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Communication characteristics between clients and stakeholders within the Swedish sickness insurance system – a document analysis of granted and withdrawn sickness benefit claims

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ABSTRACT

Purpose: The purpose of this study was to investigate how communication within the Swedish sickness insurance system differs between cases of sick leave and how this may affect clients’ cases.

Materials and methods: This was a document study using 30 client files from the Swedish Social Insurance Agency (SIA). The clients included had been on a work ability evaluation during their sick leave spell and were aged 32–64 years. The material was analyzed using qualitative document analysis.

Results: The results show different approaches to communication, characterized by emotional argumentation, matter-of-fact driven argumentation and information exchange, which have diverse success in affecting official decisions. Arguments characterized by emotions such as frustration or desperation are to a larger extent neglected by the authorities compared to those characterized by a matter-of-fact driven approach and referring to regulations and medical certificates.

Conclusion: There are differences regarding how clients and stakeholders communicate the clients’ needs and prerequisites, and how this affects official decisions. Further research must be carried out in order to establish social insurance literacy, initially for individuals on sick leave within the sickness insurance system, and whether there are differences between diverse groups that could lead to injustices.

IMPLICATIONS FOR REHABILITATION

- Within a social insurance context, professionals need to provide clients with adequate and individually adapted information in order for procedures to be perceived as comprehensible and manageable by the clients.
- The support from stakeholders such as the treating physician and/or employer can affect clients’ sick-leave process.
- Clients’ treating medical professionals can contribute to ensuring that clients’ rights are met by communicating the clients’ needs to other stakeholders in a formal way.

Introduction

Over the past few decades, many welfare systems in western countries have increased the focus on early return to work for clients on sick leave, and there has been similar policy development in Sweden. This has diverse effects on different individuals since it could lead to a neglect of their injuries and difficulties as well as the appropriateness of the return-to-work program [1]. Individuals with visible physical disabilities are less likely to be questioned or to have a confrontational relationship with the system [2,3], compared to those with, for example, neurological or mental health disabilities. Women and ethnic minorities are also more likely to be questioned and to have difficulties receiving benefits [2]. Lippel [1] describes four issues that need to be considered when examining equity within compensation systems: 1) non-adversarial access to adequate benefits and health care, 2) protection of the dignity of claimants by preventing stigma and ensuring balance, 3) appropriate use of evidence when determining compensability, and 4) using appropriate measures for promoting return to work [1]. Clients’ difficulties in understanding the sickness insurance system has previously been demonstrated [3,4]; however, facilitating factor is belonging to a helpful community that provides support in understanding and going through the processes [3]. In previous research, there are further indications of differences among diverse groups regarding which clients receive interventions on sick leave [5], and which clients have their request for sickness benefits refused [6]. This may risk damaging the legitimacy of sickness insurance, if sickness benefits continue to be withdrawn on inconsistent grounds and with differences geographically and between different groups of clients [7]. There are also indications in previously collected material (files from the SIA) [8] that there are differences in clients’ experiences of encounters depending on the individuals situation as well as how the SIA communicate.

Communication and interaction take place in different contexts and different ways, such as between client and case-manager by...
telephone or between client, case-manager and physician at a status meeting. Communication and interaction skills are necessary for both transmitter and recipient, such as case-manager and client, in order to express intentions and needs and to coordinate social action when interacting with others. This occurs by using gestures, physically contacting others, speaking, collaborating with others and asserting oneself [9]. The communication and interaction skills of case-managers have previously been shown to affect clients’ self-efficacy [10] as well as perceived fairness; for example, when case-managers motivate decisions [8]. Another study found that clients perceived case-managers as hard to reach, and that, due to difficulties in contact with the authorities, clients often conducted their communication with the case-manager through third parties [4].

Clients on sick leave often have contact with different stakeholders, such as the SIA, the Swedish Public Employment Service, their employer and the health-care system. Depending on the need for cooperation, the involved stakeholders can meet together with the client at a status meeting. Within most sickness insurance systems, physicians play a gatekeeper role, but which type of physician has a voice in the process varies [1]. The opinion of the treating physician is initially sufficient, but this opinion has also been shown to be set aside on occasion. Sometimes this occurs when decision-makers rely on guidelines setting out the average healing time or depend on the opinion of insurance physicians [1]. Sometimes several physicians with different roles are involved in the same case, such as the treating physician, the SIA’s insurance physician and the physician performing work ability evaluations on behalf of the SIA. Treating physicians have been blamed for being too generous in recommending sick leave, with the authorities questioning their judgement [11]. When assessing work ability, physicians must not only refer to the diagnosis and medical condition but also consider whether the functional limitation this leads to is enough to prevent a client from working. It has also been demonstrated that clients who take the initiative in their recovery and vocational rehabilitation gain their physician’s trust, because it implies that they are not taking advantage of the insurance system, while the cases involving more passive clients become more complicated. The assessments made by physicians are to a large extent contextual [11] and are crucial for clients’ opportunities to receive continued sickness absence. Employers play an important role when workers absent due to sickness enter the return-to-work process. When individuals experience fair treatment and recognition of their disabilities from their employer, they report fewer depressive symptoms compared to those who do not experience such support [12]. However, a source of conflict between employer and employee is when the insurance system demands an early return to work, before the disabled individual is ready for it [1].

The Swedish sickness insurance context

The SIA is a public authority with a central role in the Swedish sickness insurance system with the tasks of assessing clients’ eligibility for sickness benefits and coordinating vocational rehabilitation interventions. The SIA has a substantial impact on clients’ lives as the authority has power over their financial subsistence. In Sweden, as in other countries [11] the focus is on more objective assessments, which leads to excluding emotional and subjective considerations. In the Swedish system, the SIA is by law barred from taking individual and social factors, such as age and education, into consideration when assessing eligibility for sickness benefits. In Sweden, you are eligible for sickness benefits for up to 90 days if you are unable to do your regular work or any other temporary work that your employer can provide [7]. After these 90 days, and up to 180 days, you are eligible for sickness benefits if you cannot do your regular work or any other work that your employer can provide. From day 181, you are eligible for sickness benefits if you cannot perform any work in the regular labor market, unless it is likely that you will return to your regular work before a year has passed; in this case, you are assessed in terms of your regular work. There is a sharp limit after 180 days, when the criteria for receiving benefits become tougher. This is shown through an increase in withdrawals of sickness benefits and an increase in clients being sent to work ability evaluations on behalf of the SIA [7]. Initially, a sick note from the clients’ physician is enough to receive sickness benefits, but the SIA can also order a work ability evaluation when further material regarding clients’ pre-requisites are needed. The work ability evaluation used in Sweden is a national assessment tool, performed by specific units within health care, under which clients first see a physician and, if necessary, an occupational therapist, physiotherapist and/or psychologist. The professionals involved in the work ability evaluation carries out an independent assessment and have not previously met the client. Since the assessment from day 181 is directed towards the entire labor market and all possible jobs that may exist, the SIA does not take the context into consideration, unlike assessments for a specific job which consider work tasks and unique workplace factors. This leads to assessments of work ability being only hypothetical, since the client is simply assumed to be able to perform some kind of job. Case-managers can discuss their cases with the SIA’s insurance physician when medical certificates or other documents are perceived as hard to interpret. The insurance physician does not meet clients but has an advisory function within the authority to facilitate the decision-making process for case-managers. Individuals on sick leave who are subject to potential withdrawal of sickness benefits first receive a letter with information from the SIA about the preliminary withdrawal and are given the opportunity to submit supplementary material and certificates within two weeks, before their case-manager makes the formal decision on whether or not to grant sickness benefits. Before the formal decision to withdraw benefits, specialists at the SIA with knowledge of the regulations go through the case material as a way of ensuring quality in decisions. A Swedish report [7] highlights a set of characteristics that frequently appear among those who have their sickness benefits withdrawn. Their results showed that those with low education, 60–64 years old and/or born outside of Sweden more frequently had their sickness benefits withdrawn. There are remarkable variations in the number of withdrawals over time. The SIA has a goal (set by the Swedish government) of reducing sick leave numbers to 9.0 days per person per year, which may well have had an impact on the priorities in their decision-making [13]. It is problematic if there are no other acceptable explanations for these variations over time. The term sickness benefits, as used in this study, refers to both sickness absence (SA) and disability pension (DP). SA in Sweden is a compensation for inability to work, set to a maximum of one year but with the possibility to make exceptions in particular cases. DP is a more permanent compensation for those unable to work for the foreseeable future. However, DP requires that all reasonable medical and vocational interventions have been tried and is therefore quite hard to receive.

As previously described, there are indications that the characteristics of communication can have an impact on the sick leave process, as seen in previously collected material [8], which
motivates a further examination of the data with the following purpose.

**Purpose**

The purpose of this study was to investigate how communication between clients and stakeholders within the Swedish sickness insurance system differs between cases of sick leave and how this may affect clients’ cases.

- How do stakeholders and clients communicate with each other within the sickness insurance system?
- How can different types of communication affect authorities’ decision-making?

**Materials and methods**

**Study procedures**

‘Material culture’ such as documents, records, artefacts and archives provide a valuable source of information regarding organizations and programs, since they can give a behind-the-scenes look at processes [14]. Documents in terms of case files from the SIA were collected and examined with a focus on the character of the communication between client, SIA and other stakeholders. The SIA was asked by the researchers in 2015 to approach the 200 most recent clients who had been on a work ability evaluation in Sweden. The clients received information by letter from the SIA asking whether they consented to the SIA passing their contact information to the researchers. Of these, 36 clients approved, and were interviewed in another study where they described their experiences of their contact with the SIA and the work ability evaluation [8]. Of these 36, 30 gave written consent to share their files with the researchers. There were no reasons given by the dropouts for not participating, the written consent just wasn’t received by the researchers. The clients’ case-managers were not informed about the clients’ participation in the study, thus the process was not biased by this. The data in this study thus consisted of 30 files, including all documentation from the clients’ case such as work ability evaluations, physicians’ certificates, statements from physicians, employers and others, as well as the clients’ e-mails, letters and the documentation of telephone calls with their case-manager on the SIA. This material gives a unique insight into the bureaucratic reasoning and logic of the SIA. Of these 30 clients, 17 had their sickness benefits granted while 13 received the decision that the SIA was considering withdrawing their sickness benefits, and giving them the opportunity to submit supplementary information to argue for their right to receive sickness benefits. Of these, 10 had their sickness benefits withdrawn.

**Context of the documents**

When using documents as data, it is important to define their context as well as their original purpose and who documented them [15, 16]. The files used in this study served to ground research within the context of the Swedish sickness insurance system, but were originally created with the purpose of investigating clients’ eligibility to receive sickness benefits. The documented correspondence mainly took place between clients on sick leave and their case-managers at the SIA, but also between employers and case-managers, as well as physicians and case-managers. The work ability evaluations were documented by professionals such as physicians, psychologists, occupational therapists and physiotherapists. The main contents of the files are written by the case-manager and may therefore represent more of the case-managers’ and SIA’s points of view and their reasoning about official decisions. However, e-mails and letters from individuals on sick leave were also scanned into the files and can, therefore, contribute with clients’ unique perspectives, at least to some extent. Clients’ reactions and emotions about events and official decisions are also documented by the case-manager in the files, but the details are often limited.

**Participants**

The study sample consisted of 20 women and ten men aged 32–64 years old (see Table 1). There was a spread in both geography and the diagnoses of participants.

**Data analysis**

Data was analyzed using a qualitative document analysis. Usually, some sort of content analysis is employed [14–16]. This study focused on documents, in terms of client files from the SIA. Bowen [16] describes a document analysis as including elements of both content analysis and thematic analysis. These include skimming, careful reading and interpretation where the researcher recognizes patterns within the data. The process requires focused re-reading and review of the coding and category construction, to uncover themes relevant to a specific phenomenon [16]. Content analysis of the manifest and latent content of data is also described by Graneheim and Lundman [17] as a process where meaning units are condensed and then abstracted into codes, categories and themes. Meaning units, codes and categories are referred to as the manifest content while themes are referred to as the latent content [17]. In this study, the files were first skimmed, then read through more carefully several times while meaning units were discovered. Meaning units were condensed, coded and categorized based on differences and similarities (see example of coding procedure in Table 2). The first author performed these steps; however, all authors took part in the interpretation procedure through discussions regarding the analysis, thus all authors were familiar with the data. Further, all authors have previous experience of qualitative research.

**Results**

The results emerged in three categories based on the character of communication in the case (see Figure 1). In total, these categories resulted in eight subcategories, whose content will be described below. Those cases with the highest number of case-managers involved are those where sickness benefits are withdrawn with clients either protesting on their own or not reacting at all. The diagnoses in the cases vary and there is no obvious imbalance regarding which diagnoses occur more or less frequently in the granted or withdrawn sickness benefit cases. In most cases, several forms of communication are used; in particular, telephone calls and letters from the SIA. The cases where frequent cooperation between stakeholders occur are mainly granted sickness benefits, even though there are exceptions. All citations are presented in italics.
Emotionally driven argumentation

Pleading to the case-managers' good will referring to circumstances of life

Emotional argumentation in terms of appealing to the case-managers’ good will is the most common characteristic of the communications seen in this study, especially after a preliminary withdrawal of sickness benefits. For example, pleading for the case-manager to change their mind by referring to the client losing their quality of life or breaking down because of the stress they are being put through.

I only have one word on my mind and that is HELP!! I am lying here sleepless wondering why I do not have the right to a better life ... Hope you can take my words into account so that I can continue a worthy life. [Letter to case-manager from Client 8 after receiving a letter of preliminary withdrawal of sickness benefits.]

Some clients also refer to their age as one factor reducing their employability, as it could be difficult to find a new job with only a couple of years left to retirement.

Sure I can be re-educated, but then I guess I will be finished by the time I am 70! Fine! [Letter to case-manager from Client 15 after receiving a letter of preliminary withdrawal of sickness benefits.]
In the two cases quoted above, case-managers noted the reaction but continued the process as they had planned, without meeting these clients’ emotions in any particular way. There are also examples of argumentation moving from being fact-based at the beginning of the spell towards being more emotional later on; for example, due to pressure to enter work training or the stress caused by a preliminary withdrawal of sickness benefits. These clients sometimes send supplementary information to object to a preliminary withdrawal of sickness benefits, mainly in terms of a new medical certificate, but often they seem to react with desperation, mainly referring to previous information and their life situation. This kind of argumentation when pleading to the case-manager’s good will seems to have little impact and is not likely to change the case-manager with desperation, mainly referring to previous information and how other stakeholders act.

Emotionally driven argumentation
• Pleading addressed to the case-manager’s good will will referring to circumstances of life
• Frustration about the SIA’s regulations and how other stakeholders act
• Imposing guilt upon others and being disappointed because of lack of support

Matter-of-fact driven argumentation
• Arguments referring to medical certificates and regulations
• Thorough description of pre-requisites with arguments referring to work ethics and public welfare

Information exchange
• Communicating practicalities
• Difficulties in understanding the information from the SIA
• Medical documents and the client’s pre-requisites – a matter of interpretation

Figure 1. Results as presented in categories and subcategories.

Frustration with the SIA’s regulations and how other stakeholders act
Frustration with the regulations within the SIA emerged in this study, which in several cases were forcing clients to leave their employment and search for a new job. In cases where the clients are working part time, they seem to have more difficulties comprehensiong why they cannot stay at their current workplace with part-time sickness benefits at a level that works for them, instead of becoming unemployed and having to search for easier work that would theoretically allow full-time work. Often their work is manageable due to modifications made together with a supportive employer, and their current work is therefore well adapted to their pre-requisites.

“In... understand that the SIA has its rules but think it is terrible that he will be forced away from his permanent employment. [Case-manager’s own documentation after telephone call with Client 7.]

The case highlighted in the quote above, according to the case-manager’s own documentation, was responded to by informing the client that he will receive information from the SIA about whether his sickness benefits will be withdrawn or not. After this conversation, the client was sent to a work ability evaluation to investigate his ability in relation to any other work on the labor market. There are also examples of clients being stressed when the return-to-work process is perceived as too slow for them. This kind of communication tends to result in actions from the case-manager aimed at pushing the other stakeholders to engage in the client’s return-to-work process, on behalf of the client eager to work. The following quote illustrates a client calling the case-manager when other stakeholders are not acting quickly enough; this leads to the case-manager calling both the physician and the employer and urging increased activity and effort for this client’s return to work.

The client is worried and frustrated and experiencing that nothing is happening from the physician and employer. [Case-manager’s own documentation after a telephone call with Client 10.]

Imposing guilt upon others and being disappointed by lack of support
In some cases, blame is directed towards the case-manager for causing the client’s suffering when sickness benefits are not granted or when the amount is reduced. The clients give personal examples of how this affects them, mainly related to personal finances. Some also highlight their disappointment in the physician for not paying enough attention to them, their manager at work for not understanding their difficulties, or state that they have too many official contacts to handle. These opinions, however, are not taken into account by the case-manager in the decision-making process. The case highlighted below, according to the case-manager’s own documentation, did not lead to any particular actions from the case-manager, except agreeing to another telephone call the following week.

X states that it is the SIA’s fault, the physician’s fault and the employer’s fault that he is not getting any better. He believes that the SIA has forced him to return to work even though he has been too ill to work and would have needed full sick leave. He also thinks that the physician set the wrong diagnosis. [Case-manager’s own documentation after telephone call with Client 5 regarding reduced compensation due to unemployment.]
Matter-of-fact driven argumentation

Arguments referring to medical certificates and regulations

The matter-of-fact driven argumentation is mainly characterized by arguments based on medical certificates and laws regulating sickness insurance and is presented in a sober way. For example, clients and stakeholders argue for the client’s eligibility for sickness benefits by stating that this is their right according to specific paragraphs in the law, or by quoting medical certificates or investigations by specialists in health care who have made certain recommendations or conclusions regarding prognosis. The clients in this category seem to know which certificates to send in, since the majority of them complete their own arguments with new certificates from their physician, physiotherapist or occupational therapist. The two examples below were both granted sickness benefits after the case-managers received these letters.

You chose not to approve my sickness absence for the period [date]. According to the conclusion in the Administrative Court [date], I am eligible to half-time sickness absence for this period. [Client 3 questioning withdrawn sickness benefits in a letter to the case-manager.]

According to the medical certificate from the pain rehabilitation center [date], an injury of this kind may take up to two years to heal. At the time of the SIA’s decision it has been one year. [Letter to case-manager from Client 14 after receiving a preliminary withdrawal of sickness benefits. Sent along with medical certificates from several health-care professionals.]

In some cases, argumentation shifts from being emotional at the beginning of the spell, to becoming more precise and formal. There are also examples of argumentation that is more fact-based and formal when relatives are involved; for instance, by helping the client in the process of writing complaints and sending supplementary information to the case-manager. There are several cases where clients state that they have experienced support from their employer and colleagues. But there are also several cases where clients report conflicts with their employer, lack of support, a workload that is too heavy when on work training, negative attitudes towards them from their employer after being absent sick, or that the employer refuses to adapt work tasks or to consider transferring the client to another position. Those clients who seem to experience support from their employer and where the employer seems to try to facilitate the client’s return to work, for example, by being in close contact with the case-manager, are more often granted sickness benefits than those who report lack of support and other difficulties concerning the employer. A similar pattern emerged when physician and case-manager are in frequent contact; and, in cases where the physician knows the client and takes an active role, the case-manager seems more likely to go along with the physician’s suggestions.

There are examples of cases where the client is communicating in an emotional way and the case-manager seems not to take the client’s pleading into consideration, but when the client’s physician takes an active and decisive part in the argument, using new medical certificates, this convinces the case-manager to approve sickness benefit claims. For example, in one case, when the physician heard about the preliminary decision to withdraw sickness benefits, they called the case-manager on their own initiative, explaining the client’s pre-requisites thoroughly as well as sending an extra medical certificate. After this, the client was granted further sickness benefits. Some physicians also raise objections to the work ability evaluation and its results, or towards the insurance physician, mainly when they experience that the client’s difficulties have not been sufficiently highlighted.

Thorough description of pre-requisites with arguments referring to work ethics and public welfare

Some clients describe their pre-requisites to work quite thoroughly; for example, by describing what consequences their condition have and what strategies they use to cope with these. The clients often pay attention to details and express themselves in a distinct way by giving concrete examples. Some clients also refer to work ethics and public welfare by stating they are doing their best to recover and to contribute to society. In the case below, the preliminary decision to withdraw sickness benefits was changed into prolonging them, after the case-manager received this letter from the client. This client argued on his own and was sent to another work ability evaluation while sickness benefits were prolonged.

I have seen my choices of workplace as part of my rehabilitation, not to strain society with another person on disability pension. Something that even the specialist at the back-rehabilitation center agreed on. [Letter to case-manager from Client 15 after receiving a preliminary withdrawal of sickness benefits.]

Information exchange

Communicating practicalities

Several of the cases in this study include very little documented communication between the client and the case-manager and are mainly concerned with practicalities. In these cases, questions about regulations and information regarding the process are communicated and there seems to be less friction between the client and the case-manager. These cases are either granted sickness benefits directly or withdrawn without protest from the client. Those granted benefits directly seem to be unequivocal cases where this scanty communication is sufficient. Several of the clients who had their sickness benefits withdrawn without any objection were already searching for new jobs on their own initiative before this decision. In addition, some seem to accept the decision despite difficulties in returning to work. Another reason for communication between case-manager and client is when a work ability
evaluation is initiated or when official decisions are communicated. In the majority of cases, the work ability evaluation is initiated by the case-managers and simply notified to the client. But in some cases, this is discussed at status meetings with both the client and other stakeholders as an alternative they all agree upon. In some cases, a work ability evaluation is discussed and agreed upon with the client’s physician, or with the insurance physician and thereafter notified to the client. Several of the clients received this information at a personal meeting or status meeting, but sometimes by letter or telephone. Reasons for the evaluation being initiated are often related to limited medical certificates and/or lack of clarity as to clients’ activity limitations, as well as a complex medical background. Another reason is when the case-manager is considering a disability pension but desires further material. The reactions of clients when a work ability evaluation is initiated are sparsely documented, the file consisting rather of documents and forms that are provided by the case-manager to the client. In those cases where reactions from clients are documented, case-managers state that clients are positive or that they consent. For example, in the quote below the client was clearly expecting the work ability evaluation to lead to continued sickness benefits, which in fact it did.

He is positive about the evaluation, thinks himself that he should not work full time in the future. [Case-manager’s documentation of a personal meeting informing Client 5 about the work ability evaluation.]

Clients are generally informed about the official decision after a work ability evaluation when the SIA considers withdrawing sickness benefits. This is introduced to clients by telephone and/or a personal meeting, a status meeting or just in a letter. When sickness benefits are granted, the case-manager just keeps approving the sickness benefit payments without any feedback to the client. The preliminary decisions to withdraw sickness benefits are justified mainly by stating that clients could perform physically lighter work without stress, without any concrete examples of specific work being given.

… a job that is not heavy or static, that is not stressful and without contact with a lot of other people. [Letter giving the preliminary decision of withdrawal of sickness benefits from case-manager to Client 22.]

**Difficulties in understanding the information from the SIA**

Several clients express that the information from the SIA is complicated and that they have a hard time knowing which forms to fill in, especially while sick. Some express their gratitude towards the case-manager when this is explained to them and some contact their case-manager afterwards to find out what forms they have signed. Among the clients who clearly expressed difficulties in understanding the information from the SIA, the majority were granted sickness benefits on the condition that they participate in work training. Several of them state that this is too demanding for them, but their objections are not taken into account. One participant received a formal letter about preliminary withdrawal of benefits and the following quote reflects the uncertainty about what is expected from the client after this.

The insured asks what kind of opinions or documents he is supposed to enter due to the preliminary withdrawal of sickness benefits. [Case-manager’s documentation of a telephone call with Client 4.]

According to the case-manager’s documentation, the client quoted above received information that a new medical certificate must be entered in order for him to have a new assessment of eligibility for sickness benefits. No opinions or appeals against the official decision were thereafter entered in this case, which led to a formal decision to withdraw sickness benefits. This client returned to work, but with continued difficulties.

**Medical documents and the client’s pre-requisites – a matter of interpretation**

The case-managers seem to consult the SIA’s insurance physicians at some point in most cases, mainly after receiving the results of a work ability evaluation, but also to gain help in interpreting medical certificates or other issues. The insurance physician seems to have a significant impact upon the case-manager’s final decision, whether the recommendation is to grant or withdraw sickness benefits. One finding in this study is the different interpretations of clients’ pre-requisites and work ability. For example, regarding the results of the work ability evaluation, or what demands the client’s current work actually includes. There are examples where the case-manager assesses the client’s current work tasks to be manageable enough to initiate returning to work, and others where the case-manager states the work tasks are too demanding for the client’s abilities and requires the client to resign and search for a new job. This can occur despite the client and other stakeholders arguing against the case-manager’s interpretation. When different interpretations occur in the case, this leads to discussions and sometimes conflicts between case-manager and client and/or case-manager and physician. It seems to be quite difficult for clients to change the case-manager’s opinion without support from new medical certificates or other professionals’ statements arguing against it.

Quote from your [case-manager’s] letter: The significant activity limitations regarding psychological functions correspond poorly with the information that you can perform on stage… My [the client’s] comment: First, I would like to say something about stage performances. For most people this is extremely challenging and stressful… But I have done this for 30 years and mastered it to perfection. I am calmer and better settled than at a private dinner. To me it’s as easy as riding a bike. [Client 19 objecting to a preliminary withdrawal of sickness benefits.]

In the case above, the case-manager consulted the insurance physician and they agreed that the client’s work tasks are inappropriate due to his cognitive difficulties and sensitivity to stress and state that the client should be able to perform other work that is not as stressful, suggesting resignation and involving the Public Employment Service. The client argues against this assessment and states that the case-manager has also interpreted the work ability evaluation inaccurately. In a telephone call documented after these protests, the client refers to quotes in the work ability evaluation that support his being eligible for sickness benefits, while the case-manager refers to other parts of the evaluation that support the decision to withdraw them. This client’s sickness benefits were withdrawn despite his objections and supporting statements from his employer and a relative within health care. Several clients raised objections to the work ability evaluation, stating, for example, that they had only seen a physician and not also the psychologist, occupational therapist and/or physiotherapist, or that the evaluation was conducted on a ‘good’ day for the clients and was therefore not representative of their difficulties. Clients also raised objections towards the evaluation for not evaluating endurance due to the short amount of time it took and that it was conducted in a calm environment that would not capture their reaction to stress. There were also several clients stated who after the preliminary decision to withdraw sickness benefits that the case-manager and insurance physician had interpreted the results of the evaluation incorrectly, not in line with the recommendations of the evaluation, or in a way that was only beneficial to the SIA.
I feel like I have to fight the SIA to make you believe in me, and that you chose to interpret those parts of the work ability evaluation that are supporting you to kick me out of the insurance system. [Client 20 in a letter to case-manager after receiving a preliminary decision to withdraw sickness benefits.]

This client objected to the preliminary decision to withdraw benefits with a letter, but did not enter any new medical certificates and had the sickness benefits withdrawn.

In the majority of cases, cooperation between different stakeholders exists, mainly in terms of telephone calls between case-manager and physician, and between case-manager and employer, as well as status meetings. In some cases the Public Employment Service, physiotherapist, occupational therapist or relatives are also involved in the process. Cooperation is mainly initiated by the case-manager, but sometimes by the employer or physician. Some cases stand out, in which cooperation seems to be a mutual responsibility whereby different professionals initiate cooperation at different times during the case. For example, in the case of Client 28, where updates and cooperation occur continuously during the spell, both between the physician and the case-manager involving planning the return-to-work process and medical interventions, and also between the case-manager and relatives. This client is granted sickness benefits but is later able to fully return to work. There are also examples where cooperation is imperfect, such as when a case-manager tries to get in touch with physicians without results, or when previous plans are forgotten when a client receives a new case-manager. Among the cases that do not seem to involve any cooperation between different stakeholders, the majority have their sickness benefits withdrawn. And in those cases where the information from different professionals is in accordance, such as from the treating physician, the employer and the work ability evaluation, the decision seems quite easy and clients are granted sickness benefits directly without being questioned.

Discussion

In this study, emotional and matter-of-fact driven argumentation were the two main characteristics of the communications in the files. The category “Emotional argumentation” in this study is characterized by how the clients express themselves and how they argue. There may be highly relevant facts in their argumentation as well, but these seem not to be taken into account by the authorities if the clients present them in a manner characterized by such emotions as frustration or desperation, even though factors that affect eligibility for sickness benefits should be related solely to the content of the arguments, rather than how they are presented. This study indicates that there is a risk that important aspects of the clients’ work ability and pre-requisites are neglected if they react in an emotional way. There are also examples of arguments that may seem relevant but are not included in the SIA’s task when assessing eligibility for sickness benefits. The subcategory “Pleading to case-managers’ good will” mainly refers to arguments such as employability, age, quality of life and personal finances, which to the general population may seem logical and reasonable factors to take into account. Nevertheless, from the SIA’s point of view, and in accordance with current regulations, these factors are irrelevant since the SIA only consider clients’ work ability in relation to any work on the labor market, and do not consider a specific context. The neglect of emotional and subjective factors described by Meershoek et al. [11] was also found in this study. When authorities’ versus clients’ perspectives of what factors affect work ability differ in this way, there is a risk of perceived injustice that may cause clients to feel mistreated. Previous studies have shown that the diverse perspectives on the content of work ability, whereby case-managers use a biomedical perspective referring to function and medical status, while health professionals use a more holistic view relating to a variety of factors in the clients’ lives, also cause tension between the two stakeholders [18]. In this study, diverse interpretations of medical documents and the pre-requisites at work also existed. This led to discussions and conflicts of client versus case-manager or case-manager versus physician, where each argued their side of the story. The results show, however, that it is hard for clients to argue alone against the case-manager’s view and actually have an impact, even though one would expect the client to be the best judge of his or her situation, especially in terms of pre-requisites at their current workplace. The example of Client 19 objecting to the case-manager’s opinion that the client’s job was too demanding for him illustrates how the case-manager makes a hypothetical assumption based on the client’s profession, without taking into account workplace factors or the client’s individual circumstances such as education, experience and motivation, which contribute to the client being able to perform this job. Clients who work part time in jobs to which they are well adapted move from security to insecurity when the authorities demand that they search for a new job that would hypothetically enable them to work full time. There is generally a considerable amount of effort required when the unemployed search for a job. a situation that could risk clients’ health due to the increased demands and stress. In this study, the potential scenario of being forced to become unemployed was considered very stressful to clients. Nevertheless, according to current regulations, the authorities have the right to demand that clients seek another job instead of remaining in their current well-adapted part-time job, if the client is not likely to be able to work full time at his or her current job, but might be able to do so in another job. Case-managers’ professional exertion includes both interpreting the law and the authority’s guidelines but also making individual assessments. The discretion of case-managers is affected by both the regulations and the organization, available resources, the case-manager’s vocational experience and age [19] and the organizational culture [20]. Their discretion is often limited to small details since overall work routines are controlled. The organizational culture, i.e. the values and norms within their organization, affect case-managers’ professional exertion and discretion and can make policy changes quite difficult to implement [20]. In a best-case scenario, street-level bureaucrats’ work leads to clients being treated fairly and correctly with individual consideration. In the worst-case scenario, however, it leads to stereotyped or favorable treatment depending on the case-manager’s opinion of the client [21].

As mentioned earlier, the SIA does not include the context, such as specific workplace factors or social environment, when assessing work ability from day 181, leading to assessments being based mainly on individual function rather than the holistic content of work ability as defined by, for example, Nordenfelt and Tengland [22]. Terminology for what is being evaluated varies in different contexts, along with different methods and instruments used [23] when assessing for instance functional capacity, work capacity or work ability. The SIA’s work ability evaluations represent a reductionist approach of assessing general work ability [18]. The assessments are also made only at a theoretical level since the client is just assumed to be able to perform some kind of job. From the SIA’s point of view, clients can be well enough to perform “physically light work without cognitive demands”. This was a common phrase seen in this study, as well as others, when it comes to how case-managers motivate the withdrawal of
sickness benefits, often justified in vague terms, and without any substantial examples of what this could be. This may also risk causing clients to feel treated in an unfair way, if the decisions taken are not explained and justified in a comprehensible way. There is a discrepancy between law and practice, in how the authorities interpret the law and how policies are applied [24]. In this study, official decisions were justified in vague terms and lacked any connection to specific jobs with their required skills, which is not in accordance with current regulations [24]. This is likely to be an issue in other countries as well when strict direction is applied.

A trusting, transparent relationship between client and case-manager, providing the client with a feeling of cooperation, respect and being taken seriously, has been demonstrated to be a strengthening factor contributing to clients’ ability to make informed decisions during the rehabilitation process [25]. Furthermore, interactions within the sickness insurance system affect clients’ recovery [4,26] and their ability to take charge of their own rehabilitation process [4]. In the present study, clients’ participation in and understanding of the sickness insurance system seemed to vary. Some of them seemed to know which certificates may have an impact on the case-managers’ decisions and argued with reference to laws and previous certificates. In contrast, some clients do not send any supporting certificates, and in some cases ask the case-manager what is expected when challenging a preliminary decision to withdraw sickness benefits. With support from others, and when using new medical certificates, clients were more successful in affecting their case-manager’s decision. Authorities interacting with clients need to facilitate the understanding of the system in order to enhance clients’ perceived sense of justice; for example, by adapting information according to clients’ individual needs. Bureaucratic letters are not enough, their content and consequences need to be explained clearly. The communication and interaction skills of case-managers has previously been shown to affect clients’ self-efficacy [10] as well as their perceived fairness; for example, when justifying official decisions [8]. Clients who had their sickness benefits withdrawn accepted this if they were able to have a relevant dialogue with their case-manager. The quality of information seems to be essential in order to gain clients’ acceptance and understanding [8]. In this study, communication that concerned basic practical information when clients had difficulties in understanding the system often led to clients expressing gratitude towards their case-manager when regulations where explained to them. These cases were characterized by less friction, but also by sickness benefits granted on the condition that the client would participate in work training. These clients often stated that this would be too challenging for them, but in quite gentle terms. None of these clients objected in a decisive way, by raising their questions repeatedly if not listened to, or by referring to something or someone that would support their opinion. These cases reflect a vulnerable group, clients who clearly have a hard time understanding the regulations and processes within the system and are characterized by powerlessness, in which leads to putting up with decisions without agreeing. Many clients on sick leave have limited resources to take charge of their own case when ill, or they lack the courage or competence that this requires [22]. It is therefore unreasonable for the sickness insurance system to require that clients with an illness or injury are able to shoulder this responsibility in order to gain access to sickness insurance.

In this study, emotional or matter-of-fact driven features in argumentation achieve diverse levels of success when arguing for clients’ rights. The extent to which clients are supported by significant others, such as their physician or employer, is also important. Previous studies show that a supportive employer facilitates the return-to-work process [22,27]; our study suggests that the employer’s support could also have an impact on the outcome of official decisions, and on clients’ perceived justice in their contact with authority. In this study, clients with a supportive employer were granted sickness benefits to a greater extent than those who reported difficulties or conflicts with their employer. The case-managers’ decision-making process may well have been facilitated when also receiving material from the employer regarding the clients’ abilities and limitations. In those cases where the employers are distant, it seems that the clients are placed in a vulnerable situation due to circumstances beyond their control, and thus the lack of support has consequences. Nyberg [28] states that the shift from sickness absence to workability has led to a need for clients to be able to act on the diverse range of policies that affect their situation. If they fail to engage competently in the process, decisions are made for them [28].

Methodological considerations

This was a document study using client files from the SIA with the purpose of investigating how communication within the Swedish sickness insurance system differs between cases of sick leave and how this may affect a client’s case. Document analysis was used, which provided a unique insight into other components of the lived experience [15], in this case experiences with the Swedish sickness insurance system. As in all qualitative research, considerations must be made regarding how to evaluate spoken or unspoken responses [15]. A written word can ‘say’ different things in different contexts, which naturally increases the possibility of different reinterpretations compared to the spoken word [15]. In a qualitative document study, the documents’ relevance must be evaluated as well as their representativeness, authenticity [16], and whether or not they are able to address the study’s aim and questions [17], along with evaluating the study’s trustworthiness in terms of transferability, credibility, dependability and confirmability [14]. To begin with, the documents were considered relevant since they included all documentation from the clients’ case, such as medical certificates, work ability evaluations, the SIA’s documentation of the case, statements from physicians, employers and others, as well as clients’ e-mails, letters and documentation of telephone calls, which were all of interest in this study. However, the documentation was mainly produced by the case-manager, although e-mails and letters from clients were scanned into the files, and this risks not fully capturing the clients’ perspective. The documents were collected directly from the SIA with their full content as used within the authority to assess clients’ eligibility for sickness benefits, which supports their authenticity. Case-managers were not informed that their cases were included in this study, thus had no opportunity to give their consent. However, with consideration to the clients’ anonymity and that case-managers as public servants should be expected to be reviewed, this procedure was considered reasonable. Further, ethical approval was given for the study and the case-managers employer i.e. the SIA was involved in the recruitment of clients.

The files included cases in which clients have been on a work ability evaluation, which mainly occurs after day 181 in the sick leave and only if the case-manager assesses it to be necessary. Hence, they cannot be considered representative of clients with a shorter sick-leave spell or for those who have not participated in a work ability evaluation. The selection of participants was, however, considered appropriate for this study since there is not
always much need for detailed communication before day 181, when the criteria for eligibility are sharpened and work ability is assessed in terms of the entire labor market. Although these cases represent different geographical areas within Sweden, further studies with more participants must be conducted to evaluate the transferability of these results. Data saturation was discussed during the analysis and was considered to have been reached by the end. The aim and all questions could be addressed in this study. Triangulating data would have increased this study’s confirmability, such as adding interviews with, for example, clients and case-managers, confirming or refuting our interpretations of the case, as well as filling in gaps where the case-managers’ documentation of reactions and emotions was sparse or absent. This has been achieved to a limited extent as interviews with these clients were previously conducted in another study with the purpose of studying the social validity and perceived fairness of a new method of assessing general work ability [8]. Exploring how clients communicate was not the primary aim of this previous study, although indications of differences in communication style were noticed in these clients’ files and further examined in the present study. The interpretations throughout the analysis have been discussed by all the authors, who all have experience in qualitative research and were all familiar with the data (first author through this study and the other authors through carrying out the previous study [8]), which supports this study in terms of credibility. The different steps in the analysis as described by Bowen [16] and Graneheim and Lundman [17] facilitated keeping the process systematic, as they were thoroughly followed and documented, which supports this study’s dependability.

**Continued research**

There seem to be several potential factors to further investigate regarding clients’ pre-requisites to enable them to make informed decisions within the sickness insurance system. Whether or not a trusting relationship between clients and case-managers affected the clients in this study cannot be established, but could be of interest in future studies. It would also be of interest to use a larger sample to further examine employers’ impact upon official decision-making and hence clients’ opportunities to receive sickness benefits. When the process and eligibility for sickness benefits are skewed in favor of those with engaged physicians and supportive employers, further studies should also focus on how the authorities can ensure justice and equal assessments for all clients. An instrument to measure social insurance literacy is currently being developed and a survey study to investigate social insurance literacy for clients on sick leave is planned.

**Conclusion**

This study contributes with knowledge about the character of communication between clients and stakeholders within the Swedish sickness insurance system and the consequences for clients’ sick-leave process. There are differences regarding how clients and stakeholders communicate the clients’ needs and pre-requisites, and how this affects the SIA. Two major differences in communication are seen in this study: emotionally driven argumentation and matter-of-fact driven argumentation, which are shown to have diverse success in changing an official decision. These differences motivated further research in terms of the extent to which clients understand the sickness insurance system and how this affects the outcome.

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