

# Legitimacy and comprehensibility of work-related assessments and official decisions within the sickness insurance system

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To Sixten, Gustav & Joel



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# ABSTRACT

The aim of this thesis was to contribute to the development of empirical and theoretical knowledge about the legitimacy and comprehensibility of assessment and decision-making processes within the sickness insurance system from a client perspective. The focus has been on interactions between clients and other stakeholders within the system, and the extent to which the clients understood and accepted the procedures. In addition, the legitimacy and comprehensibility of the system were studied through the lens of three theoretical concepts: social validity, social insurance literacy (SIL), and moral hazard. These were considered relevant and interesting for studying complex matters, such as clients' perceptions of sickness insurance procedures.

This work has been guided by four research questions:

- How are the interactions between clients and other stakeholders in the system (such as the Social Insurance Agency and health care institutions) perceived by clients, and what impact do these encounters have?
- What characterizes an acceptable and fair sick leave process from a client perspective?
- What understanding of assessment and decision-making processes within the sickness insurance system do clients on sick leave have?
- How does a client's comprehension of assessment and decision-making processes within the system relate to perceived fairness, background factors, and being granted or denied sickness benefits?

For this thesis, a mixed methods approach was adopted, consisting of one quantitative and three qualitative studies, including interviews, case files, register data, and a questionnaire. This approach aimed to provide rich knowledge about a complex phenomenon from different perspectives, which naturally led to several different analytical methods being selected. The three theoretical concepts used (social validity, SIL, and moral hazard), were further developed in this thesis and proved helpful in providing frameworks that may be relevant for a diverse range of disciplines focusing on interactions within sickness insurance systems.

Overall, the findings demonstrates that interactions between clients and other stakeholders were of considerable importance, both for the client's sick leave case and for their perceptions of sickness insurance procedures in terms of

legitimacy, comprehensibility, and fairness. However, these interactions were often perceived as either supportive or mistrustful. A continuing dialogue between client and case manager tended to facilitate the client's understanding and acceptance of the steps taken in the sick leave process. Furthermore, a client's perception of the justice of processes in the system was clearly associated with the system's ability to provide understandable and logical information and procedures. The interactions between other stakeholders involved in the process, such as treating physicians or employers, and the client's case manager, could sometimes influence the client's case; for instance, if the treating physician argued for the client's needs in a formal, fact-driven way and was available for cooperation. This thesis also demonstrates that acts of power and mistrust occur between stakeholders, in diverse directions and constellations, as different stakeholders try to influence the client's sick leave process. Assumptions of moral hazard were clearly present, directed not only towards clients but also towards other stakeholders.

An acceptable and fair sick leave process was described by the clients as being one that consisted of relevant procedures, was applicable to the unique client, and was a result of support from other stakeholders, including an open, frequent dialogue with the case manager. The clients' understanding of sickness insurance procedures was generally insufficient. In order to increase the comprehensibility, as well as the legitimacy and fairness, the authorities need to explain and justify a diverse range of steps beyond just the official decisions, so that clients are able to comprehend the *what*, *how*, and *why* of sickness insurance. This thesis demonstrates that the official decisions had limited social validity, and that when these were considered unrelated to previous steps in the sick leave process, such as a work ability evaluation, this led clients to question the legitimacy of the procedures and the authority itself and could also lead them to retrospectively perceive the work ability evaluation as a waste of time and a false show.

Another interesting finding in this thesis, in terms of SIL, was that clients' abilities to obtain, understand, and act on information had weaker associations with sickness benefit outcomes compared to their perceptions of the system's comprehensibility. Further, higher scores of perceived justice were associated with high scores of perceived system comprehensibility. This indicates that what the system does, and what it does not do, influenced clients' opinions of it, regardless of their prerequisites.

# SVENSK SAMMANFATTNING

Syftet med denna avhandling har varit att bidra till utveckling av empirisk och teoretisk kunskap om legitimitet och begriplighet för bedömningar och beslut inom sjukförsäkringen, ur sjukskrivnas perspektiv. Fokus har riktats mot att studera interaktion mellan sjukskrivna och andra aktörer i sjukförsäkringssystemet som sjukskrivande läkare, handläggare på Försäkringskassan eller arbetsgivare. I avhandlingen undersöks hur dessa kontakter upplevs av sjukskrivna och vilket inflytande denna interaktion kan ha på sjukskrivningsprocessens utveckling. En central del i denna avhandling har varit att studera om bedömningar och beslut är begripliga och legitima för den som är sjukskriven. Mer specifikt så handlar detta om hur sjukskrivna upplever deltagandet i arbetsförmågeutredningar initierade av Försäkringskassan och hur pass väl myndigheten förklarar och motiverar beslut om rätten till sjukpenning för personerna. Det har varit av särskilt intresse att studera hur sjukskrivna själva förstår dessa bedömnings- och beslutsprocesser, och vad som faktiskt kännetecknar en acceptabel och rättvis sjukskrivningsprocess.

Tre teoretiska begrepp har använts som konceptuellt ramverk: social validitet, socialförsäkringslitteracitet, och moral hazard. Dessa begrepp har även utvecklats vidare teoretiskt i avhandlingen vilket bidrar till en rad olika discipliner där interaktion inom sjukförsäkringen studeras. I avhandlingen har både kvalitativ och kvantitativ metod använts, då de fyra delstudierna har inkluderat såväl intervjuer med sjukskrivna, deras akter och registerdata från Försäkringskassan, samt en enkätstudie till sjukskrivna. Målet var att få en rik och nyanserad bild av ett komplext område.

Resultatet visar att interaktionen mellan sjukskrivna och andra aktörer spelade stor roll, både för personernas sjukskrivningsärende och för hur sjukskrivna uppfattade sjukförsäkringssystemets legitimitet, begriplighet och rättvisa. Dessa möten uppfattades ofta som antingen stödjande eller misstroende. Ett exempel på det föregående pekar på att en kontinuerlig kontakt mellan sjukskriven och handläggare underlättade personens förståelse och acceptans för kommande steg i sjukskrivningsprocessen. Maktspel och misstro förekom mellan flera aktörer, i olika riktningar och konstellationer, när aktörerna försökte påverka sjukskrivningsärendet. Misstron mot andra aktörers intentioner kan relateras till antaganden inom moral hazard-teorin, vilket var ett framträdande drag i avhandlingen. Sjukskrivna upplevde ofta att den egna beskrivningen av de svårigheter man hade förminskades, till förmån för andra aktörers bedömningar

av deras situation och att de behövde bevisa att de inte var fuskare som försökte utnyttja systemet. Resultatet visar också att samspelet mellan handläggare och sjukskrivande läkare eller arbetsgivare också kunde påverka sjukskrivningsärendet, exempelvis när en läkare argumenterade för personens behov på ett formellt sätt och fanns tillgänglig för samverkan med Försäkringskassan. I de sjukskrivnas beskrivningar framkom några framgångsfaktorer för att nå en mer acceptabel och rättvis sjukskrivningsprocess. Några aspekter som framkom kring detta var att bedömningsmetoder måste vara relevanta och anpassade för den enskilda personen, och att stödet från aktörerna runt dem var betydelsefullt, såsom en öppen och frekvent dialog med handläggaren. Sjukskrivnas förståelse för bedömningsprocesser och beslut i sjukförsäkringen var ofta bristfällig. För att öka begripligheten, legitimiteten och upplevd rättvisa, så behöver Försäkringskassan förklara och motivera en rad olika steg som tas i personens sjukskrivningsärende, och inte enbart beslut om sjukpenning. Detta är viktigt för att sjukskrivna ska ges goda förutsättningar att förstå *vad, hur* och *varför*, och därmed möjliggöra för dem att vara delaktiga i sin sjukskrivningsprocess. Det framkom att Försäkringskassans beslut om sjukpenning hade en bristande social validitet, och att när dessa beslut ansågs sakna en röd tråd till tidigare steg i processen, exempelvis resultaten från en genomförd arbetsförmågeutredning, så fick det den sjukskrivne att ifrågasätta legitimiteten för både bedömningsprocessen och Försäkringskassan som myndighet. Sjukskrivna kunde då i efterhand uppleva att arbetsförmågeutredningen varit slöseri med tid eller ett "spel för gallerierna".

När det gäller socialförsäkringslitteracitet, så visade det sig att sjukskrivnas individuella förmågor att inhämta, förstå och agera på information i sjukförsäkringssystemet hade en svagare koppling till sannolikheten att beviljas sjukpenning jämfört med skattningarna av systemets begriplighet. Dessutom fanns det ett tydligt samband mellan höga skattningar av systemets begriplighet och högre skattningar av upplevd rättvisa, dvs. att huruvida processerna i systemet ansågs rättvisa eller inte var tydligt relaterade till Försäkringskassans förmåga att förse sjukskrivna med begriplig information och logiska metoder. Detta indikerar att vad systemet gör eller inte gör, påverkar sjukskrivnas syn på sjukförsäkringssystemet, oavsett vad personerna själva har för bakgrund eller förutsättningar.

## LIST OF PAPERS

- I. Karlsson, E., Sandqvist, J., Seing, I. & Ståhl, C. Social validity of work ability evaluations and official decisions within the sickness insurance system: a client perspective. *Work*. 2021. 70, 109-124. DOI: [10.3233/WOR-213558](https://doi.org/10.3233/WOR-213558)
- II. Karlsson, E., Sandqvist, J., Seing, I. & Ståhl, C. Exploring interactions in the sickness insurance system in terms of power and trust. *Journal of Occupational Rehabilitation*. 2021. DOI: <https://doi.org/10.1007/s10926-021-10017-4>
- III. Karlsson, E., Seing, I., Sandqvist, J. & Ståhl, C. Communication characteristics between clients and stakeholders within the Swedish sickness insurance system – a document analysis of granted and withdrawn sickness benefit claims. *Disability and Rehabilitation*. 2020. 42(23), 3316-3326. DOI: [10.1080/09638288.2019.1592247](https://doi.org/10.1080/09638288.2019.1592247)
- IV. Karlsson, E., Hellgren, M., Sandqvist, J., Seing, I. & Ståhl, C. Social insurance literacy among the sick-listed - A study of clients' comprehension and self-rated system comprehensibility of the sickness insurance system. In manuscript.

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## ABBREVIATIONS

PES	The Public Employment Service
SIA	The Swedish Social Insurance Agency
SIL	Social Insurance Literacy
SILQ	Social Insurance Literacy Questionnaire
SILQ-SE	Social Insurance Literacy Questionnaire, Swedish version

# INTRODUCTION

This thesis studies the legitimacy and comprehensibility of assessments and decisions within the sickness insurance system from a client perspective. The focus is on interactions within the Swedish sickness insurance system, and how processes such as work ability evaluations and official decisions, are understood and accepted by those on sick leave.

Assessments of work ability are a key feature in sickness insurance systems, as these determine a client's eligibility to sickness benefits and may direct vocational intervention, although such procedures are carried out in diverse ways in diverse sickness insurance systems. Assessments and official decisions within the sickness insurance system have a major impact upon those who are unable to work and rely on sickness benefits, referred to as "clients" in this thesis. The focus within many sickness insurance systems has moved towards making objective assessments (Ekberg, 2014; Meershoek, Krumeich, & Vos, 2007), which leads to the exclusion of emotional and subjective considerations. Further, activation policies have influenced strategies of sickness insurance systems in western countries, for instance, in terms of restricting access to sickness benefits (Eichhorst & Konle-Seidl, 2008; Lindqvist & Lundälv, 2018) and focusing on clients responsibilities in their sick leave process (Junestav, 2004, 2009; Lindqvist & Lundälv, 2018; Nord, 2018). From a client perspective, this may not be an obvious procedure. When assessments and decisions are perceived as incomprehensible, illogical, or irrelevant by a client, there is a risk that this client will also perceive the authority and the entire system as unfair. For the client, perceived unfairness can in itself have consequences, not only for their trust in the authority, but also for their health and work (dis)ability, which risks causing a prolonged sickness absence and may aggravate attempts to return-to-work.

Complex interactions often permeate sickness insurance systems, for instance in terms of communication between several stakeholders, and actions that may be more or less understandable and logical to those involved, in particular the client. A problem with many kinds of information exchange is that the provider of information can never know, with certainty, that the information has been received and comprehended by the recipient in the specific way that it was intended. This becomes problematic in a sickness insurance context where an authority's legitimacy and comprehensibility are dependent on clients and citizens perceiving assessments and decisions as understandable and fair. This thesis is the result of an interdisciplinary approach, at the intersection of public health, medicine, political science, and sociology, as illustrated in Table 1, hence

different parts of the thesis are more inspired by certain fields than others. I had the benefit of being a part of an interdisciplinary research group with supervisors from different disciplines, which reflects in this thesis. The common denominator has been the processes within the sickness insurance system, such as the interactions between stakeholders and the work ability evaluations performed, including how these can be understood from different perspectives. Although all of the above-mentioned fields have influenced this research, I would say that this thesis can primarily join the fields of work disability research and insurance medicine. As Loisel and Anema (2013) stated, different scientific disciplines are required to be able to grasp the bigger picture of such a complex area as work disability.

This thesis' research setting is within the Swedish sickness insurance system, that is neither unique nor an ideal example of sickness insurance, but has its strengths and weaknesses, similarly as sickness insurance systems in other western countries. The Swedish system is a comprehensive, tax-funded social insurance system under which all citizens are insured in their "current state" independent of what caused the work disability, as opposed to countries that adopt cause-based systems, in which eligibility for sickness benefits requires the cause of the work disability to be proven as causally work-related (Loisel & Anema, 2013; MacEachen, 2018). All sickness insurance systems have their strengths and weaknesses that eminently include consequences at different levels affecting some or several of the involved stakeholders, both in cause-based and comprehensive systems. The features of the interactions between clients and other stakeholders to some extent also reflect the characteristics of the specific system.

The first overarching concept in this thesis, legitimacy, relates to whether sick-listed clients perceive the processes of the sickness insurance system as legally secure, fair, and to be trusted. A legitimate sickness insurance system is essential in order for citizens to perceive these processes as fair and to trust the authorities. This is also important in comprehensive systems, such as the Swedish one, where all citizens are insured and expect to be covered in the event of work disability. From a client perspective there is often a power disadvantage in relation to the authority that is determining the continuation of their sick leave case. A problem within the sickness insurance system is that these crucial processes seem to be insufficiently explained or justified to the client. This may lead to the perception of these processes as irrelevant or unfair, which will reduce the legitimacy of sickness insurance systems.

The second overarching concept in this thesis, comprehensibility, refers to whether clients perceive the procedures and interactions as understandable and logical, and how clients can navigate through the sickness insurance system. Interactions between clients and other stakeholders in the sickness insurance

system are often characterized by an extensive amount of information, some of it complicated, that needs to be articulated, obtained, understood, and potentially discussed. System representatives face the challenging task of explaining an abstract system to others, which involves explaining and justifying assessments, interventions, and official decisions, and ensuring that the client has understood. Furthermore, clients may need individually adapted information, depending on their disabilities. For the client, the ability to assimilate information is crucial for understanding the sequence of steps in the sick leave process, for being able to fully participate, and make informed decisions. Moreover, this may need to be done over time throughout the sick leave process, rather than on a single occasion.

## The contribution of this thesis

The importance of clients understanding and accepting the procedures in which they take part has been highlighted in different social insurance systems in western countries. When examining clients' perceptions of procedures within the sickness insurance system it is also interesting to examine their prerequisites for understanding them and the perceived comprehensibility of the information provided by the system. Other studies have investigated encounters between clients and stakeholders within a sickness insurance system (Hubertsson, Petersson, Arvidsson, & Thorstensson, 2011; Lippel, 2007; Moldvik, Ståhl, & Müssener, 2021; Müssener, 2007; Ståhl, MacEachen, & Lippel, 2014; Ståhl, Seing, Gerdle, & Sandqvist, 2019; The Swedish Social Insurance Agency, 2014) or clients' perceived justice of processes within this system (Dorfman, 2017; Kelloway & Hepburn, 2010; Mladenov, 2016; Ståhl et al., 2019). There are, however, few studies focusing on the legitimacy and comprehensibility of processes within the sickness insurance system, in particular using the theoretical concepts which are employed in this thesis. There is a need not only to identify flaws in the system but also to find other perspectives for understanding them and to provide potential ways to improve some of these issues. This is important for the authorities in their exercising of public authority, but also for the clients, who deserve just treatment and sufficient information. These aspects are also important from a societal perspective in terms of trust in the authorities and the citizens' reliance on the authorities to perform satisfactory work in line with current regulations.

I add to existing knowledge within the work disability field by exploring legitimacy and comprehensibility from a client perspective using three theoretical concepts to serve as frameworks: social validity, social insurance literacy (SIL), and moral hazard, which will be further explained in the theoretical framework section.

Evaluations of social validity for processes within the sickness insurance system are rare, hence this thesis provides an empirical contribution. Since the literature on this concept has its roots in another field (behavior analysis), there was a need to adapt social validity into a sickness insurance context, which can be considered a theoretical contribution to the field. Also, the development of the new concept of SIL can be considered another contribution that this thesis provides, both empirically and theoretically. There are similar concepts to SIL, however, relating and measuring clients' perceived understanding of the sickness insurance system to their perceptions of the systems' comprehensibility is new. Additionally, the interdisciplinary approach (see Table 1) also adds to the existing knowledge by developing empirical knowledge and theoretical concepts with a basis in several fields, potentially increasing their applicability in practice and usability in future research.

Table 1. Overview of the thesis in accordance with “A structure for categorization of studies of sickness absence/disability pension”, in which my contributions are marked in bold type.

What is studied?	-Study design -Type of data -Analyses	Scientific discipline	Perspective taken in the research question.	Studied	Structural level of the data/factors included in the analyses	Diagnoses
1. Occurrence of sickness absence/disability pension 2. <b>Factors that hinder or promote sickness absence/disability pension</b> 3. Factors that hinder or promote return-to-work 4. <b>“Consequences”/“side-effects” of (being on) sickness absence/disability pension</b> 5. <b>Sickness certification/assessment practice/processes</b> 6. <b>Methods, theories</b>	<u>Study design</u> <b>-Cross sectional</b> <b>-Longitudinal</b> -RCT, CT, etc. <u>Type of data</u> <b>Interview</b> <b>Questionnaire</b> <b>Register</b> Medical files <b>Insurance files</b> - <b>Certificates</b> - <b>Documents</b> Observations Video Other <u>Type of analyses</u> <b>-Qualitative</b> <b>-Quantitative</b>	Economy Epidemiology Law Management <b>Medicine</b> Philosophy Psychology <b>Public health</b> <b>Political science</b> Social work <b>Sociology</b> Other	That of the: -Society <b>-Insurance</b> -Health care -Employer -Colleagues -Family -Patient	General population Insured In paid work (general or special jobs/organizations) Diagnosed/patients <b>Sickness absent/disability pensioned</b> Organizations Professionals Countries	-International -National -Regional -Municipality -Worksite -Health care -Family <b>-Individual</b>	<b>All together</b> Mental Musculoskeletal Cancer MS Hearing CVD Infections Injuries Diabetes Head aches Others Multimorbidity

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# AIM

The aim of the thesis is to contribute to the development of empirical and theoretical knowledge about the legitimacy and comprehensibility of assessment and decision-making processes within the sickness insurance system from a client perspective.

## Research questions:

In order to address the aim of this thesis, four research questions were developed, focusing on the sick listed client's comprehension and perceived fairness of information, procedures, and contacts encountered within the sickness insurance system.

- How are the interactions between clients and other stakeholders (such as the Social Insurance Agency and health care institutions) in the system perceived by clients, and what impact do these encounters have?
- What characterizes an acceptable and fair sick leave process from a client perspective?
- What understanding of the assessment and decision-making processes within the sickness insurance system do clients on sick leave have?
- How does a client's comprehension of the assessment and decision-making processes within the system relate to the perceived fairness, background factors, and being granted or denied sickness benefits?

## Specific aims

Study I: The purpose of this study was to evaluate the social validity of assessment methods for assessing work ability and the official decisions to which these assessments lead within Swedish sickness insurance.

Study II: The purpose of this study was to explore how power and trust are expressed by clients and other stakeholders within the sickness insurance system.

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

Study IV: The purpose of this study was to investigate social insurance literacy among clients on sick leave and its associations with perceived justice, being granted sickness benefits, and background factors.

# THEORETICAL FRAMEWORK

The two overarching concepts, legitimacy and comprehensibility, are studied through the lens of three theoretical concepts: social validity, SIL, and moral hazard (see Figure 1), which contribute by providing a conceptual framework that facilitates the understanding of these complex research questions.

Social validity is a useful tool for exploring the acceptability, comprehensibility and importance of procedures, which relates, for instance, to whether work ability evaluations are perceived as relevant and appropriate. SIL is useful for understanding the complex interactions between clients' abilities to understand and act on information, and is related to the perceived comprehensibility and transparency of the information retrieved from the sickness insurance system. This thesis also explores assumptions of moral hazard from a critical perspective, which I thought was an interesting and provocative approach because it relates to the incentives that may exist for making efforts to return-to-work, and to the view of human beings as quite rational. There are elements of all three theoretical concepts that it is possible to relate to both the legitimacy and comprehensibility of processes within the sickness insurance system, but the main content is represented in the connections visualized in Figure 1.

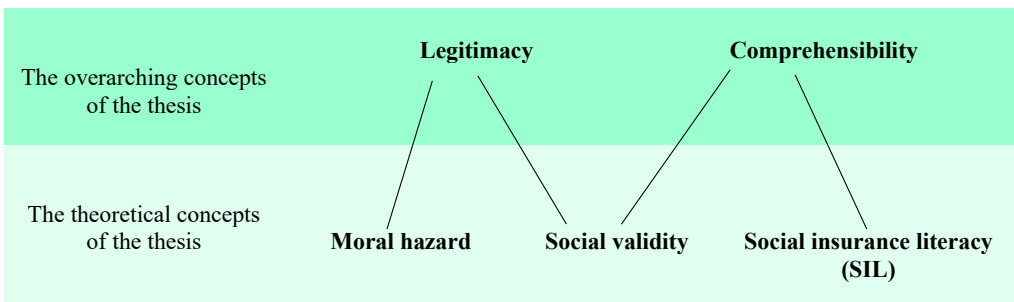


Figure 1. Key concepts of the thesis.

Legitimacy is explored by using moral hazard theory, in terms of increasing the understanding of the exposed situation and power disadvantage, as clients often feel questioned while sickness absent, and their incentives to participate in their sick leave- and rehabilitation process. Social validity also relates to legitimacy, for instance regarding the acceptability and importance of work ability evaluations and their consequences. Comprehensibility is closely linked to SIL, which facilitates an understanding of the complex interactions between a client's ability

to understand and act on information, as related to the perceived comprehensibility of the information provided by the system. Social validity is also relevant for exploring the extent to which clients comprehend sickness insurance processes, in particular its dimension of “comprehensibility” which captures what, why, and how information and procedures are understood.

Thus, I have chosen three theoretical concepts (social validity, SIL and moral hazard) that I use as frameworks in data collections and analyses, in order to study two overarching concepts (legitimacy and comprehensibility). These five above-mentioned concepts are central to this thesis, although other concepts also appear, such as work ability, interaction, power, trust, work ethics, perceived fairness, and activation policy. These other concepts have theoretical content, but I do not use them as tools in the same way. However, they are relevant to this thesis. Assessments of work ability are central for determining clients’ eligibility to sickness benefits, and hence have a major impact upon their situation (Seing, Ståhl, Ekberg, Nordenfelt, & Bulow, 2012). Furthermore, sickness insurance systems are often characterized by complex interactions between several stakeholders that also represent other systems, such as the health care system. I view these interactions as crucial for how processes are perceived and understood by clients, in terms of how information is communicated to (and by) them, and how encounters, actions, and procedures are carried out. Thus, the way I see it, interactions permeate this entire thesis. These interactions are often characterized by a power disadvantage from the client’s perspective and trust in the system is essential (Holmgren, Rosstorp, & Rohdén, 2016). Perceived fairness is used broadly in this thesis and is relevant in relation to clients’ experiences of assessment and decision-making processes. Activation policy is a key concept for describing the current context and how sickness insurance procedures have been affected by policies, which can be related to moral hazard theory and ideas of work ethic among the sick listed.

## The concept of social validity

### **The roots and application of social validity**

Social validity is a concept that was first established during the 1970s (Kazdin, 1977; Wolf, 1978), within behavior analysis (Foster & Mash, 1999; Kennedy, 2002; Luiselli, Bass, & Whitcomb, 2010; Rhule, McMahon, & Vando, 2009). Most of the social validity studies are found within this field; for example, regarding the social validation of child - parent interventions (Rhule et al., 2009). However, it is now also used within other disciplines and contexts. By tradition, social validity is often described in terms of social importance and acceptability. Social importance refers to the outcome or results and whether the client experiences a significant improvement after a given treatment, while acceptability refers to whether goals,

procedures, and outcomes are appropriate and comprehensible (Foster & Mash, 1999; Rhule et al., 2009; Sudsawad, 2005). During the development of a framework for the concept in a sickness insurance context, a theoretical synthesis of the social validity literature was performed (for instance including Carter, 2009; Foster & Mash, 1999; Gresham & Lopez, 1996; Kazdin, 1977, 1980a, 1980b, 1981; Kazdin, 2005; Rhule et al., 2009; Ståhl et al., 2019; Sudsawad, 2005; Wolf, 1978). This theoretical synthesis was a founding inspiration for the interview guide used in Study I, as well as related research of encounters within the sickness insurance system (such as Müssener, 2007; The Swedish Social Insurance Inspectorate, 2013). Three dimensions of the concept emerged, based on the social validity literature: Acceptability, Comprehensibility, and Importance. I chose to refer to these as dimensions, as they seem to interact with each other, and to some extent they are overlapping, and hence cannot be separated like categories.

Acceptability refers to whether a procedure is appropriate and relevant, or if it could be perceived as insulting. Comprehensibility refers to whether information is understandable and given in a way that the client can comprehend. Importance refers to whether the procedure was worth the effort, and hence whether the outcome was desired and if the process in reaching it was perceived as reasonable. These three dimensions interact in a dynamic way. For instance, if a client is given comprehensible information about the purpose and the intention of a specific procedure, and where this might lead, it is more likely that the client will perceive the procedure as acceptable and worth the effort. And if a client experiences a positive change, a performed procedure can be perceived as acceptable retrospectively, even though the client may initially have been skeptical.

### **Measuring social validity**

There is a broad range of approaches to evaluating social validity within behavior analysis, where most studies are found. For this thesis, I explored both conceptual descriptions of social validity and ways to measure it, in order to gain an understanding of potentially appropriate paths within a sickness insurance context and from a client perspective.

The concept of social validity includes both clients' and professionals' perspectives, as well as that of the wider society. It can therefore be evaluated from different perspectives. The clients being assessed can state whether they perceive the assessment to be acceptable, comprehensible, and worth the effort. The professionals performing the assessment can also be approached to

investigate whether or not they consider it to be acceptable, comprehensible, and worth their effort. The wider society represents those who are not directly affected, but could be of interest if the researcher wants to investigate how an assessment is perceived from “the outside.” Social validity is a multifaceted construction (Kennedy, 2002) and usually one or two dimensions are evaluated in relation, for example, to a specific procedure using data from one source, such as professionals. In a sickness insurance context, and for work-related assessments, it has so far been unusual to use social validity. It has been explored in a few studies (Karlsson, Liedberg, & Sandqvist, 2018; Ståhl et al., 2019) but the concept is not widespread or well-recognized within this area, even though it may be quite useful.

Social validity can be evaluated using both qualitative and quantitative methods, although a literature review demonstrated that quantitative methods have been used more frequently during the last few decades. Evaluations have mainly been conducted for specific interventions, and usually using data from assessors, students, or parents. Social validity for assessments and using data from clients is not common, but it is necessary in order to understand the experiences of those directly affected. Within the field of behavior analysis, where social validity has its origins, there are multiple examples of studies evaluating interventions for children. These studies tend to use either the children’s parents, or “outsiders” who are not directly affected. In a study by Kazdin (1980b), the author described the intervention to undergraduate students who were recruited from a psychology course. The students answered a questionnaire regarding how acceptable the different interventions seemed to be and rated how acceptable the treatment was and how willing they would be to carry out the procedure. This approach of recruiting participants other than those who are directly affected is not uncommon, especially for studies performed during the 1980s and 90s. This is one way of evaluating procedures using data from the wider society; in this case, the acceptability of a specific intervention described to, and evaluated by, psychology students. Other studies have recruited parents to evaluate interventions in which their children had been included (Rhule et al., 2009), or the professionals who performed the procedure (Luiselli, Sperry, & Draper, 2015; Strohmeier, Mule, & Luiselli, 2014). But the clients, those directly affected by the procedure, are rarely approached.

### **The importance of socially valid work ability assessments**

Using socially valid assessment instruments is one way to enhance the quality of assessments, and how the procedure is explained and presented is an essential factor. Encounters with professionals and authorities can affect clients’ work ability, in either a positive or a negative sense (Stureson, Edlund, Fjellman-Wiklund, Falkdal, & Bernspång, 2013). It may seem simple but providing clients

with adequate information can enhance the comprehensibility and acceptability of an assessment. From a research perspective, the concept of social validity directs attention toward the ways in which assessment instruments are used to enhance the quality of assessments and, most importantly, how assessments are perceived by the clients. For example, clients need to know the purpose of an assessment before they take part in it. Is it to investigate their right to sickness benefits or to determine what interventions could be appropriate during rehabilitation? How will the assessment be conducted? Is it through an interview, physical tests of different functions, or an activity-based assessment? And where might this lead? What possible outcomes could be the consequences? These questions need to be answered in order for the client to comprehend the *what*, *how*, and *why* of the assessment. The information provided also needs to be individually adapted, because an oral description is not always enough.

Another important aspect is to give clients comprehensible feedback after an assessment. What were the results? Can the client recognize these? What will be the next steps in the process? Social validity is important since clients can perceive a non-socially valid measure as inappropriate and irrelevant. If clients accept and understand the procedures in an assessment, it is more likely that they will cooperate and commit to the assessment itself, but also to the following rehabilitation (Rhule et al., 2009). Professionals using socially valid instruments have the potential to reduce the complexity of assessment results. Clients' understanding of the assessment they take part in is important for increasing their participation. If clients question the assessment, or feel insulted in any way, how can we ensure natural behavior and accurate assessment results? In order to facilitate assessments and interventions, it is essential that they are acceptable and appropriate for those being assessed, as well as for the professionals conducting the assessment (Rhule et al., 2009). The social validity of work-related assessments using data from clients is an area that has been only sparsely investigated and it can contribute with knowledge about how assessments are perceived and understood by those directly affected. This is beneficial information for assessors as well as the authorities. In addition, social validity is a psychometric property that provides structure in evaluations and can potentially also strengthen the importance of acceptability for receiving valid assessment results.

## The concept of social insurance literacy

### **Speaking the system's language and guarding one's rights**

Studies have demonstrated differences between groups of clients on sick leave, regarding whose eligibility for sickness benefits is questioned and who receives

vocational rehabilitation interventions (Burström, Nylen, Clayton, & Whitehead, 2011; Dorfman, 2017; Hubertsson et al., 2011; Lippel, 2007; The Swedish Social Insurance Inspectorate, 2013, 2018). Literacy exists in several different forms, such as health literacy, financial literacy, health insurance literacy, legal capability, and social security literacy, aimed at explaining individuals' understanding of a specific context or phenomenon and how this affects the outcome (Ståhl, Karlsson, Sandqvist, et al., 2021). For instance, health literacy includes the knowledge and understanding that a client has and uses regarding their health, which affects when they seek health care and how they choose to prevent illness (Rudd, 2013). Few individuals seem to possess the basic knowledge about how social insurance systems function and what rights they have, which limits the possibility of making informed decisions and guarding those rights (Greenwald, Kapteyn, Mitchell, & Schneider, 2010).

The concept of “literacy” comprises a well-ploughed furrow in research on learning and social interaction in various disciplines. However, in relation to a sickness insurance context, there was need for a concept that recognizes the interactions between individuals and the system, how this relates to the social resources possessed by individuals, and the communication strategies used by systems. When examining clients' perceptions of their understanding and acceptance of the procedures they take part in, it is also relevant to examine their prerequisites for understanding them and the perceived comprehensibility of the information that is provided to them by the system. Relating clients' perceived understanding of the sickness insurance system to the perceived system comprehensibility seems to be a new arena. In 2017, a project was initiated at Linköping University, Sweden, aiming to develop a conceptualization and a measure of the concept. One of those studies is included in this thesis (Study IV).

### **The development of a new concept**

The theory behind SIL has its roots in sociology, social medicine, and public health, such as the social determinants of health that recognize structural differences between groups of people in society. Literacy in this context is not considered a skill that is simply possessed by the client but is a dynamic relationship between the client and the system, where a social gradient can impact upon the client's ability to guard his/her rights. For instance, the system can facilitate the client's understanding of processes by providing understandable and individually adapted information. SIL was established through a scoping review of similar concepts and in cooperation with a panel of international experts. It is now defined as *“the extent to which individuals can obtain, understand and act on*

*information in a social insurance system, related to the comprehensibility of the information provided by the system” (Ståhl, Karlsson, Sandqvist, et al., 2021).*

The content of the concept includes areas such as an individual’s ability to obtain, understand, and act upon information regarding how to contact, navigate, and deal with decisions and appeals within the sickness insurance system. It also includes the system’s comprehensibility and its perceived ability to provide accessible, understandable, and transparent information (Ståhl, Karlsson, Sandqvist, et al., 2021). The hypotheses of this project were that 1) the degree of SIL is related to background factors, following a social gradient, 2) higher SIL is related to a higher probability of being granted sickness benefits, and 3) higher SIL is related to a higher degree of perceived fairness in interactions with the sickness insurance system.

### **Measuring social insurance literacy**

After the conceptualization of SIL (Ståhl, Karlsson, Sandqvist, et al., 2021), an instrument to measure it was developed, exploring areas of the concept that are of interest in relation to a sickness insurance system. The instrument contains domains, or subcategories, such as the individual’s ability to obtain, understand, and act upon information regarding how to contact, navigate, and deal with decisions and appeals within the sickness insurance system. It also includes a domain aimed at exploring the system’s ability to provide accessible, understandable, and transparent information (Ståhl, Karlsson, Sandqvist, et al., 2021). This instrument is called the Social Insurance Literacy Questionnaire (SILQ). A panel of international experts with expertise within working life research and/or sickness insurance systems and representing diverse disciplines, including sociology, law, insurance medicine, occupational medicine, and social medicine, was selectively recruited based on the experts’ area of expertise and experience of these topics. This expert panel evaluated the SILQ through a Delphi study, in terms of whether or not the statements in the questionnaire corresponded to the content of the domains and the definition, as well as the relevance of the statements to different sickness insurance systems.

The Swedish version of the SILQ, called SILQ-SE was evaluated through Rasch analysis. This Rasch analysis provided the researchers with information about the psychometric properties of the SILQ-SE and what variables to exclude because they did not fit into the model or were difficult for respondents to answer (Ståhl, Wenemark, Karlsson, Sandqvist, & Årestedt, in manuscript). This evaluation led to an original 47 items being reduced to 23, representing four subcategories, or

domains, the first three of which are related to the individual abilities of the client and the fourth relates to the rated abilities of the sickness insurance system: Obtaining information, Understanding the information, Acting upon the information, and the rated System comprehensibility. The SILQ-SE and its remaining 23 items demonstrated satisfactory internal consistency reliability, construct validity and also supported unidimensionality. This psychometric evaluation study demonstrated that the remaining 23 items represents four domains, in accordance with the theoretical construct of the concept of SIL (Ståhl, et al., in manuscript). This thesis contributes to the theoretical and empirical development of social insurance literacy through Study IV, in which SIL is empirically investigated among clients on sick leave and the hypotheses of the SIL-project are tested.

## Moral hazard theory

### **The content and definition of moral hazard**

In this thesis, I use moral hazard from a critical perspective, because this theory is quite influential in the development of policies within sickness insurance, and often include certain simplified assumptions. There is a movement of researchers adopting this more critical perspective when studying moral hazard in relation to clients and sickness insurance (see for example Dembe & Boden, 2000; Stone, 2011), which this thesis adheres to. However, an introduction to the origins and content of this theory is in order. Like the concept of social validity, moral hazard is also primarily found in another field, in this case economics. It is a concept that is used widely by economists, and since its origins in the 1960s it has played a central role in health policy (Nyman, Koc, Dowd, McCreedy, & Trenz, 2018). The concept was first defined in relation to health insurance by Arrow as “medical insurance increases the demand for medical care” (Arrow, 1963; Finkelstein, 2015) and is often used to describe the effect of insurance incentives on behavior, such as the tendency for health insurance to increase the frequency of visits to physicians (Dembe & Boden, 2000; Stone, 2011), which several studies have demonstrated (Aron-Dine, Einav, & Finkelstein, 2013; Finkelstein, 2015; Finkelstein et al., 2012). Since its inception, moral hazard has been divided into two sub-concepts: ex ante moral hazard and ex post moral hazard (Finkelstein, 2015). Ex ante moral hazard refers to the idea that an individual will have fewer incentives to invest in his or her health when they have health insurance that will bear the cost of a potential illness or injury, leading to a less healthy lifestyle, including more drinking, more smoking, and less exercise. The second sub-concept, ex post moral hazard, which is the most commonly adopted version in the literature, refers to the idea that an individual with health insurance will consume more medical care due to the reduced expense. Over the years, moral

hazard in relation to health insurance has come to refer to the price sensitivity of demand for medical care, i.e. the ex post moral hazard, rather than the impact of health insurance on investment in one's health (Finkelstein, 2015).

Moral hazard is a complex and provocative concept because an individual's behavior is driven by several things and does not depend solely on costs. Finkelstein (2015) states that if moral hazard were seen as simply the notion that individuals with health insurance use health care services more, we could also draw the conclusion that health insurance kills people, due to this group's mortality being higher than the mortality of the uninsured. Individuals with and without health insurance have different incomes, employment status, and states of health. Those who are less healthy are also more likely to get decent health insurance (Finkelstein, 2015). The concept of moral hazard is widely used across countries and systems, although it's applicability may be different in a system with universal health care coverage compared to the type of market-based system in which it was originally developed.

### **The worthy client and work disability**

Within work disability research there has been a particular focus on detecting morally hazardous behavior and policies of proof of entitlement within cause-based systems (i.e. where workers have to prove that their injury or illness was caused by work, in order for them to be able to receive sickness benefits) compared to comprehensive systems (i.e. where all citizens with a work disability are eligible for sickness benefits, independent of the cause) (MacEachen, Varatharajan, Du, Bartel, & Ekberg, 2019). However, implications for policy can be seen in both cause-based and comprehensive systems, leading to questions emerging about what differences there may be in how the assumptions and implications of moral hazard are demonstrated in cause-based versus comprehensive systems.

Voices critical of the assumptions and implications of the concept have been raised in different fields and scientific disciplines; for instance, challenging the assumption that having insurance could tempt people into immoral and potentially even criminal behavior (Stone, 2011). The concept is commonly used, but some of the assumptions about moral and immoral behavior may be questioned and it can be discussed whether they are appropriate and value neutral or not (Dembe & Boden, 2000) However, economists sometimes claim that morality has little to do with the concept within economics literature, as opposed to within insurance-industry literature (Rowell & Connelly, 2012). Moral hazard is often associated with malingering and feigned disease within sickness insurance and worker compensation systems (Dembe & Boden, 2000; Saunders, MacEachen, & Nedelec, 2015; Stone, 2011). This has led to the legitimization of

insurer and employer attempts to expose these potentially immoral workers (Biscardo, Bucciol, & Pertile, 2019; Dembe & Boden, 2000; Junestav, 2009), for instance, by restricting the criteria for eligibility for sickness benefits and by increasing eligibility assessments (Junestav, 2009; Ståhl & Seing, 2018). An alternative view, also within the field of economics, has emerged, stating that medical care is determined by need rather than by its price (Finkelstein, 2015). Finkelstein (2015) highlights an article by Gladwell (2005) in a news magazine in which the very existence of the concept of moral hazard is questioned, and whether the assumptions it holds are realistic or not: “Do people really like to go to the doctor? Do they check into the hospital instead of playing golf?” (Gladwell, 2005, pp 4).

Although studies have demonstrated procyclical sickness absence in terms of a generous sickness insurance system leading to higher rates of sick leave and vice versa (Johansson & Palme, 2005; Pichler, 2015; Ziebarth & Karlsson, 2010), and the perceived job security influencing whether individuals’ go on sick leave (Khan & Rehnberg, 2009; Pichler, 2015), the actual determinants of workers’ behavior (such as sickness absenteeism or presenteeism) and the length of their work disability are probably quite complex and include a variety of factors (Dembe & Boden, 2000). Adverse associations with long-term sickness absence have been demonstrated in several studies in relation to increased mortality, future exclusion from work, poor health, economic stress and dissatisfaction with the overall life situation (Alexanderson et al., 2012; Floderus, Göransson, Alexandersson, & Aronsson, 2005; Helgesson, Johansson, Nordqvist, Lundberg, & Vingård, 2015; Melin, Fugl-Meyer, & Fugl-Meyer, 2003), hence activation strategies such as restricting access to sickness benefits can be performed by the authorities as a sign of caring, given the demonstrated risks, as well as a way of fulfilling political goals to reduce sick leave rates. However, the notion of moral hazard in sickness insurance becomes problematic because it may also be considered a matter of what view of human beings one takes. This in turn may influence stakeholders’ views and actions in diverse ways. For instance, studies have shown that employers refuse to hire workers with a history of filing claims or with long post-injury recovery periods, assuming them to be cheating, as well as physicians discounting clients subjectively reported narratives (Dembe & Boden, 2000). Another study (Jacobsson, Wallinder, & Seing, 2020) from the Swedish system highlights how case-managers at the SIA find it important to prevent individuals from remaining in the system and described themselves as sickness insurance guardians. There were also norms within this authority designed to restrict interaction with clients, which made it easier for case-managers to make negative decisions regarding sickness benefits (Jacobsson et al., 2020). A British study highlights that citizens are often concerned about the risk of “undeserving” individuals being granted sickness benefits. However, most citizens turned out to be more concerned that those who are “genuinely” disabled are being unfairly denied them (Baumberg Geiger, 2018).

# PROVIDING LEGITIMATE AND FAIR SICKNESS INSURANCE

The legitimacy of the processes in the sickness insurance system can be related to whether these are perceived as legally secure and fair. There is also an aspect of legitimacy in which trust is important; both in terms of the trust that clients and other stakeholders may have in the SIA to perform correct assessments in accordance with regulations, and also the clients' perceptions of whether the SIA is treating them as trustworthy citizens. Trust, as used in this thesis, refers to the belief in someone's moral obligation to do something, and that they have the proper competence and intentions to do it (de Fine Licht & Brülde, 2021). An example would be clients trusting the SIA to perform accurate and just assessments.

This chapter provides a background of previous research and takes its point of departure primarily within the disciplines of political science and sociology, by introducing activation policy and the strategies used in it. Thereafter, I describe clients perceived fairness of processes within the sickness insurance system.

## Activation policy and the incentives for clients

Many welfare systems have been influenced by activation policies using diverse strategies for activating clients on social welfare, focusing on rapid integration from inactivity and social exclusion towards working life (Eichhorst, 2008; Lindqvist & Lundälv, 2018; Seing, 2014). Strategies used within an activation policy can be either enabling or demanding, with the demanding ones often including the restriction of clients' access to financial benefits (Eichhorst & Konle-Seidl, 2008; Lindqvist & Lundälv, 2018). Work and the inability to work are often associated with a work ethic, and when clients are unable to work the authorities often require some kind of counter-performance before granting sickness benefits (Junestav, 2004). Junestav (2004) refers to this paternalistic view as the control and disciplining perspective, in which the client's own responsibility for his or her sustenance is prominent, sometimes also referred to as workfare. The counter-performances required often include participation in assessments, work training or some other kind of vocational rehabilitation. If the client refuses, their sickness benefits could be withdrawn. Bauman (2012) highlights that promoting work ethics and cutting financial support are means towards activation where work in itself determines the client's self-worth. Through the use of the work ethic, work is portrayed as good and the normal state, from which happiness and welfare follow. There is no such thing as a "free lunch," hence a proper counter-

performance is always required whereby the client must first contribute before enjoying the benefits (Bauman, 2012). Other perspectives within activation policy are the self-help and nurturing perspective, and the rights perspective, in which the focus is either on nurturing good productive citizens or on the citizen's right to welfare through paid work (Junestav, 2004).

Over time, the sickness insurance system has increasingly focused on individuals' obligations rather than their rights (Junestav, 2004, 2009; Lindqvist & Lundälv, 2018; Nord, 2018), in line with the control and disciplining perspective (Junestav, 2004). This has led to a shift in responsibility, whereby those unable to work are encouraged to take charge of their own case or in other ways take responsibility for their spell of sick leave. As the authorities' opportunities to impose sanctions have increased, stricter and more frequent assessments occur (Lindqvist & Lundälv, 2018; Nord, 2018). From a client perspective, there is often a disadvantageous power position in relation to the authorities. This is perhaps even more true in a sickness insurance context as their eligibility for sickness benefits is being assessed, as opposed to within the health care system where professionals have a different role and task. Power, in this thesis, refers to the ability to influence and affect other stakeholders, or the possibility to acquire resources (De-Moll, 2010), and here I focus in particular on the client's sick leave process. The Swedish sickness insurance system has several stakeholders, who play different roles in the process, hence the strategies they use tend to differ. The SIA is a public authority with a central role in the Swedish sickness insurance system. It has the tasks of assessing clients' eligibility for sickness benefits and coordinating vocational rehabilitation. The case managers are the authority's street-level bureaucrats, who work in teams that for instance discuss difficult cases, sometimes also with the SIA's own specialists and insurance physician (a physician who does not meet clients but has an advisory function within the authority).

Clients on sick leave often have contact with different stakeholders, such as the SIA, the Public Employment Service (PES), their employer, and the health care provider. Depending on the need for cooperation, the involved stakeholders may meet together with the client at a status meeting or interact in other ways and constellations. In the Swedish system, employers have the responsibility to facilitate clients' return-to-work by adapting their work environment and work tasks, and to document a rehabilitation plan for the client. The PES is a public authority in Sweden that is responsible for labor-market integration; hence it is also required to cooperate with the SIA and other stakeholders in cases where clients on sick leave need work training or a trainee post as part of their vocational rehabilitation. Treating physicians within the health care system are responsible for submitting medical certificates which serve as the foundation for the case managers' assessment regarding sickness benefits. These stakeholders may have different expectations and opinions upon activation, and the strategies used

within activation policy are often justified in terms of participation rather than activation, and by portraying work as a positive activity. This may not be the reality for everyone, and the legitimacy of these strategies may be hampered if a client is not work ready, or if the workplace is not properly adapted for the client to return successfully.

## Perceived fairness of processes in the sickness insurance system

Whether a procedure is perceived as fair or not depends on multiple factors. In general, clients who feel that they had to return-to-work too soon, or who have had their sickness benefits withdrawn, perceive this as unfair (Franche et al., 2009), but the concept is more complex than that. Perceived fairness is referred to as the balance between an unbiased procedure and individual adaptation (Cooper, 2004), which is likely to depend on a client's needs and prerequisites. Hence, fairness does not necessarily mean treating everyone the same.

The perceived fairness of processes within the sickness insurance system, such as assessments and interactions with system representatives, is important not only in relation to comprehensibility, the dignity of clients, and the quality of procedures. Research has also shown adverse effects on clients' health when the system is perceived as unfair. For instance, perceived unfairness can worsen the mental health problems of already vulnerable clients, and when interactions within the system cause perceived unfairness, this is associated with higher degrees of depression, pain, prolonged disability, and poor mental health, also in the long run (Barr et al., 2016; Elbers et al., 2016; Ioannou et al., 2016; Orchard, Carnide, & Smith, 2020; Sullivan et al., 2008; van Leeuwen et al., 2016). In contrast, other studies have demonstrated positive effects when the system is perceived as fair, such as perceived fairness counteracting the negative effects of age on sickness absence (Goštautaitė & Shao, 2020). Thus, from a client's perspective, perceived fairness is essential for their health and for the continuation of their sick leave process.

Comprehensibility and perceived fairness seem to be closely linked in terms of communication and interactions being crucial for clients to understand and accept procedures (Ståhl et al., 2019). Sometimes, the terms "perceived justice" or "organizational justice" are used, often divided into several dimensions, such as distributive, procedural, and interactional justice. These terms refer to the delivery of services or outcomes (distributive justice), the perceptions of the processes of reaching certain outcomes (procedural justice), and the client's treatment and communication from management or stakeholders (interactional justice) (Cohen-Charash & Spector, 2001; Colquitt, Conlon, Wesson, Porter, & Ng,

2001). The literature is somewhat mixed in its usage of the terms fairness vs justice, although the dimension of perceived justice seems to be included in a long tradition of research and theoretical development. In this thesis, I mainly use the term “perceived fairness”, employing it as an overarching concept, for instance relating to the acceptability and appropriateness of official decisions, assessment procedures, and encounters within the sickness insurance system. Hence, the included topics may relate to aspects of both procedural and interactional justice, although this thesis does not aim to explicitly distinguish between these. However, in Study IV the perceived justice measure developed by Franche et al. (2009) was used in relation to SIL, leading to a somewhat mixed terminology between the studies.

# COMPREHENSIBILITY IN WORK ABILITY ASSESSMENTS

Work ability assessments in a sickness insurance context are the foundation for decisions about granting or withdrawing sickness benefits. They can also be used to direct the course of interventions and rehabilitation. But what is actually being assessed? There are multiple concepts used by different stakeholders involved in clients' sick leave process, and how the literature and regulations define them is not necessarily the same as how the concepts are used in practice. Furthermore, assessments in general (not only that of work ability) are performed by several stakeholders for various purposes and in various ways. This leads us to the second central concept in this thesis: comprehensibility. Broadly, I use this to refer to whether clients perceive procedures and interactions as understandable and logical, and how they can navigate through the sickness insurance system.

This chapter highlights and problematizes the concept of work ability and related concepts, primarily moving within the discipline of medicine (including, for instance, insurance medicine and occupational therapy). In addition, I will devote some space to describing how such assessments can be performed.

## Work ability and related concepts

The meaning and usage of the concept of work ability differ depending on the context in which the term is applied. The conceptualization also depends on the underlying view that serves as the foundation for reasoning, and hence guides the way of thinking about the concept, hereafter referred to as the perspective. Different perspectives exist in diverse contexts, such as between different stakeholders and disciplines, and these perspectives also tend to change over time (Ekberg, 2014).

The most commonly adopted are the biomedical and insurance perspectives, which historically have been established for the longest (Ekberg, 2014; Lederer, Loisel, Rivard, & Champagne, 2014). The biomedical perspective focuses on the reduced physical functioning that causes reduced work ability. The insurance perspective relates more to administrative, regulatory, and financial consequences, such as the duration of a client's sick leave and its costs. Objective findings are generally required in order to ensure that a disability claim is valid. These perspectives are typically used by social insurance agencies that employ a reductionistic approach. Over time, the conceptualization of work ability in the literature and in research has moved towards a more relational and dynamic

concept. This includes several factors that interact with each other, hence providing a complex but more holistic approach (Ekberg, 2014; Lederer et al., 2014; Sandqvist & Henriksson, 2004) representing a biopsychosocial perspective, and approaching an ecological perspective. The biopsychosocial perspective emerged during the 1960s, and integrates physical, mental, and social prerequisites. A more recent perspective is the ecological perspective, which adds another layer regarding the interaction of a diverse range of factors, including the cooperation with and between the workplace and other stakeholders. The ecological perspective also encompasses the importance of structural circumstances and regulations that affect the rehabilitation process (Ekberg, 2014; Lederer et al., 2014). A range of contextual factors may be relevant in order to understand a client's work ability, such as the support the client receives from their employer, colleagues, or others, the demands of current work tasks with potential time limits and interactions with others, the accessibility of the workplace, and the client's motivation and life circumstances. Thus, the same individual may have the ability to perform specific work tasks or to function effectively in a specific workplace but be unable to work at another job although the work tasks may be similar. Hence, work ability cannot be established solely on the basis of physical and mental abilities, since it is not a quality carried by the individual.

Tengland (2011) argues that we need two definitions of work ability, which relate either to an existing occupation (specific work ability) or employment in general (general work ability). He suggests that we should separate the specific work ability that every employee naturally has, given their experience of their current job and potential education, from general work ability, which relates to the abilities commonly required to perform some kind of work, given an appropriate degree of training (Tengland, 2011). Others have illustrated work ability as a cone consisting of different dimensions (Sandqvist & Henriksson, 2004) or as a house with different floors (Ilmarinen, Tuomi, & Seitsamo, 2005; Ståhl & Fagerlind Ståhl, 2021). The lower levels refer to the client's individual capacities and qualities, interacting with both the work-related and private contexts. As we move up in the cone or house, work ability becomes more related to the specific job, including leadership and the client's ability to actually perform work tasks (Ilmarinen et al., 2005; Sandqvist & Henriksson, 2004). Sandqvist and Henriksson (2004) add a final dimension relating to employability in terms of actual participation in work being dependent on the current labor market and existing regulations. The original "work ability house" developed by Ilmarinen et al. (2005) has recently been further developed and illustrated by Ståhl and Fagerlind Ståhl (2021), who added complex interactions between the floors, such as the negative effect of poor working conditions on a client's health, potentially leading to the client sliding down to the bottom floor of the work ability house. There is also a time factor that may affect a client's health negatively, illustrated with a ticking clock, whereby regulations and time limits in the sickness insurance system may

affect the rehabilitation process and put pressure on the client to recover more rapidly. In addition, social relations and support at work and in client's private lives can influence each other and also affect their work ability (Ståhl & Fagerlind Ståhl, 2021).

A related concept, commonly used within health care, is occupational performance. This is a broad concept encompassing everyday life activities relating to areas of leisure, self-care, and productive activities (Townsend & Polatajko, 2013). The ability to perform a task or action can be related to everything that we do but, similarly to the work ability concept, the literature (Townsend & Polatajko, 2013) describes it as a relational concept that emphasizes each client's interaction with their unique context. Although the ability to work is not the specific focus, it is included in this broad concept. Hence, occupational performance can be viewed at as a prerequisite or basis for work ability. Functional capacity or ability is another concept often used by health care professionals when referring to separate functions of the client. According to the World Health Organization (2020), functional ability includes intrinsic capacities such as walking, thinking, and hearing, which interact with environmental factors (World Health Organization, 2020). This concept can be useful in medical rehabilitation, for instance, but do not provide a full picture of work ability.

Employability is another relational concept that is sometimes used in conjunction with work ability, and in relation to the current labor market, regulations, and policies (Ekberg, 2014; Sandqvist & Henriksson, 2004). This concept has developed over time, from an individualistic approach with a focus on clients being educated and activated to become more employable, to a more context-dependent concept in which the workplace, client, and a number of other factors need to be matched in order to interact successfully (Ekberg, 2014). The PES tends to use this term as its unemployed clients are matched to the jobs available on the labor market.

Different stakeholders tend to use different terms, such as employability by the PES and occupational performance and functional ability by health care organizations. Work ability is used by all stakeholders, but not necessarily with the same meaning or the same perspective as its basis. Health care tend to adopt the biopsychosocial or holistic perspective (Bertilsson et al., 2018; Ekberg, 2014), such as the PES, including multiple factors in the concept, although the PES is one stakeholder with the closest contact to the current labor market and hence often refers instead to employability and the ecological perspective. The SIA tends to use the biomedical and insurance perspectives because the focus is on the regulations governing clients' rights to sickness benefits and their reduced capacity (Ekberg, 2014). Although work ability is a well-used concept within the authority, the SIA is prohibited by law from including labor-market-related factors or social and financial circumstances in its assessments. In practice, this variation

becomes problematic in communication between stakeholders because they do not share the same perspective. Others have concluded that clients risk falling between stools as they are assessed as not being ill enough to receive sickness benefits, but are too ill to attract a potential employer (Lindqvist, 2019; Lindqvist & Lundälv, 2018; Melén, 2008). This can indeed cause insecurity and frustration among clients, who may be assessed by the SIA as able to perform some kind of work (general work ability in line with a biomedical and insurance perspective) but assessed by the PES as unable to manage the demands of the current labor market (employability in line with an ecological perspective). Meanwhile, health care practitioners may argue that the client is not work ready due to needing more medical rehabilitation and a functioning everyday life before work training is introduced (occupational performance or work ability in line with a biopsychosocial perspective). The conceptual confusion among stakeholders within sickness insurance can be considered incomprehensible to clients as the perspectives and foundations for assessments and decisions differ, for instance between the treating physician and case manager.

## The performance and usage of work-related assessments

Assessments of work ability have an important function in both sickness insurance and in the vocational rehabilitation process because they can provide direction regarding which steps in the rehabilitation process it is desirable to take next, but they can also be used to justify whether or not the client is eligible for sickness benefits (Ståhl, Svensson, Peterson, & Ekberg, 2009). The purpose of a work-related assessment depends on the context in which the assessment takes place, and the mission and mandate of the stakeholder; for example, if it is conducted in a rehabilitation center by professionals working to improve clients' health and work ability, or if it is conducted by professionals on behalf of the SIA, where clients' eligibility for sickness benefits may be questioned. Work-related assessments can be performed in diverse ways, such as focusing on the testing of different physical functions, i.e. functional ability, or by assessing work ability in a constructed context, or by assessing clients' actual work performance in real work contexts (McFadden, Macdonald, Fogarty, Le, & Merritt, 2010). The purpose of the assessment, as well as the perspective taken by the stakeholder, affects how the assessment is performed and how it is justified to the client. For instance, an assessment made by the PES in order to find a suitable trainee post for the client may contain specific tests and assessment instruments in line with this purpose and the authority's task, while health care practitioners may design an assessment differently, depending on what best serves their purpose and task.

Returning to the work ability models in the previous section (Ilmarinen et al., 2005; Sandqvist & Henriksson, 2004; Ståhl & Fagerlind Ståhl, 2021), work ability at the lower levels is often assessed through tests of function upon which conclusions are drawn, i.e., functional ability. Higher up in these models, work ability is assessed by requiring the client to perform activities or work tasks that require multiple functions to interact, either at an actual workplace or in a constructed assessment setting, i.e., specific or general work ability. All work-related assessments are simplifications of reality and can only provide a glimpse of the client's daily life. Work-related assessments of clients performing activities or work tasks (i.e., occupational performance or work ability) provide more comprehensive assessment results as they require the client to demonstrate multiple skills in comparison to more defined tests of certain functions (i.e., functional ability). If possible, it can also be valuable to assess a client over time, in order to gain a broader understanding of the factors influencing their work ability. For instance, difficulties may vary in severity during the day, or comparing a 'good day' with a 'bad day'. How the assessment is set can have an impact upon the assessment results in terms of different contexts providing different possibilities for the client to perform; hence, work ability differs. An assessment in a real-world context, for instance in a workplace or a trainee post, provides more information than an assessment in a constructed context such as at a health care center. This is due to the occurrence of natural moments of disturbance and potential interactions with colleagues. However, one study has shown that an assessment in a constructed context can be a more gentle and protected way to begin and to test clients' abilities without risking them losing face in front of their colleagues and employer, or causing damage in production if they do not succeed (Karlsson et al., 2018).

When assessing work ability, it is essential that professionals use assessment instruments that are valid and reliable in order to make correct decisions based on adequate information about the client (Kjellin, Cizinsky Sjö Dahl, & Eklund, 2008; Sandqvist & Ekbladh, 2020). A wide range of instruments for assessing work ability has been developed over the last few decades and evaluated for validity and reliability (Ekberg, 2014). It is largely the traditional forms of validity and reliability that are tested, such as content validity, criterion-related validity, and inter-rater reliability. Validity is broadly defined as the degree to which an instrument measures what it is intended to measure (Polit & Beck, 2021). Assessors and stakeholders need to be careful about the conclusions they draw based upon assessment results, and which concept they use. Work ability assessments can be performed by different stakeholders, but it is essential to focus not only on the assessment results but also the methods chosen for the assessment and whether they have been psychometrically evaluated, and hence are valid and reliable. The interpretation of work-related assessments can have a substantial impact upon a client's life. Depending on the assessment setting, the

specific tests conducted, and the client's prerequisites, the assessment can mirror reality to a greater or lesser extent.

## Assessing work ability in the context of insurance medicine

Studies relevant for insurance medicine are often also influenced by other fields, and tend to focus on the consequences of being sickness absent (Helgesson et al., 2015; Holmgren et al., 2016; Hubertsson et al., 2011; Palme & Persson, 2019), factors that hinder or promote sickness benefits or the return-to-work (Andersén, Ståhl, Anderzén, Kristiansson, & Larsson, 2017; Cronin et al., 2013; Goštautaitė & Shao, 2020; Kilgour, Kosny, McKenzie, & Collie, 2015; Moldvik et al., 2021; Saunders et al., 2015; Svensson, Müssener, & Alexanderson, 2006), different views about the content of work ability (Sturesson et al., 2013; Ståhl et al., 2009), and procedures for assessing work ability (Baumberg Geiger, Garthwaite, Warren, & Bamba, 2018; Bertilsson et al., 2018; Karlsson et al., 2018; Meershoek et al., 2007; Nordling, Priebe, Bjorkelund, & Hensing, 2020; Ståhl et al., 2019), similar to the categories highlighted in Table 1. Studies of the Swedish system demonstrate a lack of knowledge regarding the effects that sickness insurance procedures have on clients' (The Swedish Social Insurance Agency, 2020a, 2020b) and encourage future studies that also focus on outcomes other than sick leave days (The Swedish Social Insurance Agency, 2020a).

In the Swedish system, the SIA is barred by law from taking into consideration individual or social factors, such as age and education, when assessing eligibility for sickness benefits (Ekberg, 2014). That eligibility exists for the first 180 days of the sick leave spell if the client is unable to do their regular work or any other work the employer can provide. The term sickness benefits, as used in this thesis, refers to both sickness absence and disability pension. Sickness absence in Sweden is a compensation for temporary inability to work. Disability pension is a more permanent compensation for those unable to work for the foreseeable future. Usually, a sick note from the client's treating physician is sufficient during the early phase of sick leave, but case managers at the SIA can initiate a more extensive work ability evaluation. They do so when further information is required before the case manager can make an official decision about sickness benefits, or plan other steps in the sick leave process. From day 181 in the spell, the criteria become stricter and work ability is assessed in relation to any work in the regular labor market. This increased strictness is demonstrated through an increase in withdrawals of sickness benefits and a greater number of clients being sent to work ability evaluations by the SIA (The Swedish Social Insurance Inspectorate, 2018). Previous research has revealed that assessments of work

ability in the Swedish system are characterized by a reductionist approach (Ekberg, 2014; Ståhl et al., 2009). The assessment is more in line with general work ability from a biomedical and insurance perspective, because the SIA's assessments focus on the diagnosis, the individual's reduced functioning and the limitations on activity, rather than relating this to contextual factors. In this thesis, I use the broad term "assessment of work ability", referring to case managers' decision-making about sickness benefits throughout all of a client's sick leave processes. The term "work ability evaluation", is used, however, to refer to the more extensive assessment for which clients are sent to evaluation units where medical professionals perform an independent assessment.

Work ability evaluations in the Swedish sickness insurance context are an administrative tool, which is often initiated and interpreted by the case manager in collaboration with the insurance physician (The Swedish Social Insurance Agency, 2017). The SIA's work ability evaluation consists of assessments performed by special evaluation units on behalf of the SIA. It is contemplated as a one-time, objective, and independent medical evaluation, as the professionals involved have not previously met the client and have no role in treating them. The professionals at the evaluation units who conduct the tests consists of: a physician; whose tests can include a basic physical examination and an interview; an occupational therapist, who performs activity-based tests in constructed work tasks; a physiotherapist, who carries out tests of physical functioning; and/or a psychologist, who performs cognitive and mental tests. The specific tests in the evaluations captures either functional ability or occupational performance, and the overall evaluation results represent the client's occupational performance. The evaluation results are then interpreted by the SIA and translated into work ability and eligibility for sickness benefits. Clients who are subject to the potential withdrawal of sickness benefits first receive a letter from the SIA containing information about the preliminary withdrawal decision. They are given the opportunity to submit supplementary material and certificates within two weeks, before their case-manager makes the formal decision about whether or not to grant sickness benefits. Before the formal decision to withdraw benefits is taken, specialists at the SIA with knowledge of the regulations go through the material in the case, aiming to ensure high quality in the decisions (The Swedish Social Insurance Agency, 2017). Currently, sick leave rates in Sweden have increased during the pandemic year, with a total of 680 000 people having received sickness benefits at some point during the year 2020, approximately 8.7 % of the population of working age (20-64 years) (The Swedish Social Insurance Agency, 2021). According to internal processing data from the SIA, 1.1 % of these sick listed clients were sent on a work ability evaluation, hence a minor part of the total group although several thousands of clients per year.

In other sickness insurance systems, the lack of contextual connection has been criticized (Barr & McHale, 2019; Baumberg Geiger, Warren, Garthwaite, & Bamba, 2015). In the British system, for example, the so-called work capability assessment has received a substantial amount of criticism, referring to adverse health effects on clients (Barr et al., 2016) and unemployment (Barr et al., 2015), instead of social protection and a sustainable return-to-work. The tests included in the British system for deciding upon a client's eligibility for sickness benefits include a checklist of potential impairments in which a predetermined set of points is attached to each impairment. Independent of the severity of the impairments, the total score of the ticked boxes determines whether the client will receive sickness benefits or not (with a few exceptions). An example of an impairment that in itself directly leads to being granted sickness benefits is the inability to pick up a coin. Hence, these tests are unrelated to a real world context and does not assess actual work ability (Baumberg Geiger et al., 2015), but the way I see it: they rather focus on functional ability. In the Netherlands, the assessment of work ability is carried out by focusing on tests of specific functions, similarly to the UK. However, these are then matched to potential jobs using a specific database that includes the requirements of different jobs; this could also be a desirable option for the British system (Baumberg Geiger et al., 2015). In line with this desire for increased contextualization in work ability assessments, and as a continuation of a governmental report (Swedish Government Official Reports, 2020), a similar database, or body of knowledge (in Swedish: kunskapsmaterial), is currently being developed for the Swedish system on behalf of the government as a step towards a more comprehensible and secure sickness insurance system (Swedish Government, 2021). Developed in collaboration between the SIA, PES, and labor market experts, this body of knowledge will highlight the demands and requirements that different occupational groups place on clients' occupational performance, as a support for the SIA and its case managers in their assessments of work ability. How this development works in practice remains to be seen as it is to be implemented in September 2022 (Swedish Government, 2021).

# METHODOLOGICAL FRAMEWORK

Because I was diving into an interesting but complex research area and given the aim and research questions of this thesis, I have adopted a mixed methods approach, in which interview-, case file-, register-, and questionnaire data is analyzed using a variety of qualitative and quantitative methods, in order to approach the research questions from different perspectives. As stated by Leech and Onwuegbuzie (2009), a mixed methods approach involves both qualitative and quantitative data in either a single study or a series of studies investigating the same underlying phenomenon. This thesis represents the latter.

Studies I-III have a qualitative design, although using different methods of analysis, while Study IV is quantitative. Study I aimed to evaluate the social validity of work ability assessments and for this a qualitative deductive analysis was selected because the concept provided a clear framework for what was to be investigated. This study generated an extensive amount of data, leading to other aspects being found in the data that did not match the purpose of Study I. Thus, a new analysis of the data was undertaken and presented in Study II in order to explore these matters further. Study II explored expressions of power and trust, which required a more open-minded approach; thus a qualitative thematic analysis was applied. Study III investigated the communication between clients and stakeholders using solely client files from the SIA. Therefore, a qualitative document analysis was adopted. This study, together with another (Ståhl et al., 2019) was the beginning of the Social Insurance Literacy project, a larger project from which one study was included in this thesis: Study IV. The aim of Study IV was to investigate social insurance literacy among clients on sick leave and its associations with perceived justice, being granted sickness benefits, and background factors. To investigate the level of literacy that actually exists and how this relates to other outcomes, a quantitative approach was chosen, using regression analysis.

When finalizing this thesis, and in an attempt to broaden the perspective, beyond the individual studies, the results of the four studies were synthesized using moral hazard as a theoretical tool. The new insights from this process are presented in a separate section under the synthesis of results. During this synthesis, using the lens of moral hazard theory, new quotes were highlighted to illustrate common denominators between the four studies that constitute this thesis. These new quotes were not discovered by going through the raw data, but rather by returning to early versions of the manuscripts.

To illustrate the position of this thesis within sickness absence research, an overview of the methods, perspectives taken, disciplines represented, and other

aspects are presented in Table 1. The content of what was studied includes the factors hindering or promoting sickness absence, especially in terms of how communication and SIL may affect clients' cases (Studies III-IV). It also includes the consequences of being sickness absent, which are particularly highlighted in Studies I-II. Sickness assessment processes are prominent in all four studies, although in diverse ways, while methods and theories are particularly investigated through the concepts of social validity and SIL (Studies I and IV). The perspective taken in the research questions is that of the insurance system, in terms of focusing on features of the system, although this is investigated using individual client data.

Table 2. Methodological overview and my role in the process.

	Study I	Study II	Study III	Study IV
<b>Study design</b>	Qualitative longitudinal	Qualitative longitudinal	Qualitative cross sectional	Quantitative cross sectional
<b>Participants</b>	30 clients on sick leave who had performed an SIA work ability evaluation	31 clients on sick leave who had performed an SIA work ability evaluation	30 clients on sick leave who had performed an SIA work ability evaluation	1152 clients on long term sick leave (>180 days)
<b>Data</b>	Telephone interviews, texts, emails	Telephone interviews, texts, emails, and the clients' SIA files	SIA files	Questionnaire and register data
<b>Analysis</b>	Deductive content analysis (Hsieh & Shannon, 2005).	Thematic analysis (Braun & Clarke, 2006).	Document analysis (Bowen, 2009).	Regression analysis
<b>My contribution</b>	Design, recruitment, developing interview guide, performing interviews and analysis, writing manuscript, publication process.	Recruitment, developing interview guide, performing interviews and analysis, writing manuscript, publication process.	Performing analysis, writing manuscript, publication process.	Participating in development of the concept and questionnaire. Managing incoming questionnaires in close collaboration with printing office, and discussing the steps taken in analysis and overall process with co-authors. Writing main parts of manuscript and will answer for the publication process.
<b>Others' contributions</b>	Evaluation units provided clients with information letter. Supervisors provided feedback and discussions throughout the process.	Evaluation units provided clients with information letter. Supervisors provided feedback and discussions throughout the process.	Supervisors had previously collected the data as used in another study. Supervisors provided feedback and discussions throughout the process.	Main supervisor (CS) dispatched the questionnaire and managed acquisition of the register data. Analyses were performed by the second author (MH). Printing office received and scanned the questionnaires. Co-authors provided feedback and discussions throughout the process.

This chapter highlights the methodological choices made in this thesis, with a presentation of the participants, study procedures, and analyses for each of the four studies. For more details regarding the participants and the study procedures, see the manuscripts for each study. Finally, the method chapter concludes with some thoughts regarding the ethical considerations for this thesis. An overview of the methodological choices made in this thesis is found in Table 2, in which I also clarify which parts were performed by myself and by others for each of the studies.

## Studies I–II

The first two studies were qualitative, longitudinal studies based on interviews with clients and their case files from the SIA. Interviews and files were intended to supplement each other and to provide a richer picture of the clients' sick leave process.

### **Participants and study procedure**

In 2017, all units performing work ability evaluations on behalf of the SIA ( $n = 36$ ) were invited to participate. Those who accepted ( $n = 6$ ) represent different parts of Sweden and were invited to provide clients with an information letter about the study along with the invitation to a work ability evaluation. A consecutive sample was conducted until 30 participants had been interviewed. In total, 108 clients were provided with the information letter. The semi-structured interviews consisted of a first interview after their participation in a work ability evaluation and a follow-up interview after they had received an official decision. The first set of interviews examined their experiences of the work ability evaluation and their encounters with the involved stakeholders, encompassing how they had perceived the information they received before and during the evaluation and whether they found the test at the evaluation appropriate or not for them. The second set of interviews examined the clients' perceptions of the consequences after the evaluation and their contact with the involved stakeholders, in particular their case manager.

After the interviews were completed, during the summer of 2018, the clients' files were requested from the SIA. In Study II, one additional participant chose to share their file but not to participate in the interviews; hence, the data in Study II represents 31 participants, as opposed to Study I which includes only those who were interviewed. The clients' SIA files include the complete documentation of their sick leave case. The files were mainly documented by the case managers at the SIA; hence, they mirror their decision-making processes and points of view.

However, the files also include the treating physicians' medical certificates, statements from employers, and the correspondence to and from the client and other stakeholders. In several cases, the clients and I corresponded by text or email in between interviews in order to keep me updated about events in their sick leave process. This correspondence was also included in the analysis. Thus, the data consisted of interview transcripts, texts, emails, and SIA case files, representing primarily clients' perspectives, and partially, other stakeholders' perspectives.

### **Data analysis**

The approaches taken in the analyses in Studies I-II differs, with Study I using a more predetermined structure in terms of a deductive content analysis, while Study II comprised a thematic analysis that provided the opportunity to search for underlying patterns.

In Study I, a qualitative deductive content analysis (Hsieh & Shannon, 2005) was used for the interviews, texts, and emails. In this study, the files were used as a complement to the interviews, to enable me to follow the process of the clients' cases, but they were not included in the coding. Categories and subcategories were specified based on the theoretical synthesis of the concept of social validity. The work ability evaluation and the following official decision were intentionally separated into different categories in the analysis in accordance with this study's aim and design. Data was first skimmed, then read more carefully as meaning units were categorized. The data was then read through once more to ensure that no meaning units of relevance had been left out. This was continued until the chosen meaning units and their categorization seemed concordant. As is customary within deductive content analysis, the process moved back and forth from deductive to inductive as categories were revised, and new subcategories were identified. The empirical findings in this study thus also contributed to the development of the theoretical dimensions of social validity.

In Study II, a thematic analysis was used. More specifically, I used a latent thematic analysis with an inductive approach, in accordance with Braun and Clarke (2006), in order to be able to explore the underlying meanings in the data. All the data was first read briefly, for one client at a time. Patterns of interest and ideas were noted, and short summaries of each client's case were written. The data was then read through more carefully and data extracts were selected and coded into a table in one main document. During this step, some of the contexts of the data extracts were retained by stating, for instance: "from medical certificate (date)," or "case managers' documentation after telephone call with employer". I considered this to be important in order to be able to interpret the data correctly, as the amount of data was extensive. Next, codes were sorted into

potential themes, in which subthemes and main themes were identified. The themes were then reviewed and refined by defining their names and content, and some were discarded. I was aiming for “story-book themes” with rich data providing clear patterns and stories within each subtheme, rather than more descriptive and summarizing “bucket themes”. In the final step, I wrote the article and selected quotations to exemplify the themes.

I discussed the steps taken in these two analyses with my supervisors, which led to revisions such as new choices of quotes, condensation, and a reorganization of themes, categories, and text.

## Study III

The third study was a qualitative cross-sectional study using solely case files from clients on sick leave. These participants had already been recruited for another study (Ståhl et al., 2019), in which the researchers found other aspects in the data that needed to be further investigated. This data provided a unique insight into the argumentative strategies used by clients and other stakeholders, where these interactions could consist of quite dynamic actions.

### **Participants and study procedure**

The participants had been recruited in 2015 by the SIA, which sent an invitation to participate to the 203 most recent clients who had been on a work ability evaluation. In this invitation, the SIA asked whether the clients consented to the SIA passing on their contact information to the researchers. Those who gave written consent to share their files with the researchers ( $n = 30$ ) were included. Of these, 17 had recently had their sickness benefits granted, while 13 had received a preliminary decision that the SIA was considering withdrawing their sickness benefits and giving them the opportunity to submit supplementary information to argue for their right to continue receiving the benefits.

### **Data analysis**

The data was analyzed using a qualitative document analysis, which usually consists of some sort of content analysis (Bowen, 2009; Hodder, 2000; Patton, 2015). Bowen (2009) describes a document analysis as including elements of both content analysis and thematic analysis. In this study, the files were first skimmed, then read through more carefully several times while meaning units were discovered. Meaning units were then condensed, coded, and categorized based on differences and similarities. I would describe this document analysis as very similar to an inductive content analysis, and since my supervisors had conducted

a previous study (Ståhl et al., 2019) based on this data, we were all familiar with the material and were able to discuss the steps of the analysis in more detail, even though I performed the formal steps.

## Study IV

This study was a quantitative, cross-sectional study using the Social Insurance Literacy Questionnaire (SILQ-SE). As previously described in the theoretical section of SIL, the fourth study of this thesis was part of a larger project, the SILQ project, in which the concept of SIL and a measure to quantify it were developed. This specific study was the first empirical study of SIL in Sweden.

### **Participants and study procedure**

In September 2020, the questionnaire was sent to 3993 clients on long-term sick leave (>180 days). They were all of working age (18-65 years), from all regions in Sweden, and included wide range of diagnoses. This selection was performed by the SIA, which randomly selected clients who fulfilled these criteria and provided the researchers with contact details. The first invitation included a link to a web questionnaire with a personal login and was answered by 586 clients. The first reminder was sent by post a month later, and included an information letter along with the SILQ-SE questionnaire on paper. This resulted in another 482 responses. The second reminder was sent in late November 2020 to the 2927 clients who had not yet responded, and included the information and a reminder about the questionnaire. This resulted in another 89 responses. The web questionnaire closed at the turn of the year 2020/2021, but paper questionnaires kept coming until August 2021. All the paper questionnaires were read manually to locate any errors in the completion that would need to be managed. This was discussed with supervisors (CS, JS, and IS) and two statisticians (MW and KÅ), resulting in the exclusion of five respondents due to the large number of item nonresponses. In total, 1152 respondents answered the SILQ-SE, 691 on the web and 461 on paper, resulting in a 28.9% response rate.

### **Data analysis**

All statistical analyses were performed by the study's second author (MH), in close collaboration with me and my main supervisor (CS). The data was analyzed using, for instance, OLS regression and logistic regression in order to measure the existing SIL among clients on sick leave and also differences between groups, the association with perceived justice, and whether they were granted/denied sickness benefits. SIL was analyzed through four subcategories (Obtaining, Understanding, and Acting on information, and System comprehensibility).

The items in the SILQ-SE questionnaire were previously analyzed using Rasch analysis to obtain a subset of items with good psychometric properties for each subcategory (Ståhl et al., in manuscript). The estimated personal parameters, i.e., logit scores, have been used in this study. These 23 items relating to a total of four SIL subcategories were also related to background variables, as obtained from the survey, including age, gender, educational level, self-rated financial situation, country of origin, and marital status (see manuscript of Study IV for more details). The clients' perceptions of justice were obtained through a translation of an existing measure developed by Franche et al (2009), and related to the four SIL subcategories.

## Ethical considerations

In this thesis, the material consists of client data. This includes their shared experiences as discussed in telephone interviews, their documented sick leave process in their SIA files, and their own estimated perception of their understanding and the delivery of information in the sickness insurance system as stated in the questionnaires. Being sickness absent is often associated with stigmatization and major changes in clients' lives. When conducting the research for this thesis, it was therefore considered essential to perform the data collection, in particular the interviews, gently and with respect for the fact that these matters could be painful for them to discuss.

For Studies I-III, written informed consent was obtained. For Studies I-II, consent was also obtained verbally. This was ensured after the participants had been informed about the purpose of the interview and that participation was voluntary, and that the researchers had no connection with the SIA and were hence unable to affect any official decisions. This was considered important, particularly due to the risk of clients feeling pressured if they believed that the researchers could affect their sick leave process. The clients were asked whether they had any initial questions before participating, and also before the end of each interview whether any questions had arisen. Often, clients had initial questions regarding the study in terms of their anonymity and how the results would be disseminated and published. The clients were also encouraged to contact me by phone or email if any questions emerged later, which did occur in some cases. As the interviews were conducted, there were several cases when clients became upset because the questions clearly evoked strong emotions. In these situations, it was considered important to let the participants choose whether they wanted to continue or end the interview, to allow them (if they wanted) to finish their story, and not to end the telephone call until they had

settled. Although the interviews could evoke emotions of grief, frustration, and powerlessness, clients often highlighted their appreciation of being listened to and that someone cared about their stories.

For Study IV, respondents received information about participation being voluntary and anonymous, and that, if they consented, they should answer and return the questionnaire. Since this particular project was funded by the SIA, information was also given to the respondents about this fact. But it was explained that the project was being managed independently by Linköping University, hence the SIA was unable to affect the research questions, analyses, or the publications of results. This was considered important similarly as in the studies above, because the notion of the SIA's involvement could potentially lead to clients feeling pressured. Several responses were received from clients, mostly by phone but also email, including questions relating to what the invitation letter was about because several of these clients had language difficulties. The responses received also included questions asking how the researchers had found their contact details, asking for help to log in to the web questionnaire, or wanting to share their opinions of the SIA.

The procedures followed in this thesis conformed to the ethical standards of the 1975 Helsinki Declaration (World Medical Association, 2013) and were approved by the relevant ethical committees, as noted below. Data involving delicate personal information, such as the files with clients' social security numbers, was handled carefully and I was the only person with access because they were stored in a locked area, along with the written consents and identification keys to the coded interview transcripts.

Studies I & II were approved by the Regional Ethics Committee in Linköping, Sweden (Dnr 2017/271-31). Written and verbal consent was obtained from all participants.

Study III was approved by the Regional Ethics Committee in Linköping, Sweden (Dnr 2014/15–31). Written consent was obtained from all participants.

Study IV was approved by the Swedish Ethical Review Authority (Dnr 2019-01671).

# SUMMARIES OF STUDY RESULTS

In this chapter I introduce the main findings of each of the four studies that constitute this thesis. For more details, quotes, or discussion relating to each separate study, see the papers at the end of this thesis.

## Study I: Social validity of work ability evaluations and official decisions

The aim of this study was to explore clients' perceptions of the social validity of work ability evaluations and the following official decisions concerning sickness benefits.

The results demonstrate that the legitimacy of the specific tests included in a work ability evaluation, performed by professionals at evaluation units, depends on the client's difficulties and how the professionals justify and perform those tests. Consequently, they could be perceived as too simplistic or too demanding. However, the tests were often perceived as positive if they were relevant to the client's situation and had realistic features, such as the occurrence of distractions in activity-based tests. Hence, the tests need to be individually adapted to each client's prerequisites. The clients perceived the structured assessment procedure as too strict, neglecting nuances and explanations in the evaluation results that did not fit into the forms. Time was also a major concern raised by the clients, who stated that, depending on their difficulties, they could perform quite well for a limited amount of time, but that the consequences afterwards were not taken into consideration. This made them question the legitimacy of the evaluation. Mixed emotions emerged at the initiation of the evaluation, such as some clients hoping for a positive change in their situation, while others questioned it due to the extensive documentation of their difficulties that already existed, produced by other stakeholders. In terms of comprehensibility, clients stated that the purpose of initiating the evaluation was unclear, and that they would have preferred more details beforehand in order to feel prepared. Some clients described not being prepared for how they would be affected by the evaluation, and hence struggled to get home afterwards. Highlighted examples included being forced to make multiple stops on the way home by car on the highway due to exhaustion.

Some tests, such as walking in stairs in a given time or drawing a circle with outstretched arms, were described as comprehensible in terms of testing separate functions, although they were criticized for being disconnected from a context, and hence irrelevant to the client's work ability. The feedback provided

by evaluation units was perceived as comprehensible, and was especially appreciated when the results were explained and justified in a concrete way and when clients were given time to discuss the findings. However, clients lacked feedback from their case manager regarding how the assessment results would be interpreted. This lack of response from the case manager led clients to question the importance of the evaluation and how it was being used in their case. For most participants, the evaluation led to consequences, such as mental and physical exhaustion.

The conclusions arrived at by the case manager were considered to be interpretations and not representing the full truth. What clients perceived as fair differed from one client to another, mainly depending on their situation and what arguments and information they were given. For instance, clients who were recommended to receive the more permanent compensation disability pension could either perceive this as fair, if they agreed with the arguments and conclusions, or unfair if they felt that they had been judged as unable to work too soon and not given a proper chance to return-to-work. Those clients who generally perceived the official decision as fair were those who had a clear idea from the beginning of the work ability evaluation and where it might lead and had an open discussion with their case manager, regardless of whether it led to disability pension or withdrawn sickness benefits. Furthermore, some clients experienced an unfair decision as predictable, due to low expectations of the SIA's exercise of authority. The case managers' justification of an official decision was often perceived as bureaucratic and vague with a lack of solid examples, especially by those clients who only received the official decision in writing by post. Clients were confused or frustrated when the decision was contradictory to their treating physicians' or other stakeholders' recommendations. They described that their powerlessness in relation to the SIA could make them behave passively, due to the feeling that they had no say or did not have enough energy to ask for clarifications. Those clients who, in addition to the written decision, also received a phone call from their case manager or were invited to a status meeting with other stakeholders where possible alternatives were discussed, were generally more positive and seemed to understand the decision quite well, although these cases were few. The comprehensibility of official decisions also seems to be closely related to the existence of a continuing dialogue with the case manager, such as in those cases where it had been discussed beforehand and the clients had been given time to prepare themselves, or when forewarning had been given through personal contact with the case manager before a letter of preliminary withdrawal of sickness benefits arrived in their mailbox.

In general, clients had the same opinion of the evaluation both before and after an official decision, but there were exceptions. For instance, when clients were

initially critical of the evaluation but afterwards were able to appreciate it due to comprehensible feedback from their case manager related to the decision about sickness benefits. Another example was when clients initially appreciated the evaluation and recognized the results, but felt they had been fooled when the case manager withdrew their benefits despite other recommendations from the evaluation unit, therefore retrospectively perceiving the evaluation as a false show. Clients described a perceived discrepancy between the conclusions drawn by the evaluation unit and the official decision about sickness benefits, stating that the findings of the evaluation unit were representative, but that the decision from the SIA was not.

## Study II: Exploring interactions in the sickness insurance system in terms of power and trust

The aim of this study was to explore how power and trust are expressed by clients and other stakeholders within the Swedish sickness insurance system.

In the results, the main theme *Acts of power and distrust* were prominent because mistrust between the stakeholders and their usage of instruments of power occurred. The first subtheme illustrates how clients and other stakeholders were *Highlighting the clients' work ethic*. Mainly clients and their treating physicians tended to feel the need to state and verify that the client was morally trustworthy and not trying to misuse the system, and hence was not on sick leave by choice. The clients felt that they had to prove their worthiness by being genuinely work disabled and therefore their right to sickness benefits. Clients' work ethic and their strong desire to return-to-work were expressed through assertions of their skills and passion for their work, followed by grief and loss of identity when unable to work. Motivating factors for returning to work included perceptions of work as a strong social norm, and the stigmatization and shame attached to being sickness absent. Both in interviews and in documents from their files, clients highlighted that they had not chosen to be absent from work, that it was not their fault, and that obviously they would work if they were able to. In the few cases where clients were not positive about activation and returning to work, this seemed to be related to having lost faith in their ability, due for instance to too many previous failed attempts to return. The clients also stated that they did their very best during the work ability evaluation, often trying too hard and wearing themselves out, due to a desire to manage work and perform well, hoping to prove themselves able. Clients who had their work disability questioned stated in the interviews that the case manager did not understand how hard they had really tried during the evaluation and the physical and mental consequences they had suffered afterwards. Clients stated that the

case manager seemed to expect their work ability to be even better in real life than in the tests. The efforts that clients made during evaluation tests were further verified at some evaluation units, where the assessment results sometimes included statements from professionals observing that the clients had overestimated their ability, pushed their limits during the tests, or were “crying and being sad when it didn’t work”.

The second subtheme, *Distrusting other stakeholders’ intentions and efforts within the sick leave process*, included situations in which both clients and other involved stakeholders were mistrusted and a suspicion was explicitly expressed, i.e., mistrust, about other stakeholders’ agendas and competence. This commonly led to friction. Often clients and treating physicians expressed frustration and mistrust when the physicians’ assessments were diminished by the SIA, stating that the physician often knows the client well, while those who may never have met the client (the case manager and the insurance physician) had the most impact and set the agenda in the client’s case. The clients described their powerlessness in terms of their own narrative being neglected and of being questioned as malingerers when forced to stop working due to illness or injury. This was primarily described in relation to the SIA, but in some cases also in relation to health care practitioners and the clients’ colleagues at work.

The evaluation units were also sometimes mistrusted by the clients, and considered to have been “bought” by the SIA; hence, they were perceived as not being objective. Some clients stated that they thought the evaluation had been initiated when the case manager did not believe them and wanted them to be tested for cheating. However, some clients were positive, hoping for solid documentation that would prove the case manager wrong stating that they had nothing to hide, even though they believed the evaluation was a “cheat test”. Case managers’ medical competence was questioned primarily by treating physicians and clients, but sometimes also by evaluation units and other health care professionals. Case managers objected to such allegations in the files, where they stated they had the support they needed from insurance physicians and SIA specialists.

The third and final subtheme, *Using instruments of power*, includes how stakeholders used different means to justify their conclusions and to stake a claim to their authority for directing the clients’ sick leave process, such as results from the work ability evaluation, other documents, or alliances. Different stakeholders (primarily the SIA and health care practitioners) tended to refer to the parts of the work ability evaluation that supported their opinions, but the health care professionals’ arguments using evaluation results seldom affected case managers’ decision-making; hence, the SIA’s interpretation usually had priority. Another instrument of power was alliances, which were mainly found between the client and their treating physician, characterized by the physician defending

the client's rights, but also in other constellations. In one case, the case manager and the client had a clear alliance, as there was a conflict with the client's employer. Insurance physicians and case managers form an example of an alliance within the SIA that it is difficult for other stakeholders to successfully challenge. Furthermore, some clients stated in interviews that official decisions are directed by the SIA management and the government, and hence are not a particular case manager's fault. Taken together, the study shows that expressions of power and mistrust are widely present in today's sickness insurance.

### Study III: Communication characteristics between clients and stakeholders – a document analysis of granted and withdrawn sickness benefit claims

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

The study revealed three main categories with quite different communication characteristics. In most cases, several forms of communication were used, such as telephone calls and SIA letters. The cases with the largest number of involved case managers were those where sickness benefits were withdrawn, with clients either protesting on their own or not reacting at all. In contrast, clients in the cases with frequent cooperation between stakeholders were usually granted sickness benefits. The first main category, *Emotionally driven argumentation*, represents how the majority of clients in this study responded to situations in their case. The emotional argumentation could consist of clients appealing to the case-managers' good-will by referring to their life situation. This was seen especially after a preliminary withdrawal of sickness benefits. There were also arguments referring to a previous unsuccessful period of work training and the difficulties and consequences of this, or mentioning new diagnoses. These arguments did not have any particular impact on the clients' case managers and hence the sick leave process, when they were presented in a manner that was characterized by desperation or anger. However, when the client's frustration was directed towards another stakeholder for not committing enough to the client's return-to-work process, this often resulted in actions by the case manager, such as pushing the other stakeholders to act on behalf of a client who was eager to work.

The second main category consists of *Matter-of-fact driven argumentation*, in which a minority of clients referred to medical certificates and regulations when arguing their case and presented these in a formal way to their case manager. For

instance, clients argued for their eligibility for sickness benefits by stating that this was their right according to specific paragraphs in the law, or by quoting medical certificates or investigations by health care specialists who had made certain recommendations or drawn certain conclusions. These clients also seemed to know which certificates to submit, in order to potentially affect their case. In some cases, the argumentation shifted from being emotional at the beginning of the spell of sick leave, to becoming more precise and formal. There are also examples of argumentation that was more fact-based and formal at the beginning but changed into an emotionally driven argument when clients were requested to initiate work training or a work ability evaluation, and hence began to feel pressured. This study also revealed that social support matters, not only for the client's well-being but also for the ability to influence one's sick leave process. For instance, clients who had support from their employer and/or treating physician, in terms of commitment to the client's case and cooperating with the case manager, were more likely to be granted sickness benefits than those who reported a lack of support. Also, for those clients who argued in a more emotional way, the other stakeholders could have an impact on the sick leave process if they argued in a matter-of-fact driven way on behalf of the client.

The third category, *Information exchange*, includes examples of clients' difficulties in understanding the information provided to them by the SIA. For example, clients stated that the information from the SIA was complicated, or that they had a hard time knowing which forms to fill in, and some clients asked their case manager afterwards which forms the client had filled in. The majority of clients who expressed difficulty in understanding the SIA information were conditionally granted sickness benefits when they participated in work training. This category also reflected the different interpretations of medical documents and the clients' work ability; for instance, regarding work ability evaluation results, or the demands of the client's current work. Sometimes the case-manager assessed the client's current work tasks to be manageable enough to initiate return-to-work, and sometimes the work tasks were assessed as being too demanding for the client's abilities. The client was then required to resign and search for a new job. This occurred despite objections from clients and other stakeholders arguing against the case-manager's interpretation.

Some cases stood out. In these, cooperation seemed to be a mutual responsibility as different professionals initiated cooperation at different times during the case. For example, in one case, updates and cooperation occurred continuously, both between the physician and the case manager involved in planning the return-to-work process and medical interventions, and also between the case manager and relatives. This client was granted sickness benefits and was later able to fully return-to-work. There were also examples where cooperation was imperfect, such as when the case-manager tried to get in touch with the treating physician without results, or when previous plans were forgotten when a client was

assigned to a new case manager. Among the cases that did not seem to involve any cooperation between different stakeholders, the majority had their sickness benefits withdrawn. And in those cases where the information from different professionals was in accordance, such as from the treating physician, the employer and the work ability evaluation, the decision seemed to be quite easy and clients were granted sickness benefits directly without being questioned. Overall, the findings of this study indicate that interactions are essential for a client's sick leave case, and that *what* is being communicated is not everything, but rather what also matters is *how* the information is presented.

## Study IV: Social insurance literacy among the sick-listed

The purpose of this study was to investigate social insurance literacy among clients on sick leave and its associations with perceived justice, being granted sickness benefits, and background variables.

Relating SIL to background variables showed negligible to medium effects. However, education and self-rated financial situation stands out, showing that having a higher level of education or a perceived better financial situation, yields higher abilities to Obtain, Understand, and Act upon information. Thus, the hypothesis that background variables influence SIL (i.e., SIL having a social gradient) is partly supported, although the influence is marginal.

The results also demonstrated that rating one's abilities to Obtain, Understand, and Act on information as higher, were associated with receiving sickness benefits, although this association was quite weak. What in fact showed a stronger association with sickness benefit outcomes was perceiving System comprehensibility as better. Regression modelling points to system comprehensibility being the strongest factor for predicting whether sickness benefits are granted or not. Thus, the hypothesis that a higher SIL will be associated with a higher probability of receiving sickness benefits is partly supported.

Furthermore, there was a significant difference between the sample groups (i.e., those with an ongoing sick leave case versus those with a recently closed one), in terms of those with a closed sick leave case having a higher proportion (76.9%) of being in a relationship than those with an ongoing case (68.9%). This indicates that the social support from a spouse is not a strong predictor for whether sickness benefits are granted or not.

Clients' perceptions of system comprehensibility were significantly associated with perceived justice, showing moderate to high correlations with coefficients ranging from 0.55 to 0.71. This indicates that clients who found the system understandable and logical to a larger extent also rated it as fair. The relation between the individual SIL measures and the justice measures, however, are weak to moderate with positive correlations between 0.20 and 0.40. Also, being in the group of clients who had an ongoing sick leave case was strongly associated with a higher score of perceived justice, compared to those clients who had recently had their sickness benefits withdrawn. These findings indicate that the third hypothesis, in which we assumed that a higher level of SIL would be related to higher perceived justice in encounters with the sickness insurance system, is partly supported. More specifically, the findings indicate that system comprehensibility is essential for perceived justice, but that the client's individual abilities are not.

In table 3, I visualize the four studies' contributions and connection to the thesis, and the main concepts used in each individual study.

Table 3. Overview of the included studies and their contribution to the thesis.

	Study I	Study II	Study III	Study IV
<b>Method</b>	Semi-structured interviews with clients and their SIA files (n = 30). Analyzed using a deductive content analysis.	Semi-structured interviews with clients and their SIA files (n = 31). Analyzed using a thematic analysis.	Clients' SIA files (n = 30). Analyzed using a qualitative document analysis.	Questionnaires from 1152 clients. Analyzed using regression analysis.
<b>Research questions</b>	1, 2, 3, (partly 4)	1, 2	1, 2, 3, 4	3, 4
<b>Main concepts</b>	Social validity	Power, trust	Perceived fairness	Social insurance literacy
<b>Findings</b>	The acceptability and comprehensibility of the tests during the work ability evaluation depended on the client's difficulties and whether they were perceived as relevant and properly explained to them. The importance of the official decision was considered low due to lack of connection with the previous evaluation and vague arguments.	Stakeholders used different means to justify their conclusions and often mistrusted each other. Clients felt powerless, often stating that they felt they had to prove their worthiness as genuinely disabled and expressed a strong desire to contribute to society. Clients also highlighted their work ethic, which other stakeholders verified.	Different communication strategies were used, which had diverse success in affecting the case manager and hence the client's sick leave process. Emotionally driven argumentation characterized by desperation and frustration was common, yet ineffective in comparison to the matter-of-fact driven communication which was more successful in changing the direction of the case.	Rating the system as comprehensible was associated with a higher score on perceived justice and also associated with being in the sample group of ongoing sick leave cases, as opposed to the recently closed cases. Furthermore, a higher score for clients' individual abilities in SIL did not have an impact on receiving sickness benefits.
<b>Contribution to the thesis</b>	Relates to both legitimacy and comprehensibility, by exploring acceptability, comprehensibility, and the importance of procedures in the system.  Also, theoretical as an existing concept was re-conceptualized into a new context.	Relates primarily to legitimacy in terms of acts of power between stakeholders, trust in the SIA and clients, and the perceived fairness of processes in the sickness insurance system.	Relates to both legitimacy and comprehensibility, by exploring the characteristics of interactions between stakeholders and how different communication strategies may impact upon clients' sick leave processes.	Relates in particular to comprehensibility as it focuses on clients' ability to understand the system and their experiences of the SIA's comprehensibility.  Also theoretical, as a new concept was developed.

# SYNTHESIS OF THE RESULTS

As a continuation of the previous chapter, which presented the findings for each study separately, here I present a synthesis of the overall findings of this thesis. Firstly, a section describing the perceived legitimacy and fairness is presented, followed by the clients' comprehension of the *what*, *how*, and *why* of the processes involved in the sickness insurance system. Lastly, the clients' experiences of moral hazardous assumptions are described.

## The legitimacy and fairness of sickness insurance procedures

The legitimacy of work ability evaluations and official decisions seemed to be closely linked to their perceived relevance and applicability to the clients' unique situation (Studies I-III). Hence, specific tests performed at evaluation units, and the arguments provided by the case manager, could be perceived as either acceptable and fair or insulting and unfair. The latter was the case if clients did not see a clear connection to their work ability (Study I). Assessment procedures could also be perceived as illegitimate in terms of being too structured and lacking individual adaptation, and hence not relevant for everyone (Studies I-III). Clients could theoretically appreciate a solid structure, providing a legally secure assessment for everyone on sick leave, but in practice they perceived irrelevant questions and tests as insulting, unfair, or a waste of time. In terms of contact with the case manager, clients were often well aware of political goals and the impact that regulations and governmental tasks assigned to the SIA had on the case managers' discretion. Hence, they often did not blame single case managers for what they perceived as illegitimate procedures in the sickness insurance system (Study I).

Vague arguments from case managers and evaluation tests lacking connection to a real-world context were aspects that enhanced clients' perception of the work ability evaluation and official decisions as unfair (Studies I-III).

*"The tests you have to expose yourself to are sick, it feels humiliating to stand there and be evaluated... You've made a circle in a minute with your left hand, then you can work" [Interview with Client 1, Study I].*

The frequency and characteristics of the contact between client and case manager varied among the clients, but perceived fairness seemed to require an open and frequent dialogue between client and case manager. This could

enhance a client's acceptability of official decisions, even when being denied sickness benefits (Study I), create an alliance in which the case manager supported the client in the event of conflicts with other stakeholders such as employers (Study II), and facilitate cooperation with other stakeholders, which could have a positive impact on the client's return-to-work process (Study III). It seemed to be crucial for perceiving the system as just, that a client was of the opinion that the system was comprehensible and logical, and commonly also having an ongoing sick leave case as opposed to recently having experienced the withdrawal of sickness benefits (Study IV). Interestingly, a client's ability to obtain, understand, and act on the information provided by the sickness insurance system had weak associations with perceived justice, indicating that the system and the strategies contained within it are key for improving the opinion of sickness insurance as fair (Study IV). Sparse or unclear communication between client and case manager could create uncertainty and anxiety regarding how the evaluation results would be interpreted and thus impact upon official decisions (Study II). It could also create frustration when the chain of connections from work ability evaluation to official decision seemed broken (Study I). Often, clients appreciated the evaluation results but felt they had been fooled if the case manager's subsequent decision pointed in another direction, which was considered illegitimate in terms of the evaluation being a false show (Study I).

Studies I-III show that the interpretations of work ability evaluation results and other documents vary and are given different levels of priority between stakeholders. Commonly, the SIA has the mandate to interpret the work ability evaluation results performed by special evaluation units. Other work ability evaluations, performed by other stakeholders such as the PES are given less priority and do not have the same impact upon the client's case, even though these evaluations can be more extensive. The different stakeholders tended to justify their conclusions by arguing with reference to different parts of the same evaluation, each choosing aspects that supported their opinion (Studies I-III). In the quote below, the client and case manager have been arguing for and against the client's right to sickness benefits by using the same evaluation.

*"I feel like I have to fight the SIA to make you believe in me, and that you choose to interpret those parts of the work ability evaluation that are supporting you to kick me out of the insurance system"*  
[Client 20 in a letter to case-manager after receiving a preliminary decision to withdraw sickness benefits, Study III].

## Comprehending the what, how, and why of sickness insurance

Commonly, clients perceived the sickness insurance system as incomprehensible, stating that the regulations, SIA letters, and often case managers' arguments were difficult to understand (Studies I-III). In addition, Study IV demonstrated that the system's ability to provide clients with comprehensible, transparent information was clearly associated with perceived justice. However, the information provided by the SIA to clients was often considered to be complicated and bureaucratic, and clients said that it was difficult to know what forms to fill in (Studies I and III). Sometimes clients asked their case manager afterwards what forms the client had filled in, or what they were supposed to fill in (Study III).

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

In the quote above, the client received an answer from the case manager but did not supply any additional documents. There were also cases where the clients described themselves as passive, and not bothering to ask for clarifications due to feeling powerless to have an impact anyway (Study II). This indicates that, although clients can comprehend the "what", in terms of being denied sickness benefits or prompted to initiate work training, the "how" and "why" may become less important to them if they feel that they have no say in the matter. The argumentation differed among clients and stakeholders, with the most common form of argumentation seen among clients being emotionally driven, characterized by desperation or anger (Study III). However, some clients seemed to know what arguments to use and what documents to supply and argued in a more matter-of-fact-driven way, which was more successful in influencing the case manager and their case. This indicates that a minority of clients may have the ability to "speak the systems language" and such clients were more frequently granted sickness benefits (Study III). In Study IV, the individual abilities of SIL (i.e., the client's self-rated ability to obtain, understand, and act upon information in a sickness insurance context), had weak associations with the probability of receiving sickness benefits, and did not influence how respondents perceived justice. But what in fact did have a clear association with receiving sickness benefits and perceiving the system as just was a higher score on system comprehensibility (i.e., the system abilities of SIL). This indicates that it is not a matter of the clients' individual abilities, but rather the system's ability to provide solid arguments and appropriate procedures (Study IV). In addition, social support matters, both in terms of preserving a client's perceived wellbeing and

also in affecting their sick leave case (Study III). This was demonstrated through the finding that clients in cases where treating physicians or employers were committed to the client's case, and cooperated with the case manager, were more likely to be granted sickness benefits than those clients who stated that they lacked support and where cooperation between stakeholders was absent (Study III). However, Study IV demonstrated an association between being in a relationship and being in the sample group of recently withdrawn sickness benefits. Social support, from a spouse or from professionals, is probably not a sufficient factor to explain who receives sickness benefits, and likely multiple factors may influence this process.

Further, clients stated that the purpose of initiating a work ability evaluation was not clear to them (Studies I-III), although they may have some idea of why, such as having their eligibility for sickness benefits questioned or when disability pension is considered an option (Study I). Additionally, the structure of the SIA, in which insurance physicians provide case managers with advice on the client's case, often caused frustration and confusion among both clients and their treating physicians (Studies I-III). This manifested as a feeling that the treating physician's recommendations were being diminished by another physician who had never met the client. The insurance physician's impact on the client's case was often substantial, and clients often perceived it as difficult to comprehend why their treating physician, who often knew them well, did not have the final say. In Study I, clients were also frustrated and confused when the SIA's decision was not concordant with their treating physician's recommendations; for instance, regarding whether work training should be initiated or not. Furthermore, different stakeholders, such as the SIA and health care institutions, referred to different parts of a work ability evaluation, focusing on aspects that supported their opinions (Study II). To the clients, the *how* and *why* of this became incomprehensible and enhanced their perception that the case manager's decision was an interpretation and hence not the full truth.

The SIA's official decisions regarding sickness benefits were criticized for being vague and lacking solid examples and arguments supporting the case manager's decision (Studies I and III), especially by those clients who only received a formal letter and not a verbal explanation as well (Study I). In contrast, those few clients who were provided with information about an official decision both in writing and verbally tended to comprehend it quite well even when being denied sickness benefits (Study I). Clients stated in Studies I and II that it was their perception that the case managers picked certain parts of the evaluation results to justify their decision, rather than looking at the full picture, similarly as in Study III, and that it was difficult to understand on what grounds the case manager had reached their decision. Their case manager's decision-making process was highlighted by many clients, who desired increased transparency in order for them to comprehend what was going to happen in their case.

## Assumptions of moral hazard and the experiences of clients

Clients in Studies I-III described being questioned and feeling mistrusted. This was characterized, for instance, by their experience of a work ability evaluation as a “cheat-test” (Study II) or when they had a general feeling that their disability, and hence their right to sickness benefits, was being questioned (Study I-III). This was also observed in the responses to the final open-ended question in Study IV. These will need a more thorough analysis in another study. However, after reading through these answers, it was clear that elements of moral hazard were also prominent in the data from Study IV; for instance, when clients stated that their case manager did not seem to find their narratives trustworthy.

The clients’ descriptions illustrate a system based on suspicion and mistrust rather than trust and reliance, which often enhanced their feelings of powerlessness and frustration. The quote below comes from an interview in which the client expressed frustration at not being treated as trustworthy:

*“You’ve labored hard (in working life) and have been there (for the employer) in every way and in all manners demonstrating that you’re no slacker. And then when you become this, well, you’re compelled to lie on the couch even though you don’t want to, then you don’t even- then you don’t even have that credibility...why don’t they take me seriously? [Client 10, from the data gathered in Studies I-II].*

The perception of fairness was not always linked to receiving sickness benefits (as in Study IV), but rather to the clients’ situation and the arguments and information provided (Studies I and III). A recommendation to receive disability pension could either be perceived as fair if the client agreed with the arguments and conclusions, or unfair if they considered themselves to have been judged as unable to work too soon and not given an honest chance to return-to-work (Study I). Clients also stated that they tried their very best to manage the tests at the work ability evaluation, often trying too hard and wearing themselves out (Study II). Sometimes the evaluation units verified that the client had done his/her best during the test, stating in the evaluation results that the professionals assessed that the clients had overestimated their ability or pushed their limits during the tests (Study II), seemingly as a way to validate the results and the client’s disability. In one interview, a client spoke about this topic after her sickness benefits had been questioned, and how surprised she was that the case manager seemed to expect her to be able to do more, despite the consequences she suffered afterwards:

*“And the stupid part is that when you’re in a place like that (a work ability evaluation unit), you suck it up, because you want to, so damn much, I want to be able to do this, of course I want to show that I can, I want to endure. And then when you can’t, you’ve still done too much. So the fact that I’ve overdone things while sticking it out, will that be held against me? Because I’m used to, just stick it out goddam it and do it”* [Client 1, from the data gathered in Studies I-II].

The interpretation of work ability evaluation results, medical certificates, or other arguments was a topic that was highlighted in several studies (Studies I-III). Clients, and sometimes also their treating physician, stated that the conclusions upon which official decisions were based were interpretations made by the case manager and insurance physician, and hence did not represent the full truth. In the clients’ SIA files in Studies I-II, there was a prominent feature whereby the interpretation of work ability evaluation results by the SIA (case manager and insurance physician) was characterized by suspicion rather than trust. Case managers often consult insurance physicians in order to interpret the findings of an evaluation. The quote below is taken from a statement by an insurance physician after such a consultation:

*“A normal psychological status appears and the insured reports having leisure time involving both physical and creative activities. Yet the insured yawns through the evaluation tests and demonstrates very low physical ability such as walking and gripping with the hands”* [Client 21, from the data gathered in Studies I-II].

This led to the client’s sickness benefits being questioned, although they were granted temporarily while the case manager requested further medical certificates about the prognosis and potential risks of initiating work training. The interpretations were based not only on the documented test results or objective findings, but also on the characteristics of *how* such findings and arguments were delivered (Study III). Clients who were able to deliver arguments and information in a matter-of-fact driven way were more likely to be able to affect their case manager and hence the sick leave process, as opposed to those clients who expressed their objections through emotionally driven arguments (Study III). Thus, clients who had the ability to speak the system’s language were treated as more trustworthy. One could easily assume that these findings indicate an unfair disposition depending on the clients’ abilities, and in Study IV we saw that higher educational level and a better self-rated financial situation were associated with a higher SIL, indicating that a social gradient is present. Although those with a higher SIL to a higher extent also were receiving sickness benefits, the individual abilities of SIL were an insufficient explanatory model for sickness benefit outcomes. Perceiving the system as comprehensible was significantly associated

to receiving sickness benefits and the importance of the system's ability overshadowed the influence of the individual's abilities (Study IV).

# DISCUSSION

This thesis has aimed to contribute to the development of empirical and theoretical knowledge about the legitimacy and comprehensibility of assessment and decision-making processes within the sickness insurance system from a client perspective. Thus, this chapter begins with a discussion of the difficulties in understanding the sickness insurance system, which were widely demonstrated among the participants in the studies that constitute this thesis. A concern raised by both clients and other stakeholders was that not knowing what would happen next in their case, or why or how, caused anxiety and frustration.

This chapter also devotes a section to discussing the diverse perceptions of the concept of work ability, and what it is that is actually being assessed within the sickness insurance system. These perceptions may influence the expectations that clients have when being assessed. Thirdly, I summarize and discuss the findings of this thesis in an attempt not to pinpoint flaws in the system, but rather to highlight potential ways to improve the legitimacy of assessment procedures. The apparent features of mistrust between stakeholders are discussed in the following section, in relation to moral hazard theory and the consequences that such assumptions may have for clients and their sick leave process. Lastly, I devote a section to discussing the theoretical contribution of this thesis.

## Limited understanding of the sickness insurance system

This thesis demonstrates that clients often have difficulties in understanding assessments and decisions within the sickness insurance system. The findings show that this also affects their perception of the system's fairness, indicating that clients who found the system understandable and logical were also more likely to rate it as fair. The strategies and resources of the system impact upon several aspects of the client's sick leave process, not just in terms of the client's understanding of these processes but also their fairness and the support provided by the system. The findings reveal that frequent cooperation between stakeholders and a continuing dialogue between a client and case manager had several beneficial features in relation to the client's case. Also, the client's individual abilities to comprehend information seem to be of less importance than the ability of the sickness insurance system to provide comprehensible information and procedures. This indicates a rather important bottom line: that improving the comprehensibility it is not a matter of educating clients or teaching

them about the regulations and sickness insurance processes, but instead of reviewing the system and how assessments and decision-making processes can be performed more tangibly and logically, from a client perspective.

Similarly as in this thesis, Kaluza (2018) describes how clients are made responsible for obtaining new certificates from their physician or their employer, when the case manager requires it. Some clients may perhaps be able to manage this for a while, depending on their difficulties and resources, but one might wonder to what extent it is reasonable to require them to continuously make some of these efforts. Kaluza (2018) states that clients on sick leave face a substantial workload in co-creating sickness insurance together with their case managers. For instance, clients often need to gain insight into how the sickness insurance system works and take responsibility for driving their case forward, as well as filling out forms and participating in work ability evaluations. In this way, clients are being activated as well as delegated tasks from the case manager. In terms of comprehensibility, it is essential to consider which tasks it is meaningful for the client to carry out, in order to avoid frustration and confusion. An example of this is described by a client in Study II (see quote in the manuscript), in which she was sent back and forth communicating a disagreement between the case manager and her treating physician.

## Comprehension of the concept of work ability

From a client perspective, this thesis demonstrates that the SIAs work ability evaluation was comprehensible in terms of testing different functions (i.e., functional capacity) and to some extent also in terms of (general) work ability when the client performed tasks that included realistic features similar to a job. However, each unique client's perception of the evaluation's relevance to them as well as the information provided to them by stakeholders, is crucial for their comprehension of what it is that is being assessed. Previous research indicates that the most accurate measure and predictor for work ability and return-to-work is the client's own self-rated ability (Bethge, Spanier, Koehn, & Schlumbohm, 2021; Hensing, Bertilsson, Ahlberg, Waern, & Vaez, 2013; Lundin, Kjellberg, Leijon, Punnett, & Hemmingsson, 2016; Ståhl, Karlsson, Gerdle, & Sandqvist, 2021). Potentially, this is because it tends to include multiple factors from a more holistic perspective, similar to current perspectives on work ability (see Ekberg, 2014; Ilmarinen, 2009; Lederer et al., 2014; Tengland, 2011). Work ability is a concept used by many stakeholders, but they often include different aspects of it, and hence are speaking of different things. The SIAs work ability assessments use a biomedical and insurance perspective on work ability (Ekberg, 2014). To some extent, this may explain the friction that was sometimes seen in this thesis between stakeholders such as treating physicians and case managers, because

they represent different systems with different perspectives on what factors to include in assessments of whether a client is able to work or not.

From a client perspective, this thesis demonstrate that what is being assessed is not obvious, and the connection between the assessment and the official decision was considered unclear because clients did not comprehend how tests of functions could be translated into work ability. These findings mirror a problem in the sickness insurance system, where there is a non-trivial degree of interpretation in the authority's assessment. In Swedish work ability evaluations relating to sickness insurance, tests of both functional capacity and occupational performance are included. These are then interpreted by the case manager at the SIA, who uses the results to translate them into general work ability before making an official decision. A client's current comprehension of the content of the concept of work ability, may direct that client's expectations of an assessment. Literacy, or the knowledge and understanding, also of the concept of work ability, is likely to be insufficient among clients, compared to that of the stakeholders who work with assessing it. A study by Baumberg Geiger (2021) demonstrated that the public seems to rely more on visible and verified medical conditions and symptoms than on contextual factors in their perception of work ability, although current best practice is real-world assessments (Baumberg Geiger et al., 2018). There is a need for different assessment methods for different purposes, but what is it that is actually being assessed? For instance, when tests of physical or cognitive function are performed, they can provide valuable insights that facilitate the client's rehabilitation. However, this is not an assessment of work ability but rather of functional ability. We need assessment methods for functional ability as well as occupational performance and work ability, because they focus on different things and can be useful for different purposes, but we also need to clarify what we are actually assessing.

The stakeholders who may be involved in a client's sick leave process, such as the SIA, the PES, health care practitioners, and the employer, are drawn from different systems. As systems try to reduce the complexity of reality by focusing on selected aspects of it, they naturally speak of the same phenomena (such as work ability) in different ways (Ståhl, 2010). Thus, a systems perspective may facilitate the understanding of why interorganizational communication is complex. The health care system and the sickness insurance system obviously have clear differences, both regarding their main tasks in society, and in their regulations and organization. As Ståhl (2010) states, the interpretation of reality is always of a specific system's reality, and hence context-bound, which leads to the question of whether consensus regarding work ability could (or should) ever be reached. However, in order to facilitate communication between stakeholders it is essential that they have an awareness of the differing interpretations of the

concept and how this may be demonstrated in practice (Ståhl, 2010). Similarly, Knudsen and Vogd (2014) suggest that, instead of a principle of consensus, system representatives could ensure that different voices are heard, and hence that diverse perspectives are recognized. There is a need for adequate communication both between and within stakeholder organizations to ensure precise and accurate assessments of work ability that could lead to relevant rehabilitation efforts for the client (Sturesson et al., 2013). In order to do so, stakeholders need to define the meaning of work ability when they refer to it in their communication with other stakeholders. This is essential because which components of the concepts are included differs depending on which stakeholder is using it. It is also important in relation to the client, who may have particular expectations and a different perspective on his or her work ability. Clients are likely to benefit from the other stakeholders explaining what they perceive as the content of the concept, rather than just using work ability as a term with an implied meaning. This thesis has demonstrated that social support, in particular from professionals, matters for the client's comprehension of the processes within the sickness insurance system and also for how acceptable they find them. Elaborating upon the *what* of the concept of work ability, and also the *how* and *why* of assessment procedures, is probably of even greater importance for those clients who have limited social support. This leaves an important task for, especially, the SIA's case managers, in terms of elaborating what it is that the SIA is assessing and how and why, so that clients can enter a work ability evaluation with reasonable expectations and an idea of where it might lead.

## Towards legitimate assessment procedures

A common denominator between the studies in this thesis is that legitimacy, (referred to here as whether processes are perceived as legally secure and to be trusted), and fairness (referred to here as the balance between an unbiased procedure and individual adaptation; hence, not treating everyone the same), appear almost as each other's antitheses, or at least as a complex balancing act. The balancing act between legitimacy and fairness can be further elaborated in terms of structure versus individual adaptation, in which structure or standardization provides clients with some assurance that procedures are reliable. However, clients commonly advocated individual adaptation in order for procedures to be perceived as suitable and helpful in their particular case. Hence, providing a legitimate *and* fair sickness insurance system is not an easy task.

Cooper (2004) states that, as systems or organizations apply standardized procedures responding to a diverse range of clients, this often leads to clients feeling unfairly treated because these procedures are not always applicable to the unique client. The authorities need to provide structured procedures in order

to be perceived as fair and legitimate, but at the same time this can be considered quite the opposite if they fail to individually adjust procedures so that they are relevant and applicable to a specific client. Thus, a suitable balance between structure and flexibility is not easy to find (Cooper, 2004). It may instead become a matter of compromise whereby stakeholders and (primarily) politicians and other decision makers need to carefully determine the extent to which sickness insurance should include structure and standardization. Obviously, a sickness insurance system requires nationally structured procedures that provide legitimacy and evoke trust that the SIA and its representatives are performing their exercise of authority correctly. However, the extent of this structure needs to be carefully considered, with awareness of potential pros and cons. Incorporating strategies to increase the perceived fairness of SIA procedures is also important because a public authority needs to be considered just by the citizens it serves. There is a risk that further striving towards structure and standardization for assessments and official decisions may hamper a client-centered approach and by extension, their perceived fairness. So, the question posed by Cooper (2004) is clearly still an issue: When should we treat people differently in order to be fair and when must we treat them the same?

Quality in work-related assessments is a topic that has been debated in many western countries, especially within sickness insurance systems; for example, in relation to acceptability, the dignity of clients, perceived justice, transparency and legitimacy (Baumberg Geiger, 2018; Lippel, 2012; Ståhl et al., 2014; Ståhl et al., 2019). A British study (Baumberg Geiger, 2018) states that assessments not only need to be fair, they also need to be perceived as such. Mladenov (2016) argues that society is fair only when it provides adequate disability support without stigmatizing clients and when society enables clients to have a say in the policies that have affected them. One aspect found in this thesis, which clients often highlighted as being illegitimate, was that the case managers assessment and decision was a matter of interpretations, and hence did not always represent the client's true situation and work ability. The SIAs work ability evaluation results were commonly given priority by case managers in determining the course of a client's case and tended to be treated as truth rather than guidance. In terms of legitimacy, the clients would have preferred that the case manager took their treating physician's and health care practitioners' recommendations into consideration to a larger extent. The tests during the work ability evaluations are performed across a limited amount of time, and hence provide only a glimpse of reality. These evaluations can be very valuable for the client's case, such as revealing potential ways forward for a return-to-work, or in clarifying new diagnoses. However, depending on the client's difficulties, the evaluation results can be more or less representative, and it is crucial for case managers to acknowledge this before drawing their conclusions. Assessments over time and involving actual work tasks have the potential to improve the precision of the assessment results. The increased contextualization gained from real-world

assessments has also been requested in other systems (Barr & McHale, 2019; Baumberg Geiger et al., 2015). The current work for the Swedish sickness insurance system to develop a database of the demands and requirements of occupational groups on clients' occupational performance (Swedish Government, 2021) has the potential to become a helpful tool, although it also raises questions (see the section on future studies).

A finding of this thesis that is important for the legitimacy of assessments and official decisions, was that a continuing dialogue between client and case manager throughout the client's sick leave spell had several beneficial features. For instance, frequent dialogue, including open and clear communication, enhanced the acceptability to the client of the steps taken in the sick leave process, including when they were denied sickness benefits. A continuing dialogue between client and case manager could also promote cooperation with other involved stakeholders, which often had a positive impact on the client's rehabilitation process. Other studies have demonstrated the importance of respectful and supportive encounters with SIA representatives, in facilitating the return-to-work process and enhancing the clients self-estimated ability (Lynöe, Wessel, Olsson, Alexanderson, & Helgesson, 2013; Olsson, Alexanderson, & Bottai, 2016; Pasanen, 2021; Svensson et al., 2006). A continuing dialogue is also a matter of transparency and consideration for the client's journey through the system, because the client is provided with opportunities to ask for clarifications when needed and to gain insight into the upcoming steps in the sick leave process. This may be facilitated by some form of personal contact, rather than occasional bureaucratic letters.

## **Moral hazard and mistrust between stakeholders**

One of the main findings in this thesis is that clients' have a strong desire to participate in society, through work or other activities. This indicates that work provides meaning and purpose, as well as reducing the shame associated with the stigma of being sickness absent because of the work norm being strong. Other studies have similarly demonstrated clients' persistent efforts to return-to-work (Bertilsson, Löve, Ahlborg, & Hensing, 2015; Bertilsson, Petersson, Ostlund, Waern, & Hensing, 2013; Moldvik et al., 2021; Saunders et al., 2015). The debate over sickness absence has become more and more a discourse of cheating and excessive usage, which can be seen within the media and in public reports aimed at investigating the "cheating" by clients or "inaccurate payments" made by social insurance systems (Junestav, 2009). In addition, the public's perception of who is deserving of sickness benefits differs depending on several factors. A recent study demonstrated that clients who are described as being to blame for their disability are considered undeserving by the public, while clients who have previously

contributed to society through years of working are considered more deserving (Baumberg Geiger, 2021). Furthermore, there was a hierarchy of symptoms that were perceived as more or less deserving of sickness benefits, with using a wheelchair as the most deserving and suffering from back pain or depression as the least deserving (Baumberg Geiger, 2021). This is rather interesting because wheelchair usage per se does not indicate whether a person is able to work or not, since this is dependent on the specific characteristics of their job and the clients' prerequisites. The clients in this thesis often felt questioned and mistrusted, which led to feelings of powerlessness, shame, and frustration. Other studies of the Swedish and other systems have demonstrated similar findings (Dembe & Boden, 2000; Lippel, 2007, 2012; Mandrup Poulsen et al., 2021; Moldvik et al., 2021). In Sweden, the welfare state has taken a controlling administrative function by primarily assessing clients' eligibility for sickness benefits (i.e., their reduced work ability), rather than focusing on coordinating vocational rehabilitation. This is exercised by emphasizing the clients' responsibilities towards society and by ensuring that social security is connected to work and activity (Junestav, 2009; Lindqvist & Lundälv, 2018; Seing, 2014). One may reflect upon whether the system is designed to suspect and control, rather than to trust and support.

This thesis demonstrates that mistrust and suspicions were directed not only towards clients but also towards system representatives, i.e., case managers and insurance physicians. Case managers, for instance, might be mistrusted by clients and other stakeholders on the grounds that they lacked medical competence and were accused of profiting when withdrawing sickness benefits, and hence not having the client's best interests at heart. This indicates that the system itself is perceived as morally questionable. Research and theory on moral hazard tend to focus on clients' incentives, or in some cases on physicians' practices, while assumptions of moral hazard relating to system representatives, as discovered in this study, seem to be relatively unexplored in the literature. Other studies have explored related topics regarding system representatives' exercise of authority. The term "institutional violence" (described as violence that is impersonal and produced within the power structures by the authorities that govern societies), has been studied and previously demonstrated in the British employment service. It manifested as encouragement of its street level bureaucrats to perform their work in ways that led to a range of physically and psychologically harmful outcomes for clients (Redman & Fletcher, 2021). Commonly, institutional violence is preceded by stigmatizing portrayals of the group of people in question, often casting doubt upon their morals and work ethic. The legitimization was derived from politicians and the media, who presented an image of the societal costs of cash benefits as a threat to British national security. The political goal of reducing the number of clients on benefits, along with a top-down managerial

pressure, led to employment service officials prioritizing cases and actions where it was easier to withdraw benefit claims while keeping an emotional distance from clients. Furthermore, the emphasis on the total performance of the team and competitiveness also seemed to reduce the attention paid to the potentially harmful outcomes for the clients (Redman & Fletcher, 2021).

This has similarities with the previous work to reduce sick leave rates in the Swedish sickness insurance system by setting the goal to a maximum of 9.0 sick days per person per year. In this case, political goals and managerial pressure led to the rational behavior of case managers striving towards reaching this goal by performing stricter assessments of eligibility for sickness benefits. Jacobsson et al. (2019) stated that the political goal of reducing sick leave rates to a certain number was justified through tales circulating within the organization that presented the matter as “truth” and the “correct” number. Similarly to the findings of Redman and Fletcher (2021), an emphasis on team performance drew the focus towards the goal and the rationality of abiding by orders, which led case managers to create an emotional distance from their clients (Jacobsson et al., 2019). Keeping an emotional distance facilitated decisions to withdraw sickness benefits, and this distance was considered more legally secure than frequent contact with clients, although a question may be raised as to whether the case managers’ compliance with political goals was a matter of risk rather than a strength in terms of legal security (Jacobsson et al., 2019). One may wonder for whom this approach was legitimate, for the clients or for the SIA? Furthermore, something that may be perceived as legally secure, and seems to be equal for all, is not necessarily perceived as legitimate. Swedish regulations pertaining to sickness insurance make it clear that this is a matter of needs assessment; hence, it cannot be limited to any specific number of days if the client’s work ability is reduced. System representatives certainly have incentives that direct their behavior in morally suspect directions; for example, policies and organizational goals that affect the granting or withdrawing of sickness benefits, and clients in this thesis seemed to be well aware of this. Olofsdotter Stensöta (2009) demonstrated that case managers’ attitudes and political preferences, such as being left wing or right wing, also affected regional differences in sick leave rates. Case manager characteristics and other factors affecting the sick leave process are topics that is not explored in this thesis, but it is important for future research. Moral hazard of system representatives within a strict system is also a potential avenue for future research, which could be explored through other methods and within other sickness insurance systems. This double-edged form of moral hazard, directed towards both clients and the system, as found in this thesis, could potentially lead to developments in the theoretical understanding of the concept of moral hazard.

## Theoretical development

As we approach the very end of this thesis, I would like to devote a section to the theoretical development to which this thesis contributes. Below, I discuss the reconceptualization and usability of the concept of social validity within a sickness insurance context, and the development and potential usage of the concept of social insurance literacy. Lastly, some thoughts on moral hazard theory, which I have used from a critical perspective.

### **Social validity: reconceptualization of an existing concept**

Social validity is a much-used, well-recognized concept and psychometric property within behavior analysis. For this thesis, I have re-conceptualized and adapted the concept for a sickness insurance context. Commonly, social validity is divided into two dimensions: 1) the acceptability of goals, procedures and outcomes, and 2) their social importance. While these two branches of the concept are quite prominent in how I have used the concept, in the literature they are also often discussed in terms of comprehensibility and the importance of solid information in order for clients to accept procedures and appreciate the importance of outcomes. Since sickness insurance systems often involve a complex bureaucratic authority directed by regulations and policies, comprehensibility is highly relevant. Thus, my interpretation of the concept included a re-conceptualization in which the two original dimensions (i.e., acceptability and social importance) were expanded to include a third: comprehensibility. This interaction between the dimensions made the analysis in Study I somewhat complex, although the conceptualization provided a facilitating structure with clear frames, which was suitable for the deductive directed analysis approach. It is likely that this re-conceptualization and the content of the three dimensions will need further development and adjustment, which can be achieved by exploring the concept in other studies within this field.

In an attempt to visualize the content of the concept as re-conceptualized in this thesis, a figure was developed (see Figure 2). In this figure social validity is presented through the three dimensions acceptability, comprehensibility and importance, including an example of relevant questions to ask for each of these.

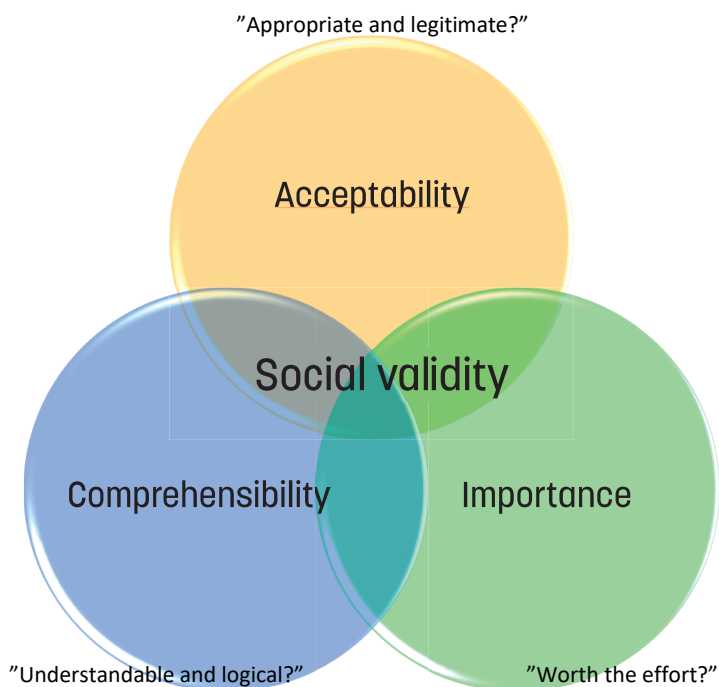


Figure 2. The dimensions of social validity.

A reflection based on the work with this concept is that social validity is truly a multifaceted construction. This naturally leads to the outcome that some parts or dimensions may be socially valid for a specific phenomenon while others are not, and that the desirable intersection at the center of the figure where the three dimensions meet represents a phenomenon that is considered acceptable, comprehensible *and* important. In my view, social validity is useful for anyone who is interested in how procedures and outcomes are perceived. In order to achieve a nuanced picture, it is beneficial to include participants with different perspectives. This is also important for the continued theoretical development, because the client perspective, as studied in this thesis, may need to be expanded to also include other aspects of the concept's content.

### **Social insurance literacy: development of a new concept**

Through the SILQ-project, several thoughtful steps were taken towards developing the concept and measurement of SIL. Yet, as we come to the end of this particular project, the project's outcome study (i.e., Study IV in this thesis),

may lead one to wonder: what have we actually captured with this measure? For instance, the subcategory of system comprehensibility is rated by clients on sick leave; hence, it reflects their experiences and understanding of the system and this ought to differ substantially depending on their encounters and the information provided to them by their case manager. Hence, the characteristics of the interactions between stakeholders is a factor that may influence SIL (which studies I-III in this thesis indicate), similar as the potential influence of learning through previous experiences with the system, and we need to explore this further through qualitative studies. This also raises the question of whether all clients need or want to learn the system's language and processes, and thus invest in this.

The system comprehensibility may also, to some extent, indirectly mirror the client's abilities to actually understand the information. Hence, it may be difficult to determine whether we have captured the system's ability to provide comprehensible information, or the clients' actual ability to comprehend it. To determine a proper answer to this issue we would have to include a component in the SILQ in which we test the client's ability to actually comprehend and interpret the meaning of an example of bureaucratic letters or regulation texts. Nevertheless, one may debate the precision of these kinds of self-ratings and whether SIL is also related to other factors not covered by this project, which may differ from other literacy concepts, such as health literacy. Aspects of system comprehensibility may be more crucial in a sickness insurance context than for health literacy, due to the structure and impact of sickness insurance. For instance, a sickness insurance system is obligated to assess clients' work ability and their right to sickness benefits, and this process is influenced by political demands, as well as internal processes within the organization, directing it to achieve certain goals and outcomes. Furthermore, sickness insurance representatives often act as sickness insurance guardians (Jacobsson et al., 2020), as opposed to professionals in the health care system, who have another role. Thus, the four subcategories of SIL need further investigation in relation to a sickness insurance context and the SILQ-SE needs further evaluation. In this thesis, the four SIL subcategories were used as a model to explain the concept and can be considered a rough estimate of the parameters relevant to SIL. These subcategories are considered prerequisites for SIL and distinguish the concept's theoretical content. The concept may, however, be difficult to fully grasp at this stage, in particular when using quantitative measures from which nuances and explanations are excluded.

### **Moral hazard: from a critical perspective**

The usage of moral hazard theory emerged as an idea when we found patterns of power and mistrust in the data gathered for Study I. This led to the design of

Study II focusing on these topics and later on the synthesis of this thesis' findings (see the section on synthesis of results). At that stage, inspiration was obtained from other critical moral hazard studies, such as Dembe and Boden (2000), and Stone (2011).

However, this theory is commonly used to describe the incentives of clients, focusing on them as rational human beings who will claim sickness insurance if entitled to it. This is quite the opposite of my perspective and preconception, as I believe (similarly to statements by Dembe and Boden 2000), that the motivators can be many and complex, and that income is clearly important but not the only factor affecting a client's behavior. So, what I have done in this thesis is to use moral hazard theory as a framework from a critical perspective, to enable me to describe whether it fits as an explanatory model for clients' views and reasoning upon their situation and their prospects while sickness absent. One could argue that this choice was not an obvious one, as there are plenty of other relevant theories that could have been adopted, such as sociological interaction theories. As in all research, there is an ocean of options and endless choices to be made. This theory was helpful in framing and digesting the components of the data and could easily be related to the clear topics that emerged, such as clients' work ethics and the stigmatization of the sick-listed. The approach of this thesis thus belongs among other studies adopting a critical perspective on moral hazard.

# METHODOLOGICAL CONSIDERATIONS

In this section, I reflect upon the methodological choices that I made while conducting this thesis and their impact upon the results. Initially, the trustworthiness of this thesis is discussed using the more qualitative terms transferability, credibility, confirmability and dependability, in relation to Studies I-III. Finally, I discuss the generalizability and validity of the findings in relation to Study IV.

Transferability is referred to as a direct function between the contexts of sending and receiving regarding applicability (Patton, 2015), and in this thesis, the participants represent several different evaluation units and regions in Sweden, with a broad range of background factors and disabilities. There were slightly more female participants and psychiatric and musculoskeletal disorders were the most common disabilities, which is similar to the general population of clients on sick leave. However, at the time of recruitment for Study I-III, there were three different insurance medical evaluations in existence, subsequently reduced to one. This means that, of these participants, several underwent an insurance medical evaluation that no longer exists. In terms of transferability of the results, one could question the extent to which these findings represent a contemporary view. However, I argue that the findings are transferable despite this, because the aim, research questions, and interview guide did not focus on a particular sort of evaluation with specific components, but rather insurance medical evaluations in general which are performed in a very specific context: the sickness insurance system. In addition, the descriptions provided by the participants, likely also mirror elements of the insurance medical evaluation currently in use.

Regarding confirmability, i.e., involving aspects such as triangulation and recognizing limitations analogous to objectivity (Patton, 2015), the data gathered for this thesis consists of a variety of material, including interviews, case files, and questionnaires, which have been analyzed using several different analytical methods. This can be considered a strength. My conviction is that the usage of mixed methods enriches the understanding of the research question, and that qualitative and quantitative methods should be considered to complement each other, rather than as opposites. The strength of using mixed methods is further described by Greene (2007, 2015) in terms of gaining a more comprehensive understanding of complex phenomenon, for instance by triangulating data and using different perspectives to engage with the research questions. The analysis chosen for each study was considered appropriate in relation to the specific aims, and also provided different approaches to looking at the data, which can be

considered a strength also in terms of credibility. Patton (2015) describes credibility as using rigorous methods while paying attention to the researcher's experience, training, and philosophical beliefs in the value of the methods. For instance, the thematic analysis employed in Study II was exactly what was needed in order to explore aspects that had been below the surface and which we had not previously been able to fully grasp. Given the experience of diverse qualitative analytical methods within the research group, there were eminent conditions to discuss and perform these analyses. The more deductively directed approach in Study I facilitated me to actually be able to evaluate social validity, by providing a solid frame for the analysis based on the conceptualization. Without it, this theoretical concept would likely not have been as prominent and the results not as structured. However, one option to replace the telephone interviews in Studies I and II would have been face-to-face interviews. Potentially, non-verbal communication such as body language could have deepened the understanding of the topics discussed. A face-to-face approach would however have limited the opportunity to achieve a wide geographical spread among the participants.

This thesis was produced within a multidisciplinary research group which enriched the understanding of the research questions and results due to the researchers' different perspectives. This facilitated the development of problematizations and a nuanced view. Continuous discussions with supervisors, statisticians, and others have been invaluable. Also, in terms of credibility, the longitudinal design of the first two studies was important because it enabled a separation of the clients' opinions of the assessment from the official decision that followed. This prevented their statements of the work ability evaluation from being colored by, for example, a decision to withdraw sickness benefits, and thus evaluating assessment procedures and official decisions separately.

The flexibility when conducting the interviews, for example by dividing one interview into two or three sessions, rescheduling depending on the client's daily condition and prerequisites, or allowing one participant to also answer questions by email, could be considered a weakness because the procedure has to some extent been inconsistent. This could negatively affect this study's trustworthiness in terms of dependability. Dependability is defined as having used a systematic process that should be followed, analogous to reliability (Patton, 2015). The argument for retaining a flexible structure in this way was to facilitate clients' participation, and hence enable the inclusion of those experiencing difficulties with fatigue or cognition, thus increasing transferability as clients with a variety of difficulties were able to participate. There is always a risk, however, that those who choose to answer a questionnaire or participate in an interview are those with a greater interest in the topic of the study or with a more negative view who are taking the opportunity to share their experiences and critique. The participants in this thesis definitely include clients with negative experiences, but there are also many clients with more positive views. For me it has been

important to highlight not only the flaws in the sickness insurance system and clients' critiques, but also more specifically what it is that they experience as negative about these assessments and decisions in the system, as well as what aspects that are considered positive, and why.

To elaborate the more quantitative terms generalizability and validity, in relation to Study IV, an initial question is what we have actually captured, in terms of SIL. This has partly been discussed in the previous chapter under theoretical development, but a few more words are in order. Validity is broadly defined as the degree to which an instrument measures what it is intended to measure (Polit & Beck, 2021). Initially, we established construct validity for the SILQ-SE (Ståhl et al., in manuscript), i.e., whether the measure captures the theoretical content (Innes & Straker, 1999), and reliability in relation to each of the four subcategories (Ståhl et al., in manuscript). However, what we saw in Study IV indicates that this is a complex concept and that also other factors may influence SIL. The concept of SIL and the measure SILQ-SE needs to be further explored and psychometrically evaluated. For instance, qualitative interview studies of content validity could deepen the understanding of SIL and what factors that may influence this. In terms of generalizability, we would argue that the characteristics of the respondents in Study IV represent the average population of sick listed clients. This argument needs to be verified through a non-response analysis, comparing those who responded to this study to those who declined, which to this date has not been finalized but will be included before submission in the manuscript of Study IV. However, the aim of this study was not to be able to generalize conclusions of SIL to the broader population, but to be able to analyze differences in SIL and the associations to other factors, such as perceived justice.

# CONCLUSIONS AND IMPLICATIONS

In order to wrap up this thesis, I end by summarizing the main findings into a set of concluding remarks, followed by my ideas for future research that has attracted my interest over these past few years.

## Concluding remarks

This thesis contributes with theoretical and empirical knowledge about the legitimacy and comprehensibility of sickness insurance procedures and provides an improved understanding of clients' perspectives on these matters. The client is a central actor in their sick leave case, but is often in a vulnerable situation due to work disability and dependent on other stakeholders. This research is important because it contributes with concrete examples of what characterizes an acceptable, comprehensible, and fair sick leave process, and what does not. These findings have implications for clients, sickness insurance authorities, other stakeholders who encounter clients on sick leave, and policymakers. This research also has a societal value because the sickness insurance is of public interest and the universal coverage of comprehensive systems, such as in the Swedish one, may lead to expectations among citizens that public authorities are there to serve.

In response to my research questions, this thesis demonstrates that interactions between clients and other stakeholders are often perceived as either supportive or mistrustful. Furthermore, these interactions seem to play a major role in a client's sick leave case and in their perception of sickness insurance procedures as legitimate, comprehensible, and fair. For instance, a continuing dialogue between client and case manager tended to impact upon the client's situation in positive terms, by facilitating their understanding and acceptability of the steps taken during the sick leave process. The system's ability to provide understandable and logical information and procedures was also clearly associated with clients' perceived justice. Other stakeholders, such as treating physicians or employers, could sometimes influence their clients' case by arguing for the client's needs in a formal, fact-driven way and by being available for cooperation. The interactions among clients and other stakeholders could be characterized in best-case scenarios by cooperation and concordant opinions that were beneficial to the clients, but there were often features of power struggles and mistrust that permeating the client's case to a greater or lesser extent. Acts of power could be expressed, for instance, through friction between stakeholders, who used different means to justify their conclusions and to direct

the course of the client's case. Irrespective of whether it is the acts of power causing mistrust, or the other way around, clear communication should be facilitated and encouraged, in particular when the stakeholders have different perspectives on the same phenomenon or process.

The characteristics of an acceptable and fair sick leave process are highlighted in this thesis consisting of instances when procedures were considered relevant and applicable to the unique client, when the client and case manager had an open and frequent dialogue, or when the client felt supported by the other stakeholders. The acceptability of work ability evaluations to clients was commonly negatively affected by the lack of individual adaptation, but this was also dependent on the information they received before, during, and after the evaluation. In order to improve acceptability and fairness, the authorities need to explain and justify the reasons for a diverse range of steps during a client's sick leave process, not only the official decisions. If official decisions are unrelated to previous steps in the process, such as the results of a work ability evaluation that served as the foundation for the decision, clients may perceive the process as a waste of time and illegitimate.

This thesis also demonstrates that the understanding of assessment and decision-making processes within the sickness insurance system is often insufficient among clients. This can partially be related to the conceptual confusion around what exactly is being assessed during a work ability evaluation. This confusion was seen among both clients and other stakeholders as different perspectives upon work ability emerged. Case managers need to clarify what it is that is being assessed, how, and why, in order for clients to feel prepared and included, and to have reasonable expectations of these assessment procedures. The information provided to clients by the system needs to be individually adapted so that the client is able to comprehend the *what*, *how*, and *why* of sickness insurance, preferably through some kind of personal contact because bureaucratic letters are considered incomprehensible if the content is not also explained and justified by the case manager.

The relation between a client's comprehension of sickness insurance procedures and their perceived fairness, background factors, and being granted or denied sickness benefits, seemed to be closely linked to the system's ability to provide logical and comprehensible information and procedures. For instance, clients who found the system understandable also rated it as fair to a higher degree and were often also those who were granted sickness benefits. However, some of the clients' background factors did in fact influence their SIL, namely educational level and self-rated financial situation, although the individual abilities to Obtain, Understand, and Act upon information seemed to be of lesser importance for

sickness benefit outcomes compared to the perceptions of System comprehensibility. What the system does and what it does not do, influenced clients' opinions of it, regardless of their own prerequisites.

Thus, the characteristics of interaction and information, as well as the structure and design of sickness insurance procedures, plays an essential role in how clients perceive their sick leave process, as opposed to the individual characteristics of the client. An important implication of the findings of this thesis is that the characteristics of the sickness insurance system play the key role in increasing the system's legitimacy and comprehensibility.

The contribution of this thesis can also be related to the variety of approaches it takes in adding to the existing body of knowledge within the field, representing a rich body of data material, which was processed using several different analytical methods and theoretical concepts. The theoretical contribution, using social validity, SIL, and moral hazard, is described in more detail in the previous section, under discussion. In short, the usability and potential of these theoretical concepts is apparent and relevant to a diverse range of disciplines focusing on interactions within sickness insurance systems. This is particularly true for social validity because it is a multifaceted construction incorporating a broad range of aspects, and hence suitable for complex research areas. Hopefully, both the empirical and theoretical contributions, can inspire new ideas and provide frameworks for other studies to come.

## Future research

This thesis is characterized by a client perspective on assessment and decision-making processes within the sickness insurance system, through their shared experiences of such matters gathered from interviews, case files, and questionnaires. Other stakeholders' perspectives are also present to some extent, in the documented correspondence and certificates in the clients' SIA files, but it is important to devote future research to exploring the perspectives and impact of the characteristics of these other stakeholders. Social validity has the potential to enhance the quality of work-related assessments by providing information about acceptability, comprehensibility, and the importance of goals, procedures, and outcomes. By tradition, other psychometric properties are evaluated first for assessment instruments. However, social validity is an important concept that can contribute with information not only about how an assessment instrument functions but also about how clients, professionals, or the wider society perceive it. Future studies of social validity for assessment procedures could be evaluated through interviews or questionnaires with

professionals from evaluation units, as well as with case managers, to explore other stakeholders' perspectives. In addition, social validity should be further explored in order to both evaluate the three dimensions, and to examine how clients in other contexts beyond sickness insurance experience work ability assessments, for instance by means of interviews or focus groups with clients in rehabilitation settings. This could facilitate the pinpointing of important factors that are shared or differ depending on the setting, in order to ensure quality in the assessments for clients, assessors, and case managers.

This thesis also demonstrates acts of power between stakeholders, mistrust and difficulties in communication. Similar power struggles have been also demonstrated in other studies (Seing et al., 2012; Shutzberg, 2020; Strindlund, 2020), for instance in terms of the stakeholders attempting to dominate and influence the process, due to having different expectations and unclear areas of responsibility in the process (Strindlund, 2020). Exactly how such acts of power, mistrust, and unclear communication may affect and/or cement each other is difficult to reveal based on the findings of this thesis and could preferably be further explored in future studies.

Researchers of another literacy concept, mental health literacy, have stated that it is important for all stakeholders within the return-to-work process to possess sufficient mental health literacy to be able to manage clients' mental health problems (Furnham & Swami, 2018; Jorm et al., 1997; Jorm, Reavley, & Ross, 2012; Porter, 2019). Future research into social insurance literacy should focus on the literacy of the involved stakeholders, such as treating physicians and SIA case managers, because their own understanding of and attitudes towards the sickness insurance system probably influence clients' sick leave process. In particular, it would be interesting to study the case managers' role further, in relation to case managers' discretion, resources and competence to encounter and communicate with clients, both in order to enhance the social validity of sickness insurance procedures and also in relation to SIL and perceived fairness. Furthermore, future studies using qualitative methods could deepen and add nuance to the knowledge of SIL and how to fully capture it in a measure (if this is indeed possible). During the SIL project, an important area for further investigation has emerged: the importance of system comprehensibility for clients' perceived justice.

Other concepts can also be related to the topics addressed in this thesis, such as transparency and participation, which are only briefly mentioned in this text. They will not be elaborated further here, but future research could focus on exploring them in more detail. As previously mentioned, in the section on assessing work ability in the context of insurance medicine, a database is

currently being developed in the Swedish sickness insurance system, in which the demands and requirements placed by different occupational groups on clients' occupational performance are described. This database aims to provide support for the SIA and its case managers in assessing clients' work ability, but without the opportunity for clients to actually try to perform such occupations, it is still a matter of interpretation. When the case manager believes that the client has some degree of work ability within an occupational area in the upcoming database, that client should be given the opportunity to actually try out their abilities in such a job, and hence be given the opportunity to manage working, while the case manager has their assumptions validated. Such a procedure would clearly be costly and time-consuming, and would probably require cooperation between several stakeholders, but from a client perspective, drawing upon the findings of this thesis, it could improve clients' perceptions of fairness, legitimacy, and comprehensibility due to the close connection with an actual job and the client's performance of it. The implementation of this database is planned for September 2022, thus future studies should focus on evaluating this policy change, both from a client perspective and the perspectives of the authorities and other stakeholders.

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