To be in-between

The road to disability pension
with reference to the Swedish social insurance system

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Do unto others as you would have them do unto you
Luke 6:31
Abstract

Background: The Social Insurance is part of the Swedish welfare system that is intended to create economic security for citizens in the event of unemployment, sickness, functional disability, and old age. The Swedish sickness-benefit insurance is based on the standard insurance principle meaning that sickness benefits are related to level of lost income. The increasing number of sick listed people and people with disability pension (DPs) in Sweden may lead to marginalisation of individuals as they are not part of the labour market. The government has decided that the number of sick-listed people should be halved by 2008, which means a tougher judgment of the applications for sick leave compensation. To be qualified for sickness benefit the disease has to impair the work ability in relation to the specific demands of the work of that person. The evaluation of the work ability in a percentage is an important element with regard to the policy on disability. The social insurance officers (SIOs) who are assessing the work ability are dependent on judgments from the physicians as expertise, and the guidelines in the social insurance act. The eligibility criteria for DP and the process of dealing with applications for DP is scarcely studied.

Objectives: The overall aim of the thesis was to explore demographic and health differences between those, who were granted and those, who were not granted disability pension. The second aim was to study how the process from applications to decisions on disability pensions were executed and perceived by the social insurance offices and to elucidate their working conditions during the decision process.

Material and methods: The first two studies explored differences between those granted DP and those not granted DP. Study I was a register-based retrospective case-control study carried out in the area of a county in Sweden. The cases were all individuals rejected a full disability pension 1999-2000, in all 99 cases. Controls were every tenth person who was granted a full DP during the same period, 198 controls. Determinants were recorded from the Social Insurance (SI). In study II demographic data and medical diagnoses were obtained from the SI records. Data concerning self-reported health, HRQoL, social networks and use of health care were collected by a postal questionnaire. The study objects were the same as in study I. In study III and IV indepth interviews were carried through to study the social insurance officers’ perspective on the process from application to decision on disability
pensions as well as their experiences of prerequisites and hindrances in their work with DP applications. The transcribed data were analysed by an inductive content analysis.

**Results:** Unemployment, living in the main municipality and age below 50 years were determinants for rejection of DP. Medical status as described in the Social Insurance records had less association with the outcome. There are variations in praxis of rejection of applicants between social insurance boards in different geographical areas due to other reasons than medical. The nDP group had more often multiple diagnoses, and lower self-reported health and HRQoL compared to those granted DP. Those not granted DP also had significantly smaller social networks.

The SIOs perceived that they had to make rapid decisions within a limited time frame, based on limited information, mainly on the basis of incomplete medical certificates, and with no firm criteria for the regulations on the individual case level. Communication among the various authorities as employment offices and social services suffered from lack of common goal-directed strategy. In study IV the SIOs described their working conditions when executing the applications for DP. The SIOs perceived recurrent changes in rules and regulations as frustrating as they at the same time had to face the client. The large number of clients prevented them from being able to offer clients activities and support them in the way they were supposed to do. The SIOs powerful position and how their discretion was implemented made them feel responsible for performing their work well. SIOs are to be considered as typical street-level bureaucrats as they have to perform their work between the policy, rules and clients.

**Conclusions:** The individuals had an increased risk to be rejected DP if they were younger than 50 years, unemployed, and lived in the main city. No evident differences in medical diagnoses were found between the groups. The results indicate that there may be other reasons than medical in praxis. Contrary to expectations, those not granted DP do not seem to have better health, but rather to suffer from more sickness than those, who were granted DP. Unemployment leads to inability to qualify for compensation and benefits that are associated with participation on the labour market. The group not granted disability pension appears to be a disadvantaged group in need for a co-ordination between different parts of the social welfare system.
The different perspectives were perceived as obvious obstacles in the communication between professionals in the welfare system as they had other goals and demands. Clients, that have comprehensive problems and are in need of coordinated measures from many authorities to get entrance to the labour market still suffer from lack of coordination. One question is how the different public officers use their discretion when handling clients and how the cooperation can be improved.

**Key words:** Disability pension, social insurance, social insurance officers, clients, practice, work ability, street-level bureaucracy
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Original Papers

The present thesis is based on the following articles, which in the text are referred to with their roman numerals.

**Paper I**


**Paper II**


**Paper III**


**Paper IV**

Ydreborg Berit, Ekberg Kerstin and Nilsson Kerstin. Executing applications for DPs- social insurance officers’ experiences of prerequisites and hindrances in their working conditions. Submitted.

Reprints were made with permission from the publishers.
Abbreviations and concepts used

DP= Disability Pension. Temporary or permanent disability pension granted to an insured individual with a permanent or prolonged reduction in work capacity with at least 1/4. Work ability expressed as the individual’s functional capacity in relation to demands at the workplace or to any job in the labour market if the individual is unemployed. Work capacity is used as a synonymous to work ability

Client = in this thesis the individual that is covered by the sickness insurance.

nDP= nonDisability Pension

RTW= Return to work

SI = Social Insurance

SSIA= Swedish Social Insurance Agency

SIB= Social Insurance Board

SIO= Social Insurance Officer

SLB= Street Level Bureaucrat

SC= Sickness Compensation. Corresponding terms could be sick pay or sickness benefit.

AC= Activity Compensation The same as above (SC) but covers individuals between 18-29 years and includes activities.

Immigrants=

In this group is also included refugees.
Introduction

My work history started almost 50 years ago by working in the health care sector. For many years I worked with occupational medicine assessing environment and the perceived health among employees in small-sized settings. In connection with that work a standardised questionnaire set was developed that made it possible to compare different workshops and branches with each other and to build up a database for other customers within occupational health services.

As an occupational health nurse I also studied employees, who had become long-term sick in a large hospital. The possibilities to make up plans for their return to work or to finish their work in the hospital were studied. These duties made me wonder at the issue return-to-work or not. What were the differences among those individuals that successfully returned to their former work and those who did not? The result of a master thesis of the effects of a rehabilitation programme among different occupational groups in health care, who had musculoskeletal disorders showed differences among women with different educational level. Working with and studying rehabilitation was performed in collaboration with social insurance officers. That in turn raised question about who was qualified for sickness benefits and who was not. A pilot study on the topic on those individuals, who were not granted disability pension made me interested into further study the matter from the perspective of the clients applying for disability pension and how the social insurance officers executed the applications.

Accordingly the field of research in this thesis is disability pension (DP) in the social insurance system in Sweden. The thesis has two specific focuses. The first one is on clients, who have applied for DP (disability pension), but are not granted the benefit and those who received DP and potential differences between these two groups. The second is on the social insurance officers’ experiences of the decision making process of application for DPs and their working situation when performing the applications for DPs.
Background

The Swedish Social Insurance Agency

The Swedish Government and Parliament form a base for all actions in health care through the legislation. The Social Insurance (SI) is part of the Swedish welfare system that is intended to create economic security for citizens in the event of unemployment, sickness, functional disability, and old age. The Swedish sickness-benefit insurance is based on the standard insurance principle meaning that sickness benefits are related to level of lost income. The SI is considered to be a solidarity insurance and is meant to be both effective and fair. The Swedish Social Insurance System (SSIA) was implemented in Sweden in the beginning of the 18th century. At that time all employed people contributed with a fee and in that way a means test was avoided. It is nowadays financed by a proportional payroll tax.

The National Insurance Act in Sweden covers all people between 16-65 years of age (110). The role of the social insurance system is two-fold: Firstly to administer the social insurance, that is, to ensure that individuals that are granted the benefits and allowances they are entitled to according to the regulation and, secondly, to assess whether the applicants are granted the benefits. The Swedish government issues regulations and instructions to the Swedish Social Insurance Agency (SSIA). The SSIA have to implement those regulations throughout all the local offices to ensure legal security and a fair handling of the individual cases. The public social insurance offices locally administrate the social insurance offices.

In Sweden as in many other Western European countries the sickness absence has increased considerably in recent years, both with regard to the number of people on sick leave and length of sick-leave spells, as well as with regard to the number of people granted disability pension (DP) (20,5). The Swedish sickness rate is the highest in the EU-countries (75). The increasing number of sick listed people and people with DPs may lead to marginalisation of individuals as they are not part of the labour market. The long-term economic burden for society is a risk of the future welfare of the society (65). As a preventive measure the government has decided that by 2008 the number of sick-listed people should be halved. This entails a tougher judgment of the applications for sick leave compensation. Greater responsibilities are also laid
on the sick person, the employer and the SSIA to collaborate in rehabilitation measures. The proposed changes may imply a shift in Sweden’s approach to sickness and disability insurance, which may imply advancement to figures on sick leave and disability pension of other countries. It may especially concern people with non-distinct disorders and affect those who have a weak position in the society (76). As the labour market demands people with high qualifications, who are fit for work, those with disorders and reduced work capacity -run the risk of being unemployed or receiving short-term work.

The government proposes new laws and regulations, which after decisions in the parliament are implemented by the Swedish Social Insurance Agency (SSIA) through the social insurance officers. They have to ensure that relevant grants and benefits are considered and disbursed to the clients. If one is unable to work and provide for oneself and the family due to sickness, it is possible to get benefits from the social insurance agency (Table 1). To be covered by or eligible for a social insurance benefit the individual either has to be resident in Sweden or working in the country.

The Swedish welfare system is well developed compared to international standards, but during the recent decade the country’s economic growth has diminished and the Swedish welfare state has been under heavy pressure. The expansion of the welfare state has been discontinued and the economic security systems, as well as the social insurance agency, are struggling with serious structural and financial problems (81). The agencies in charge of handling complicated cases have to meet the expanding requirements. Many clients do not fit into only one benefit system and have to be handled by more than one agent of the social security system, which demands cooperation and communication between different welfare agents (81,91).
Table 1. Pathways in the Swedish welfare system

<table>
<thead>
<tr>
<th>Pathway</th>
<th>Reason</th>
<th>Levels of compensation</th>
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<tbody>
<tr>
<td>Sickness allowance</td>
<td>Sickness</td>
<td>¼, ½, ¾, 1/1 (80% of income)</td>
</tr>
<tr>
<td>Work injury insurance</td>
<td>Work injury</td>
<td>100 %</td>
</tr>
<tr>
<td>Rehabilitation benefits</td>
<td>Need of rehabilitation</td>
<td>¼, 1/3, ½, 1/1 (80% of income)</td>
</tr>
<tr>
<td>Disability pension</td>
<td>Long-term sickness</td>
<td>¼, ½, ¾, 1/1 (About 64% of income)</td>
</tr>
<tr>
<td></td>
<td>Permanently or temporary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>reduced work capacity</td>
<td></td>
</tr>
<tr>
<td>Unemployment</td>
<td>Loss of job, never entered the</td>
<td>100 days with 80% of income max 730 skr,</td>
</tr>
<tr>
<td></td>
<td>labour-market</td>
<td></td>
</tr>
<tr>
<td>Retirement</td>
<td>Old age pension from 65 year</td>
<td>Depending on earlier income</td>
</tr>
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OECD recently reported (OECD 050609) that nearly a fifth of the potential Swedish workforce is on sick leave or receives disability pension, one reason being that the sickness benefits are generous and easy to get. Sweden also has most lost working days due to sickness in the OECD countries. This means that it is important to study eligibility criteria and the process of dealing with applications for DPs. A systematic literature review concluded studies of high quality in the area of sick leave are rather few (5). This review also stated that females, who were belonging to low socio-economic groups and living in specific areas, were overrepresented among those on sickness absence. But it is above all factors on an individual level and workplaces that have been studied.

One problem in the area of research is to distinguish the causes of disease from causes of sick leave since most people, who are having a disease are not on
sick leave. To be qualified for sickness benefit the disease has to impair the work ability in relation to the specific demands of the work of that person.

The evaluation of the degree of work ability is an important element with regard to the policy on disability. This process could be considered a journey from work through sickness to disability and sometimes back to work (1). Part of this journey is the assessment of the social insurance agency of the rights to have sick leave compensation for the loss of income. The social insurance officers (SIOs) who are assessing the work ability are dependent on judgments from the physicians as expertise, and the guidelines in the social insurance act. A physician assesses if an individual falls ill and if the disease reduces the work capacity fully or partly (107).

Contacts with the health care and social insurance system are important parts of the welfare system for the sick individuals. For people on long-term sick leave the social insurance system has the role to initiate and coordinate rehabilitation efforts. A few qualitative studies (11,34) have shown that one major problem in this process is the ineffective communication between health care and the social insurance officers, which considerably prolongs the assessment process.

The SIO is depending on the rules and regulations for applying compensation from the SSIA and is at the same time also representative for interpreting the authority’s rules and regulation. (7,12,93). Very few studies have been performed on how criteria for DP are applied and how decisions are taken in the social insurance system (48).

The decision making process and long-term disability arrangements were studied by Boer et al (20). The daily practice of disability evaluation in 15 countries was compared and the authors found several differences between the countries. The concept of disability is a central concept, found to be assessed in various ways: Disability in various countries is defined as loss of capacity to work, or as a loss of earning income and or as anatomical damage. In Sweden the work degree of capacity is defined as incapacity due to disease or injury that restrains the individual to work and earn money for one’s living, which hence is a combination of various approaches.

Boer et al also points at the fact that there are large differences in the formal competence of the assessors of DPs in different countries. The medical
assessors were all physicians, who had been academically trained, in the Netherlands, with four years of specialisation in social medicine. One concern is that there is no formal academic training in the field of evaluation of disability. In Sweden there is some training for the insurance physicians. Physicians issuing the medical certificates in the health care may have some training depending on where and when their formal education took place.

The assessment of disability pension in Sweden lays upon a SIO with support of a sickness certificate issued by a physician in the health care. Complementary assessments are bought from specialised departments in order to judge whether and to what degree there is a reduced work capacity. Decisions on disability pension (DP), which is the focus in this thesis, are in Sweden taken by special, politically chosen social insurance boards (SIB). Insurance physicians, who are partly employed by the SI act as medical advisers to the SIOs and do not make decisions on individual cases, but provide the social insurance officers (the SIOs) with explanations and data on medical matters.

The work-line

In Sweden the work-line is a political agreement with the goal that the individuals will be able to provide for themselves and that active measures are preferred before passive economical support. The work-line has its roots in the 1920ies when the unemployment rate in Sweden was high and the government decided that people should be offered some relief work. The modern strategy is from the beginning of the 1990s, and aims to prevent long-term sickness through encouraging joint activities between authorities (the employer, employment office, health care and the SSIA) focusing on return to work (RTW) for different groups (99). The main issue is to propose active measures instead of income compensation. There is a correlation between source of income and level of compensation from the SSIA. Unemployed people, with no or low previous income may instead have to rely on social assistance to provide for their daily life. The number of people, who on a long-term basis receives social allowance has increased during the last years, as the unemployment rate increases (58). As a consequence of the regulation, these people have no opportunity to benefit from the active efforts of the work line principles.
In several governmental investigations (98,100,101) it is stated that the resources available for rehabilitation are often not utilized by the social insurance, and that the rehabilitation methods may not always be appropriate for the needs of the individual. There are gender differences when the SIOs propose activities to get clients back in the labour market (2).

Development of newly granted disability pensions during the 90’s

In most European countries sickness absence has increased during the last ten years (www.oecd.org). Sickness absence has been found to be of predictive value/risk marker for future disability pension (53,15). Many countries have carried out reforms in order to decrease costs related to sickness absence and to achieve equal and fair use of sickness insurance resources (20). The reforms lead to increased numbers of unemployed as those assessed to have some work capacity are at risk to be discharged if they are unable to return to their ordinary work. In Sweden the number of DPs as well as the number of unemployed have increased during the last years, while the number of people on long term sick leave decreases (97). Clients with long-term sickness absence have been granted DPs instead of sickness benefit on the initiative from the SI (81). In a recent study was stated that as many as 46 percent that had been receiving vocational rehabilitation ended up in DP (3).

The labour market condition and the labour force composition are often referred to as contributing factors of sickness absence and DP. In spite of the new regulations that aim to eliminate the influence of the unemployment rate on decisions of DP, there are large regional variations in the frequency of early retirement, which coincide with a weak labour market (95). The sickness rate and the DP rate are higher in the northern part of Sweden, which is sparsely populated and with a high unemployment rate (97). High unemployment rates are associated with low rates of short-term sick leave, which generally is assumed to be due to job insecurity. A consequence may be that the sickness presence at the work place increases, which in itself may increase the risk for future long- term sick leave. High unemployment rates also lead to a selection, partly based on health, partly on competence, of people who get a job (102). People with low education and/or high sickness absence have larger difficulties to find a suitable alternative job.
Figure 1. The proportion individuals with disability pension (2003) in Sweden by gender, educational level and country of birth among 16-64 year old residents. Source: Statistics Sweden, registry of LISA 2005.

As seen in figure 1 there are more women than men that are granted DP no matter of education and country of birth. It is not possible to answer the question why there are proportionally so many from other Nordic countries that were granted DP compared to other countries. According to the study in question there may be that immigrants are not granted DP to the same extent as people born in the Nordic countries. The lower education the more DPs, which also could be corresponding to the available labour market with a heavy work load for women with low education. To be born out of Sweden increases the risk of being granted DP.

Demography, socioeconomic status, health status and lifestyle have been found in several studies to be correlated to DP (81). Age has been found a significant factor of DP (37). Månsson (72) also propose that self-reported health, low socioeconomic status, independently predict DP.

Changes in working life have influenced the panorama of diseases. The strains in working life have shifted from heavy agriculture work, forest work and industrial work to “occupations” in public and service sectors. In particular the cognitive and emotional strains have increased (46). The proportion of women has increased in the working population in Sweden during the last decades and is internationally at a very high rate (6).
As it appears, reasons for sick leave, factors influencing return to work, consequences of being sick-listed and the physicians practice concerning this matter are scarcely studied (4). Apparently, however, there are other reasons for granting DPs than strictly medical criteria. A multidisciplinary approach to elucidate these problems is needed (114).

The development of unemployment and disability pension rates for the last ten years could be seen in figure 2. There is an obvious increase of females granted DPs. But even the unemployment rate appears to increase for both women and men.

**Health, illness, disease, and sickness**

When discussing DP, health and ill-health have to be elucidated, and in order to do so the concepts of illness, disease and sickness are useful. Health has
been considered the absence of sickness. In 1946 WHO defined health as: “A status of complete physical, psychological and social wellbeing and not only absence of disease and handicap” (74). This concept has been criticized as it seems to be a vision or something to strive for but not possible to realize. Boorse (14) defined disease as a dysfunction within an organ or a system of an individual and health was considered as the absence of disease. This very bio-statistical view was challenged by Nordenfelt and others, who have a holistic view of the concept health (73). Nordenfelt defines a healthy individual as someone who within accepted circumstances, is able to realize her vital goals. This means that the individual may suffer from some disease and still be healthy and able to fulfil her vital goals. Thereby, health is a process that is changeable, possible to affect and which could be attained and sustained by active measures.

The concept disease refers to symptoms and conditions as a bio-medical phenomenon that is categorised and diagnosed by the medical expertise while the individuals experience sickness as a reduced ability to be active in the way one wants (73). Alexanderson means that there is a certain point where the individual “draws a line in the assessment of symptoms and says, I’m ill” (6). The conditions of illness are associated with certain norms and cultures of the societies. The concepts of health and ill-health are also according to Sachs based on cultural conceptions (89). That is to say individuals from other cultures may perceive their health and symptoms in another way than individuals from e.g. the Nordic countries (64,89). This may be frustrating for both the primary health care and the SIOs when encountering the clients with a background in other cultures than Sweden. This is especially obvious when handling patients with long-term pain disorders (64). Grönblom states in her thesis that the health care system identifies the cases, which are to be assessed as “normal cases” (diseased in a bio-medical sense), however peoples’ needs of care can be seen as a process influenced by their social situation and cultural attitudes, resources in the social network and educational level (39,87).
Work ability and disability

Work ability is related to the concepts of health, disease and sickness and it is sometimes a consequence of the notions mentioned above. Parallel to the term work ability work capacity and work disability are used. Work disability is defined in different ways: loss of capacity for work or loss of capacity to earn an income or an anatomical damage (20). Most definitions of work disability are based on the assumption that it is caused of a disease, impairment or injury.

In Sweden work ability is defined in the field of insurance medicine as the individual’s possibilities to work and earn one’s living (49). Work ability is recognised as depending on several factors, such as personal health status, what kind of work is offered, the individuals’ motivation and qualifications. The formal basis in the social insurance system for assessing disability pension and other forms of sickness benefits is, however, solely based on the assumption that work ability is reduced due to medically defined illness.

Work ability is assessed by the physician in a medical certificate that has to include information on diagnosis, the degree and duration of reduced functional capacity, the person’s occupation and required measures for promoting return to work. The physicians have to write in a way so laypersons can understand the content,(5) which implies that it must be possible for the SIOs to understand and interpret the certificates in order to make the right decisions. The judgement of the client in the social insurance system is then made in seven steps according to a recommendation made by the government (49). The first step is about the patient’s possibility to perform his/her usual work tasks after necessary treatment, next is if the patient has capacity to perform the usual tasks after adaptation to his/her situation. The last two steps are about if the patient after rehabilitation and/or education have abilities to do some work in the labour market or if he/she for a considerable time has reduced work ability. The last step will lead to a DP.

Some diagnoses are considered more distinct and easier to evaluate while others are more diffuse or vague. The main medical reasons for DP are diagnoses on musculoskeletal diseases, mental, and cardiovascular disorders (59). Examples of distinct diagnosis are cancer diseases; coronary diseases and fractures, while psychic disorders or pains in the locomotive organs often are
perceived as less distinct. Distinct diagnoses are considered to be easier to judge with regard to work ability than less distinct diagnoses as the physicians to a great extent base their diagnosis and assessment of functional capacity on the symptoms of the client. Clients experience and express their complaints in different ways. To be able to work may be perceived as possible for one client but not for another, even if the functional limitations are the same (39). Even if age, gender and occupational history should be put a side in the assessment, it appears impossible for the physicians not to take such aspects in to consideration when encountering the clients.

Work ability is difficult to assess. A medical disorder may reduce the individuals’ work ability in some professions, while he or she may have full or some ability to work in other professions. Stone claimed that disability is inherently subjective and that the medical science has difficulties to determine if a patient is capable to work or not (105). Ability to work is for most individuals highly desired for economical and social reasons. Guidelines on how assessment of work ability should be performed are partly missing (108), and studies on criteria for assessment of work ability are scarce. Englund et al (29) studied the sick-listing-attitudes and doctor’s practise and found no correlation between the degree of medical impairment and work ability. Many health problems lack bio-medical ground and objective findings. The doctor often neither can confirm nor deny the presence of disease (109). The question of work incapacity raises ethical issues. Doctor-related factors as well as the patient’s attitude may influence decisions about sickness-certification. Work ability was assessed by both patients and their doctors in a study by Reiso et al (86). The patients and the GPs agreed on their assessments in 81 percent of the cases but on different grounds. The physician judged the work ability as decreased based on clinical findings, while the patients judged it as decreased due to work-related factors. Sick-listed people are better than the professionals to predict the length of the sick-leave according to a study from Norway (33).

The relationship between self-assessed and clinically assessed health status and work ability was elucidated in a questionnaire study on work ability by Eskelinen et al (31). The questionnaire was compared to the clinical examinations by health care personnel. In the clinical examinations different aspects of the subjects’ work ability and functional capacity were measured, based on separate clinical methods (medical, psychological, and physiotherapist’s examination). Combined clinical information improved the correspondence between the subjective work ability ratings and the results of
the clinical examination, compared to the physicians’ judgement alone, indicating the need for a broader assessment of work ability than medical judgements only.

One shortcoming of a traditional clinical evaluation of work ability may be that it is poorly related to the work demands. In a Swedish study an analysis was performed of 102 certificates made by physicians (103). The study showed that the concept of work ability is no absolute fixed condition and hard to estimate. When determining work capacity it is often difficult to draw a line between the capacity and the individuals will to work. Some persons, who have a strong will to work might be considered less sick than people who have a weak will to work, even though the work capacity is the same. There are several possible mechanisms in the interplay between sickness absence and unemployment. The most widely known is that of Steers and Rhodes, who suggest interaction between work, individual characteristics, and the social environment (104). They argue that presence at work is a function of motivation and ability. If the individual feels sick the ability and/or motivation to work may be reduced.

Unwillingness to work has not been considered within the SI as it does not legitimate compensation from the SI (103). In this study, the decisions regarding DP were often vague and ambiguous as important information needed to determine if a person’s work ability was lacking.

Physicians’ role as gate-keepers or sick-listing agents (42,83,108) is based on a double role as they have to weigh the patients’ medical needs against the costs to the society (10). There can be an uncertainty when patients claim illness, but there are few objective findings and the degree of inability to work is difficult to assess. The physicians may have insufficient knowledge of the demands at the workplaces or may lack knowledge about the social insurance legislation. These circumstances make it more difficult to issue the necessary sickness certificates (79). The physicians’ primary concern is the patients’ return to a good functional ability in contrast to the SIOs, who wish to get the clients back to work (10,25).

If an employee in Sweden is unable to return to the ordinary job due to reduced work ability, the employer should offer her/him another suitable job or try to adjust the work tasks. If there is not a suitable job available by the employer, the work ability is judged in relation to the Swedish labour market in common, rather than to the individuals’ own job. If the individual is
assessed to have ability to take another job at the labour market he or she is not eligible for a disability pension.
Theoretical framework

Socioeconomic position and health

Socio-economic position is commonly understood as the social and economic factors influencing what position individuals and groups hold within the structure of society (63). People in socially and economically vulnerable groups run a greater risk than others of being ill or injured. Illness and mortality vary with social position, almost irrespective of disease. The range of diseases and causes of death are more common among lower classes than further up the social scale.

There is a strong inverse relation between the grade of employment (measure of socioeconomic status) and sickness absence (66). Men in the lowest grade had rates of sickness absence six times higher than those in the highest grade. For women the corresponding differences were two to five times higher.

In the Black Report from 1992 (112,118) the authors point at the inequalities in health in Britain and that the causes of the inequalities are difficult to account for. However, deprivation is considered a key concept. When looking at causes of death but also self-reported longstanding illness it is obvious that it is relevant to consider socio-economic variables. It is also stressed that there is a complexity of factors that affect inequalities in health. The differences in health are also further studied by e.g., who points at the consistent evidence in the world that people with a more severe socio-economic disadvantage suffer from more illness and have higher mortality rates than people better-off (118).

Differences in morbidity and mortality between socio-economic groups have been observed in many studies (68). Poor socio-economic status and economic hardship are associated with worse health and quality of life as well as increased mortality rates (50). Low socio-economic status, as defined by occupation, is associated with an increased prevalence of e.g. DP. Socio-economic inequalities in health are suggested by Machenbach and Kunst (67) to be ”differences in the occurrence of health problems between individuals with higher and lower SES”. SES is in the author’s opinion operationalised as level of education, occupation and/or income. Wilkinson maintains that it is the inequalities in itself that causes the differences in health among people (121). He has during his research work pointed at the income gaps in the
society as a whole and of that follows that groups of people with a low income are more vulnerable and hit by different diseases, different from groups of more well-situated people.

Despite the high level of welfare in the Nordic countries, there are differences in health in different socio-economic groups. Lundberg et al (62) found that health inequalities between different socio-economic groups have remained constant during the periods 1986-87 and 1994-95. Health inequalities among men in Norway have been studied by Krokstad in two cross-sectional health surveys (56). He found increasing health problems with decreasing socioeconomic status for four health variables: self-perceived health, temporary disability, any long-standing health problem and chronic conditions.

After reviewing studies on the relationship between socio-economic status and sickness absence, it was concluded that “there is a clear negative association between socioeconomic status and sickness absence, but no scientific evidence as regards the causal mechanism” (4).

As a consequence of the cut-downs in the Swedish welfare system the living conditions have undergone a number of changes in the 1990s. From the beginning of the 1990s, very clear socio-economic differences were evident in individual welfare resources as the economic welfare resources diminished. Unskilled workers and women had more health problems as well as lower wages and more financial problems.

Individuals, who are not established or are only partly established on the labour market like youth and/or immigrants, have a worse security than others in case of unemployment or sickness. The increasing amount of people, who are unemployed leads to an increase in the number of people who are unable to qualify for compensation and benefits that are associated with participation on the labour market (8).

The hardship perceived by people is reflected in the income gap that has been strengthened between different groups in the society (50,63,68,120). It is not only the individual’s income that means something for the health, but also the society or the community in which one lives. Unemployment among people with low education and or immigrant status is a reason for increasing income gaps. Immigrants, however, are a heterogeneous group and the welfare levels
of its members are to a great extent depending on their country of origin and duration of stay in Sweden. In Whiteheads (1997) research on equity in health and health care she defines the equity in health as “[...]everyone should have fair opportunity to attain their full health potential and more pragmatically, that none should be disadvantaged from achieving this potential if it can be avoided” (119).

People born outside Sweden have considerable difficulties to enter the labour market and they report of worse health than those born in Sweden. A number of studies have shown that immigrants in Sweden belong to the most vulnerable groups from a health perspective. (22,35,62,80).

In several studies (50,62,67,68) it is stated that people with economical compensation from the society perceive their health as less favourable and have decreased work capacity compared to the population in common. In a register study from the National Board on Health and Safety (2001) it is reported that among those who, had had a long-lasting economical compensation one fourth perceived their health as bad. One of four was both unemployed and sick. An explanation may be that they had never been qualified for sickness benefit, as they had never had an income qualifying for that. Without an income they are not entitled to benefit from the universal systems but are referred to the social welfare office and dependent upon means-tested social assistance (80).

**Street-level bureaucracy**

Those individuals, who are the representatives of the government and the authorities are described by Lipsky (61) as street-level bureaucrats (SLBs) as they interact with citizens and also have substantial discretion in managing the work tasks. Lipsky’s theory is rather general and could be applied to e.g. social workers, health care workers, school-teachers and policemen. The theory is built on similarities in the structure and working conditions.

There are two main characteristics of the SLBs: They work directly with people they are to serve, and they are mandated to support and promote the clients. A significant part of street-level bureaucracy is according to Lipsky (61) the encounter between the SLB representing the public sector and the client irrespective of their needs or problems. The essence of street-level bureaucracy
is that the SLBs make decisions about other people, as is the case when SIOs execute applications for DPs. The citizens experience governmental policy and legislation mainly through the public service worker. The ways SLBs perform their work, influence the individual’s life opportunities through delivery of benefits or sanctions. The applicants for DPs are at the most depending on the assessments and decisions made by the physicians in the health care and/or SIOs, which both are to be considered as gatekeepers in two different systems.

A Danish researcher (122) has studied Lipsky’s theory on SLBs’ coping behaviour among front-line staff in different policy and national settings. He studied two different groups, one that implemented Integration Act and another implementing agro-environmental policy in Danish municipalities. He found that there were great similarities between the two groups regardless of varying policies. The theory of SLB seems to be equivalent in different settings and useful regardless of understanding difficulties in handling the position between citizens and governmental policy and legislation. Hasenfeld (40) points at human service organisations as dealing with clients that need some assistance from the public sector to support and promote the clients.

The main characteristics of SLBs’ working conditions are that resources are almost always inadequate in relation to the tasks that should be performed Lipsky (61). The conflict between resources and the bureaucrats’ ambition to help the clients are frustrating to SLBs. The conditions of the SLBs are characterised by vague, conflicting and ambiguous goals for the agency, often combined with inadequate levels of resources. They work with high caseloads in a context of uncertainty. Brehm and Gates (16) also describe bureaucrats. Bureaucrats make choices in common, which influence daily life of all citizens. Bureaucracies and SLBs are rather unpopular as they in their roles have a combination of discretion over many facets of people’s lives e.g. in schools, health care, taxation authority, and social insurance. Critical issues, according are: Who or what controls the work, to shirk or sabotage public policy? (16). Officials’ accountability depends almost only on the preferences of individual bureaucrats. Despite the substantial literature on this topic there are no definite answers or consistent understandings about who or what influences bureaucratic choices (16). Evans and Harris (32) have investigated the literature on Lipsky’s theory on street-level bureaucracy especially on the matter social workers and their discretion. They conclude that Lipsky’s theory provides a useful set of tools which give possibilities to analyse the way SLB use their discretion.
SLBs are mainly responsible for carrying out the policy objectives developed by the government (19, 83,105). SLB’s must in many government programmes categorize citizens to determine whether or not they should receive government benefits or punishments. It is not always clear whether individuals fit into those categories (84). In their position of SLBs the public field-workers are interacting directly with the clients in implementing and delivering public policies. A reform is nothing but a paper until the policy is delivered to the citizens. The implementation process in a way hampers the achievement of policy goals as there is a gap between resources and expected implementing work. The organisational structure in bureaucracies is rather cemented and difficult for the SLB to manipulate (61). The SIOs have difficulties to connect the demands from the rules and the judgement of the work ability to comprise the individual in her/his total life-situation including a demanding labour-market.

The SLBs are in one way victims of the organizational situation and have minor opportunities to influence their work. Keiser (52) has investigated if large amounts of information under conditions of ambiguity influence decision-making due to limitations on human’s cognitive abilities. He stated that bureaucratic culture (mission and attachment to rules) and emotions are some parts in the decision making process.

According to Lipsky, responses to different conflicting situations may be to develop conscious and subconscious coping strategies such as trying to decrease demands for their services by limiting information, letting clients wait and making access difficult. Another coping strategy could be to prioritize among the clients and concentrate on selected clients, cases and solutions. They could also try to standardize their work by setting priorities among clients. In that way a few rough standard categories can be handled by using rules-of-thumb for further treatment of that category. A related coping strategy is “creaming”, implying that SLBs often choose (or skim the top) the clients who seem most likely to succeed in terms of bureaucratic success, although they might not be the most needy ones (61). According to Musil et al (71) social workers as SLBs either avoid dilemmas or justify their patterns of behaviour when interacting with clients. Meyers (69) describe the way policy reforms in the local welfare offices are implemented by SLBs to the welfare clients’ needs. The transactions were poorly transformed in accordance with new policies aiming at changing the services. The SIOs as SLBs are hitherto
scarcely studied (42,108) and the references available are mainly from the USA or Great Britain where the bureaucratic cultures may differ.

**Ethics and justice in the judgements of applicants for DP**

The SI is considered as a solidarity insurance and is meant to be both effective and fair. It is proposed to give a standard protection for the individual. It is based on the assumption that it is possible to judge applications for e.g. DP in a standardised way within the SSIA. There is a service dilemma of street-level bureaucracies how to provide individual responses or treatment on a mass basis. Lipsky (61) state that "The typical conflicts are individual client treatment versus routinization and mass processing, and response to the needs of individual clients versus efficient agency performance" (Lipsky, 1980, p.44). There seem according to the SIOs working situation as there are incompatible goals to fulfil both service to the client and the goals of the SSIA.

Some questions have been raised on the coordination between the different parts in the social insurance as Sickness Insurance and Social Services and Employment Offices. For people who do not have full work ability, but are assessed not to have reduced work capacity due to medical reasons, are sometimes circulated between the authorities. There are different opinions between the authorities that handle clients that are more or less sick and/or unemployed and what kind of assistance the client is entitled to. The employment office has small opportunities to offer some activities to those clients although the clients have some work ability. There are few vacant jobs for clients that don’t have full work capacity and at the same time don’t qualify for sickness benefits. This is obvious according to people that do not have a full work ability and are therefore circulated between the authorities. It seems as there is need for a revaluation as the society changes there is need for an adaptation to the modern working-life. What clients are entitled to and what assistance one can expect seems to be unclear.

The rules and regulations in the social insurance system are very complicated (116). The SIO’s role is to assess the right of the individual to a benefit, administer benefits, and follow up measures. In the SIO’s implementation of the rules, the handling of the cases is the main issue. To improve the decision process the central administration has given out directions on how regulations
should be implemented and how the cases should be handled. This process is mentioned as quality insurance and control of the judgements. It is of special importance to document all executed applications. In order to standardize the processes and to keep the quality high comprehensive checklists on what items should be fulfilled have replaced the legal system. However, the extent to which it is possible to consider potentially important individual variations within a highly standardized system is questionable.

The government has proposed an elucidation of the rules. Especially the concept work ability should be investigated to ensure reduced costs for the SSIA. The legal security could be at risk if the application of the rules is more focused on reducing high numbers of people on sick leave than on applying the rules in a fair and just way.

There are uncertainties regarding the interpretations of some medical conditions especially on how it affects work ability. Is it possible to judge medical conditions in an objective way? There seem to be a lack of comprehensive views of the concept disease, but in the so-called seven-step model that the SSIA refers to, a client will be able to any suitable work in the labour market. Hitherto, the interpretations of that statement are unknown.

In a review of cases handled in court it was evident that there is a dominance of different conditions of pain and differences in judgments by the SSIA and the clients (117). The courts have the judgments from the physicians as a basis for their decisions as to whether a disease exists and if the work ability is reduced. If the client is unemployed the court has to rely on an indirect judgment in the certificate on the work ability. There is according to Westerhäll (117) a lack of ability to strictly interpret what is meant by “normally occurring work tasks” in the courts and how they are correlated to the reductions in the physical work ability. There seem to be a lack of a common view of the concept work ability, the different authorities/agencies have their specific interpretation, which limits the process towards a solution for the individual.

It seems that strict interpretations of the rules within each agency have resulted in circulation of cases between the agencies. The concepts disease and work ability have been scrutinized in court (117). The client has the opportunity to appeal against the decision both from the SSIA as well as from employment offices.
General aims

The first aim of the thesis was to explore demographic and health differences between those who were granted and those, who were not granted disability pension. The second aim was to study how the process from applications to decisions on disability pensions were executed and perceived by the social insurance officers and to elucidate their working conditions during the decision process.

Specific aims:

In the first study the focus was on clients that were not granted DP and if they differed from those who were granted DPs (paper I). In this study the registers at the SI were studied. The results from the first study led to the question on how the assessed groups perceived their own health, social network and contacts with the welfare actors (paper II). Data from the first two studies showed differences according to who was granted DP and who was not. The question arose how the basis for decisions were performed due to law and regulations in the SI (paper III). In the fourth study the SIOs’ own working conditions were described (paper IV).

The thesis is multidisciplinary involving theories from social medicine, insurance medicine and sociology. It is mainly descriptive and explorative and contains both quantitative and qualitative data.
Material and Methods

This thesis comprises both quantitative and qualitative studies. An overview of the studies is given in table 2. In order to explore differences between those granted DP and those not granted DP a case-control design was chosen. To study the social insurance officers’ perspective on the process from application to decision on disability pensions in-depth interviews were carried through.

An overview of the study objects, data and methods are presented in table 2.

*Table 2. Overview of the studies of the thesis.*

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Paper I and II

Subjects and methods

The study population is all persons, who applied for a full disability pension during the period 1999-2000 in Örebro County, about 2000 individuals. The cases were all individuals, who were rejected a full disability pension during the period 1999-2000. A total of 102 eligible cases were identified and fulfilled the criteria (e.g. applied for full DP during the period 1999 and 2000), three of
which were missing in the Social Insurance office’s registers. Thus, 99 cases were included in the study.

The control group consisted of approximately every tenth applicant (n=202), who received full disability pension during the same time period. Four controls were not found in the Social Insurance office’s registers leaving 198 to be included in the study. At the follow up in study II one person had deceased among the controls.

All files of the cases and controls were searched for information on socio-economic data and other variables; year of birth, civil status, name, address, country of birth, housing-conditions, educational level, occupation, employment, medical diagnoses (number of diagnoses and first diagnoses) and geographical living area. The first medical diagnoses listed were grouped into four main categories: musculoskeletal disorders (ICD-10: M00-M99), cardio-vascular diseases (ICD-10: I00-I99), mental diseases including abuse (ICD10: F00-F99), and others. The group “others”, comprised a number of different diagnoses with few observations in each. Special attention was paid to the described decreased work ability in the acts. Information on who took the initiative to apply for the DP (the applicant or the social insurance officer) and whether the physicians’ certificate was available were also recorded. The information was recorded manually in a structured form with predetermined codes for each possible outcome. Data on occupational status was missing for 15 cases and three controls.

The cases comprised 47 women and 52 men, and the controls 108 women and 90 men. Eighteen persons, who were rejected DP (cases) had no medical certificate in their application.

In paper II cases and controls received a mailed questionnaire including questions on self-reported health, health-related quality of life (HRQoL), social networks, and use of health care (in-hospital treatment, specialised care, and primary care) during the last 12 months. The questionnaire was mailed to all individuals in the two groups approximately one to two months after the decision by the Social Insurance Board about their DP. Two reminders were sent out. The response rates were 58 percent (n=57) in the nDP group and 69 percent (n=136) in the DP group. The low response rates were partly due to the fact that some respondents had unknown addresses.
Self-rated health and HRQoL were measured with the SF-36 (106,115) and the EQ-5D (18,21). The questions on social networks are adapted from (113) and (77). The original questionnaire comprises eighteen items on social networks (77) and essentially explores the size of available social networks. In order to reduce responder burden, six of the 18 items were used in the present study.

Data (HRQoL and social network) from two large population surveys carried out in the counties of Östergötland and Kalmar (n=9489) (27) regions adjacent to the actual county, were used as reference (30).

Statistical analyses

Chi square analyses were used for analyses of differences in distributions between cases and controls in demographic variables. Univariate analyses of associations between case status and each determinant were performed in paper I. To estimate the degree of association for each determinant odds ratios (OR) and confidence intervals (CI) were calculated. Statistically significant determinants were included in a multivariate logistic regression analysis, which also included sex and civil status. Applications with missing medical certificates (n=18) were excluded in the regression analysis, as it is compulsory to have the certificate as a basis for decision. Illiterates (cases=14, controls=2) were also excluded, as their prospects of a job at the Swedish labour market were considered as non-existent. In paper II differences between the DP group and the nDP group were assessed using the Chi-square test or Fisher’s exact test and Student’s t-test. Also, multiple linear regression analysis was used to perform adjusted comparisons of self-rated health and HRQOL outcomes, controlling for gender, age, education, immigration, and first diagnoses (musculoskeletal, mental illness, cardio-vascular versus others). Associations were considered as statistically significant at the 5% level in both papers.

Paper III and IV

Subjects and methods

A qualitative descriptive study was carried through to reach knowledge about how the SIOs’ perspectives and experiences assessing the applications during the process of getting the information necessary for making a decision on DPs. Interviews were performed with ten SIOs. A thematic guide was used to direct
the interviewer to explore the SIOs experiences (96). The guide focused on the following themes: 1) the SIO’s experiences of meeting with the client, 2) the process of handling the applications for DPs, 3) the working conditions as well as 4) the SIOs’ own background. In paper III the focus was on the SIOs’ work with the decision-making process and in study IV the focus was on the SIOs’ experiences of their working conditions when assessing applications for DPs. The thematic guide, according to Sandelowski (90), enables the interviewer to direct open-ended questions, which in turn allows the respondents to freely and in their own words describe their experiences from their daily work with clients applying for DPs. In these qualitative studies we have tried to ascertain what the participants feel in depth about the facts they experience in their work (70).

The ten SIOs were chosen to get a broad variation of experiences. The interview subjects voluntarily registered for participation at staff meetings in the four geographical districts in the county. All ten were willing to be interviewed after they had received information about the study. They received a letter presenting the aims of the study and information about their voluntary participation, with a guarantee of confidentiality and utilization of the results. The interviews were carried out by the author of this thesis (BY) in early 2004 (Jan-March) mainly at the respondents’ workplaces. Each interview lasted about 1-1.5 hours and was audio taped and transcribed verbatim by a secretary experienced in transcribing interviews. Eight women and two men were included, representing different ages, experiences and geographical districts. Four individuals worked in the main municipality and six in smaller districts. Seven were older than 50 years of age and three were younger. The experience of working in the social insurance office varied between 3 years and 40 years. The participants’ different work-experiences, age and gender were expected to give variations in their statements about handling applications for DPs.

Analysis

The transcribed data were analysed by two analysers using an inductive content analysis (38,54,96). The analyses of the interview texts focused on the content of the answers, not the interaction between the interviewer and the respondent (26). This means that the starting point was in the respondents’ statements as described in the interview protocols. The texts were read and reread to get a whole picture of the data with the aim of the study in mind.
Words and sentences illustrating a meaning were noted in the margins of the protocols. In the second step they were grouped together according to the content and were given new preliminary names. When new questions appeared they were reduced in number and expanded in content to finally form the themes reported in the results. The result of the analyses was continually discussed to obtain consensus.

**Ethical considerations**

Ethical principles for scientific research in the Humanities and Social Sciences were adopted by the Swedish Council for Research in the Humanities and Social Sciences. In our studies have the requirements been that negative consequences would not occur nor for clients neither to the SIOs. Information, consent and confidentiality have been the aspects of special importance.

In the first register study the SI gave their approval to study those clients who had applied for DP during the years 1999-2000 in the county. In the second study the applicants received a letter together with the questionnaire about what the study would entail, in order to be able to give their informed consent. In study three and four the SIOs were given both oral and written information about the purpose of the study to be able to give their informed consent.

The committee for research ethics at the University of Örebro approved all studies.
Results and comments

Paper I

Diagnoses from the musculoskeletal system were most common in both groups; 37 percent among the cases and 40 percent among the controls. The second most common diagnosis was mental diseases, 22 percent and 27 percent respectively, and cardiovascular diseases, 5 percent and 10 percent respectively. Other diseases occurred among 35 percent of the cases and among 24 percent of the controls. These diagnoses comprise psychosomatic disorders or symptom-diagnoses, cancer, asthma, diabetes, skin-diseases and neurological diseases. Ten percent of the cases and seven percent of the controls had an abuse diagnose. The medical diagnoses, as described in the social insurance act, had no association with the outcome.

Among those not granted DP, 91 percent made an application for DP by themselves and in 9 percent the SI took the initiative. Among those granted DP 13 percent applied themselves and in 87 percent the SI proposed a DP.

The work ability of 29 male cases and 37 female cases were assessed by a physician not to be reduced. 18 applicants had no medical certificate and were rejected for this reason. These cases were excluded in the statistical analyses. Of the remaining clients, one male case and 14 female cases were rejected full DP as the work ability was declined for other reasons. This could be social reasons that not qualify for DP. All in the group granted DP had a medical certificate indicating reduced work ability due to medical reasons.

A total of 54 percent of female and 79 percent of male cases were born in the Nordic countries compared to 92 percent females and males among the controls. Of the illiterates were 15 cases and two controls immigrants. Among the cases 72 percent lived in the main municipality compared to 42 percent in the control group. A larger proportion of cases (78 percent) than controls (51 percent) lived in rented flats. 89 percent among cases and 38 percent among controls were unemployed at the date for application.

Unemployment (OR= 7.1, CI=3.1-16.4), living in the main municipality, (OR=2.8, CI= 1.4-5.8) and age below 50 years (OR=0.4, CI=0.2-0.8) were
observed in the multivariate logistic regression analysis to be determinants for rejection of disability pension.

There appear to be variations in praxis of rejection of applicants between social insurance boards in different geographical areas due to other reasons than medical. One possibility is demographic differences between urban and rural areas. The socio-economic situation of the applicant and the ability to communicate in Swedish may have an influence. Another major difference between the groups regards who took the initiative to apply for DP.

Established criteria for determining work ability are needed.

**Paper II**

In the questionnaire follow up the nDP group had more often multiple diagnoses, and lower self-reported health and HRQoL compared to those granted DP. In particular, their average scores were lower on the SF-36 scales: social functioning, role limitations due to physical problems and mental health. The nDP group also had significantly smaller social networks. The nDPs more frequent reported inpatient care and more often had refrained from buying medicine and making visits to health care facilities due to financial reasons.

The picture of disease according to the type of diagnose was almost the same but the nDPs suffered from more diagnoses than the DPs. Contrary to expectations, those not granted disability pension do not seem to have better health, but rather to suffer from more sickness than those who were granted disability pension. The nDPs appears to comprise disadvantaged individuals with respect to health, social and financial resources.

**Paper III**

The SIOs’ descriptions of problems with assessing the applications for DP were described with seven themes. The themes identified were: Complicated applications for DP, changing type of compensation, application by own initiative or by request, work capacity described in the certificate, delayed and incomplete certificates and changes in society and different regulations for authorities.
The descriptions showed that the SIOs’ perceived several obstacles when handling the applications for DP. The clients differed with regard to e.g. diagnoses as ADHD, and Aspergers syndrome that demanded an extended documentation in special departments with long waiting-time. The applications were incomplete and some clients had non-distinct diagnoses, which demanded clarifications and further medical assessments, which delayed the process. The clients also differed with regard to who applied for DP. Those who applied themselves demanded a lot more of completing assessments, since they often did not have certified absence due to sickness before. The client had to receive a medical certificate and an appointment with a physician by herself. They also had to pay for this by themselves, which was perceived as another obstacle for the clients.

Some clients were unemployed with a medical complex history, and multiple symptoms that were sometimes referred to the SI from employer’s office or from social services as they were considered too sick to get an employment or social assistance. How work capacity was judged was a key concept between the authorities in question. The SIOs perceived that changes in society together with a tightening-up of resources affected how they approached the clients. The SIOs role was often to inquire into which of the different authorities was responsible to support and provide for the individual in question.

Paper IV

Prerequisites and opportunities due to changing rules and regulation were mainly experienced as a burden in the SIOs’ working conditions, rather than something to rely on and feel safe about with respect to proper performance of applications. The SIOs experienced organizational cut-downs and changes in the regulations almost every year. Downsizing in the public sector has influenced working conditions for the staff in several authorities. They did not feel enough support from the management. The SIOs felt trapped in that they could not work in a proper way, since the work was time-limited and stressful as the client waited for her/his compensation. The SIOs perceived their work in some respects as piece-work due to the high tempo and the lack of possibilities to keep qualitative aspects as follow-ups, and lack of possibilities to support the clients. They always had to prioritize the clients’ economical compensation and additional needs, that the client felt had to be put aside. The
SIOs sometimes blamed other authorities as a way to cope with their own shortness.

Finally the results showed that personal competence differed between the SIOs. Most of the SIOs in Sweden have been employed in the organisation for many years. They started as office workers and their role as SIOs has developed during the last two decades to handle all complicated clients. The organisation has tried to increase the formal competence among the employees by recruiting SIOs with an academic background.

The SIOs pointed at the lack of time for reflection and development and opportunities to catch up with colleagues. The SIOs powerful position and how their discretion was used made them feel responsible to perform a good work.
Discussion

In this discussion, emphasis is laid upon methodological questions, general discussion of findings and finally conclusions.

Methodological considerations

Different methodological approaches and methods were used for collecting data and to analyse how DPs were handled. The methods used in the different studies are described in detail in the individual papers and are therefore not repeated here. As the field of being granted or not granted DP is scarcely studied data were collected both from the perspective of the applicants by quantitative data, and from the perspective of SIOs by qualitative data (Table 2, p.34). This approach is supported by (57,96) since they consider different kinds of data to strengthen the trustworthiness of the studies, especially in an unexplored field.

Validity and credibility

Paper I and II

The study population, about 2000 individuals, comprised all individuals applying for full DP in the period 1999-2000 in a county in mid-Sweden. The cases consisted of all 102 clients, who were not granted full DP during the period. Three clients were not possible to find in the registers as they were out on loan to other offices or to the court. The study hence comprised 99 cases. The controls were every tenth applicant who received full DP during the same period. There were 202 individuals defined and 198 were found in the registers and included. The four missing controls were not possible to trace. In the central Social Insurance office all documents are filed and should be possible to study.

The documents are compiled to fulfil administrative purposes of the Social Insurance legislation system and are not collected for specific research studies. Many different SIOs at different offices have filled in the acts and some data, such as the clients’ occupations, were missing in a few cases. It is worth noting
that the documents were not fully completed in all respects. Missing occupations did not affect the results of the present study, while information on education was used as an indicator of socio-economic position.

The response rate (57% among the cases and 69% among the controls) in the questionnaire-study was low, in particular among the cases, compared to Swedish survey norms. During the last years response rates have decreased, and even in population surveys, response rates around 50% have been reported. Those who did not participate among the cases had unknown address in 16 cases (five were known as homeless) and in both groups (DPs and nDPs) immigrants and abusers were comparably common. Earlier studies on non-participants have shown that non-responders are more common among men. In population surveys non-responders are most common among young men. Differences in socio-economic back-ground as well as alcohol abuse, criminality and morbidity caused by social problems were indicated by (13,78,88). Bias due to a self-selection in responding would in study II most likely be due to a lower response rate among those most vulnerable in the group. A self-selection bias would therefore rather lead to an underestimation of differences between cases and controls.

Retrospective studies may suffer from recall bias, i.e. the responses may be influenced by systematic bias of how and what people remember. In particular recall of health care utilization may be influenced by frequency of visits and severity of the disorder (43). The number of regular visits, e.g. due to a chronic disease, are more difficult to keep track of, compared to rare visits. As the questionnaire was mailed to nDPs and DPs some months after the decision from the SI, it is possible that the decision in itself may have influenced the self-rated health. The administrative process from application to decision varied from two months to about a year. In a recent study it was found that those, who were granted DP found several positive things in their situation as disability pensioners such as functional improvement, relief of pain and symptoms and that they were qualified for compensation benefits (125). It was also suggested that those who were granted DP may feel that they were taken more seriously with regard to their disorders.

It is conceivable that the information given by the respondents in the questionnaire has been influenced by the decision of the Social Insurance Board regarding the rejection or granting of DP. If so, the decisional bias is most likely to have affected psychosocial health, while it is less likely that
information on health care consumption and social networks is biased. Selection is an important factor in this study as those who received DP already were accepted as sick while the nDPs tried by themselves to be granted a benefit. This may mean that the DPs were more likely to answer the questionnaire.

**Paper III and IV**

To increase the trustworthiness in Paper III and IV the SIOs were chosen to give varied descriptions of their experiences and of circumstances in different geographical areas, as well as variation in educational background, gender and ages. Another effort made to raise the credibility was to try to make the data collection as optimal as possible e.g. to get the interviewee to feel comfortable during the interview (96).

In the analysis process of qualitative data there is always a risk that the analysis process will be influenced by the researcher’s preconceptions, as the researcher is the instrument in this process (96). An effort made to minimize the influence of preconceptions in the work of analysis was to use a co-analyser. On the other hand there is a risk of using a co-analyser, which is necessary to be aware of during the analysis process. Discussions between co-analysers may increase the consciousness on preconceptions but at the same time the efforts to reach consensus in the analysis work can contribute to that the result will be reduced to a uniform level. To avoid those pitfalls attempts were made to attain an awareness of the preconceptions during the whole research process (96). In Paper III and IV a qualitative design was used to describe how the cases were performed within the SSIA. Was it possible to study representatives from the SSIA to receive true statements from the SIOs? Neutrality should be considered as “possible” as the interviewer were involved neither in the SSIA nor in the health care.
General discussion

A central issue in this thesis is the entitlement or denial of applications for disability pension. Another issue is how the process towards the decision is performed and perceived by the social insurance officers. The SIos performing applications for DPs meet several obstacles, such as insufficient quality of the information given in the medical certificate, and differences in the conceptions of work ability. Their own role as street-level bureaucrats performing the applications for DP is an important part to elucidate towards the decision granted DP or not.

Differences between individuals granted and not granted disability pension

The primary aim of the first study was to determine if decisions for disability pension was based according to medical criteria. To be granted DP implies that the client has a disease that reduces the work ability for a considerable time. According to the results there were no significant differences in diagnoses between DPs and nDPs but slightly more of “other diagnoses” in the nDP group (124). Other diseases occurred among 35 percent of cases and among 24 percent of the controls. These diagnoses comprise psychosomatic disorders or symptom-diagnoses, such as cancer, asthma, diabetes, skin-diseases and neurological diseases. There are few studies on the subject not granted DP but in a longitudinal study from Norway persons not granted DP were followed for three years with regard to their main sources of income (9). Twenty percent were found to be occupationally active throughout the three years, 25 percent received DP within two years, while the remaining 55 percent were dependent on different kinds of public social support or social welfare. Thus, in terms of societal costs, 80 percent of those not granted DP remained dependent on other types of social support. In a study of 144 chronic pain patients, who applied for DP, a lower utilisation of health care was found among those, who received DPs compared to those, who did not (44). In addition, chronic pain patients, who did not receive a DP, or who were dissatisfied with level of the compensation, maintained their previous levels of health care utilisation after the decision.
The degree of severity of a disease is important in relation to the context of insurance medicine. In this study associations were not always evident between the degree of disease and the degree of work ability. Diagnoses are most often based on the patients’ information and can seldom be diagnosed by objective tests. The physicians have to rely on the patients’ stories about symptoms and possibilities to work. The individuals’ experience of his or her own work ability has been shown to differ from the physicians’ assessment (29,86). Work ability is in all probability influenced by the actual working conditions, which, according to Wahlström and Alexanderson, in general are unknown to the physician(114). Lindqvist (60)describes how even different physicians’ interpretations of the same disease lead to different results, which underscores the difficulties experienced by the SIOs in their assessment process. Lack of criteria may lead to differences in decisional criteria in the welfare system, when physicians and SIOs interpret the possibility for the client to be able to work or not.

Another factor influencing work ability is the perceived likelihood of being able to get a job at the Swedish labour market. People with no formal education, i.e. illiterates, which was one group rejected DPs in paper I, have in practice no possibility to enter the regular labour market in Sweden as they have to fulfil the studies in Swedish for Immigrants which is not adapted to illiterates. All of the illiterates in paper I and II are refugees or immigrants. Also after excluding illiterates in the multivariate regression analyses in study I, unemployment was associated with an increased risk of not being granted disability pension. The difference may also be due to differences in medical status and work ability that could not be revealed merely from reading the records in the SI.

One difference between the groups was that nDPs to a greater extent (91%) applied themselves for DP (paper I). Due to the rules it is possible to apply oneself even if one is not on sick leave. The applications have to be issued by a physician, and the applicant is responsible for providing the medical certificate. Of those not granted DP, almost 20 percent or 18 applicants never presented a medical certificate in the SI and they were therefore rejected DP. This fact may imply that those applicants have difficulties to get in touch with the health care. These applicants have not influenced the obtained results, since they were excluded in the statistical analyses.

A total of 66 cases had, according to the judgments by the physicians, not reduced work ability due to diseases. The remaining 15 cases had reduced
work ability due to other reasons than medical, mainly mentioned in the SI-records as “social reasons or other than medical”. As social reasons do not make the clients eligible for DP they were not granted the DP-benefit. Those clients have perceived themselves to be sick as they applied for a DP but the physician did not certify that or the SIO judged it to be not-medical reasons.

It was found in paper III that the concept work ability imply difficulties when assessing applications for DPs. The meaning of work ability has to be communicated between the authorities involved in the process of assessing application for DPs. In paper III the SIOs expressed that clients could be assessed as too healthy for sickness benefits by social insurance standards, while employment officers judged them to be unemployable due to bad health. The individual may hence fall between two stools in the assessment process and not be subject to attention from any of the authorities. Lindqvist points at the fact that it is difficult to define the limits between what health is and what is a disease (60). The individuals own conception and motivation to fulfil vital goals, such as to be able to work is part of the changeable process towards sickness and/or disability. Communication problems between different welfare authorities have also been found in other studies (11,34), which may result in a feeling of dis-empowerment among the clients.

Work ability seemed not only to be a communicative problem. In study III the SIOs experienced difficulties in assessing the applications due to shortcomings in the medical certificates. The physicians had difficulties to assess work ability based on symptoms and/or illnesses, without full knowledge about the patients’ working conditions. These difficulties were confirmed by (25,29,86,114). They found that a high level of uncertainty exists in decisions relating to medical diagnoses on whether a person has reduced work ability or not. These difficulties in the health care system are partly due to lack of knowledge about working life conditions among physicians, but also due to difficulties within both the health care and the SI systems in translating the intentions in the rules and regulations to the client level. One might ask if physicians in the regular health care should have knowledge of working conditions and requirements in various occupations, or if these assessments rather should be made by occupational health care specialists as is done in some other countries (20). To judge unemployed patients’ work ability could be even more difficult for the physician.
Socio-economic conditions

The groups DPs and nDPs (paper I) differed significantly with respect to the proportion of unemployed, born in other countries than the Nordic, and living in urban areas. These differences indicate other socio-economic circumstances among nDPs than the DPs. Khan and Krokstad indicate that decisions in the welfare system may vary due to individual, socio-economic and labour market reasons (51,56).

The two Social Insurance Boards in the main municipality were more prone to reject applications for DP compared to the three Boards in the rural parts of the county (paper I). If these differences are based on differences in work ability between the populations, or if praxis differs between different Boards, cannot be fully determined.

The differences could possibly be explained by population differences. The characteristics of the population differ in the main municipality and in the rural areas, e.g., most immigrants and unemployed live in the main municipality in the large dwellings. However, as the differences between different social boards remained significant in the multivariate regression analyses (paper I), results indicate that praxis actually differs. As the confidence intervals are relatively wide for some variables due to small groups, firm conclusions cannot be drawn. The differences may depend on the fact that those granted DP already were assessed to have diminished work ability as most of them had been sick-listed. The nDPs on the other hand were to great extent unemployed and therefore not qualified for sick leave benefits from the social insurance as they had no income. This is also confirmed in a Norwegian study, where 55 percent of those not granted DP were still after three years dependent on social support or social welfare(9). Further research is necessary to elucidate this important question.

Many of those, who were unemployed (paper I and II) were in need of economic support from the social welfare to provide their daily life. This result could be seen in the light of the fact that there is an obvious association between increasing numbers of persons with DP and decreasing socio-economic status and lower education (56). One reason for the client to apply for DPs could be that it would provide a safer economic situation and social legitimacy compared to assistance from the social welfare. The results in paper I indicate that it is difficult to qualify for DP when the clients have not been
working for a long time and have not been on sick leave. The social insurance system is meant to compensate for reduced or no income due to medically certified disease. For those individuals, who do not fulfill the criteria on income, or on medical disorders, the social insurance is not available as a means of support. A number of applicants are in a “grey-zone” between different welfare systems and it appears that these people are at risk for less qualified handling.

As the number of unemployed in Sweden has increased during the last decade there are an increasing number of people, who are not qualified for contributions and benefits from the social insurance system. The demands on other parts of the welfare system increase and at the same time there are requirements that the welfare costs must be reduced (82). There seem to be a risk that the individual will fall between the different systems. Some individuals seem to be circulated between the different authorities with a lack of coordination.

Knowledge of the Swedish language seem to be another crucial factor when applying for DP, since many of those not granted DP were immigrants or illiterate (paper I). If the individual was an immigrant, who had not completed the training course in “Swedish for Immigrants” it is not possible to apply for unemployment benefits according to the rules. The difference between the groups may also be due to communicative abilities between applicants and SIOs. Types of diagnoses, and social position, may influence the communication between the individual and the SIOs in various ways. In a recent study (125) respondents who were granted a DP perceived their contact with the SIO as more supportive and more empowering than respondents who were not granted a DP and had returned to work. Östlund et al (125) suggest that several positive things may accompany a DP, including functional improvement, relief of pain and symptoms, meeting people in similar situations, and qualifying for compensation benefits.

Even if interpretive assistance is used the communication between immigrants and SIOs may cause obstacles. The cultural differences between the SIO and the applicant could result in discriminating judgments (41,64). In study I it was found that there were differences between cases and controls in particular with regard to employment status and immigrant status when applying for DP. This findings could be interpreted as socio-economic background factors that may have influenced the decision making process.
Perceived health and social networks

Study II aimed to increase knowledge about self-reported health and quality of life (HRQoL) among people, who applied for but were rejected DP. In this study, self-reported health, HRQoL, social networks and health care consumption were compared among those, who were and those who were not granted a DP. The nDP group had, after adjustment for demographics and diagnosis, lower self-reported health overall in terms of the EQ-5D VAS and, more specifically, lower psychosocial health as captured by the SF-36 scales social functioning, role limitations due to physical problems, and mental health. As self-rated health was not measured before the decision on DP was given, it is not possible to draw causal conclusions on whether the nDP group had worse health due to the decision or due to other circumstances. As harsh socio-economic conditions are associated with worse health (35,64,69) the situation of several cases in the nDP group may have contributed to the average differences between the groups.

It is reported in a study from Denmark of 144 pain patients, who applied for DP a lower utilisation of health care among those, who were granted DP compared to those, who were not. This is confirmed in study II where the nDPs had a higher utilisation of health care, which may imply that the clients are not satisfied with their situation and still are in need of treatment and assistance from the health care (44).

Another significant difference is the reported smaller social networks among the nDPs. The importance of social networks for physical and mental health and mortality, both as being directly preventive, and as acting as a buffer against bad health are shown in a number of studies (17,45,92). An explanation could possibly be a general susceptibility to illness in people who are exposed to stress, and lack resources for coping with stress in an adequate way. A striking result in the present study is the apparent lack of social resources in the nDP group. Social networks indicate the existence and structure of relationships with other people (77). Small social networks, few leisure-time-activities, worse self-image and economic hardship were also shown by Edén (23,24) to be associated with lower HRQoL among disability pensioners as compared to the general population. Uncertainty about financial support in one’s everyday life situation has also been shown to be associated with worse health and a greater need for societal support (9,121).
The decision-making process; prerequisites and hindrances

The SIOs as SLBs are hitherto scarcely studied (42,55,108) and the references available on other SLBs are mainly from the USA or Great Britain, where the bureaucratic cultures may differ from Swedish conditions. Similar bureaucratic organisations seem, however, to be at hand even if there are discrepancies between policemen, schools, health care and social welfare in the different countries (61). The situations as SLB seem to be similar. These professions all handle clients in need of support from the society, it is important to study their working situation. As great deal of the working population is in those fields hence it is necessary to enlighten the situation of how to handle clients, who need support in one way or another.

The SIOs role when managing clients is elucidated in study III. Management of clients applying for DPs was perceived by SIOs as efforts towards accomplishing policy goals. Individual decision-making should be understood in the framework of the organisational context (111). The SIOs had to implement the public policy when interacting with the clients. Seen from a street-level bureaucrat’s perspective (61) this means that SIOs in their meetings with the clients interpreted the principal intentions of the regulations and transferred the rules to an individual level. The regulations presume that it is possible to carry out the rules in the same way for every client, which, however, appears questionable, or even not desirable in practice. One may also point at the clients’ situation as non-voluntary. Welfare recipients in a sense “volunteer” to apply for a benefit but they hardly volunteer if there are no alternatives.

Handling the clients

It was found in study III that those, who have been on long-term sick leave are the ordinary clients. An obstacle to the SIOs were the new rules implying that long-term sick leave with a duration of more than one year should be changed to a DP, which has increased the number of clients. This burden for the SIOs makes them feel stressed. An obvious hindrance is the waiting time for the medical certificates that were needed to assess the client’s work capacity. One reason for delays to occur relating to incomplete assessments could be that the SIOs did not communicate clearly enough with the physicians. This situation
illustrated the encounter between different bureaucrats (62). Such encounters are difficult as the social insurance and the health care service have different bases for valuation. In health care the patient’s health is the core issue, with less consideration of the individual’s life situation in general, while the social insurance system focuses on the economic and public service perspectives to be applied to the client’s individual needs. The differing perspectives contribute to communication difficulties. A critical point is whether it is possible for street-level bureaucrats from different authorities to interpret the rules and regulations in the same way (61). To judge whether or not a person is unable to work is a difficult process, as SIOs have to use their personal discretion in relation to the regulation. This implies that the rules are not the governing, as it should be.

It seems to be a need for a developed support to increase the SIOs possibilities to interpret the rules according to the intentions. The implementation process in a way hampers the achievement of policy goals as there is a gap between resources and expected implementing work. The organisational structure in bureaucracies is rather cemented and difficult for the SLB to manipulate (61). SIOs have difficulties to connect the demands from the rules and the judgement of the work ability to comprise the individual in her total life-situation including a demanding labour market. The SIOs have to show consideration to the individual client’s needs and at the same time obey laws and regulation. The SIOs’ decision latitude expressed as how the work is performed is important in perspective of their work situation (47,123).

Lack and deficiency in medical certificates cause the clients problem to receive economic compensation in time, as well as hindrance in the judgment process of applications. SIOs often have to remind the health care on issuing the medical certificates. This is frustrating as the physicians are not easy to get in touch with and even if they are asked to call back it happens rather seldom. This problem was confirmed by Palacios (79). Lipsky (61) states that SLBs often try to standardise their work by setting priorities among clients and develop few rough standard categories as rules-of-thumb for handling problems in that category, which would help SIOs to cope with their difficulties. This strategy is also in line with the check-lists proposed by the system (117). SIOs have difficulties to standardize their work in the way described to be common among SLBs since the clients differ considerably with
regard to background and problems associated to their work ability. Their position is squeezed between the regulations and the client and cannot be simplified by systematisation.

**Social Insurance Officers**

In study IV was found that the SIOs have considerable decision latitude but also feel responsible to handle this in a correct way. They felt “caught between a rock and a hard place” as they have to respond both to the clients and the current regulation. The interplay within the organisation and between SIOs and the clients were perceived as barriers. The SIOs were concerned about the many changes in the rules and regulations (42,82) that influence their daily work and caused more stress. These circumstances lead to that SIOs felt that they had small opportunities to feel updated and secure with the ambiguous goals. They ask; Is it possible to judge the clients according to laws and regulations in a fair way? This is also a main issue for street-level bureaucrats’ characteristics (61). SIOs were lacking concrete guidance and time for reflections together with others in the organisation (28,94). They expressed a need of increased knowledge on how the insurance system should be applied and improved for various clients in order to reduce the frustration in the decision-making process and to minimise the lack of equivalence in the decisions.

Söderberg (108) found in her review study of SIOs as gatekeepers that they sometimes used their decision latitude to prioritise clients who were easier to deal with, e.g. men or non-immigrants, even though this was against the rules. Findings in this study and in Hensing (42) point to the fact that a common basis for the assessment of work capacity was an important as well as complex task in the SIOs’ day-to-day work. This “gate-keeping task” in encounters between SIOs and clients has not been studied to any great degree. Gard (36) and Klanghed (55) studied similar encounters when rehabilitation professionals worked with people in the rehabilitation process.

Reconcilement of differences between various street-level bureaucracies appears to be a core issue in improving welfare processes, as also discussed by Friesen (34) and Baril (11). They describe in their studies how delays of all types, including ineffective communication among stakeholders, influenced return to work. Friesen (34) indicated how e.g. the insurer system and health
service system functioned partly parallel on one level, while the individual function in-between on another level. The results show that there was a lack of regular communication among all the stakeholders and the clients. Most of the employees at the SI are women with long employments and experience-based training. During the last years SIOs with an academic education have been recruited, often they have training in social and psychological management of clients (paper IV). The mixture of different educational cultures has caused expanded need for reflections and supervision, which not have been managed. There is an obvious need for support and guidance so the SIOs will be provided to meet the expanding demands and the encounters with the clients.

Comparisons can be done to other groups of service-providers as e.g. social workers at the Social Services that also have undergone considerable changes in their working role with demands on academic exam. The comparison can be done according to increasing demands on scientifically based knowledge in the field of social assistance and the support from the professionality. Both SSIA and the Social Services have large responsibilities both to the authority and the clients. In study IV the lack of communication between the authorities became apparent. These shortcomings may lead to that the clients’ rights to activities and follow-ups during the DP may be more difficult. There are obviously many clients who are caught in a “grey zone” and nobody feels responsible for their need of support. People that have comprehensive problems and are in need of coordinated measures from many authorities to get entrance to the labour market still suffer from lack of this coordination (85).

Clients were often transferred between authorities with divergent goals, which was experienced by SIOs as very frustrating (paper IV). They met with the clients and at the same time had to take into consideration rules and regulations that restrained their activities or forced them to refer clients to other authorities. The clients perceived frustration due to lack of coordinated actions. Hensing describe the pressure of the SIOs regarding long-lasting cases as a “mission impossible” as some of the clients were not covered by insurance rules (42). Some SIOs raised the question of whether DP was a failure that reflected incompetence among actors or indicated an impossible labour market for individuals with diffuse or unclear health problems.
The SLBs are in one way victims of the organizational situation and have minor opportunities to influence their work. Keiser (52) pointed out that large amount of information under conditions of ambiguity influence decision-making due to limitations on human’s cognitive abilities. He stated that bureaucratic culture (mission and attachment to rules) and emotions are some parts in the decision making process. In study IV was found that the SIOs perceived “to be in-between” in their work with the applications for DPs in the work with other authorities as well as in client management and in the social insurance system. Consequences of the perceived obstacles influenced the SIOs in terms of frustration, stressful work, strain and kept the clients waiting for delayed decisions.
Conclusions

This thesis and its four studies comprise two perspectives; the clients applying for disability pension (papers I and II), and decision process and working conditions for the social insurance officers in relation to the rules and regulation. (papers III and IV).

There were differences between those granted and those not granted DP according to the way they applied for DP. Those who were granted DP was proposed by the SI to change one benefit (sickness compensation) to another (disability pension) while those not granted DP to a great extent applied themselves. The applicants may have been recommended to turn to the SI instead of receiving social allowance or judged to be unable to fit in the regular labour market by the employment office. The nDPs differed regarding demographic factors in that the greater part were unemployed and one third of the clients, were born outside the Nordic countries. Contrary to expectations, those not granted DP do not seem to have better health, but rather to suffer from more sickness than those who were granted DP. The key issue is the concept work ability that is judged from different perspectives of social insurance, employment office and social services. The group not granted disability pension appears in many ways to be a disadvantaged group in need for a co-ordination between different parts of the social welfare system.

Problems described by the SIOs were the many different clients that cannot be considered as uniform, the ineffective and time-consuming delays in communicating with the health care and waiting for the medical certificates and, finally, the differing stakeholder perspectives on the issue of work ability. The role as co-ordinating actor with other counterparts in the welfare system was perceived as frustrating as they had other goals and demands.

SIOs have to consider the ambiguous rules on the one hand, while being supportive to the clients on the other. Recurrent changes in rules and regulations caused SIOs constant anxiety over how to handle those changes in encounters with the clients. The SIOs felt that, due to the large number of clients, they were inadequate in being able to offer the clients the activities they were entitled to and were unable to pay sufficient attention to every client. The SIOs’ powerful position and how their discretion was used made them feel responsible for performing their work well.
There was a need for time for reflection, teamwork and better management to develop the manner of dealing with DPs. The results of this study suggest some important factors to be implemented in work organisation. Among these factors are increased support and feedback from management, and elaborated training and guidance for SIOs in how to implement regulations into practice.
Svensk sammanfattning


Även om regler och riktlinjer finns för hur bedömningen ska genomföras så är det en subjektiv bedömning både i sjukvården såväl som i Försäkringskassan som ligger till grund för beslut om personen är berättigad till förtidspension (AE/SE) och i vilken grad. Det formella beslutet fattas av socialförsäkringsnämnden. Kriterier och bedömningar är i liten utsträckning studerat.

Syfte: Det övergripande syftet med avhandlingen var att undersöka demografiska och hälsomässiga skillnader mellan dem som beviljats förtidspension och dem som fick avslag på sin ansökan. Ett andra syfte var att studera hur processen från ansökan till beslut utfördes och belysa hur handläggarna upplevde sina arbetsförhållanden i arbetet med förtidspensioner.
Material och metod: Studie I var en registerbaserad fall-kontroll studie med personer som ansökt om full för tidspension i ett län i Mellansverige under tidsperioden 1999-2000. Fallen var alla individer som fått avslag på ansökan, 99 personer. Som kontroller valdes var tionde person som beviljats full för tidspension under samma period, 198 personer. De flesta av fallen ansökte om för tidspension själva medan de som beviljats för tidspension hade fått för tidspension i utbyte mot en långvarig sjukskrivning. Data om de studerade personerna inhämtades från Försäkringskassans register. Demografiska data och uppgifter om diagnoser studerades i både studie I och II. Ett frågeformulär som innefattade självrapporterad hälsa, socialt nätverk och nyttjande av sjukvård skickades till fall och kontroller och kompletterade andra data i studie II.

I studierna III och IV genomfördes intervjuer med tio handläggare med olika erfarenheter och geografisk tillhörighet för att få så god spridning som möjligt. Åtta av tio var kvinnor. Intervjuerna belyste frågor om handläggarnas erfarenheter om processen av för tidspension från ansökan till beslut såväl som handläggarnas egen arbetssituation. De transkriberade intervjuerna analyserades med induktiv innehållsanalys.

Resultat: Arbetslöshet, boende i huvudkommunen och att vara under 50 år var determinanter för att få avslag på ansökan om för tidspension. Medicinsk status som beskrevs i Försäkringskassans register hade mindre samband med utfallet. Det fanns skillnader i praxis emellan de geografiska områdena beroende på andra orsaker än rent medicinska. Socio-ekonomiska förhållanden kan ha haft betydelse vid bedömning av rätten till för tidspension.

De som fått avslag på ansökan hade ofta flera diagnoser, lägre självskattad hälsa och ett mindre socialt nätverk än de som beviljades full för tidspension. Läkarnas möjlighet att bedöma olika personers arbetsförmåga upplevdes som begränsad särskilt då klienten inte hade ett arbete att relatera arbetsförmågan till.


**Konklusioner:** Personen hade en ökad signifikant risk att inte bli beviljade förtidspension om de var under 50 år, arbetslösa och boende i huvudkommunen. Inga skillnader i diagnoser fanns. Resultaten tyder på andra orsaker än rent medicinska. Tvärt emot förväntningar, hade de som fått avslag på ansökan en upplevd sämre hälsa och mer sjuklighet än de som fått förtidspension. Långvarig arbetslöshet med inkomstbortfall gör att många personer inte är kvalificerade för ersättning från Försäkringskassan samtidigt som de inte heller anses ha tillräcklig arbetsförmåga för att stå till arbetsmarknadens förfogande. Dessa personer hamnar då i ett långvarigt beroende av ersättning från socialtjänsten. Det förefaller som de som inte beviljats förtidspension är en marginaliserad grupp med behov av en bättre samordning mellan parterna i välfärdssystemet. De olika perspektiven mellan myndigheterna upplevdes som klara hinder i kommunikationen eftersom de hade olika mål och krav. Personer med sammansatta problem har stora behov av samordnade insatser från olika myndigheter för att ha en möjlighet till inträde på arbetsmarknaden.
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