking the client's view – identifying themselves with the latter and their social situation. Even a more authority-oriented official can, though, feel that it can be too strict:

And, we are very very strict, and it is a hard system we many times think. We have our frames and that also our general director agrees about, that we maybe need to change the rules a little because it is like that that we are granting too few applications today in relation to the percent we are expected to. (Resp 4)

A further interesting background factor here may also be “time in the authority.” Experienced officials may have developed a know-how about the regulatory framework and how it can be used, even manipulated, in accordance with their view of professionalism. New officials are not that acquainted with what is actually possible. They may therefore be more afraid of bending rules.

In spite of a high level of detailed regulation of a social insurance benefit such as sickness compensation there exists, and probably must exist, quite a discretionary space for investigating officials to assess and propose the granting or rejecting of applications on the basis of the unique circumstances of individuals. Such flexibility is of utmost importance for an authority (and a social insurance system) that in the end depends on citizens’ trust. How then to counteract the risk of arbitrariness in the handling of cases? Instead of furthering the development of how to define central concepts, of rules and regulations towards an even higher level of detail, and enhancing the standardization of investigative tools and so forth, it seems that focusing the officials’ occupational role may be a key component. A development



towards more of a unified conviction about the role – a professionalization towards a common field of knowledge about the mission and how it should be practiced, and on the basis of what fundamental values may counteract risks of arbitrariness and too big differences between different investigators. In relation to this – the room for discretion, how and why it is used by different officials in different ways – our next step is to take the analysis further and deeper.



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