In Cooperation We Trust

Interorganizational Cooperation in Return-to-Work and Labour Market Reintegration

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thought I could organize freedom
how Scandinavian of me
you sussed it out, didn't you?

Björk Guðmundsdóttir

Contents

Abstract

The overarching aim of this thesis is to study Coordination Associations (CAs) as a structure for interorganizational cooperation in rehabilitation, return-to-work and labour market reintegration. This has been done through empirical studies of two CAs in eastern Sweden.

Central questions for the thesis are:

- How have representatives on different hierarchical levels in the participating organizations experienced cooperation within the structure of CAs?
- What influence do different organizational and/or professional preferences have on interorganizational cooperation?

The four studies in this thesis have had different approaches to studying interorganizational cooperation.

Study I was concerned with a specific work form, namely interdisciplinary rehabilitation teams, where the analysis concerned how the different professionals in these teams perceived the common work, and how they interpreted the concept of work ability, which is a central concept for determining eligibility for sickness benefits.

Study II focused on managers and board members of the CAs in order to determine their motives for and commitment to interorganizational cooperation. The analysis was concerned with the organizational identification and the self-interest of each actor, where the issue of trust between representatives from different organizations was specifically targeted in the analysis.

Study III aimed to elucidate the perspectives of officials in different organizations connected to the CAs regarding both the development of cooperation in the CAs, and how the recent changes in sickness insurance regulations will influence future cooperation.

Study IV focused on different perspectives regarding the concept of work ability among representatives from all participating organizations, since changes in sickness insurance regulations have changed the assessment process and therefore also the demands for interorganizational cooperation.

The general methodological approach to the studies in this thesis has been explorative; qualitative methods have been used, involving interviews, focus groups and problem-based group discussions. Interviews and focus groups have had an open-ended structure, and the material has been analysed through qualitative content analysis.

The aim of the Coordination Associations studied in this thesis has been to bridge the gaps between the participating organizations by promoting consensus through common work forms. However, the results from the studies show that such ambitions are troublesome in highly specialized public organizations. Cooperation in the CAs has to a large extent been organized as collaborative work forms rather than as coordination of existing practices. The collaboration has been based on an idea of consensus, where all organizations were expected to participate on equal terms and find common work forms. Although it has been shown that officials from different organizations can work together, the managerial level's priorities are more determined by their organizational goals and values, which makes them unwilling to finance collaborative work on a longer term.

Another theme of the thesis is the lack of cooperation between the public rehabilitation system and the employers. The public actors lack knowledge of working conditions, and since the work principle guides the rehabilitation process, it is necessary to incorporate employers into the cooperation to facilitate sustainable return-to-work and labour market reintegration.

A central conclusion of the thesis is that consensus is not a reasonable starting point when designing cooperation structures between public organizations. A sustainable cooperation structure needs to incorporate and coordinate the different actors' priorities into a long-term cooperation strategy, rather than base the cooperation on vulnerable collaboration projects.

List of papers

I.   Christian Ståhl, Tommy Svensson, Gunilla Petersson, Kerstin Ekberg (2009): "The Work Ability Divide: Holistic and Reductionistic Approaches in Swedish Interdisciplinary Rehabilitation Teams", *Journal of Occupational Rehabilitation*, 19 (3), 264-273.

II.   Christian Ståhl, Tommy Svensson, Gunilla Petersson, Kerstin Ekberg (2010): "A Matter of Trust: A Study of Coordination of Swedish Stakeholders in Return-to-Work", *Journal of Occupational Rehabilitation*, in press.

III.   Christian Ståhl, Tommy Svensson, Gunilla Petersson, Kerstin Ekberg: "Discretion, governance and cooperative learning: Swedish rehabilitation professionals' experiences of financial cooperation" (submitted).

IV.   Christian Ståhl, Tommy Svensson, Gunilla Petersson, Kerstin Ekberg: "Swedish Rehabilitation Professionals' Perspectives on Work Ability Assessments in a Changing Sickness Insurance System" (submitted).

Abbreviations

CA: Coordination Association

CEO: Chief Executive Officer

EU: European Union

FINSAM: The Financial Coordination of Rehabilitation Measures Act

ICF: International Classification of Functioning, Disability and Health

OECD: Organisation for Economic Co-Operation and Development

OMC: Open Method of Coordination

SSIA: Swedish Social Insurance Agency

SPES: Swedish Public Employment Service

WHO: World Health Organization

Preface

Writing a thesis takes a while. I am aware that I have done so faster than I originally planned and that some people seem to think that my fingers (as opposed to my thoughts?) are moving too fast. Anyhow, the journey towards this book – because it *is* a book in the end, isn't it? – began long before I even started to work on it.

When writing the thesis for my master's in sociology in 2003, I had a very committed supervisor. He introduced me to the idea of becoming a PhD student, which up to then I had not even considered – I barely knew what it was. Later, he read the first draft of this text and gave valuable comments on how to improve it. John Boman, you set me up on this path, and here I stand. The book is done. Thank you!

Between 2004 and 2006, while working on various smaller projects at the Sociology Department, I struggled constantly to make the idea of becoming a PhD student come true. John Boman, Helena Klöfver, Tommy Svensson and Gunilla Petersson supported me throughout this time, for which I am grateful. I will not forget that. However, money for research does not simply fall from the sky; and I realized that writing grant applications to national research councils with only a master's degree is an act of hubris. I never became a PhD student at the Sociology Department.

Instead, I stumbled into the hands of my supervisor-to-be, Professor Kerstin Ekberg. She needed somebody to work on a new project, and somehow my name was mentioned. A few days later, in the lift up to the top floor of a building I had never set foot in before, I took a last look in the mirror and noticed that I had accidentally put on my T-shirt inside out. After a second of panic I took it off and turned it the right way round, after which I entered for the first time the National Centre for Work and Rehabilitation. I met

Kerstin, we talked, and I accepted the offer. Bringing with me Tommy Svensson and Gunilla Petersson from the Sociology Department as co-supervisors, the team was all set. I would like to direct a huge thank you to the three of you for supporting me during these years. Kerstin, for never giving up your belief in me; Tommy, for your down-to-earth approach to research; Gunilla, for constantly keeping me on my toes with your intriguing questions.

At the National Centre for Work and Rehabilitation, many people have come and gone during the time I have been there. The original group (for me, that is) made me feel welcome and made me think that my sociological background could actually add something. Here, for the first time, I realized that I *had* a sociological background. I would like to mention the names of Maria Antonsson, Hanna Arnesson, Josefin Barajas, Elinor Edvardsson-Stiwne, Maria Gustavsson, Mats Liljegren and Åsa Tjulin. Thank you! Since then, some of these people have left for different reasons, and others have come to take their place. Dörte Bernhard, Gun Johansson, Nadine Karlsson, Ann-Christine Larsson, Ulrika Müssener, Emma Nilsing, Karin Nordström, Ann-Mari Pykett, Ida Seing, Johanna Wibault – you all have a special place in my heart.

Six months or so after I started working on my project, a graduate school was started at the newly formed Helix VINN Excellence Centre, in which the National Centre for Work and Rehabilitation is a partner. I was enrolled on the courses and became part of a group of researchers and PhD students from a variety of backgrounds, including sociologists, economists and engineers, to name a few. Although I have not been as physically present in the Helix corridor as I might have wished, the group has been very helpful to me in broadening my understanding of my research questions. I feel that I am part of something when I talk to these people, and I would have been a much less open-minded researcher without them. Hanna Antonsson, Maria Bennich, Dzamila Bienkowska, Andreas Bolling, Erica Byström, Jörgen Eklund, Per-Erik Ellström, Mattias Elg, Annika Engström, Anna-Carin Fagerlind, Linda Forssén, Anders Hallqvist, Leif Jonsson, Magnus Klofsten, Henrik Kock, Erik Lundmark, Daniel Lundqvist, Jostein Pettersen, Cathrine Reineholm, Elisabeth Sundin, Lennart Svensson, Olga Yttermyr. Thank you!

Several people have helped me undertake my studies, either hands-on or by providing valuable comments. Here I would like to mention Anne-Marie Eeg-Olofsson, Linda Schultz, Madeleine Öberg, Peter Johansson, Grace Hagberg, Lars-Christer Hydén,

Johanna Nählinder, Owe Grape, Elisabeth Sundin and Hilary Hocking. Special thanks are also due to all the participants in the studies who have generally been very interested and willing to share their experience and thoughts with me.

In 2008, I had the great opportunity of travelling to Graz, Austria to attend a workshop for young researchers, arranged by the European Institute for Social Security. At the workshop, I met PhD students from all over Europe (with a certain bias towards law students) for an intense week of seminars. Here, I gained many insights on the complexity of studying social security, and in particular in comparing systems. Especially memorable were the lectures by Danny Pieters, Jos Berghman and Koen Vleminckx. Thank you! (Another memorable event from this week was an animated discussion between two of the students who will remain anonymous here. The discussion, between a leftist sociologist and a neo-liberal economist, concerned the organization of society from the most fundamental ideological standpoints, and was by far more interesting than the football game that was in progress on the big screen of the pub.)

In 2008, I also had the privilege to be accepted into an international transdisciplinary educational programme, the Work Disability Prevention CIHR Strategic Training Programme at Université de Sherbrooke in Canada (later at the University of Toronto). This three-year programme has been beneficial beyond description, offering not only valuable courses but also the opportunity to meet, discuss and connect with researchers from different disciplines from all over the world who share a common interest in rehabilitation and return-to-work. This network has been an extraordinary resource for me in my development towards becoming a researcher. The network is too large to include all the names here, but I would like to mention those with whom I have worked more closely. First of all, Åsa Tjulin from my work corridor back home has accompanied me back and forth to Canada for two years; to a large extent, we have made our pedagogical journey together. Dörte Bernhard, who became a colleague of mine through the programme. Katherine Lippel and Ellen MacEachen, my mentors for my optional courses; you have helped me more than you can imagine. And, of course, Patrick Loisel for starting and running the programme and constantly being committed to it. Thank you!

The last part of a thesis preface is most often directed towards the family. Mine is no exception. My children have probably not understood much of what I am doing, since my work is rather hard to explain to a six- and a four-year old. Anyway, Alvali and Vincent,

when you are old enough to read and understand this preface, thank you for existing and for keeping me down to earth. And thank you, Sofia, for helping me bring them up. To my parents, Annica and Carl-Gustaf, thank you for always believing in me and supporting me in whatever I do.

I also count as part of my family my eternally best friend, Mr. Thomas Sleedoorn. Thank you for always keeping my sanity at arm's length! And thank you to the rest of Noutheim: Emil Kling for the heavy drum beating and Eddie Andersson for the synthesizer textures. For years to come!

To Kim Ekerstad and Johanna Lundberg, my coffee mates. we would not want to underestimate the power of coffee, would we?

Words are not everything. Anna-Carin, I love being silent with you.

<p style="text-align:center">* * *</p>

Before turning to the actual work (where I am no longer allowed to speak this personally), I would like to direct a couple of quotes to certain people. First, I would like to dedicate the following quote by Deborah Stone to Katherine Lippel and Ellen MacEachen.

> Living abroad turns out to be an excellent way of getting oneself hopelessly lost, and there's nothing like being lost to make one see the exotic monsters in ordinary forests (Stone 1984, p. xi).

I did not have to live abroad to get lost; it was enough to spend time with you, having to answer your tricky questions, in order for me to get a better understanding of the Swedish social security system and how it relates to other systems. I am forever grateful.

While writing this thesis, in order to clear my head I have spent several nights watching Twin Peaks, in which the Log Lady has offered many words of wisdom. As an introduction to episode seventeen, the Log Lady says:

> Complications set in. Yes, complications. How many times have we heard: "It's simple"? Nothing is simple. We live in a world where nothing is simple. Each day, just when we think we have a handle on things, suddenly some new element is introduced and everything is

complicated once again. What is the secret? What is the secret to simplicity, to the pure and simple life? Are our appetites, our desires undermining us? Is the cart in front of the horse?

This quote pretty much describes the pitfalls of writing and doing research – from time to time you find yourself sitting in front of the horse. That is when you need your supervisors, so I dedicate the quote to Kerstin Ekberg, Tommy Svensson and Gunilla Petersson.

Of course, the Log Lady also has an answer – although I am still wondering how to interpret it.

Balance is the key. Balance is the key to many things. Do we understand balance? The word "balance" has seven letters. Seven is difficult to balance, but not impossible if we are able to divide. There are, of course, the pros and cons of division.

Fortunately, the Swedish word for balance – balans – only has six letters. Unfortunately, although I may think in Swedish, I am writing in English.

Here and there, from time to time; mostly at the end of a very long winter,

Christian Ståhl

Introduction

California in the 1930s. Many were unemployed, many were poor. To manage this situation, two public organizations were to administrate benefits: one organization for the employable and one for the unemployable. When this administrative categorization of people met reality, it soon found that there were many borderline cases; for instance those that *maybe* could work, or those who could but that nobody would hire. Thus, the two organizations kept passing these cases between them since they were not clearly in line with the purpose of either of the organizations. And the people in need did not see any resolution to their problems.

This example from history (as told in Simon 1997) illustrates that failure to cooperate is not a new phenomenon. It also shows that it is a persistent problem, since the situation Simon describes is still common. In an interview study with social security administration CEOs in fifteen European countries, Schoukens and Pieters (2006) conclude that nearly all of the CEOs express complaints on the isolation of social security schemes: in many countries it appears that different benefit schemes exist parallel to each other without much interaction. Consequently, a desire for a coordinated and holistic view of the social protection systems is expressed.

These two examples illustrate different aspects of the need for cooperation. On the one hand there is a need to have well-functioning collaboration between officials in different welfare organizations, and on the other hand there is a need to coordinate the systems.

Furthermore, several studies on return-to-work and disability prevention conclude that there is a need for a multi-stakeholder approach for return-to-work to be purposeful (Brunarski et al 2008; Franche et al 2005; Lindqvist & Grape 1999; Loisel et al 2001).

However, there are numerous problems in implementing conclusions from return-to-work research, since cooperation is complicated by the different interests, values and languages of different actors in the disability management process (Loisel et al 2005a).

Thus, making cooperation work is a challenge, especially if it is a question of interorganizational cooperation in an environment where different legal systems influence practice.

Creating structures for cooperation

In Sweden, there has been growing political discontent with the sectorized responsibility for rehabilitation, since it involves a risk that disadvantaged people will suffer from the conflicting priorities of welfare institutions. A set of pilot programmes was initiated in local areas in the 1990s, resulting in several arenas for cooperation between the public authorities. For instance, specific cooperative work routines have been initiated between the Social Insurance Agency and the Public Employment Service to manage people who are both sick and unemployed.

In 2004, permanent legislation in the form of the Financial Coordination of Rehabilitation Measures Act (FINSAM) came into effect. This represents the most structured form of interorganizational cooperation yet enacted. In the legislation, it is stated that financial coordination may be carried out through the forming of Coordination Associations (CAs), with municipalities, healthcare services, the Social Insurance Agency and the Public Employment Service as participating authorities. According to FINSAM, CAs are to operate on a local municipal level with measures targeted to people in need of coordinated rehabilitation from more than one of the participating organizations, for instance long-term sick, disabled or unemployed people. The CAs are intended to facilitate return-to-work for individuals and promote a more cost-effective use of available resources.

FINSAM also regulates the organizational form of the CAs, where the associations are formed as separate organizations with pooled budgets of a maximum of 5% of the budgeted cost for sickness benefits in the working district. Every CA involves a local political board and an office with a coordinator. By public law, a CA is considered a legal body

which implies that the state authorities, the municipalities and the county councils share the legal responsibility for decisions regarding a specific target group. By April 2008, 65 CAs had been formed, involving 120 of Sweden's 290 municipalities.
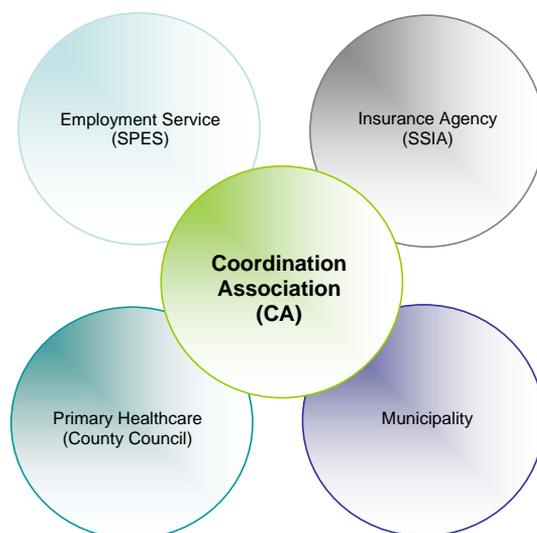
Figure 1: CAs relationship to the participating organizations.

The boards of the CAs consist of representatives from the four organizations, including officials from the two public authorities (the Social Insurance Agency and the Public Employment Service) and political representatives from the municipality and the county council. The boards decide what course of action the CA should take, and administrate the pooled budget. An operative group of managers from the participating organizations has the dual purpose of preparing tasks for the board and putting the board's decisions into practice. Thus, a CA can be considered a separate organization, built by representatives and financial contributions from the four participating organizations (see Figure 1).

CA activities include both broadly oriented work forms, such as interdisciplinary teams in dealing with sick-listings, and more targeted work forms, such as integration of immigrants or interorganizational teams to manage labour market reintegration for the long-term unemployed. Thus, the CAs comprise preventive and promotive activities as

well as occupational and socio-medical activities, aiming for activation and early return-to-work as well as labour market reintegration for the long-term sick or the unemployed (Prins 2006).

Aim of the thesis

The overarching aim of this thesis is to study Coordination Associations (CAs) as a structure for interorganizational cooperation in rehabilitation, return-to-work and labour market reintegration. This has been done through empirical studies of two CAs in eastern Sweden.

Central questions for the thesis are:

- How have representatives on different hierarchical levels in the participating organizations experienced cooperation within the structure of CAs?
- What influence do different organizational and/or professional preferences have on interorganizational cooperation?

The CAs will also be analysed in relation to policy development in disability and labour market issues, where a welfare theoretical perspective forms the starting point.

The thesis is composed of four different studies, presented in four articles. Each of these articles has had its own aim and research questions, which has approached the overall aim in different ways.

The first study focused on one of the specific cooperative work forms within the CAs' interdisciplinary rehabilitation teams. The aim of the study was to explore how the interdisciplinary work form has been experienced by the different professions in the teams, and focuses on how the interpretations of a central concept – work ability – differs between healthcare professionals and social insurance officials, and what these different interpretations imply for the work they have in common.

The second study focused on the managerial level of the CAs. The aim of the study was to explore how managers and board members in the two CAs perceived the purpose and experience of their participation in cooperative work.

The third study was concerned with how officials from all the participating organizations had experienced the development of interorganizational cooperation four years after the start of the CAs, and how (or whether) cooperation has been implemented.

The fourth study is based on the same material as Study III. It focused on the concept of work ability, which is a central concept in Swedish sickness insurance, and how a recent reform of the insurance regulations affects work ability assessments, with a specific focus on interorganizational cooperation.

Central concepts underlying the thesis

In this thesis, many empirical and theoretical concepts are used, some of which require definition. The central theoretical concepts (field, habitus, social system) will be discussed in Chapter 3, while this section will specify some of the concepts used in research and how they will be used in this thesis.

Coordination, cooperation, collaboration

The reader may already be confused by the use of the concepts of coordination and cooperation. This far, they have been used without any clear distinction between them, although they are actually different concepts with different meanings. To add to the confusion, the concept of collaboration may sometimes be seen in similar contexts.

The title of this thesis is In *Cooperation* We Trust, while the organizational structures that are studied are called *Coordination* Associations. Why is that?

Let us begin by defining the concepts.

Coordination, according to Kärrholm, "is a structural term referring to the elaboration of systems which promote different organizations' goals for the best, i.e. organizing e.g. finance, administrative management and functional support to increase efficiency" (Kärrholm 2007, p. 6).

Cooperation, on the other hand, is defined as "when two or more organizations systematically design their decision-making or work processes towards a mutual goal. Cooperation may include collaboration as well as co-ordination" (Kärrholm 2007, p. 6).

Collaboration, finally, is defined as "when people communicate within or between organizations with the aim of achieving common goals" (Kärrholm 2007, p. 6).

These definitions are useful in so much as they distinguish between the levels on which actions are performed. Coordination, it may be understood, concerns actions on a strategic and managerial level, not implying any specific interactions in practice. Collaboration on the other hand has more practical implications: it means that people actually work together. Cooperation, according to the above definition, could mean both these things, and is therefore understood as a broader term than the others.

When looking at the definitions and comparing them with the aim for the CAs, the definition of coordination is, not surprisingly, to a large extent in line with this aim. However, when studying what CAs actually *do*, one soon finds that it may involve a variety of things, and often may have more to do with collaboration than coordination – interdisciplinary team work, for instance. One also soon realizes that the terms are often used interchangeably, implying that the difference between them may sometimes be unclear in practice.

Thus, from now on in this thesis, *cooperation* will be used as a generic term that may incorporate coordination as well as collaboration. When the more specific meanings of coordination or collaboration are intended, these terms will be used.

Concepts in research on rehabilitation

In the research field of rehabilitation and disability prevention there are a number of central concepts, many of which are used in this thesis.

First, the very concept of *rehabilitation* may be defined differently depending on perspective and discipline. In this thesis it is used as a generic term for a process in which an individual, through assistance from professionals (from healthcare services, workplaces, authorities or other), is to regain lost abilities and be reintroduced into some sort of social context (e.g. work). The concept is thus used in its broadest sense, implying that the narrower meanings of medical or vocational rehabilitation will be specified when they are discussed.

The concept of *disability prevention* is also used broadly in the thesis, involving measures directed towards individuals (e.g. rehabilitation or health promotive activities) as well as structural measures (e.g. the organization of work in healthcare, cooperation between professionals to prevent prolonged disability for individuals).

The *return-to-work* concept is used to indicate the process in which an individual returns to his or her workplace after sickness or disability, and this process may involve rehabilitation and activities from professionals from different disciplines and organizations.

Labour market reintegration is understood as the process where an individual is not able to return to his or her work, and instead will look for a new job. The labour market reintegration process bears similarities to the return-to-work process, since they both deal with the rehabilitation of sick or disabled people to working life; however, the process will involve other actors (e.g. employment services). Labour market reintegration may further be contrasted with *labour market integration*, which is directed towards individuals without previous experience of work (e.g. young people or in some cases immigrants). Labour market integration will not be discussed in any detail in this thesis; the focus is on the processes of rehabilitation, return-to-work and labour market reintegration, and how different actors cooperate in these processes.

Outline of the thesis

After this introduction, the first chapter will proceed with a description of different kinds of welfare systems and how they have developed over time with regard to policies for managing unemployment and rehabilitation. At the end of the chapter, the Swedish sys-

tem will be placed in this context, with a focus on the development of sickness insurance over the last few decades. In Chapter 2, research on rehabilitation, return-to-work, disability management and interorganizational cooperation is presented, which will be used as a reference point for discussions in later chapters. Chapter 3 introduces theoretical perspectives that have been used to interpret the findings from the studies. The theories used in the articles are described here and put into a broader theoretical context, using primarily Pierre Bourdieu's ideas on social structures. The fourth chapter begins with a section on the philosophical starting point for the thesis, and continues with the methodological perspective and the empirical methods for the studies. Chapter 5 presents the main findings from the four studies. These findings are finally discussed in Chapter 6, regarding recurrent themes and similarities between them, rather than discussing the studies separately. The thesis ends with a Swedish summary of the main findings and conclusions.

1. A story of welfare

In order to understand the context in which the studies in this thesis have been developed, it is necessary to begin at the system level. Since countries differ with regard to political and ideological origins as well as their historical development, their systems for social insurance will also differ in fundamental ways. A reasonable starting point for any study of social insurance is, thus, to identify the characteristics of the specific system in relation to others.

This starting point is of course an entire research field of its own, where a variety of different academic disciplines are represented (sociology, political science and economy, to mention a few). Research on welfare systems is such a broad field that trying to describe it in full is not reasonable. Hence, this chapter focuses on describing a few leading scholars' contributions to the field, and relating them to recent political developments in the work disability and rehabilitation field.

The welfare state: origins and two typologies

Parallel to the industrialization of the 19th century and the growth of industrial capitalism, welfare states developed in most Western countries. Explanations for this development differ with regard to political perspectives, ranging from the socialist emphasis on the welfare state as a counterweight to the market to the more liberal view of the welfare state as a

service for employers, providing them with an army of healthy and skilled workers (Bauman 2004; Esping-Andersen 1990).

The concept of *de-commodification* has been central to the understanding of how welfare states function. Whatever the political perspective on the aims of the welfare state, the de-commodifying effect is one of its prominent expressions. Commodification began with the development of capitalism, where labour became a commodity. De-commodification means, in short, that people are no longer dependent on selling their labour in order to survive. With the welfare state as a guarantee for maintenance, the individual becomes less dependent on the market. Thus, de-commodification strengthens the worker in relation to the employer (Esping-Andersen 1990). De-commodification is further dependent on the individual having certain *rights*, meaning that the welfare state is based around the concept of *citizenship*. According to Marshall (1950), citizenship consists of three aspects: civil, political and social, of which the social aspect constitutes the right to income security and welfare. Such rights are de-commodifying as long as they are grounded in citizenship rather than performance. However, for de-commodification to occur, welfare services need to be at such a level that they in some respect emancipate the worker from the labour market (Esping-Andersen 1990).

Apart from de-commodification, another central concept in welfare research is *redistribution*, which is a measure of the different welfare states' abilities to fight inequalities regarding economic resources. The concepts are interrelated: a high amount of redistribution supposedly implies a higher de-commodifying effect.

Esping-Andersen (1990) has suggested a much cited typology of welfare regimes, dividing the range of welfare models into three categories.

- In *liberal* welfare regimes, the market is a strong force, and the de-commodification of the welfare services is generally low, since benefits are modest and means-tested. Examples of this model can be found in the United States, Canada and Australia.
- *Corporative* welfare regimes, such as Germany, France, Italy and Austria, are based around a post-industrial class structure, preserving conservative values. In these states social rights are connected to the social position of the individual rather than

citizenship as such; for example, non-working wives are often excluded from social insurance.

- *Social democratic* welfare regimes are grounded in principles of universalism where welfare services are based on citizenship, covering the entire population. This implies higher benefits in order to gain support from the middle class, as well as less means-testing. Easy access and high benefits give the social democratic welfare regime a more prominent de-commodifying effect than the others. Examples of this model are found in the Scandinavian countries.

As a contrast, Korpi and Palme (1998) have suggested a more detailed typology, including five different types of social insurance models.

- The *targeted model* is based on minimal benefits after means-testing. Today, the model is prevalent in Australia and to some extent in New Zealand.
- The *voluntary state-subsidized model* is based around voluntary funds, which implies membership in order to achieve benefits. Today this is partly in use in Switzerland, but otherwise it is extinct.
- The *state corporatist model* is also based on membership, which is compulsory for the working population, with benefits closely linked to one's earnings and employment. The system is governed partly by the employers. This model is prevalent in continental European countries such as Germany, France, Italy and Austria.
- The *basic security model* includes the entire population with flat rate benefits on low levels. Examples of this model can be found in the United States, Canada, the United Kingdom and Denmark.
- The *encompassing model* combines universal low benefits with higher benefits for those with previous incomes. "By providing earnings-related benefits and non-means-tested benefits, the encompassing model generates incentives to work and also avoids poverty traps" (Korpi & Palme 1998, p. 682). This model is prevalent in Sweden, Norway and Finland.

The main difference between the two typologies is the indicators used. While Esping-Andersen uses a broad set of indicators concerned with the relation between state, market and families, Korpi's and Palme's typology is based on the institutional structures for handling old-age pensions and sickness cash benefits. In Korpi's and Palme's typology, the targeted and the voluntary state-subsidized model are relatively peripheral; if these were to be combined with the basic security model, it could be argued that the typology would roughly fit with Esping-Andersen's. However, some countries have been categorized differently in the two typologies; Denmark, for example, is by Esping-Andersen considered a social democratic regime, while Korpi and Palme place it in the basic security model.

Henceforth, Korpi's and Palme's typology will be preferred in this thesis, since it is based on indicators that are relevant to the subjects studied, i.e. sickness insurance and disability management.

Prior to the Second World War, the basic security model was a common form for providing social welfare. However, the fact that it was common does not imply that it was free from ideology or conflict. Korpi notes that

> …the basic security model, with its low benefit level, became the centerpiece of a 'social liberal' political strategy focused on limiting political interventions in markets. This institutional model has had the indirect effect of gradually driving a wedge between the interests of white-collar and blue-collar employees via the development of private forms of insurance among better-off citizens. During the period after the Second World War, the basic security model therefore became a focus for conflicts in many countries, and in three of them was superseded by the encompassing model (Korpi 2001, p. 268).

Thus, Korpi looks upon the encompassing model as an ideologically driven development of the basic security model, in order to make it withstand criticism from the middle class as well as managing to decrease class conflicts.

Studies show that the encompassing model has had the most redistributive (and de-commodifying) effect (Korpi & Palme 1998), and also that a high degree of de-commodification has positive effects on the labour market (Huo et al 2008).

Developing social security: insurance and moral hazard

One of the central elements of the welfare state has been to develop social security systems as safety nets for people who for one reason or another are not able to provide for themselves through work. Apart from the often means-tested social allowances for the poor that exist in most countries, the most common forms of income replacement are organized as insurance systems, such as sickness insurance, work injury insurance or unemployment insurance. This implies that the concept of insurance is a fundamental part of the welfare state.

A basic conception of insurance is that it spreads individual risks over a collective. In comprehensive social insurance systems, this conception relies on the recognition of citizenship, that every individual is a part of society, and that society thus has a shared responsibility for each of its citizens (cf. Marshall 1950). In practice this implies that an individual who falls ill does not have to rely on individual premiums to be covered by insurance; instead, the risks and the premiums are spread across all citizens through taxes. Through this notion of citizenship, social insurance differs in a fundamental way from many other forms of insurance – for instance property insurance, which is based on individual premiums, managed primarily by private insurance companies.

In a conceptualization of insurance, based on Ewald (1991), Baker and Simon identify four different aspects: (1) institutions, (2) forms, (3) techniques and (4) visions (Baker & Simon 2002). An insurance institution may be a social security scheme as well as a private company, while the form may be life insurance, car insurance or whatever sort of insurance is available on the market. Insurance techniques are the practical methods of determining eligibility, such as mortality tables, inspections, reviews or disability schedules.

The vision of an insurance system includes the idea behind it, for instance the idea that it should be based on individual premiums and that it will offer indemnity to those who have paid the premiums if the damage is covered by the insurance. This vision, Baker and Simon note, is so commonly accepted that it is usually not even recognized as a vision. Since social security differs from this basic insurance vision, this has caused many to question whether social security should be categorized as insurance at all (Baker & Simon 2002). In arguing for social insurance reforms, politicians popularly refer to the changes as refinements of the system to its basic function, namely insurance. When arguing for this,

it is generally the vision of traditional private insurance that is intended, and there is no acknowledgement that the term insurance may encompass other principles.

A common criticism of insurance systems (particularly social insurance) concerns the element of moral hazard. Based on the moral hazard literature, Stone (2002) defines the concept as referring to a psychological state in which insurance "is believed to encourage an insured person to behave in a way that creates a greater likelihood of loss and, eventually, of the person's making an insurance claim" (Stone 2002, p. 70). This may involve reckless driving as well as misusing sickness insurance. Stone wishes to counter this common notion of moral hazard with the idea of moral possibility, where insurance in general alters societal ideas about responsibility and obligation. Insurance, Stone argues, has helped to develop the idea of collective risk-sharing through a public discussion about the boundaries between individual and social responsibilities. Furthermore, insurance teaches citizens that they have a responsibility and an obligation to help others, and that this comes with the right to receive aid when suffering losses. Insurance is also a force in developing standards, technologies and services that is beneficial for society as a whole (e.g. healthcare, which to a large extent is financed through insurance).

Nevertheless, referring to moral hazard is a popular way of arguing for cutbacks in insurance systems (for a recent example from the OECD, see Prinz & Tompson 2009). McCluskey (2002) gives an overview of the development of workers' compensation in the USA, where the main argument for limiting the possibility of receiving compensation was the risk of misuse, i.e. moral hazard. McCluskey shows how the cutbacks have resulted in a shift, where the problem of moral hazard has increasingly been transferred to employers and insurers, since incentives for improving workplace safety and for returning workers have decreased. However, in the debate this development is generally described as virtuous, since it enhances productivity. Thus, security for workers is perceived (especially in a North American context) as an unaffordable and hazardous luxury, while security for employers is perceived as necessary and beneficial for healthy economic growth.

Development of the welfare state

The Western welfare states generally increased their scope and number of services until the mid-1970s, after which they started to regress; the same development can be observed regarding citizens' social rights (Korpi 2003). Korpi (2003) concludes that the degree of retrenchment has been higher in countries with conservative majorities than in social democratic regimes, indicating that institutional form and political coalitions matter (Korpi 2003). The level of unemployment is a key factor influencing policy changes, but the political majority and the institutional structure of a state will determine the level of regress.

Generally, support for the welfare state is higher across socioeconomic class structures in universal systems than in targeted systems (Svallfors 2004), where those who are better off cover their risks through private insurances; thus, cutbacks may be introduced without much political debate (Korpi 2003). The political development in Sweden serves as a good example of the unpopularity of cutbacks: the centre-right government of 1991-1994 made several cuts in the social insurance system and were replaced with a social democratic government. When this government continued to make cuts in the systems, due to high unemployment rates, public support for the governing party decreased rapidly.

Promoting policy convergence

As Habermas notes, nation states have become increasingly "disempowered" over the last few decades, due to the process of globalization in the economic system (Habermas 2001). Strongly emphasizing the importance of social policy as a guarantee for securing civilized society from collapse, Habermas argues that the nation state is no longer the ideal construction for handling such issues when labour markets, economic flows and political cultures span across territorial borders, and since economic and social policies are closely interrelated (Habermas 2001). Consequently, postnational constellations such as the EU have begun to develop towards becoming governing actors also in previously national issues, such as social security. Ultimately, we "will only be able to meet the challenges of

globalization in a reasonable manner if the postnational constellation can successfully develop new forms for the democratic self-steering of society" (Habermas 2001, p. 88).

However, it is not likely that national governments can implement policies into their national systems without adapting them to local circumstances. After all, different countries have different welfare states based on different guiding principles (Esping-Andersen 1990; Hall & Soskice 2001; Korpi & Palme 1998). Furthermore, history matters: welfare states show a high degree of path dependency (Korpi 2001), implying that governments cannot shift labour market policy at the flick of a switch. A system that has survived for decades tends to be quite resistant to change, and changes that occur will to a large extent happen within or in concurrence with the existing system rather than contradicting and overturning it. For instance, Korpi (2001) notes that the basic security systems in North America have led to the development of private insurance solutions that will make a future transition into a publicly run insurance system unlikely. The transition of the Nordic countries into an encompassing model took place before private programmes had emerged. This made the transition possible, and also counteracted the development of private insurance, since all workers were already covered by the public insurance system.

According to Korpi (2003), the EU has had limited influence on social insurance policies, and only indirectly through recommendations from the European Commission. However, it is possible to observe a largely convergent policy development on disability and sickness insurance in most European countries over recent decades, where there has been a shift of focus from passive compensation to active labour market reintegration (Prinz & Tompson 2009). International organizations such as the EU or the OECD may thus influence policies in so far as governments will adopt certain ideas into their existing institutional structures.

Since a joint European labour market legislation has not been considered realistic, other ways of promoting policy development have come into play. One such initiative is the Open Method of Coordination (OMC), a peer review system of the European Commission, where "good practices" are identified throughout the EU (Begg & Berghman 2002; Hemerijck 2002). These practices are reviewed by a number of representatives from other countries regarding their relevance for and transferability to other countries. The OMC system may be understood as a benchmarking system aiming to promote the Euro-

pean Employment Strategy and other policies, by auditing rather than by imposing regulations (cf. Power 1997; Habermas 2001).

An example of this soft governance is the promotion of the idea of *flexicurity*. Over the last few years, the question of how to combine flexibility on the labour market with social security has been central in their labour market reports, and the concept of flexicurity was introduced to manage such a combination (*Employment in Europe 2006*). This debate has resulted in policy changes from job security to employment security, meaning that labour market policies should focus on making their citizens employable rather than having strict job security policies (cf. the Anglo-Saxon focus on workfare, Dostal 2008).

Bekker and Wilthagen (2008) identify four main pathways to flexicurity. The first involves balancing standard and non-standard work contracts in order to secure labour protection for all workers. The second focuses on securing transitions between jobs through systems of lifelong learning and vocational training in order to enhance skills and employability. The third pathway is also focused on education, where investments are to be made in individual skills to mobilize low-skilled workers. The fourth pathway, finally, is concerned with transitions to work for people outside the labour market, through active labour market programmes. An important factor in achieving a proper return-to-work process, according to the authors, is to condition the benefits and to support cooperation between the labour market and social security institutions.

A key element in combining flexibility and security is, thus, to concentrate on the concepts of work ability and employability, as is being done in many social security systems, including the Swedish one. By strengthening a person's work ability and employability, he or she is thought to stand a better chance in the competition on the labour market. According to Jacobsson (2004), this implies a change in the social security system from unemployment insurance to employability insurance. The former focuses on supportive structures for economic compensation (passive), while the latter focuses on the individual's personal development (active). The task of the state in the latter is not to provide for its citizens, but to contribute to their ability to provide for themselves. This results in a more individualized social insurance system, where personal abilities are in focus.

In a study of who flexibility is good for, Karlsson (2007) concludes that flexibility in most empirical investigations proves to be positive for employers, while having negative consequences for workers (cf. Sennett 1998). In the flexicurity debate, flexibility is gener-

ally understood as employer flexibility (Jonsson 2007). The security part of the concept is not concerned with offering workers a similar amount of flexibility, but with avoiding too much instability for workers when employers are allowed to dismiss more easily. Stability in this context means employment security rather than job security, through investments in active labour market policies and educational systems. Income stability is also emphasized through generous unemployment benefits.

Regarding the change from a passive to an active welfare state, Esping-Andersen (2002) notes that the new emphasis on activation in the European debate stems from the Third Way politics of the UK, which in many ways is inspired by the welfare model in the Scandinavian countries, and its focus on employment. What is easily forgotten while considering an activation policy, according to Esping-Andersen, is that one cannot replace a basic welfare service (such as income guarantee) with a social investment model (such as strengthening abilities and lifelong learning). It seems to Esping-Andersen that the Third Way failed to take in the whole picture of the Scandinavian model. Also, he claims that the Scandinavian welfare model is better fitted than other models to meet the new challenges on the labour market and changes in family structures, since it is simultaneously oriented towards employment (through the work principle), individualism (through putting emphasis on women's work) and basic security (through universalism). Egalitarianism, says Esping-Andersen, is the most rational choice for a welfare model where risks are universal, and where uncertainty on the labour market is a concern for most citizens (Esping-Andersen 2002).

The Swedish case: flexicurity in practice?

The Swedish welfare system carries several of the flexicurity characteristics from the outset. Sweden has a history of active labour market policies, where a work principle is prevalent both in the unemployment benefit schemes and in the sickness insurance system. The Scandinavian countries are the highest spenders on active labour market policies, and Sweden is the highest spender among the Scandinavian countries (OECD 2003). Simultaneously, Sweden has a history of investing in lifelong learning, which supposedly con-

tributes to making citizens employable. The modern social security system proposed in the flexicurity debate is expressed as needing to provide income support while facilitating labour market mobility, as well as providing systems that help people to combine work with family life (Auer 2007). In this respect, the generous Swedish parental leave system, as well as the emphasis on childcare, is in line with the flexicurity paradigm. On the other hand, Sweden has rather strong labour legislation, which makes dismissal of workers, at least in theory, a relatively complicated process.

Thus, the Swedish welfare system comprises at least three of the four components of flexicurity. It serves as an illustration that Auer (2007) discusses the Nordic countries as "best practice" regarding flexicurity, although only Denmark has had an explicit flexicurity policy. It may also be of importance to note that flexibility in the Swedish system is directed at employees rather than at employers, since individual security is emphasized. Furthermore, elements from at least three of the four pathways to flexicurity suggested by Bekker and Wilthagen (2008) can be recognized in the Swedish system, where the fourth pathway is particularly emphasized through active welfare policies.

The similarities between Swedish active welfare policies and EU policies may, on the other hand, prove to be superficial. As Esping-Andersen notes, the Third Way politics of the UK, constituting a similar activation strategy to the EU policies, have derived much inspiration from the Nordic welfare models; however, the need for conventional income maintenance guarantees tends to be ignored, in the belief that the activation strategy can be a substitute for these basic welfare functions (Esping-Andersen 2002). Similarly, the flexicurity policies of the EU have focused more on the need for loosening employment protection to enhance flexibility than on strengthening labour market security. Esping-Andersen (2002) concludes that minimizing poverty and income insecurity is a precondition for a social investment strategy, and that preventive measures in early life are needed to ensure that citizens possess the necessary abilities and motivation for participation in social and economic life.

In this respect, the Swedish welfare state has a tradition of investing in preventive measures. Also, Swedish welfare institutions have far-reaching responsibilities for their citizens' welfare through an emphasis on income security for the socially disadvantaged. This has a decommodifying effect, where dependency on the market for survival is considerably decreased (Esping-Andersen 1990). At first glance, decommodification and poli-

cies for full employment seem to be in conflict, since decommodification generally implies exit from the labour market with little loss of income. However, decommodification policies and employment-friendly policies most commonly go hand in hand (Huo et al 2008). Thus, the neo-liberal notion that a generous social policy only creates disincentives for work is not accurate; rather, generous social policies and active employment policies may complement each other (cf. Esping-Andersen 2000, chapter 7; Huo et al 2008).

Promoting disability policy development

Simultaneously with the development of employment and social security policy, a similar development has occurred in the field of disability policy. The focus on activation and labour market reintegration in employment policies is mirrored by an equally strong focus on activation in policies on disability management and return-to-work. Sickness absence is a common and costly problem for most Western countries, and promoting return-to-work and labour market reintegration is an increasingly popular way of approaching it. In a report from the OECD (2003), a set of policy conclusions are drawn:

- the importance of recognizing the difference between disability and work disability;
- the necessity of introducing obligations for the disabled, such as engaging in vocational rehabilitation and other activation measures;
- the need for involving employers in the rehabilitation process;
- promotion of early interventions;
- development of flexible benefits that follow the work capacity of the individual;
- an individual and active approach to interventions.

These policy recommendations are in line with a general shift towards activation policies throughout the whole spectrum of welfare and social security, and as will be discussed, these ideas have had a clear influence on the recent reforms in Swedish sickness insurance.

The Swedish social insurance system

According to the typology of Korpi and Palme (1998), Sweden is categorized as an encompassing welfare system. This implies that everybody who lives or works in Sweden is covered by social insurance, and that benefits from most income replacement systems (sickness and unemployment insurance for instance) are based on the individual's previous earnings. It is thus a universal system that provides basic income support as well as earnings-based benefits for those who are unable to work for a period of time. The universal scope of the Swedish system can be contrasted with North American systems, where eligibility for certain compensation systems (such as work injury insurance) is restricted to certain occupations and certain situations (cf. Lippel 1999; McCluskey 2002).

The Swedish social security system is based on the work principle. This principle states that everyone as far as possible shall provide for themselves through work. The interpretation of this principle has differed over time and across political parties, the two main perspectives being a disciplinary and controlling perspective or a rights perspective. The former would imply that any job is preferred over unemployment, while the latter would emphasize education and competence development in order to find a suitable job (Grape 2001; Junestav 2004). Depending on the perspective, the work principle will thus have different policy implications.

The work principle is prevalent in unemployment insurance as well as in sickness insurance, which means that unemployed people are required to apply for jobs in order to receive benefits, and sick-listed people are to be assessed with regard to their work ability rather than their disease.

The most common forms of income replacement or compensation are outlined in Table 1. The Social Insurance Agency is responsible for determining eligibility and paying out most of the benefits, such as sickness benefits, disability pensions and work injury compensation. The Social Insurance Agency is also responsible for paying out retirement pensions, as well as child and housing allowances.

Table 1: Public compensation systems in Sweden.

Compensation system	Administrating authority
Sickness benefits (80% of wages, time limit of one year)	Social Insurance Agency
Disability pension (64% of wages, no time limit)	Social Insurance Agency
Work injury compensation (annuity and/or 80% wage replacement, no time limit)	Social Insurance Agency
Unemployment benefits (80/70% of wages, for 300/450 days depending on situation)	Unemployment funds, Public Employment Service
Social allowances (means-tested, no time limit)	Municipalities

Eligibility for sickness benefits is based on whether the person's work ability is affected by his or her current medical condition. Thus, healthcare physicians have a gatekeeping role in assessing the medical status and functional ability of the individual. In order to be eligible for disability pension, one needs to be assessed as work-disabled for life.

Since the sickness insurance system is relatively generous and does not differentiate between work-related and non-work-related conditions, work injury compensation is generally not used as a compensation system for medical conditions. Instead, work injury compensation primarily functions as an additional insurance for those cases where a work injury has resulted in loss of earnings, and the system will compensate this loss through an annuity. However, the individual will need to prove that the condition is work-related in order to be eligible for compensation.

The limited use of the Swedish work injury compensation system may be contrasted with North American workers' compensation systems. Since there is no broad sickness insurance in North America, workers' compensation is the only compensation system for many who are work-disabled, which implies that it is more widely used. In these systems, the issue of whether a condition is work-related or not becomes more important than in a comprehensive system such as the Swedish one (cf. Lippel 1999).

Eligibility for unemployment insurance is based on individual contributions to unemployment funds, implying that a person needs to have worked for a certain period of time to be eligible for benefits. The Public Employment Service functions as a gatekeeper, by checking that the person receiving benefits is actively looking for a job. Unemployment benefits may be paid out for 300 days unless the person has children, in which case the period can be prolonged to 450 days.

Social allowances are means-tested and administrated by municipal social welfare offices. The amount paid is low, estimated at the minimum level of maintenance.

Since sickness insurance is of a specific interest for the studies in this thesis, the description of the Swedish system will proceed by focusing on how sickness insurance has developed over the last few decades, and how this relates to other systems for income replacement.

Swedish sickness insurance: work in progress?

After the 1990s, there was an intense debate on Swedish sickness insurance, due to figures that indicated a rapid increase in the number of people receiving sickness benefit. However, as Larsson et al (2005) have shown, this increase was the result of longer periods of sick leave rather than an increasing number of cases. What seems like a paradox is that this increase took place a few years after the work principle was introduced into sickness insurance, meaning that the Social Insurance Agency was to primarily rehabilitate people back to work instead of using disability pensions as an exit from the labour market. It has been shown that these developments, both the increased duration of sick leave and the failure of work-oriented rehabilitation, are to a considerable extent due to the increasing demands on work ability by employers on an increasingly competitive labour market, which makes work-oriented rehabilitation difficult (Hetzler 2003; Larsson et al 2005). The officials at the Social Insurance Agency seem to have preferred to grant people disability pensions than to rehabilitate them to unemployment (Hetzler 2003).

Nevertheless, the work principle is still supposed to guide rehabilitation, and the focus on return-to-work and labour market reintegration has increased rather than decreased

during the last decade. As Johnson (2010) has shown, there was a shift in the media discourse about sickness insurance after 2002, from a focus on working conditions to a focus on moral hazard, over-utilization and system failure. This shift has resulted in policy changes towards centralization, standardization and stricter eligibility criteria (Johnson 2010).

After the 2006 election, the new conservative government introduced a time schedule for work ability assessments, called the "Rehabilitation Chain". Prior to these changes, sickness benefits could be paid out for an unlimited time. Furthermore, work ability assessments were not scheduled in time, although they were to be broadened to a wider set of work tasks if a person was assessed as unable to return to his or her previous occupation. Simultaneously with the introduction of the time limits, a system of temporary disability pension for people with more long-term diseases was abolished in order to make the sickness insurance system more oriented towards rehabilitation and return-to-work.

Thus, eligibility for sickness benefits in Sweden is based on decreased work ability due to sickness. If they are eligible, those on sick leave will receive 80% of their previous earnings for up to one year. The sick-listing process can be described in the following steps:

- The worker reports sick to the employer, who provides sick pay for the first two weeks.
- After one week, a medical certificate concerning the person's functional ability is required; this is generally issued by physicians in primary healthcare.
- After two weeks, the Social Insurance Agency will assess the person's work ability to determine whether he or she is eligible for sickness benefits, on the basis of the medical certificate.
- The Social Insurance Agency's assessment of work ability is made in three steps. During the first 90 days, work ability is assessed in relation to the present work task. After 90 days, work ability is assessed in relation to other available work tasks with the same employer, and after 180 days, work ability will be assessed in relation to any job on the national labour market, without taking into account factors such as education or whether jobs are actually available.

- At the six-month point, the Public Employment Service can assist the individual with vocational guidance, and the individual is also allowed to take time off from their current employment to try to find another job.
- After one year, sickness benefits will no longer be granted except for cases of severe illness.
- If a person's work ability is assessed as decreased for life, disability pension may be granted.

By and large, the reform of the sickness insurance regulations is in line with an activation strategy in disability policies, in that it focuses on work ability rather than disease (OECD 2009; Prinz & Tompson 2009). On the other hand, introducing a time frame for sickness insurance does not imply that rehabilitation will improve and return-to-work increase. What it does imply is that the demands for providing timely interventions increase. Whether this leads to an actual improvement in work disability prevention is ultimately an empirical question which remains to be answered. Since the changes were introduced recently the consequences of the reform are yet to be seen, and have thus not been the focus of the studies in this thesis.

Actors in the return-to-work process

The Swedish sickness insurance system is organized and managed through an institutional system in which a variety of actors are involved in different ways. As outlined above, the Social Insurance Agency is a central authority that administrates benefits and decides upon eligibility. Other important actors are: the healthcare services, where the medical assessments are made; the Public Employment Service, who have received an increasingly important role since the time limits were introduced in delivering vocational guidance and rehabilitation; and the municipalities, which are responsible for social rehabilitation as well as being a last resort for financial support (through social allowances) for those who are unable to return to any type of work.

However, it is notable that the employers are not a central actor in the system. After their first two weeks of financial responsibility for the person on sick leave, their responsi-

bility is limited to investigating whether the person can be assigned alternative work tasks. Up to 2007, employers were required to submit a rehabilitation plan for each sick-listed individual. However, employers generally failed to do so and no sanctions were used to force them, which led to the abolishment of this obligation. Furthermore, contacts between the Social Insurance Agency and employers in rehabilitation issues are generally scarce (Riksrevisionen 2007). After the introduction of new time limits in 2008, the focus has largely been shifted from return-to-work to labour market reintegration, which further decreases employers' incentives for involvement. Furthermore, the importance of well-functioning cooperation between the public actors has increased, since the new time limits presuppose that there are no gaps or waiting times between the healthcare services, the Social Insurance Agency and the Public Employment Service.

As outlined in Table 1 above, there are several public systems for financial support to people who are unable to work. In the process of return-to-work or labour market reintegration after a period of work disability, several of these may come into question in different phases of the process. Thus, there are several actors other than the Social Insurance Agency that may be involved in this process, the most common of which are presented in Table 2.

Table 2: Actors and their responsibilities in rehabilitation and return-to-work in Sweden.

Actor	Responsibility
Employers	Pays sick pay during first 2 weeks of sick leave, responsible for workplace rehabilitation and work accommodation
Social Insurance Agency	Pays sickness benefits for up to 1 year, assesses work ability, coordinates the RTW process
Public Employment Service	Vocational rehabilitation after 6 months of sick leave, gatekeeper to unemployment benefits
Healthcare services	Assesses functional ability, gatekeeper to sickness benefits, medical rehabilitation
Municipalities	Social rehabilitation, social allowances

One of the consequences of the fact that many actors are involved in the rehabilitation and return-to-work field is that there are many perspectives on the basic concepts, such as work ability. Since the field involves professionals from different backgrounds, it is reasonable to assume that there will be situations where perspectives clash and where different professional fields will compete for precedence for their specific definitions (cf. Bourdieu 1990).

2. Rehabilitation, return-to-work and work disability prevention

As shown in the previous chapter, policy developments in the field of disability share many similarities with the development of European social security policy in its focus on activation and work reintegration.

The policy recommendations of the OECD (2003), including elements such as promoting early interventions, activation and return-to-work, are also in line with conclusions from studies on work disability prevention, which has proved to be an increasingly active research field.

Promoting return-to-work for the disabled

Similar to the OECD conclusion that disability should be understood as different from work disability, Waddell concluded in his studies on back pain that pain and disability are separate entities and that an increasing number of disability cases from back pain do not reflect a similar increase in back pain: "The real change is not in pathology or even in clinical symptoms, but in patterns of sick certification and sickness benefits. This is very much a social phenomenon" (Waddell 1998, p. 80). Thus, work disability should not be understood as having a 1:1 relationship to medical disabilities or conditions, but should

rather be understood as being influenced by a variety of external and social factors, such as values, attitudes and legislative systems.

Consequently, preventing work disability involves more than preventing diseases; work disability prevention needs to address a wide set of issues involving the individual as well as the healthcare system, the compensation system and the workplaces (Franche et al 2005; Loisel et al 2005a; Loisel et al 2001; MacEachen et al 2006).

Beneath the focus on activation and work reintegration lies an understanding of work as beneficial, not only from an economic perspective but also as contributing to good health, social identity and status (Waddell & Burton 2006). Thus, work is generally perceived as positive for individuals. Historically, work has also been perceived as having a moral value; according to Bauman (2004), the modern form of work ethics largely developed during the industrialization in the 19th century, and was an important cornerstone in the development of welfare states. Promoting work is therefore not a new phenomenon in welfare services: various forms of work principles have prevailed throughout the 20th century, especially in employment policies.

Promoting work in disability policies has, however, not been as common historically. It is only during recent decades, since researchers have started to emphasize the positive health effects of work also for the disabled, that disability policies have begun to change. It has been concluded in several studies that return-to-work may be successful even when symptoms, such as pain, remain; in particular, the therapeutic effects of returning to work have been emphasized (Blonk et al 2006; Bültmann et al 2009; Waddell & Burton 2006). Studies also show that prolonged absence from work generally has negative effects on people's physical, mental and social health, and that it increases the risk for chronic disability and social exclusion (Waddell & Burton 2006).

The work disability prevention paradigm

In changing the perspective from a disease prevention paradigm to a work disability prevention paradigm, it has been emphasized that a systemic multi-level approach is fundamental for grasping the complexity of preventing work disability (Loisel et al 2001).

As Loisel (2009) notes, different studies have identified a wide range of determinants that influence the development of work disability. There are personal determinants such as medical conditions, where only a few have been linked to prolonged disability, such as back pain that radiates to the leg. Apart from physical determinants, there are psychosocial factors that may influence work disability, and that may need to be targeted through different sorts of treatment than the strictly medical.

The workplace may also be a source of work disability, where factors such as fast work pace, strenuous work and social relations may influence or even cause work disability (Loisel 2009). Furthermore, the healthcare system may actually have a negative impact on disability when the ambition to cure incurable diseases (such a degenerative disk disease) leads to absence from rather than return to work (Loisel 2009). Finally, the compensation systems that provide economic support for those who are work-disabled may influence the development of their disability; for instance, studies have shown that systems which involve a great deal of litigation for people to be entitled to benefits have a negative effect on the mental health of the disabled (Lippel 1999).

These perspectives have been integrated into a model, sometimes referred to as the Sherbrooke model (fig. 2), that seeks to map the relevant factors and systems that need to be incorporated into work disability prevention programmes (Loisel et al 2005a). In the model, personal factors, the workplace, healthcare and the compensation system surround the worker, influencing the possibility of return-to-work in various ways. Although a model such as this one (called an ecological model) does not offer any solutions as to how a specific case of work disability should be managed, it may be helpful in mapping relevant actors and investigating how the responsibilities of different actors are related to each other.
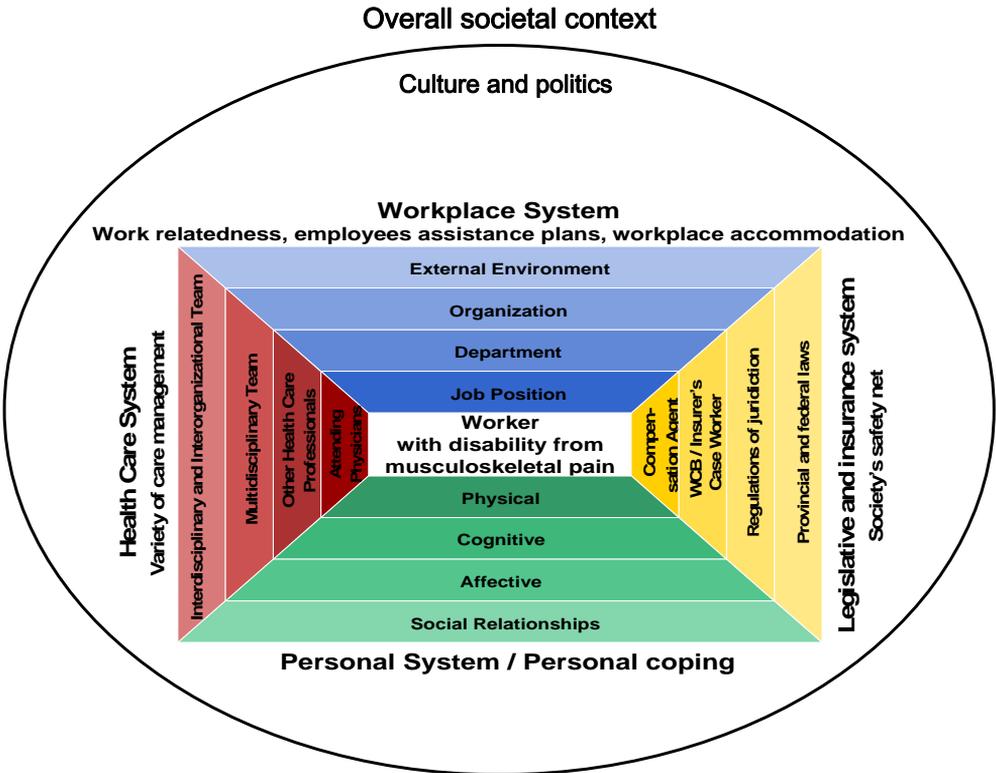
Figure 2: The Sherbrooke model, or the arena of work disability (Loisel et al 2005a).

It is important to note that the systems in the model will be fundamentally different depending on which socio-political context they are used in; thus, the model needs to be adapted and altered in order to be useful in another context. For instance, the model incorporates whether the disability is work-related or not, which may be relevant in certain systems and not in others (Canada and Sweden would serve as contrasting examples here). Furthermore, the terms used in the description of the insurance system are from the perspective of a workers' compensation system of a North American character, while a sickness insurance system of a another character (e.g. a state corporatist or an encompassing model, as defined by Korpi & Palme 1998) would have different implications, and would

imply other labels in the boxes of the model. For Sweden, there would be no need to incorporate work-relatedness, and the actors in the insurance system are different (primarily the Social Insurance Agency, governed by national legislation).

The Sherbrooke model is to a large extent in line with the policies promoted by the OECD in disability issues (OECD 2003). Both the model and the policies include an emphasis on the workplace, on early interventions and on an insurance system that is sensitive to developments in the other relevant systems. Since the Sherbrooke model is based on a large number of studies, the focus on activation may thus be considered as having certain scientific support. Nevertheless, there may still be reasons for being cautious with regard to how these perspectives should be incorporated into policies, for instance regarding the long-term effects of early return-to-work on health and well-being (MacEachen et al 2007). It is also relevant to note that a one-sided activation policy that fails to take all relevant factors into consideration may be detrimental and lead to the development of work disability.

Here, the recent Swedish reforms of sickness insurance regulations may serve as an illustration of the implementation of an activation strategy in disability policies. After the reforms, the emphasis on individual abilities has increased and a time schedule for the return-to-work process has been introduced, which stresses that interventions are made within the stipulated time. The changes primarily involve one of the systems in the Sherbrooke model: the insurance system. Fewer efforts have been made to improve performance in the healthcare system; simultaneously, the workplace system has been disregarded by placing more focus on labour market reintegration than on return-to-work, which supposedly decreases employers' incentives to return people to work. The effects of the reform are yet to be seen, but from studying its design, one can conclude that most efforts were made to control in- and outflow from the insurance system, not to improve rehabilitation and work disability prevention. The reforms thus rely heavily on the assumption that work in itself will promote good health, regardless of whether people return to work because of a carrot or a stick (cf. Waddell & Burton 2006).

Cooperation in return-to-work and labour market reintegration

An almost spontaneous insight when looking at the Sherbrooke model is that such a multitude of factors that influence the development of a work disability case are bound to put large demands on the cooperation between actors from the different systems. Cooperation requires that the relevant actors can look beyond the traditional medical perspective that has prevailed in disability management, and start incorporating also psychosocial and environmental factors that may prevent return-to-work (Loisel 2009).

The question of cooperation in rehabilitation and return-to-work has gained increasing attention over the last decade (Brunarski et al 2008; Franche et al 2005; Friesen et al 2000; Loisel et al 2001; Loisel et al 2005b; MacEachen et al 2006). More specifically, research has focused on how the different interests, policies and working methods of different actors may be coordinated, and several studies have concluded that there are obstacles to such ambitions, often due to lack of interorganizational trust and communication failures (MacEachen et al 2006).

As noted, the Sherbrooke model is designed from the perspective of North American workers' compensation systems, and is also primarily interested in return-to-work, which is different from labour market reintegration. The term return-to-work is generally understood as the process in which a person returns to his or her employer after a period of absence to do the same or an alternative work task. Labour market reintegration, on the other hand, is understood as the process in which a person has lost his or her job due to work disability, and where the goal is to find a new job that is suitable and sustainable for this person. The term may also be used for the reintegration of those who are long-term unemployed, with or without work disability. The distinction between return-to-work and labour market reintegration is important, since they imply different starting points for those involved in the process, and the two processes will involve different actors. In general, the healthcare system is less involved in labour market reintegration than in return-to-work, and the previous employer is, of course, no longer an actor in the process.

It is reasonable to assume that, although they may be interrelated, a return-to-work process and a labour market reintegration process put different demands on the actors involved. Apart from the assumption that the actors will not be the same, they will also have different roles. The insurance system, for instance, will be more sensitive to the

medical rehabilitation process in the healthcare system in a return-to-work process, while it will be more oriented towards employment issues in a labour market reintegration process. From a Swedish perspective, the Social Insurance Agency will remain a central actor in each of these processes, but the demands on cooperation will differ; both regarding cooperation partners and the purpose of the cooperation.

Studies and evaluations of interorganizational cooperation

Since the 1990s, a variety of interorganizational projects between Swedish public authorities have been tried in various settings. On an organizational level, studies show that well-functioning cooperation demands strong commitment from the participating organizations on the managerial level, and that the local socio-political context will influence how the cooperation structures develop (Fridolf 2002; Hultberg 2005). Studies have also shown that organizations tend to use the cooperation structures as a way to reduce costs rather than to improve work, and that cooperation between organizations is complicated by self-interest and distrust (Wihlman et al 2008). However, officials working in cooperation projects often experience them as leading to tighter and more constructive cooperation (Hultberg 2005). Early evaluations of CAs suggest that the measures taken seem to imply that people will benefit from the cooperation in terms of a better connection to the labour market and less dependence on public support (Statskontoret 2008).

The effects of interorganizational cooperation on measurable outputs, such as sickness absence, level of return-to-work or health, are not convincing (Hultberg 2005). There are few studies on the effects of interorganizational cooperation in the public sector, and the available studies do not indicate any increase in efficiency or quality for the individual (Hultberg 2005). On the other hand, Kärrholm concludes that cooperation between the Social Insurance Agency, employers and occupational healthcare in work rehabilitation leads to a decrease in sick leave tenure, and internationally, studies have shown positive

socioeconomic effects of return-to-work-oriented rehabilitation through multi-professional medical rehabilitation teams (Bültmann et al 2009; Franche et al 2005).

However, there is still little scientific evidence on the effects of cooperation. This can partly be attributed to the methodological problems in evaluating public services, as there is a general problem in determining what would have happened without a certain programme, or if the programme had been directed towards other people (Lipsky 1980). Furthermore, the outcomes of cooperation depend on a variety of factors, such as which organizations participate, the allocated resources, in what context cooperation takes place, and whether managers and staff are committed to the cooperation or not. However, it can be concluded that interorganizational cooperation generally demands a considerable amount of initial resources, that it takes time to develop purposeful cooperation structures and that the socioeconomic effects will not be immediate (Fridolf 2002; Hultberg 2005). These factors make the effects even harder to study.

In a study of a number of cooperative projects, Lindqvist and Grape (1999) conclude that the need for interorganizational cooperation is to a large extent a result of the increasing sectorization of welfare services. A sectorized responsibility for rehabilitation is effective for those who have well-defined problems, while those with less well-defined sociomedical problems tend not to fit into the institutional structure. Thus, cooperative projects can be seen as a way of securing the universal ambitions of the Swedish welfare model, without sacrificing the advantages of a sectorial institutional structure (Lindqvist & Grape 1999). In a comparative study between the practice in ordinary rehabilitation and cooperative projects, Grape (2001) concludes that ordinary rehabilitation tends to standardize clients, while cooperative projects tend to do the opposite: to strive for individual holistic solutions based on solidarity rather than eligibility criteria.

Furthermore, the process of rehabilitation and return-to-work involves actors with different interests. The medical system relies heavily on scientific and medical knowledge, while the Social Insurance Agency primarily focuses on laws, regulations and eligibility criteria; employers, finally, prioritize productivity. These three different logics tend to clash in managing the rehabilitation process, since the actors work in different directions and do not have knowledge of the others' domains; physicians for instance generally lack training in assessing work ability and have too little knowledge of the demands in working life (Lindqvist 2003).

There is still a general need for studies of interorganizational cooperation in different settings, both regarding the results for the individual (factors such as health, self-sufficiency, return-to-work and duration of sickness absence) and the development of practice in the participating organizations. Since interorganizational cooperation between welfare organizations has become increasingly common, it is relevant to study how these cooperation structures have developed and how they are perceived by the people working in the organizations. This is the overarching aim for this thesis.

3. A theoretical framework

The purpose of this chapter is to present a fundamental theoretical starting point for the thesis, drawing on Bourdieu's concepts of fields and habitus. These concepts are discussed in relation to the field of study and other theoretical notions that are used in the studies.

Systems, fields and habitus

In rehabilitation, return-to-work and labour market reintegration, there are a multitude of professions, disciplines and organizations that operate. To understand the complexity of these processes, it is useful to differentiate between the different systems that these professions, disciplines and organizations represent.

Social systems, Luhmann (1995) argue, are structures for communication and the production of meaning, in which a system defines how its members are to communicate about certain phenomena. A basic principle of every social system is to reduce complexity by reducing the possible interpretations of different phenomena. The medical system, for instance, communicates in terms of health and sickness, while the economic system is concerned with money, price and value. Systems therefore have their specific ways of operating, depending on their perspective, and furthermore strive to reproduce this perspective. Luhmann uses the term *autopoeisis* (Greek for self-creation) to indicate this continuous process.

Thus, systems communicate with each other based on their respective distinctions, which implies that the medical system will communicate about disability in other ways than the legal or the political system. Luhmann argues that it is impossible to communicate properly across systems, since distinctions are irreducible (Luhmann 1995). Communicating about individuals' health conditions from a legal perspective, for instance, is not to be seen as the legal system stretching its boundaries, but rather as the legal system interpreting health conditions in legal terms, thereby forcing a phenomenon into a system in which it does not belong (Michailakis 2003). A specific example of this is how social security systems redefine disability in an administrative category that determines eligibility for benefits (Stone 1984).

Luhmann's analysis of social systems is useful when analysing how different definitions of certain phenomena interact and compete. However, the systems theory may be considered overly deterministic and structuralistic, as the room for individuals to counteract system distinctions is limited. Another perspective on the importance of structures for action, which is similar in some but not all ways, can be derived from Bourdieu's use of the concepts of fields and habitus.

A field can broadly be defined as a network of relations between positions, defined by different forms of capital, either economic, symbolic, cultural or social (Webb et al 2002). Similar to Luhmann's analysis of systems' distinctions, Bourdieu discusses how every field has its specific doxa, its common-sense notions of what is right or wrong. Established fields have internalized these notions into invisibility, considering these ideas as natural and therefore impossible to question. The thinkable is thus distinguished from the unthinkable, which implies that actions which challenge established social relations become almost impossible (Bourdieu 1990). Doxa is reproduced by the socialization of new members into the field, which contributes to the relatively solid structures of fields over time. However, fields are not static, which is illustrated by the struggle between the established and the newcomers in a field. According to Bourdieu, newcomers are generally characterized by a certain amount of heterodoxy (however with enough compliance with the doxa to be accepted by those who are established in the field), while the established represent orthodoxy.

> It is important to point out that the transformation of a field, whether it is dramatic or grad-
> ual, does not occur in a consistent or homogeneous fashion. Certain sub-sections or even
> pockets of a field may embrace the transformation of the field much more quickly. As a re-
> sult, a field is usually 'traumatised' by fairly overt disagreements and agonistics, primarily
> over which part most truly represents or embodies the field and its values. (Webb et al 2002,
> p. 29-30)

In order to gain prominence in the field, newcomers may strive to restructure it by em-
bracing changes and declaring the established distinctions as outdated.

The concept of fields thus incorporates acting individuals to a higher extent than does
Luhmann's systems theory. The struggle between the established and newcomers indicates
a dynamic process in which fields are reproduced but also constantly changing, although
along the historical principles of the specific field. In this respect, Bourdieu shares Weber's
perspective that hierarchies are based on a belief in the legitimacy of social order, where a
hierarchical relationship between two people can only be valid if the dominated part ac-
cepts the subordination (Weber 1978).

To understand the practical relationship between individuals and structures,
Bourdieu introduces the concept of habitus. A person's habitus, says Bourdieu, is "embod-
ied history, internalized as a second nature and so forgotten as history" (Bourdieu 1990, p.
56). The habitus is shaped by history; by every social situation a person is a part of from
childhood to adult life. This makes it a system of dispositions and a determinant for ac-
tion. It is thus a dynamic form in which individuals internalize structurally and histori-
cally defined ideas. Consequently, structures are translated into actions through the
habitus of individuals, which makes action not a deterministic application of structural
distinctions, but shaped by them and the individual's relationship to the doxa of a specific
field. However, since the habitus is internalized, the individual will not need to reflect
upon the reason for a specific action; rather, the habitus will spontaneously and uncon-
sciously reproduce the structure it is a product of.

Structuralism or constructivism?

Studies of social phenomena may be conducted from a variety of perspectives. Referring to common sociological jargon, one could perform studies on a micro, a meso or a macro level, roughly indicating whether the studies are performed on individuals, organizations or societies. The studies in this thesis have largely been conducted on a micro or meso level by focusing on individuals within certain organizations, and how these individuals reason about working within an interorganizational structure. In the articles, the analyses and discussions are kept on this level, while the aim of the discussion in the thesis is to place the studies within a larger context, in which welfare systems are considered as macro structures that may influence the actions of individuals within them. Thus, the ambition of this thesis is to integrate several levels of analysis and to relate these to a historical and a societal perspective (cf. Mills 1959).

A recurrent debate in sociology has been concerned with the dualism of individual and structure, in which the relationship between people and the societies they live in may be understood differently. The core of the debate could roughly be described as whether individuals create structures or if structures create individuals; in other words, to what extent are individual actions determined by the social structures in which they occur, and to what extent are structures determined by the individuals they consist of? Throughout the history of sociology, these questions have been given different answers; some scholars have been more inclined to give superiority to structures, while others consider individuals more important.

A criticism of this view of society has been put forward by Norbert Elias. His main argument for disregarding the dualism of individuals and structures is that dualism is socially constructed, and is in itself a barrier for thinking about society (Elias 1978). Furthermore, it relies on an egocentric view of the world, in which the individual is seen as an actor who meets a surrounding structure: an individual self surrounded by others. Instead, Elias argues, individuals are involved in complex networks of people, reciprocally dependent upon each other, and the characteristics of these networks are shaped by the asymmetrical power balance within them. These networks form different *figurations*, which could be anything from a family to a complex organization. Elias proposes that the analytical starting point for studies of human actions must therefore be the relationship between

individuals, not the individuals themselves (Elias 1978; Olofsson 2003). As a consequence, the world should not be viewed as having a centre (as the egocentric worldview suggests), but rather as consisting of a numerous set of interdependent networks.

The characteristics of networks and figurations may differ, since different people are dependent upon each other to a greater or lesser extent. When the interdependence is strong, the situation is not a simple matter of one group having power over another. Instead, complex networks imply that groups will exercise control over each other. As the power balance within a network may change for different reasons, as well as the level of interdependence between the individuals, networks are constantly changing and should therefore not be studied as solid units.

Elias' concept of figurations bears many similarities to Bourdieu's analysis of fields, capital and habitus, which also gives significance to relations rather than individuals. Comparing the two, Bourdieu stands out as more inclined to emphasize structural influence over action than Elias does. In this thesis, Bourdieu's terminology is preferred, since it is suitable for understanding the dispositions of individuals within relatively stable structures, such as bureaucratic authorities. Furthermore, the concept of habitus is useful to illuminate the process through which structures govern practice, and vice versa.

These theoretical assumptions can be illustrated with an example from the studies in the thesis. The healthcare physicians and the officials at the Social Insurance Agency belong to different fields, but both are engaged in sick-listing practice. The sick-listing process may be understood here as an arena that in itself creates a field including several professions who are dependent on each other in order to make the process work. However, they do not enter this field on equal terms, and the power resources that each individual brings in (authority of their profession, status, legal structures; i.e. the various forms of capital) determines the power balance between them. In this example, the Social Insurance Agency officials have the power of ultimately deciding about eligibility for sickness benefits, while the physicians have their medical expertise as well as a gatekeeping role in the system. These power resources, and the way in which they are used, contribute to how the field functions.

A conclusion from this example is that one cannot simply view a person as an autonomous individual who acts as he or she pleases; neither is it possible to simply assume that a system or a legal structure will make people act according to intentions. It is

necessary to be sensitive to the interaction between individuals and how their interdependence and their respective positions in a field affect their relationship and their actions.

Professional discretion

Since welfare services involve personal contact with people, officials in public welfare services (or street-level bureaucrats in Lipsky's terminology, Lipsky 1980) constantly need to interpret organizational policies and regulations in order to enable them to take decisions. As Lipsky has noted, these decisions have a direct effect on peoples' lives, and the delivering of a policy involves a balance between meeting people as individuals and treating them in a bureaucratic way (Lipsky 1980). Lipsky's analysis is largely concerned with the level of discretion that officials practise in their work; his main argument is that discretion is necessary to do the job and that policy, in the end, is decided by officials at the street-level rather than their managers. Officials' work takes place within a multitude of rules and regulations, which according to Lipsky may actually be understood as promoting discretion: "In most public welfare departments, regulations are encyclopedic, yet at the same time, they are constantly being changed. With such rules adherence to anything but the most basic and fundamental precepts of eligibility cannot be expected" (Lipsky 1980, p. 14).

It is possible to understand Lipsky's theoretical assumptions from a relational perspective, since Lipsky places his focus on the interactions and relations between individuals rather than on the individual themselves. Even though Lipsky's conclusion is that the officials ultimately create an organization's policy through their practical interpretation of regulations, they are not understood as autonomous individuals who act regardless of their context. Rather, the officials in Lipsky's studies are tied up in social fields, involving clients, managers and fellow officials. The application and their interpretation of policy is thus made through the habitus, i.e. the embodied structure of which they are a part.

Following Lipsky, several studies have focused on the development of discretion in various social services. In the literature, two lines of arguments may be traced, where one

argues for the continuation and the other for the curtailment of discretion (Evans & Harris 2004). In the curtailment literature, references are often made to the increase of managerialism, and the argument for curtailment relies on an assumption that increased steering also implies increased compliance. However, Evans & Harris (2004) note that the empirical basis for this conclusion is weak, and that an increase in regulations could promote discretion just as well as curtailing it (cf. Lipsky 1980).

Ultimately, this theoretical development of Lipsky's work may be interpreted as scholars taking different approaches to the relationship between individuals in a structure. Some take a clearly structuralistic perspective, disregarding the officials' informal power resources. On the other hand, others seem to disregard the influence of regulations and managerial decisions. A more purposeful approach would be to view the level of discretion as the result of a power struggle between actors in a social field. Thus, the level of discretion is an empirical question and dependent on the structure of these fields and the power resources (i.e. capital) of the actors within it.

Organizational identity

Foreman and Whetten (2002) argue that members of an organization constantly compare their identity perceptions and their identity expectations, and that the level of congruence between these makes up the individual's attitudes and behaviours towards the organization. Furthermore, in multiple- or hybrid-identity organizations (such as public authorities or other complex organizations), the identity "is composed of two or more types that would not normally be expected to go together" (Albert & Whetten 1985, p. 270); for instance, organizations may involve different sets of values. Foreman and Whetten (2002) identify two seemingly incompatible value systems in hybrid-identity organizations: *normative* (ideological, altruistic) and *utilitarian* (economic rationality and self-interest). These two value systems are in turn nearly synonymous with Simon's distinction between social and organizational values, relating to two types of organizational identifications: to the organizational objective and to the conservation of the organization (Simon 1997; cf. Weber's distinction between goal rationality, value rationality, emotional rationality and

tradition, Weber 1978). The incompatibilities of different value systems result in difficulties for individuals in creating a sustainable organizational identity.

> It appears that many members of a hybrid organization identify with both aspects of its dual identity, and thus find themselves embracing competing goals and concerns associated with distinctly different identity elements (Foreman & Whetten 2002, p. 631-632).

Thus, according to Foreman and Whetten (2002), the congruence gap between normative and utilitarian values significantly affects members' commitment to their organization.

The CAs studied in this thesis can be considered meta-organizations that comprise four different organizations, whose representatives enter the CAs with their existing organizational identities. The new organization has an agenda of its own, which combined with its members' agendas imposes quite a challenge regarding the construction of a common organizational identity. As Ahrne and Brunsson states:

> … because of the considerable differences between organizations, most meta-organizations have to deal actively with the identities of their members. The differences between organizations are so great and so obvious that it is difficult to avoid doing so. (Ahrne & Brunsson 2005, p. 435-436)

Furthermore, all four organizations can from the outset be considered as hybrid-identity organizations, since as public institutions they involve a normative as well as a utilitarian value system. This implies that every participating organization represents different interests in the cooperation with others. Thus, a CA is ultimately a combination of four hybrid-identity organizations with different interests, together forming a fifth, whose organizational identity comprises four different normative and four different utilitarian value systems. To further complicate this construction, some CAs include more than one municipality, and healthcare is divided into a number of sub-organizations. If these organizations are to be included as having their own sets of values and self-interests, the construction of an organizational identity for the CAs seems to be a rather ambitious project.

The analysis of organizational identification is helpful in order to conceptualize the self-interest that often occurs in interorganizational cooperation. Organizational identifi-

cation and organizational self-interest may thus be one of the underlying causes why interorganizational cooperation does not always come easy.

Towards a theoretical framework

Starting with Bourdieu's view of the relationship between individuals within a societal structure, the discussion in this thesis will then proceed by analysing the relations between representatives from different organizations in the social field of rehabilitation, return-to-work and labour market reintegration. In such a field, there are many actors that influence the process for the individual. The interdependence between these actors is shaped by the different power relations between them, with regard to a multitude of factors (such as legislation, policies, professional knowledge, and status). Cooperation between these actors occurs in different situations under different circumstances, and the studies in this thesis can naturally only cover a small portion of these interactions.

However, when analysing cooperation between any actors, and actors involved in complex societal processes in particular, the concepts of discretion and organizational identification are useful in order to understand how the actors relate to each other. A theoretical starting point, thus, is that the structure and the actors within it dialectically influence each other, and the aim of the discussion in this thesis is to elucidate how the relations between the actors influence the possibility of developing interorganizational cooperation.

4. A methodological framework

This chapter begins with a section where the methodological starting point for the studies is discussed. After this the methods and materials for each study will be presented.

On philosophy of science

In his book on practical reason, Bourdieu outlines a philosophy of science based on two concepts. First, it is a *relational* philosophy, since it is primarily concerned with the relations between people, and between people and structures. These relations are not as easily accessible as individuals or groups, but must be "captured, constructed and validated through scientific work" (Bourdieu 1998, p. vii). Second, the philosophy is *dispositional*, which implies that people do not act – or think – autonomously, but are influenced and to a certain extent governed by the structures of relations to which they belong. An analysis of such dispositions is closely tied to the development of Bourdieu's key concepts – habitus, field and capital – where these concepts are cornerstones in the "two-way relationship between objective structures (those of social fields) and incorporated structures (those of the habitus)" (Bourdieu 1998, p. vii).

This relational and dispositional philosophy of science has been central for the studies in this thesis. The focus on relations and dispositions can therefore be traced throughout the theoretical framework – in Bourdieu's terminology, naturally; in Elias' focus on figurations, in Luhmann's analysis of systems and in Lipsky's analysis of street-level bureau-

crats. The dialectic relationship between individuals and structures is also a recurrent theme in these theories. None of the theories used accepts a one-sided primacy for either structures or individuals, though the emphasis may differ. Bourdieu, who is the key theorist in the thesis, tends to emphasize structural influence on individual action (through the habitus), which corresponds with the focus of the thesis (i.e. to study how interorganizational cooperation – initialized through legislation – affects practice).

Epistemological concerns

Bourdieu observes the dilemma for the researcher in being part of – or even a product of – the object he or she is studying, namely the social world (Bourdieu 2003). Separating "common sense" from scientific knowledge is viewed as a necessary task for the researcher, but since the researcher and his or her research object is interrelated, this is a difficult challenge. The separation of the two is necessary, since the aim of scientific thinking is to make visible issues that are concealed within the spectrum of common sense. Since the "preconstructed is everywhere", the key question which captures the aim of Bourdieu's analysis is formulated as follows:

> How can the sociologist effect in practice this radical doubting which is indispensable for bracketing all the presuppositions inherent in the fact that she is a social being, that she is therefore socialized and led to feel 'like a fish in water' within that social world whose structures she has internalized? (Bourdieu 2003, p. 388.)

How is the researcher to analyse well-known objects? This is not merely a question of closeness– distance; the issue goes further than that. Of course, distance might be needed in order to contextualize the objects of research in a proper way, and of course a certain amount of closeness is necessary in order to understand the object by its own premises. The issue raised by Bourdieu, however, questions the very possibility for the researcher to understand an object of which he or she is a product. Distancing oneself from the research object is not enough; a distance away from oneself as a researcher and a social being is

equally crucial. "To not construct […] is still to construct, because it amounts to recording – and thus to ratifying – something already constructed". This implies that a "scientific practice that fails to question itself does not, properly speaking – know what it does" (Bourdieu 2003, p. 388).

This is what Bourdieu means by the term "radical doubt". For every research project worth its name, a continuous reflection upon its premises and objects are central.

In science, the researcher has to include into his or her research objects the contributions that he or she and colleagues make to the production of official problems. However, this is no easy task, since the preconstructed appears in all contexts, all the time. Language, which is the researchers' primary tool, in itself conceals constructions which lead to further constructions. Bourdieu exemplifies with the term "profession", which is generally an unquestioned way of referring to groups within working life. Socio-economic categories are widely used in science, according to Bourdieu in an unreflected fashion, since they reflect an understanding shared by a whole society. These are the kind of terms that need to be questioned thoroughly. It is not enough to question the classification of occupations; one needs to question the very concept of occupation, or profession.

Concerning the studies in this thesis, there are issues worth discussing regarding the relation between science and the social world. One is the closeness and distance to research objects, i.e. the people and organizations that are studied, which will be discussed later. Equally interesting, with regard to the more fundamental problem raised by Bourdieu, is what effect researchers involved in the research field have on their objects, being parts of and products of the social world they are studying. To what extent are the questions the researcher asks material results of preconstructed, socially sanctioned and unreflected terminologies and concepts? The research in this thesis makes use of several theoretically and/or empirically defined concepts, as well as the bulk of theoretical understanding achieved during the author's education. All this is the result of decades of scientific practice. Of course, in certain respects, education is a form of socialization to the values and theoretical standpoints concerning the understanding of the social world and scientific practice (i.e. the doxa of the scientific field).

So, how to avoid being "trapped"? Bourdieu's suggestion is perhaps somewhat utopian, but nevertheless:

> To take one's object commonsense understanding and the primary existence of the social world as a nonthetic acceptance of a world which is not constituted as an object facing a subject is precisely the means of avoiding being 'trapped' within the object (Bourdieu 2003, p. 394).

In short, Bourdieu pleads for a rift between scientific and practical reason, to prevent that the latter will contaminate the former. The purpose is "to avoid treating as an instrument of knowledge what ought to be the object of knowledge" (Bourdieu 2003, p. 394).

One of Bourdieu's primary questions is thus in what sense the knowledge created in science is different from common-sense knowledge. Bourdieu has shown that both types of knowledge, if they can be separated from each other at all, are based on the same assumptions of the social world, and that the concepts within different fields of research are as socially constituted as any other type of concepts, that is, common sense. The interpretation of this point differs depending on what perspective one represents. Some, for example promoters of action research, would claim that this is an argument for a closer relation between science and practice, since the knowledge is based around the same presuppositions (Eikeland 2006). A critical sociologist, such as Bourdieu, would claim that this is an argument for a more distanced relationship between the two, and a more developed criticism of common-sense concepts and knowledge.

The studies in this thesis involved the participants in the introductory phase where the direction of the research (involving preliminary aim and research questions) was first formulated. Later on, the formulations were changed both as a result of empirical enquiries and theoretical influences. New research questions were introduced to the participants, but the main responsibility for the theoretical direction of the research project lay with the researchers.

The relation between the researchers and the participants in the studies has often been brief; many of the participants only meet the researcher once or twice for an interview or a focus group. Other participants have taken a more long-term part in the research, as co-producers of research ideas, as informants or as participants in interviews. These participants have had an active role in the research, and therefore also a greater influence on the research process. The third study in particular had a more interactive ap-

proach, where the same groups of participants met for a rather long period of time and were thus given more opportunities to contribute with ideas and questions.

Methods and materials

The general methodological approach to the studies in this thesis has been explorative. Interviews and focus groups have had an open-ended structure, and the material has been analysed primarily through inductive qualitative content analysis. Theories were sought after identifying relevant themes in the material, rather than letting theoretical propositions guide the reading of the interview transcripts. The specific method of each study will be described in more detail when the studies are presented below.

Research setting

After their initiation, two CAs in the county of Östergötland approached the National Centre for Work and Rehabilitation at Linköping University for evaluation. This enquiry led to an agreement in which the university would carry out studies on the development of the CAs from an organizational perspective, while the CAs would be responsible for continuous evaluations of the outcomes of the projects. This agreement forms the basis for this thesis, in which the organizational studies of the two CAs are presented. The studies were carried out between September 2006 and May 2009.

Most of the participating organizations are the same in the two CAs; the Social Insurance Agency and the Public Employment Service are national authorities and the county council (which organizes healthcare) covers the whole region in which the two CAs operate. However, the municipal representation differs. The larger CA is located in a medium-sized city where only one municipality is represented. The smaller CA covers two municipalities and is located primarily in a smaller town.

The researchers and the coordinators in the two CAs met continuously during the three years of study, in which results and the further direction of the studies were discussed. The studies have also been continuously reported back to the participating organizations through reports and seminars.

Study I

The first study focused on the experience of representatives from different professions involved in interdisciplinary rehabilitation teams. Since the approach was broadly explorative, an open interpretative approach was called for, and qualitative methods for data collection were used (Patton 2002).

Participants and data collection

The teams consisted of physicians, occupational therapists, physiotherapists, medical social workers and representatives from the Social Insurance Agency. Some teams also had additional members, such as representatives from psychiatric care, the social welfare office, the municipal human resource department and the Public Employment Service.

The material for this study was collected between October 2006 and February 2007. At the time of study, there were 40 teams in total in the region, twelve of which were selected for inclusion in the study. The selection was made strategically to attain a suitable variation regarding the length of time the team had been working in order to make comparisons possible regarding the development of the teams. The oldest team in the study was initiated in 2001, while the remaining teams were started between 2004 and 2006. One of the teams in the study included the Public Employment Service and the social welfare office as additional members, and another team included a representative from psychiatric care. These two teams were included in order to observe whether additional members affected the dynamics of the team.

To capture the dynamics of the teams and to investigate the relationship between the participants, twelve focus groups were carried out, one with each team. In the focus group method, discussion between participants concerning specific topics is central. In this method, disagreements within the groups become obvious, and generally the discussion does not result in any consensus. By using this method, a scope of perspectives on the subjects discussed is presented through interaction between participants who do not necessarily share each others' views (Krueger 1994; Wibeck 2000).

In the focus groups, teams were to discuss their work and the ways in which the new work form was put into regular practice. All in all, the focus groups involved 66 professionals, ranging from four to nine participants per group. The focus groups were semi-structured, meaning that the role of the researcher was to initiate topics for discussion, but not to act as an interviewer. A highly structured form would have resulted in a group interview, and a lower level of structure might not have managed to cover the subjects of interest (Wibeck 2000). Topics introduced by the researcher most commonly served as starting points for the discussions. These topics were the history and implementation of the teams, how the roles of the professionals were developed, and the practice of the teams. In the end, the focus group discussions covered a variety of issues.

Four of the focus groups were conducted by one researcher, while two researchers were present at the other eight. In these cases, the second researcher had an observing role, and discussions were held between the researchers after every focus group about what had come up during the meeting and how it could be interpreted.

In addition, individual interviews were conducted with the managers of the primary healthcare centres where the selected teams were located, i.e. twelve interviews. The focus for these interviews was a managerial perspective on how the teams affected the daily practice of the healthcare centres in handling sick-listing issues. The interviews were semi-structured, based on an interview guide. The interviewees were asked about the aim of the teams, how teams were implemented, about the efficiency of the teams regarding sick-leave tenure, and how the managers perceived that the teams affected the professionals' practice.

The focus groups lasted for between one and two hours, and were recorded and transcribed verbatim. The individual interviews lasted for between fifteen and sixty minutes. By request, one of the individual interviews was not recorded, but notes were taken dur-

ing the interview. The remaining eleven interviews were recorded and transcribed. Notes were taken continuously before, during and after focus groups and interviews regarding recurrent issues and analytical ideas.

Study II

The second study focused on the prerequisites for cooperation within the setting of a CA from a managerial perspective. An open-ended exploratory approach was chosen, with qualitative semi-structured interviews as the method of enquiry.

Selection of respondents

The two CAs included in the study work under different demographical conditions: one is located in a medium-sized city, while the other consists of two smaller municipalities. After discussions with coordinators in these CAs, the representatives from governing boards and operative groups of the two associations were considered as relevant informants, since they are responsible for the running of the CAs on both a strategic and an executive level. All representatives on the boards and operative groups of the two CAs were asked to participate in the study. All accepted, but one of the interviews was cancelled due to illness.

Table 3: Overview of the respondents, showing the organizations they belong to

Municipal politicians	6
Municipal managers	5
County council politicians	3
Healthcare managers	10
SSIA officials	5
SPES officials	5
Administrative staff	1
Total	35

The respondents represent a broad variety of organizational backgrounds (Table 3), where each category could have been divided further. The category of healthcare managers, for instance, includes managers at primary healthcare centres as well as managers in psychiatry. Table 4 shows the distribution of respondents in the organizational structure of the two CAs.

Table 4: Overview of the categories to which the respondents belong in the CAs

CA 1 Board	7
CA 1 Operative group	9
CA 1 Administrative staff	1
CA 2 Board	9
CA 2 Operative group	9
Total	35

Data collection

Prior to the interviews, an interview guide was developed with questions covering how the coordination is performed in practice; the organization's benefits from participating in the CA; what role the respondent's organization plays in the CA; how the CA is governed; differences and similarities between goals and regulations between the participating organizations; implementation of CA work forms into ordinary practice; and which target groups should be in focus for the coordination in a longer perspective. The interviews were open-ended, and as the interviews were carried out, new topics for discussion developed. These topics were incorporated into subsequent interviews, and they focused on the relationship between the organizations; whether existing work forms are affected by the CAs; the organization of cooperative work forms; long-term or short-term coordination; and communication between participants in the CAs. Since emergent questions were incorporated into subsequent interviews, all interviews covered approximately the same topics.

In total, 35 interviews were carried out between August 2007 and March 2008, primarily in the respondents' offices or workplaces. The interviews lasted for between 32 and 80 minutes and were recorded and transcribed verbatim. Notes were taken continuously before, during and after focus groups and interviews regarding recurrent issues and analytical ideas.

Studies III and IV

The third and the fourth studies focused on the experiences of interorganizational cooperation of officials from different public services. To facilitate an analysis of such issues, an interpretative approach was called for, and qualitative methods for data collections were used (Patton 2002).

Participants in the studies

Studies III and IV are based on the same material, where two groups of officials from the Social Insurance Agency, the Public Employment Service, primary healthcare and municipal rehabilitation services met recurrently to discuss how the changes in policy affected their practice. The selection of participants was made after discussions with coordinators in two Coordination Associations, where the criteria for inclusion was that all the relevant public actors in rehabilitation and return-to-work should be represented, and that all participants had experience of everyday work with clients. Each CA was represented by one group. The participants in the groups are presented in Table 5.

Table 5: Participants' organizational background, Study III.

Group 1	Group 2
Social insurance official	Social insurance official
Employment service official	Social insurance official
Occupational therapist, primary healthcare	Social insurance official / cooperation team
Coordinator, primary healthcare	Employment service official
Psychiatry	Coordinator, primary healthcare
Social welfare official	Coordinator, primary healthcare
Municipal rehabilitation service	Social welfare official / cooperation team
Municipal human resource manager	

Data collection: using problem-based learning as a research method

The groups met for approximately two hours on seven occasions each. The first meeting was extended by one hour in order to introduce the participants to the study and to the principles of problem-based learning (Downey & Waters 2005; Lohman 2002). Problem-based learning was used as a pedagogical tool to structure the meetings, and the educational goal for the participants was to develop cooperative strategies across organizational borders. Furthermore, a tutor was assigned to the groups to help them structure the meetings and to function as a facilitator in the discussions. The researcher attended the group meetings primarily as an observer, but at some points also as a resource person with regard to research in the rehabilitation field.

At the first meeting, the participants were to choose from a selection of newspaper articles about the recent changes in the Swedish sickness insurance system, in order to have a starting point for their discussions. At subsequent meetings, no such starting points were introduced; instead, at the end of each meeting the groups posed a question to discuss at the next meeting. The discussions evolved into dealing with a multitude of topics

over time, such as consequences of policy changes; the relation between sickness insurance and labour market policies; the participants' working conditions and relation to their managers; and cooperation within and between organizations.

The groups met from February to May 2009. All group meetings were documented in several ways: all meetings were recorded and transcribed verbatim; notes were taken by both the participants and the researcher, both during and after the meetings; whiteboards were used during meetings, and then photographed and sent out to the groups; all group members were also given a notebook for their personal reflections, which on some occasions were used as input for discussions.

There were several reasons for the use of problem-based learning. Firstly, this was done in order to give the participants a purpose for the meetings; the idea was that they would benefit from meeting and working with other professionals in a structured way. Using problem-based learning as a method for professional development contributes to illuminating and systematizing informal and tacit knowledge (Yeo 2007), and since the scenarios used are often not very structured (such as discussing a newspaper article), the method is suitable for learning to handle equally unstructured problems in practice (Lohman 2002).

As a research method, problem-based group meetings result in a rich material that is open for analyses on several levels from different disciplinary perspectives. Since the groups meet several times, a process perspective is also added, providing the opportunity to study group development and learning. Compared with focus groups or group interviews, this method provides less static and more in-depth knowledge about the participants' reality. Further, the approach enables the participants to develop practical knowledge from participating in the study (Nielsen & Svensson 2006).

Analysis of the material

Since all the studies were explorative and the material was gathered through an inductive process, the same principles for analysis were applied in each study. The analyses were guided by the principles of a qualitative content analysis (Patton 2002). The transcribed

material was read through several times and compared with notes to get an overall view of the content. Organizing the material into categories or themes is a way to make sense of the data, and a process in which research questions are constantly formulated and redefined, in order to guide the coding of the transcripts (Neuman 2006).

Since all studies involve a rich material, a broad variety of issues was covered with several possible paths for analysis. The first step was thus to make a preliminary categorization of recurrent issues in the material (i.e. open coding, Neuman 2006). This was done manually, using highlighters in different colours, and cutting and pasting. The comprehensive documentation from the material for Studies III and IV (the researcher's and participants' notes, photographs of whiteboards etc.) facilitated the reading of the lengthy transcripts from the group meetings and was used to form questions to guide the categorization.

After producing an initial suggestion for categorization, this was presented to the group of supervisors for discussion. Then the process continued until agreement was reached on a thematic structure that was well grounded in the empirical material and showed satisfactory internal homogeneity and external heterogeneity, i.e. well-defined themes that do not overlap (Patton 2002). After this, specific themes were chosen for in-depth analysis (i.e. selective coding, Neuman 2006).

The analysis was thus conducted using an inductive approach where the material was interpreted without using a predestined theoretical framework. The theories used in the articles were consulted after identifying central themes in the material. For the extended analysis in this thesis (Chapter 6), the analyses of each article have been related to a broader theoretical framework, as outlined in Chapter 3.

Methodological considerations

The studies in this thesis involve material from a broad set of participants in different organizations during a three-year period. Considered as a whole, the material for the separate studies forms a case (or in a way two cases, i.e. the two CAs) of interorganizational cooperation that allows for an in-depth analysis of how professionals from different back-

grounds perceive and use the specific cooperation structure of CAs. The limitations of qualitative data in terms of generalization are partly overcome by the size of the material and the use of different respondents for the studies, incorporating professionals from different levels in all the participating organizations in two CAs. This comprehensive material enables comparisons with other regions and cooperation structures.

Although the results of the studies should not be interpreted as generally reflecting the experience and attitudes of the studied organizations, there is no reason to assume that the results are unique to its participants; they represent authorities and public organizations, and the issues discussed (such as work ability assessments, return-to-work and labour market reintegration) are widespread in both a Swedish and an international context. The results from this thesis may thus be transferable to other contexts.

The trustworthiness of a qualitative study depends on four criteria: credibility, transferability, dependability, and confirmability (Lincoln & Guba 1985). Credibility can be understood as whether the reported findings from a study represent a credible conceptualization of the material; transferability is related to whether the results may be applicable to other contexts or projects; dependability is concerned with the overall quality of the research process from data collection to analysis; and confirmability is how well a study's findings are supported by the data collected.

Results from the studies in this thesis have continuously been reported back to the participants through meetings, seminars and discussions, which is a way of elucidating the credibility and the confirmability of the findings. The dependability of the studies is strengthened by continuous discussions about the material among the co-authors and with colleagues in seminars and informal discussions. The transferability of the results is supported by continuous comparisons with other studies in the field and by attention to context-specific conditions (e.g. legislation and policies) that may affect the results of the studies.

Ethical considerations

The studies in this thesis are based on information given by respondents through interviews, focus groups and group discussions. All participants in the studies have been in-

formed about the purpose of the studies, and have given their consent to participation and to the recording of interviews. Questions asked have been concerned with the respondents' professional knowledge in their field of work, implying that no personal questions have been asked. The respondents have been assured that their answers will be used confidentially, and that they will not be identified in the reports and articles.

The studies may be considered to fulfil the ethical principles for research in social sciences, since attention has been paid to basic ethical concerns, such as explaining the purpose of the research, not causing harm to participants, receiving informed consent and maintaining confidentiality throughout the research process (Patton 2002).

5. Findings from the studies

The four studies in this thesis have had different approaches to studying interorganizational cooperation. The first study was concerned with a specific work form, namely interdisciplinary rehabilitation teams, and the analysis was concerned with how the different professionals in these teams perceived their common work and how they interpreted the concept of work ability, which is a central concept for determining eligibility for sickness benefits.

The second study focused on managers and board members of the CAs in order to determine their motives for and commitment to interorganizational cooperation. The analysis was therefore very concerned with the organizational identification and self-interest of each actor, and the issue of trust between representatives from different organizations was specifically targeted in the analysis.

The third study aimed to elucidate the perspectives of officials in different organizations connected to the CAs regarding both the development of cooperation in the CAs, and how the recent changes in sickness insurance regulations will influence future cooperation.

The fourth study focused on different perspectives on the concept of work ability among representatives from all participating organizations, since changed sickness insurance regulations have changed the assessment process and therefore also the demands for interorganizational cooperation.

In this chapter, the main findings from each of the four studies will be presented separately. In the next chapter the findings will be related to each other and to the development of the CAs during the years of study.

Study I: The work ability divide

The aim of the study was to determine how the relationship between healthcare professionals and social insurance officials was expressed in twelve Swedish interdisciplinary rehabilitation teams. The material from the study covers a variety of issues regarding how interdisciplinary teams are started, how they function and what they can be used for. The article focuses primarily on the results that concern the relationship between health professionals and social insurance officials, and how this relationship affects cooperation within the teams. This relationship can be illustrated by the following excerpt from a discussion.

> Social insurance official: Of course, we don't look at illness – we look at work ability.
> Occupational therapist: You look at work ability and we look at illness.

The quote illustrates how different professionals focus on different aspects when managing a case of sick leave. While healthcare professionals are generally more interested in making people healthier, the officials from the Social Insurance Agency are more concerned with whether the person can work or not. Furthermore, since it is work disability rather than disease that determines whether someone is eligible for sickness benefits or not, the definition of work ability is central.

The results of the study show that the teams have had problems in reaching a common understanding of their task, due to an inherent tension between the professionals. This tension is primarily a result of two factors:

1. Divergent perspectives on work ability between the healthcare professionals and the Social Insurance Agency, where the former represent a holistic approach, considering a variety of factors as contributing to an individual's work ability, while the latter represent a reductionistic approach, considering only disease as a valid cause for work disability.

2. Different approaches to cooperative work among physicians, where "traditional" (as opposed to cooperative) physicians' dissatisfaction with changes in sickness insurance regulations negatively affects the possibility of cooperation.

The results of the study can be presented in a figure, describing different approaches to two factors: work ability and cooperative work (Figure 3).

Perspectives on work ability

	Holistic	Reductionistic
Positive to cooperative work	Cooperative physicians Other health professionals	Social Insurance Agency
Negative to cooperative work	Traditional physicians	

Figure 3: Divergent perspectives in interdisciplinary teams

As can be seen in the figure, both of these factors represent barriers between team members that need to be overcome in order to attain a common understanding of the work tasks of the team. There is thus a barrier between healthcare professionals and the Social Insurance Agency regarding the interpretation of work ability, and there is a barrier within healthcare between traditional and cooperative physicians regarding teams as a work form.

These barriers could be analysed using the theoretical framework outlined in Chapter 3, where the medical system can be identified as a social field in which there are established members and newcomers that struggle for superiority and interpretative prerogative. The doxa of this field (i.e. the common-sense knowledge of what is acceptable and what is not) lies with the traditional physicians and their autonomous position in relation

to other health professionals as well as to social insurance officials. The conflict regarding whether physicians are to take a more cooperative and deliberative position may thus be seen as a fight over the definition of a field, promoted by the heterodoxy of the younger more cooperative physicians. In this context it is interesting to notice how these physicians are influenced by another field – social insurance – which changes practice in the medical field. These changes are imposed by regulations, educational interventions and changing organizational relationships between professions (i.e. increasing opportunities for insurance officials to question physicians' assessments).

Study II: A matter of trust?

The aim of the second study was to explore views on and experiences of participating in CAs from a managerial perspective. Managers from all participating organizations in two CAs participated in the study.

The mere existence of CAs shows that it is possible to create long-term cooperative structures through legislation, but the experience of the CAs suggests that the sustainability of cooperation depends on the commitment and mutual trust between the participating organizations.

The respondents in the study generally agree upon the aims of the CAs; they describe the common goals in similar terms that correspond with the stated aims in the preparatory work and activity plans. The guiding principle for most of the representatives of the CAs is to facilitate self-sufficiency for the target group, primarily through employment. Another goal for participation is to reduce the risk of moving people from pillar to post, due to gaps between authorities. Finally, most representatives agree with the goal of reducing costs by coordinating the available resources.

However, while agreeing with the stated aims of the CAs, the interpretation of these aims differs depending on the organization represented. The participating organizations have different views on what the CAs should be used for and how the use of CAs relates to ordinary practice in their organizations.

Table 6: Summary and interpretation of the stakeholders' interests in and commitment to the CAs[*]

	Social Insur-ance Agency	Public Employment Service	Primary Healthcare	Municipalities	Coordination Association
Primary target group	Work-disabled, working age	Employable, work-ing age	Sick, ill and/or disabled, all ages	Socially excluded, unemployed, dis-abled, all ages	Work-disabled, socially excluded, unemployed, working age
Motives for co-operation	RTW for work-disabled, effi-ciency	RTW for unem-ployed, efficiency	Individual health and quality of life, cooperative work	Self-sufficiency, social security, efficiency	RTW for disad-vantaged groups
Priority in RTW process	Early-mid	Late	Early	Early-late	Early-late
Congruence with CA goals	High	Low/Medium	Low/medium	High	N/A
Experienced benefit/value of participation	High: RTW is a central issue	Low: wants more short-term efforts	Medium: low interest in RTW, high interest in cooperative work	Medium/high: wants more long-term efforts	N/A
Commitment to the CAs	High	Low	Medium	Medium/high	N/A

In Table 6, the differences between the organizations regarding motives for cooperation becomes apparent, as each organization's target group largely defines to what extent the CAs are seen as useful. The congruence between the organizations' goals and the common goals of the CAs also differs, in that the Social Insurance Agency and the municipalities are more in line with the common goals. The healthcare services have an interest in devel-oping functional cooperation with authorities in sick-listing issues, while the goal of re-turn-to-work and labour market reintegration is less expressed. The Public Employment Service does not seem to be very interested in cooperation, while their focus on labour market reintegration is more emphasized.

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[*] It should be noted that the categorization of low and high commitment and congruence displayed in Table 6 are estimations based on a qualitative content analysis of interviews, and should therefore not be interpreted as exact measures of attitudes.

Attitudes to cooperation thus seem more decisive than the focus on return-to-work and labour market reintegration, which is reflected in commitment to the CAs and the experienced benefit. This would explain why the Public Employment Service is less committed to the CAs than the healthcare services, despite the fact that both seem to be in equal agreement with the goals of the CAs.

Actions are to a high degree determined by institutional preferences, and when such preferences counteract cooperative work, there is a risk that cooperation breaks down. The cooperative motives are, then, not always translated into cooperative behaviour.

In the CAs, it is obvious that motives for cooperation differ, and that although these differences could supposedly be overcome, this is in fact not the case. One of the organizations, the Public Employment Service, limits its interest to coordinating financial resources, while the other three wish to engage in elaborated cooperative work forms, which implies crossing organizational borders. This discrepancy can largely be attributed to the fact that representatives from national authorities have difficulty in changing their priorities in order to make cooperation work.

This study shows that organizational interests have a high impact on the prerequisites for cooperation in return-to-work. By referring to organizational goals, managers engage in non-cooperative behaviour, which threatens to spoil cooperative initiatives and to develop distrust in cooperative work forms. Trust is a key condition in cooperation, while self-interest and low trust impedes the development of functional intermediary actors in return-to-work. By identifying the conditions for interorganizational trust to develop, the results of the study thus expose the complexity of cooperation, and what threatens it.

It should also be noted that cooperation in the CAs has most commonly been organized based on an idea of consensus, where all organizations are expected to participate on equal terms in common work forms. Much discussion about cooperation has also been characterized by an ambition to reach common understandings about central concepts and common goals. From a theoretical perspective, it could be considered naïve to expect that representatives from separate social systems (or fields) will be able to share the same definitions and understandings of the problems in question (e.g. how to organize rehabilitation and return-to-work). However, this does not imply that efforts to achieve cooperation are pointless; rather, it emphasizes the need to illuminate system differences and how

these could be managed to secure the best possible process for the individual. Here, the position of the coordinators in the CAs is likely to be central.

Study III: Trust and cooperative learning

The aim of the third study was to describe and analyse the experience of rehabilitation professionals from public organizations regarding CAs as a structure for developing interorganizational cooperation in rehabilitation, return-to-work and labour market reintegration. The analysis focuses on officials' perspectives on the development of the cooperation structures initiated by the CAs.

It is clear that the participants in the study have had both positive and negative experience as a result of cooperating in the context of CAs. Generally, the positive experience relates to the evolving contacts across organizational borders and new interorganizational work forms. The negative experience is more related to the development of the organizations' contributions, and how attitudes on a managerial level affect the prerequisites for cooperative work on the practical level. Interestingly, the participants in the study note that they have no problems at all in cooperating; rather, it depends on the managerial level's priorities whether cooperation occurs or not. If the decision lay with the officials, the study suggests that they would cooperate more, since the needs of everyday practice would guide work rather than the regulations of each authority.

One interesting finding is that the personal contacts achieved through formal structures for cooperation, such as rehabilitation teams, have also been used in an informal way, for cooperation in cases outside the scope of the formal purpose of the teams. A general impression is that the arenas for cooperation are used in a broad way, and that the emerging network of officials from different rehabilitation actors has facilitated their communication considerably.

Another interesting finding is that the coordinators of interdisciplinary rehabilitation teams have, at least at some healthcare centres, developed into a central actor in the rehabilitation process. The function of these coordinators was initially to administrate the teams and to acquire consent from the individual for their case to be discussed at team

meetings; however, in some healthcare centres the coordinators have had the opportunity to develop their role with regard to their clients' needs. As a result, they have spontaneously developed into a work role that bears similarities to the characteristics of return-to-work coordinators and disability managers in other countries (cf. Rosenthal et al 2007; Shaw et al 2008). The main differences between the coordinators in this study and those described in the literature are firstly that they have not received any training for their role (thus, one could speak of developmental rather than adaptive learning, cf. Ellström 2006), and secondly that they are employed in primary healthcare rather than in workplaces, which is more often the case internationally.

As such, the CAs have resulted in a development of networks on a practical level, where representatives from different authorities trust one another and cooperate both formally and informally. The informal learning suggests that the cooperation structures have been perceived and used as a learning environment, in which the participants use the learning opportunities provided by the formal cooperation structures (Billett 2004; Fuller & Unwin 2004). External support has been emphasized as important for learning environments to develop and for expansive learning to occur (Gustavsson 2009). The cooperation structures discussed in this study may be considered as learning environments under development. However, the study suggests that the level of trust between managers and officials is low, implying that officials have limited support to learn from their cooperation. In fact, at least in group one of the study, a form of distrust between managers and officials seems to have developed as a consequence of a withdrawn managerial commitment in interorganizational cooperation. The participants in the study claim that the withdrawal has been made without implementing the knowledge developed through new work forms and cooperation structures. This results in less cooperation and less opportunity for interorganizational learning (cf. Luhmann 1979).

In the study, there is a sharp difference between the two groups with regard to their experience of the development of cooperation. Both groups express that cooperation has been facilitated through the work forms that the CAs have financed. However, group one have experienced setbacks when cooperative work forms have been shut down despite positive evaluations. Thus, it becomes obvious that the strategies for developing these work forms have differed between the two CAs. While one CA has invested in long-term financing of a central cooperation team, the other has started several projects with the aim

of implement them into ordinary practice. The latter strategy seems to be more vulnerable to the participating organizations' self-interest, since it relies on the organizations' ability to take over the cost after the initial period of pooled financing.

Furthermore, the officials' level of discretion seems to be important for whether interorganizational cooperation is feasible or not. While discretion is a prerequisite for cooperation, it is also perceived as being enhanced by cooperation. Simultaneously, national governance of state authorities is increasing, which is perceived as hindering cooperation. Hence, the level of discretion in officials' work with rehabilitation is balanced by contradicting forces.

Study IV: Work ability assessments – a public affair?

The fourth study focused on how work ability assessments are made, with special attention towards interorganizational cooperation and how the recent changes in sickness insurance regulations may influence the assessment process.

The discussions between the participants in the study show that work ability assessments are often made without taking work characteristics into consideration. The officials at the Social Insurance Agency do not consider themselves competent in assessing work ability, which makes them rely heavily on medical certificates issued by physicians. However, since there is a general lack of communication and cooperation between the public system (the Social Insurance Agency and primary healthcare), employers and occupational health services, these certificates are based on assumptions rather than actual observations of the individual at work.

More specifically, the officials at the Social Insurance Agency state as problematic their lack of knowledge of working conditions and how the different factors that limit work ability can and should be weighted. According to the regulations, the officials are to limit their assessment to medical factors as the only valid cause for limitations, while there may be other, more socially oriented factors that influence an individual's situation. Since physicians in general tend to include a broader set of factors in their certificates, the Social Insurance Agency officials have to deal with sorting out the factors that permit or deny

eligibility. In doing so, they may consult insurance medicine counsellors, but these are in turn even further detached from the individual's working conditions since they do not meet the individual.

Thus the basis for decisions of eligibility for sickness benefits is weak, which is troublesome from a legal perspective. It is also notable that the officials do not cooperate with employers or occupational health services in work ability assessments, although these actors could provide necessary information. There is scientific evidence that well-functioning cooperation between healthcare, employers and the compensation system is effective for shortening the period of sick leave and for facilitating return-to-work (Franche et al 2005; Loisel et al 2005a). However, in the Swedish sickness insurance system there is a general lack of clarity regarding the responsibilities of employers and the occupational health services. This ambiguity is highlighted in the study by elucidating flaws in the cooperation between on one hand the public system (the Social Insurance Agency and primary healthcare), and on the other hand employers and occupational health services, in both return-to-work and labour market reintegration.

The ultimate goal for the rehabilitation process, according to policy, is that the individual shall return to work with full work ability within the time frame of the Rehabilitation Chain (see Chapter 1). However, the participants in this study express concerns about whether this is feasible for all individuals. Those who are not able to complete their rehabilitation in time will lose their sickness benefits and be transferred to the Public Employment Service for labour market reintegration, where they will have to compete with people with full work ability. The participants in the study experience an increasing gap between the sickness insurance system and the labour market, especially concerning those with low work ability who are not sufficiently work-disabled to receive disability pension. This situation causes the participants in the study to question the goal of the rehabilitation process.

The recent policy changes place an increased focus on activation and return-to-work, which calls for comprehensive cooperation between the Social Insurance Agency, healthcare services, the Public Employment Service, employers and occupational health services. This study shows that there are several flaws in this cooperation. Furthermore, the aim of the policy to increase return-to-work is contradicted by the design of the system, since it disregards employers as cooperation partners. The new time limits also place more empha-

sis on labour market reintegration than on return-to-work, which may further decrease employers' incentives to participate in cooperation.

6. In cooperation we trust

In this final chapter, the results from the four studies will be discussed with focus on recurrent themes in the material, relating these themes to the theoretical framework as well as previous research on interorganizational cooperation. This discussion will close with suggestions for future research.

Understanding work ability

The concept of work ability has a central position in the sickness insurance system which makes it a topic for much discussion from different perspectives. In Study I, it became obvious that representatives from healthcare services had a different understanding of the concept than the social insurance officials did. Although there are differences within and between professions (most apparent between the traditional and the more cooperative physicians), healthcare professionals have a tendency to incorporate more aspects into the assessments than the sickness insurance regulations can take into consideration. Such aspects may be the social situation or whether there are any realistic alternatives to sickness benefits for the person in question. This more holistic perspective on work ability may thus stand in conflict with the reductionistic perspective that social insurance officials have to adapt when following regulations.

In the fourth study, work ability was again in focus for the discussions, especially regarding how different actors interact in work ability assessments. In this study, it became

obvious that assessments are often made without considering the actual work task, implying that they are based primarily on the physician's and social insurance officials' preconceived knowledge of the working conditions of the occupation in question. Employers are often disregarded in these assessments, and the officials at the Social Insurance Agency state that they do not feel competent in assessing work ability.

The Swedish sickness insurance system is to a large extent based on the work principle, which makes the concept of work ability central; nevertheless, it is a concept surrounded by ambiguities. From the first phase of sick leave when the sick-listed person meets a physician in primary healthcare to the last phase, where the person may be on his or her way to a new job, there are many different actors that will manage the process from different perspectives. From the health promotion perspective of the healthcare professionals to the bureaucratic perspective of the social insurance officials, and then – if the person is not able to return to work – further to the employment service officials who compare the person's work ability with whether he or she is employable or not. At this point, the concept of work ability has a dramatically different meaning compared with the early phase: the definition that denied a person sickness benefit may at the same time disqualify the person from taking another job due to demands from the employers.

In a recent report, the OECD notes that the Social Insurance Agency lacks the capacity for assessing work ability and that they have to rely on external medical practitioners (OECD 2009). As noted, these practitioners base their assessments mainly on medical status rather than work characteristics, mostly due to lack of communication and cooperation with employers and occupational health services. The OECD notes that the process focuses more on eligibility for benefits than on activation and return-to-work. Furthermore, the new policy framework (see Chapter 1) "requires good cooperation and continuous information exchange to continue" (OECD 2009, p. 42). The studies in this thesis indicate that this requirement is not met in work ability assessments in the initial phase of sick leave.

In order to resolve issues of how work ability should be assessed within the sickness insurance system, the Swedish government decided in 2008 to set up a commission for the task. In the commission's first report, it is stated that work ability resides in the intersection between a person's abilities and the demands of a work task. The question of whether someone is able to perform a work task thus cannot be isolated from the demands of that

specific task (Hedborg 2008). Disease does not automatically imply work disability, which implies that a person's limitations must be related to the specific work task that is to be performed.

Nordenfelt distinguishes between a number of factors that together make up a person's ability to work with a specific task (Nordenfelt 2008). He introduces the concept of competence, which is divided into a general competence that is needed for most occupations (such as the ability to communicate and cooperate), and personal competence, which is an additional set of competencies that may be required for some work tasks. For there to be work ability, Nordenfelt also stresses that the person must be willing to take the job. In addition to this, a person needs the proper qualifications (such a legal conditions) to be able to take a job. However, while all of these factors are central, the person's health status is nevertheless crucial for his or her ability to work. If he or she is ill, the person's executive ability decreases or disappears; also, the person's perception of his or her work ability is affected, which may vary between individuals. As a consequence of his analysis, Nordenfelt concludes that numerically calculating a person's work ability is very difficult, especially in non-physical occupations, and that work ability needs to be assessed holistically, involving the context of sickness insurance as well as the person's qualifications and the characteristics of the work task.

The increasingly strict medical perspective on work ability assessments has been criticized with regard to the difficulty in disregarding factors that influence a person's work ability, as the assessments risk becoming unreliable and contradicting the holistic perspective promoted in research (Westerhäll 2008). The results of Studies I and IV underline this criticism by illuminating the difficulties professionals from different organizations meet when they are to assess work ability, and to communicate and cooperate across organizational borders.

A systems perspective on work ability

The political ambition in sickness insurance policies is to use work ability as a gatekeeping administrative concept based on medical status, and to aim for consensus about how the

concept is used and interpreted throughout the process of rehabilitation and return-to-work. The studies in this thesis show that such ambitions are coupled with difficulties, since different actors interpret the concept differently.

The different ways of defining work ability can partly be explained by referring to different models of work disability. The more holistic interpretation of the concept that the healthcare workers share bears similarities to an ecological model where the physical and psychosocial status of an individual is related to contextual factors (Loisel et al 2005a; Loisel et al 2001). The Social Insurance Agency, on the other hand, base their definitions on an insurance model, where the principles for eligibility govern the assessment rather than the possibility of rehabilitation and return-to-work (cf. OECD 2009). This model is reductionistic in the sense that it disregards all factors for work disability except the medical ones, which is a perspective that has been reinforced by the recent policy changes. The results of Study IV suggest that the reductionistic model for assessing work ability is not in line with a return-to-work perspective, since it is too occupied with eligibility criteria, and that it fails to include the characteristics and demands of work in the assessments.

However, it can be questioned whether consensus regarding a concept such as work ability could ever be reached. Relating to Luhmann (1995), all systems (such as the medical, the political or the legal system) seek to reduce the complexity of reality by focusing on specific aspects. Systems communicate about phenomena in different ways, and when systems communicate with each other, the meaning of the phenomenon is reconstructed by the other system. Thus, reality is always a specific system's reality. A generally accepted meaning of a concept that is used across systems is therefore not possible. Ambitions to combine perspectives into a single model (such as WHO's biopsychosocial model in the International Classification of Functioning, Disability and Health, ICF) are thus theoretically naïve (Michailakis 2003). A similar criticism could be directed towards the holistic perspective on work disability promoted by research (cf. Loisel et al 2005a), where the ambition to incorporate the different interpretations into an ecological model could be considered as an equally unrealistic attempt to achieve consensus.

However, this systems perspective does not imply that cooperation between systems is impossible. Consensus may facilitate cooperation, but should not be considered a prerequisite for it (Michailakis 2003; Andersson 2010). What is necessary, however, is a consciousness of the different interpretations and what effect the different perspectives have

on the individual in different phases of the process of sickness, rehabilitation, return-to-work and/or labour market reintegration.

The studies in this thesis highlight the complexity of interpreting perhaps the most commonly used concept in Swedish sickness insurance. As we have seen, the lack of communication and cooperation between the insurance system, the healthcare system and the workplace system implies that assessments of work ability (and thus the assessment of eligibility for benefits) are made on a questionable basis, which from a legal perspective is a notable weakness.

Organizing for freedom

The quote at the beginning of this thesis is taken from the song *Hunter* by the Icelandic artist Björk. Let us listen to her again.

> *thought I could organize freedom,*
> *how Scandinavian of me,*
> *you sussed it out, didn't you?*

She sings, wise from experience it seems, that organizing freedom is impossible; however, her Scandinavian heritage made her try. In a way, this quote is also illustrative for some of the results of the studies in this thesis. Organizing a structure for cooperation, as discussed in Study III, did actually give the officials a certain amount of freedom, since it enabled informal networks of officials from different authorities to be established. These networks were used to improve interorganizational communication and cooperation. Thus, it is possible to organize work in a way that promotes this kind of cooperation. This is not organizing freedom (one may suspect that Björk has a point in her lyrics), but the study suggests that giving officials freedom by allowing them discretion in their work will promote a more cooperative approach to rehabilitation and return-to-work.

Here, a central point for concern is the level of trust between officials and managers. As noted in Study III, the level of trust between officials from the participating organiza-

tions has developed through working in cooperative work forms, while the officials' trust in their managers seems considerably lower. They have experienced decreasing managerial commitment to cooperation that has evoked feelings of disappointment, and that the knowledge acquired through cooperative work is not recognized. Since informal cooperation is difficult to measure and furthermore is not a primary interest for managers in some of the participating organizations, it seems difficult to maintain financial support for such a structure. Being responsible for keeping budgets in balance affects managers' commitment to cooperation. This may in turn be a factor that affects interorganizational trust on a managerial level, which seems lower than among the officials (as indicated in Studies II and III).

Let us for a moment reflect upon the title of this thesis: *In Cooperation We Trust*. This title may have different meanings depending on how it is interpreted. For instance, who trusts cooperation? Cooperation with whom? About what?

Study III shows that the officials share a common trust in cooperative work, and that they generally feel that cooperative work gives them many opportunities for learning and improving their common work. Furthermore, they tend to emphasize that the goal for the cooperation ought to be a better rehabilitation process for the individual, in which organizational self-interest is not purposeful. Thus, they also trust each other in sharing this goal and working towards it, as far as possible.

On a managerial level, the trust in cooperation is of a more complex character. It is certainly a concept that comes with positive connotations; most of the managers who participated in the studies look upon cooperation as useful and necessary (There are a few exceptions where some managers talk about cooperation, especially through CAs, as a fashionable waste of money.). However, when a cooperative work form has been tried for a few years through the pooled budget, implementation may fail because managers are not willing to contribute financially on a longer term.

While being used to working bureaucratically in their ordinary practice, officials participating in cooperative work take on a broader perspective to manage the more complex situations the people in question have. Thus, it seems that cooperative work tends to go hand in hand with a holistic and solution-based approach to peoples' problems (cf. Grape 2001). Organizing interorganizational cooperation therefore seems to imply organizing for officials' discretion, which managers seem resistant to do. Acquiring trust in cooperation,

from a managerial perspective, is thus less a question of trusting cooperative methods (that by default seem non-bureaucratic), and more a question of payback on invested money. If the payback is modest or delayed, cooperation will be valued low, regardless of the positive experience of the officials.

Managing inconsistencies

In the field of rehabilitation, return-to-work and labour market reintegration, there is a plethora of norms and values regarding central issues, such as definitions of concepts and the goals of the rehabilitation process. Due to the variation of professional and organizational backgrounds of the actors, these norms are bound to be inconsistent in several ways. When studying interorganizational cooperation, inconsistent norms thus seem to be an issue right at the centre of the research field.

Organizations have different ways of managing inconsistent norms. Brunsson (1986) defines inconsistent norms as a variation of values regarding an organisation's goals, and in his analysis of organizational hypocrisy, he argues that inconsistent norms are often reflected through:

- a conflictual organizational structure where different interests are represented;
- depressive processes with more or less unsolvable problems rather than solutions in focus;
- hypocritical outputs.

The outputs of an organization, says Brunsson, come primarily in three types: talk, decisions and products.

> Organizations may reflect inconsistent norms by systematically creating inconsistencies between talk, decisions and products. They can talk in consistence with one group of norms, decide according to another and produce according to a third. Organizations dealing with inconsistencies have reason to be hypocritical. When other methods of reflecting inconsis-

tencies are difficult to use, they should even be expected to be hypocritical. (Brunsson 1986, p. 171.)

When looking at the organizational structure of the CAs, inconsistencies can be determined at the very heart of the organization. Since CAs meet many inconsistent norms in their environment (such as holistic versus reductionistic perspective on rehabilitation, or work ability versus employability), they need to reflect these norms in their structure. They do so by being governed by boards that are by definition conflictual, where the members represent different organizations with different interests. In addition, the operative groups that are responsible for putting the decisions into practice are equally conflictual, and communication between these two groups does not seem very developed (cf. Study II).

Regarding Brunsson's notion of depressive processes of problem orientation, there are a number of inherited structural problems between the participating organizations that were central for the development of the CAs, and while the CAs were initiated to work with solutions, the long history of problem orientation continues to influence practice. This, in turn, is counterproductive to action, and leaves officials in the participating organizations to deal with the inconsistencies in an informal way (as shown in Study III), which implies a decoupling of practice and rhetoric (cf. Meyer & Rowan 1977). The stated aims of the CAs may thus be different from the decisions of the boards, which in turn may prove to be different from the actions initiated in practice. Using Brunsson's terminology (1986), this could be understood as the (unintended) inconsistent outputs of an inconsistent organization.

The CAs represent a structure aiming to work with solutions to the inherited problems of lack of coordination within the welfare system. However, by striving for consensus-based cooperation through a conflictual organizational structure, there is a risk that different participants within the CAs limit their commitment to outputs where they receive some sort of payback, resulting in further output inconsistencies that are counterproductive to action (as discussed in the second and third articles). The difficulties of implementing cooperative work forms may be seen as an example of how an overly optimistic consensus perspective prevents action.

As Bourdieu argues, people do not act independently or autonomously; rather, they are governed by the inherited norms and values of specific social fields, embodied and individualized through the habitus. This suggests that individuals cannot be expected to act in a fully rational manner in interaction with others. Instead, they follow norms given to them by the contexts they belong to. In this way, institutions and organizations can be considered to both shape and create preferences (cf. institutional theory's focus on how an actor's preferences are influenced by the context in which they operate, Rothstein & Steinmo 2002; also Powell & DiMaggio 1991).

Applied to the studies in this thesis, the representatives from the participating organizations can be said to act based on preferences developed in accordance with the purpose of each organization. Taking the Public Employment Service as an example, they tend to focus their efforts on people who are already considered employable. From a holistic perspective this could be considered irrational, since it implies that they do not consider the whole system when defining their priorities. Nevertheless, their actions are rational from an organizational perspective, since they contribute to fulfilling organizational goals. Thus, the employment service adheres more to organizational values than to social or welfare values in their dispositions for action (cf. Simon 1997). The appropriate logic for an employment service official is in this case scepticism towards cooperative work, if cooperation is seen as a hindrance to fulfilling organizational goals.

A conclusion from these arguments is that CAs are structures that comprises a multitude of inconsistent norms and values, and that the ambition to reach consensus between different perspectives takes time and energy away from the purpose of the CAs, namely cooperation. It should also be noted that the perspective that was initially adapted on cooperation in the CAs was a very action-oriented approach with hands-on cooperation in common work forms. A few years later, this approach seemed less realistic due to the self-interest of the highly specialized organizations that the CAs consist of (cf. Lindqvist 2003). It could be argued that a cooperation strategy that recognizes the differences in perspectives could have better prerequisites for successful cooperation than one that tries to bridge what cannot be overcome.

Why organize cooperation?

As demonstrated in this discussion, there are many obstacles to interorganizational cooperation. Nevertheless, there has been a consistent ambition from the government and the public authorities over the last decades to promote cooperation. Furthermore cooperation has been regarded as a genuinely positive concept. This makes it interesting to pose a fundamental question:

Why?

What are the desired positive effects of cooperation that has promoted this development? What is it in the current system that is lacking, that makes cooperation necessary? Why organize cooperation?

One answer to these questions is Lindqvist and Grape's conclusion that the sectorized welfare system has developed into such an effective and specialized machine that it cannot manage people who do not fit into the grid (Lindqvist & Grape 1999). The system is designed for certain predefined problems, which implies that more complex situations require another solution. Ergo: cooperation projects.

It is therefore interesting to note that the spontaneous way of organizing cooperation in CAs (and other cooperative initiatives) has been to start interorganizational work forms, most commonly teams, rather than coordinating the existing services. This may be taken as an acknowledgement of the participating organizations' failure to manage complex cases and the need for common arenas across organizational borders. Thus it reinforces the conclusions of Lindqvist and Grape (1999).

It is also interesting that although the birth of cooperative work forms illustrates a certain self-criticism among the participating organizations, they still have problems disregarding their organizational self-interest, even in this setting. From a theoretical perspective, the difficulties are not so surprising, since the established fields involve certain forms of practice, in which the introduction of interorganizational work forms is likely to be confusing for the participants, and challenges the doxa of their field.

A more interesting finding, however, is that the difficulties seem to be more prevalent on the managerial level than among officials. The cooperative work forms have been positively received by the officials, and there is a feeling that they are finally allowed to work

the way they have longed for. Through the CAs, the managers have created common arenas that function as a structure for promoting an expansive learning process for the officials. And the officials do use this structure, at least until the implementation process fails. The doxa of the fields, to use Bourdieu's terminology, thus seems to be stricter for the managers than for the officials. A possible explanation for this is that since sickness insurance regulations have changed considerably over the last few years, managers have a greater responsibility to ensure that regulations are met in practice; officials, on the other hand, may be more comfortable with the more autonomous position they had before the changes. Cooperative work forms, as discussed above, have supported discretion, which makes its popularity among the officials – and the disappointment among the managers – understandable. Cooperative work presupposes a certain amount of heterodoxy from the participants, which is more difficult for managers in national authorities to embrace than for officials in local municipalities.

As Grape (2001) notes, cooperative work forms generally take on a more holistic perspective than ordinary practice. The studies in this thesis reinforce this conclusion and add that the officials seem to *prefer* this holistic perspective. Interestingly, they feel antagonized when trying to think holistically in ordinary practice, which implies that the cooperative work forms have been perceived almost as a refuge. Cooperative work forms can be interpreted as the antithesis to managerialism and governance, and thus as generally contradicting the development towards more governance in national authorities.

A high level of discretion could imply better decisions due to the increasing possibility of taking individual conditions into consideration. However, increased discretion through cooperation could likewise imply the opposite, since it also involves a risk of arbitrary decisions. On the other hand, as Lipsky (1980) shows, increasing governance does not automatically mean that decisions are made in compliance with policy, which means that the risk of arbitrary decisions is constantly present.

The ambitions of the decision makers when the legislation for the CAs was adapted may very well have been in line with Lindqvist and Grape's conclusions: to manage what the system is not designed for (Lindqvist & Grape 1999). What the decision makers did not account for were the positive reactions among the officials, and that this could actually imply a conflict between managers and officials when perspectives clash.

Where are the employers?

The CAs are structures for cooperation between public organizations. As shown in Study IV, there is a general lack of cooperation between the public actors, employers and occupational health services in return-to-work, although research emphasizes that cooperation between these actors is central (Franche et al 2005; Loisel et al 2005a; MacEachen et al 2006; Ekberg 1995; Ekberg et al 1994). Naturally, it cannot be expected that one cooperation structure can incorporate all actors, but it is notable that nearly all cooperation structures initiated by the government over the last few decades completely disregard employers as relevant actors. Kärrholm (2007) studied a cooperation project where employers and occupational health services were included as partners, which showed positive results on the duration of sick leave. Apart from this project, there are few examples of Swedish interorganizational cooperation involving employers.

One of the consequences of the inability to cooperate with employers is that the processes of rehabilitation, return-to-work and labour market reintegration take place in parallel universes: one process in the public insurance and healthcare system, and one at the workplace. Or, even worse, only in the insurance system.

The fact that employers are disregarded by the public authorities may have several explanations. Firstly, although the Swedish legislation that governs rehabilitation involves responsibility for employers to adapt the workplace, this is often not observed in practice (Bergendorff 2006). Furthermore, employers are often passive in the return-to-work process, specifically regarding early return-to-work (cf. Tjulin et al 2009). Since the Social Insurance Agency cannot control or fine employers that do not cooperate, there are few incentives for employers to engage in return-to-work.

However, financial incentives for employers (such as contributions to the system or experience-rated penalties) may have counterproductive effects (Hyatt & Kralj 1995; Thomason & Pozzebon 2002; Tompa et al 2007). In the Netherlands, employer contributions to the system have increased, which, according to van Oorschot and Boos (2000), has resulted in employers increasing their check on applicants when recruiting workers. A consequence of this is that people with a history of sick leave or disability will have more difficulty in finding a job. A similar scepticism about hiring people with a history of sick

leave has been noticed among Swedish employers (Mörtvik & Rautio 2008). Thus, involving employers through regulations is complicated and could have adverse effects that are difficult to predict.

Furthermore, occupational health services are generally absent in rehabilitation and return-to-work. In Sweden, 65% of employees state that they have access to occupational health services (Arbetsmiljöverket 2008). However, many of these services are directed towards prevention and health promotion or to rehabilitation in the later phases of return-to-work. In the 1990s, governmental support for occupational health services to participate in rehabilitation was withdrawn, which caused a considerable decline in the use of such services (Larsson 2000). Thus, occupational health services are generally not involved in the early phase of sick leave, and cooperation with primary healthcare – where most people go to get medical certificates for sick leave – is lacking (Alexanderson et al 2005). Many workers do not have access to occupational health services because employers are not obliged to offer such services. The level of service is therefore dependent on the amount that employers invest in such services.

A change of climate

One of the cornerstones in Swedish active labour market policies in the early 1900s was that of involving employers on the boards of the public services. This employer representation was originally introduced to prevent conflicts between the parties on the labour market, and it also contributed by legitimizing active labour market policies among employers (Rothstein & Bergström 1999). The employers also contributed with their knowledge of the field and the target group, which guaranteed a good cooperative climate in labour market policy issues. However, in 1991 the Swedish Employer Association decided to withdraw their representatives from the boards, which, according to Rothstein and Bergström (1999), was a consequence of a series of decisions during the 1980s that had increased the governmental steering of labour market policies. Thus, the employers' influence over the policies decreased, which made them re-evaluate and terminate their participation. Bearing this in mind, it is possible to assume that the government has been

restrictive in involving employers when designing cooperative projects, due to an underlying conflict in one of the policy fields in question. Today, the cooperative climate between the public system and the employers is not as good as prior to the withdrawn participation and the high level of unemployment in the 1990s.

As Johnson (2010) has shown, there has been a shift in the Swedish media discourse on sickness insurance that has had far-reaching effects on policy and the organization of the insurance system. From previously emphasizing problems in the working environment (traditionally the unions' explanation of sickness absence), the debate shifted after 2002 into focusing more on moral hazard, over-utilization and system failure (an explanation that was more attractive to employers). As Johnson points out, none of these positions can fully explain the rise in sickness absence that was observed in the early 2000s. A more reasonable explanation would involve a number of factors, most notably that the prerequisites for managing work-oriented rehabilitation for people with complex problems was obstructed by an increasingly competitive labour market and the increasing specialization and sectorization of the insurance system. These factors have made it more difficult to find tailored solutions, which is part of the background to why cooperative projects such as the CAs were started. However, as shown, the specialization remains a problem, since it tends to impede cooperative work.

A possible conclusion from Johnson's analysis of different discourses in sickness insurance issues (Johnson 2010) is that representatives from the public system and employers belong to different fields governed by different values and norms. While having problems with competing definitions within the public sphere, it is not surprising that problems arise when cooperation stretches across to the employers, whose goals (with the possible exception of public employers) are characterized by profit rather than public welfare. The doxa of the employers is thus substantially different from that of the public authorities.

Conclusions

The aim of the Coordination Associations studied in this thesis has been to bridge the gaps between the participating organizations by promoting consensus through common

work forms. However, the results from the studies show that such ambitions are troublesome in highly specialized public organizations.

Cooperation is perceived differently on different levels in organizations. On a managerial level, a consensus-based approach to cooperation is complicated by incompatible norms and organizational goals. Cooperative work forms are often considered as something outside the purpose of the organization; hence, cooperation is disregarded and managers (especially those from the state authorities) have in several cases withdrawn their organization's financing of common work forms, which excludes them from participation.

From a street-level perspective, the consensus-based work forms seem more purposeful; the officials have experienced the cooperation as a way of finding tailored solutions that enables them to take individual needs into consideration. Cooperation through CAs has thus been perceived as positive. The failure to implement cooperative work forms has consequently been perceived as a disappointment, where the managers' short-term organizational perspective is criticized by officials in all the participating organizations.

Cooperation in the CAs has to a large extent been organized as collaborative work forms rather than as coordination of existing practices. The collaboration has been based on an idea of consensus, where all organizations were expected to participate on equal terms and find common work forms. Although it has been shown that officials from different organizations can work together, the managerial level's priorities are more determined by their organizational goals and values, which makes them unwilling to finance collaborative work on a longer term.

Another theme of the thesis is the lack of cooperation between the public rehabilitation system and the employers. The public actors lack knowledge of working conditions, and since the work principle guides the rehabilitation process, it is necessary to incorporate employers into the cooperation to facilitate sustainable return-to-work and labour market reintegration.

A central conclusion of the thesis is that consensus is not a reasonable starting point when designing cooperation structures between public organizations. A sustainable cooperation structure needs to incorporate and coordinate the different actors' priorities into a long-term cooperation strategy, rather than base the cooperation on vulnerable collaboration projects.

Implications for future research

International research suggests that cooperation in return-to-work needs to incorporate a close relationship between healthcare, the insurance system and the workplace. The studies in this thesis identify the workplace connection as the weak link in Swedish cooperation in return-to-work, which calls for an increased focus on the cooperation between the public insurance and healthcare system, employers and occupational health services. In addition, more studies on the outcomes of interorganizational cooperation are needed, both regarding cooperation between public authorities and cooperation that involves employers. In future research, it is necessary to problematize the prerequisites for cooperation between different actors, and to relate the proposed goals for cooperation to the characteristics and perspectives that different actors represent.

7. Svensk sammanfattning

I denna avhandling studeras interorganisatorisk samverkan inom ramen för samordnings-förbund. Ett samordningsförbund är en struktur för samverkan som bygger på lagen om finansiell samordning av rehabiliteringsinsatser, FINSAM. Enligt denna lag tillåts kommuner, landsting, Försäkringskassan och Arbetsförmedlingen att gemensamt bilda samordningsförbund för att organisera och samordna arbetsformer riktade mot personer med behov av insatser från mer än en av de ingående parterna.

Det övergripande syftet med avhandlingen är att studera samordningsförbund som struktur för interorganisatorisk samverkan inom rehabilitering och återgång i arbete. Centrala forskningsfrågor har varit hur representanter från de deltagande organisationerna, på olika hierarkisk nivå, upplevt att samverkan fungerat inom ramen för samordningsförbund, samt vilken påverkan organisatoriska eller professionella förutsättningar haft på möjligheten att utveckla denna typ av samverkan.

I avhandlingen har material samlats in från två samordningsförbund i Östergötland. Dessa förbund vände sig 2006 till Linköpings universitet för utvärdering av förbundens verksamhet ur ett organisationsperspektiv, och det är dessa utvärderingar som ligger till grund för studierna i avhandlingen. Materialet till studierna har samlats in mellan 2006 och 2009.

Den övergripande metodologiska ansatsen har varit explorativ, där kvalitativa metoder använts för att få en fördjupande bild av de olika parternas syn på det gemensamma arbetet. I studierna har intervjuer, fokusgrupper och problembaserade diskussionsgrupper använts som datainsamlingsmetoder.

Avhandlingen består av fyra delstudier, där varje studie har specifika syften.

I delstudie ett studerades en konkret samverkansform – resursteam – i vilka försäkringskassehandläggare hade gemensamma planeringsmöten med läkare, arbetsterapeuter, sjukgymnaster, kuratorer och i vissa fall även kommunrepresentanter, psykiatrisköterskor och arbetsförmedlare. I studien gjordes tolv fokusgrupper med team samt tolv individuella intervjuer med vårdcentralschefer. I analysen fokuserades särskilt på hur de olika deltagarna i teamen förstod, tolkade och använde begreppet arbetsförmåga. Slutsatsen från studien är att arbetsförmåga tolkas avsevärt mera reduktionistiskt av Försäkringskassans handläggare än av personal i primärvården. Det finns också skillnader bland läkarna i synen på samverkan; i studien skiljs mellan traditionella och samverkansorienterade läkare, där de senare tagit till sig tanken om en multiprofessionell planering av rehabiliteringsåtgärder och arbetsförmågebedömningar.

Den andra delstudien fokuserade på samordningsförbundens styrelser och beredningsgrupper. I studien gjordes 35 intervjuer med chefer från samtliga deltagande parter i de två samordningsförbunden. Analysen fokuserade särskilt på hur organisatoriska förutsättningar och mål styr chefernas syn på och engagemang i samverkansfrågor. Studien visar hur synen på nyttan av samverkan är avgörande för engagemanget, och att organisatoriska prioriteringar (såsom ekonomiska ramar och resultatmål) i flera fall lägger hinder för utvecklandet och drivandet av gemensamma arbetsformer. I analysen fokuseras interorganisatorisk tillit som en avgörande faktor för att samverkansmotiv ska översättas till samverkansbeteende.

I delstudie tre möttes två grupper med handläggare från samtliga deltagande parter vid sju tillfällen vardera för att via principerna för problembaserat lärande diskutera utvecklingen av samverkan inom ramen för samordningsförbund, samt hur regelförändringarna i sjukförsäkringen efter 2008 påverkar framtida samverkan. Resultatet av studien visar hur implementeringen av samverkansformer i vissa fall havererat som ett resultat av de statliga myndigheternas ovilja att bidra med långsiktig finansiering av projektverksamheter. Detta har inneburit besvikelse hos de handläggare som arbetat i projekten, då dessa generellt uppfattat detta arbete som mycket positivt för såväl deras eget samarbete och för den enskilde. Samverkansprojekten har inneburit en möjlighet för handläggarna att utveckla sina arbetsmetoder, men då detta inte värdesätts tillräckligt högt på ledningsnivå tas inte denna lärandepotential tillvara. Det finns således en skillnad i synen på samverkan

mellan handläggare och chefer, där de senare tenderar att definiera nyttan i ekonomiska termer.

Delstudie fyra bygger på samma material som delstudie tre, men fokuserar på de olika representanternas syn på arbetsförmågebegreppet, och hur samverkan går till i bedömningen av arbetsförmåga. Resultatet från studien visar hur bedömningar av arbetsförmåga till stor del genomförs utan att ta faktiska arbetsförhållanden i beaktande, då fungerande samverkansstrukturer mellan primärvård, företagshälsovård och arbetsgivare i stor utsträckning saknas. Representanterna i studien är också starkt kritiska till de nya sjukförsäkringsreglernas effekter för personer med komplex sjukskrivningsproblematik, och de noterar hur sjukvårdens och Försäkringskassans bedömning av arbetsförmåga har liten koppling till arbetsgivares bedömning av anställningsbarhet.

Samverkan inom rehabilitering och återgång i arbete sker inom ett konfliktfyllt fält där många professioner möts och många perspektiv och definitioner på problem och begrepp ställs emot varandra. Den specifika samverkansform som studerats i denna avhandling – samordningsförbund – har haft som uttalad ambition att överbrygga de skillnader som finns mellan välfärdsorganisationerna genom att arbeta mot konsensus och gemensamma arbetsformer. Resultatet från studierna i avhandlingen visar emellertid att sådana ambitioner är problematiska på grund av svårigheter för organisationerna att implementera och finansiera verksamheter som ligger utanför deras kärnverksamhet. Då de statliga välfärdsmyndigheterna idag är specialiserade på vissa uppgifter innebär det att det finns stora skillnader dem emellan kring hur rehabilitering och återgång i arbete ska gå till. De normer och värderingar som styr respektive verksamhet reflekterar organisatoriska mål som ofta står i motsats till samverkanstänkande.

En central slutsats från avhandlingen blir därmed att en konsensusbaserad syn på samverkan inte är en rimlig startpunkt för organiseringen av samverkansformer mellan offentliga organisationer. En mera konstruktiv utgångspunkt är ett erkännande och synliggörande av de skillnader som finns avseende mål och syfte med samverkan, vilket möjliggör utvecklandet av strukturer som tar dessa skillnader i beaktande.

En annan central slutsats är att det finns en påtaglig brist på samverkansstrukturer mellan välfärdssystemet och arbetsmarknadens parter. Såväl svensk som internationell forskning lyfter fram samverkan mellan vård, försäkringssystem, arbetsgivare och företagshälsovård som positiv för en snabbare återgång i arbete, vilket innebär att samverkan mel-

lan offentliga myndigheter som ignorerar eller misslyckas med att etablera god samverkan även med arbetsgivare och företagshälsovård riskerar att bli verkningslös.

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