Vocational Rehabilitation between Work and Welfare - the Swedish Experience

By Rafael Lindqvist

Abstract: Vocational rehabilitation and activation of the long-term sick and unemployed have during the last decade become recognized as one of the most important objectives of welfare policy. Vocational rehabilitation incorporates several organisations, among them the medical system, the employers, social security and labour market authorities, who each have their special rules and routines. This article discusses the conditions for cooperation between organisations within this field. Are welfare agencies organised in ways that make adequate help for multi-problems clients possible? The point of departure is the so-called neo-institutionalism within organisational analysis. In the article the different parties will be presented, along with their institutional context. Then different forms of cooperation will be described and analysed, as will the dilemmas and possibilities they bring with them. It is argued that cooperation between organisations is difficult to achieve when each sector of welfare is tightened up and when boundaries between each one's duty are becoming more distinct. But there is also evidence of positive experiences of cooperation. Such cooperation was characterised by physical proximity and frequent face-to-face interaction between neighbouring agencies. The empirical basis of the article consists of policy documents, interviews with case-workers, medical doctors, human resource managers and staff participating in local cooperative projects dealing with vocational rehabilitation.

Ingress

Charlie had a problematic childhood. His time at school was also troublesome, but he managed to get through with assistance and supports from special education and social workers. Eventually he became a trained metal worker, got married and had two children. However in the 1980s, his alcohol consumption increased, he began to stay at home on Mondays, and eventually lost his job. His drinking habits worsened, and he also developed mental health problems which were treated with psychotropic medications. His backache, caused by a work injury, also got worse. Duration of his sick-leave periods became longer, interrupted by periods of casual work and unemployment. One consequence of these accumulated problems was his divorce. Now, at the dawn of the 21st century, Charlie is a regular ´customer´ of several welfare agencies. He is

registered with the public employment office, the social insurance office, and he is keeping in touch with the psychiatric health care system. He is always late paying his rent, and he receives welfare benefits from the social assistance agency. In short, Charlie is a complicated case in terms of vocational rehabilitation.

The case of Charlie raises important questions about the construction of welfare policies, and the capacities and work modes of welfare agencies. Are such agencies organised in ways that make adequate help for multi-problem clients possible? Is co-operation between welfare agencies possible, and if so, under what conditions? The article discusses the conditions for cooperation between organisations within the field vocational rehabilitation. Vocational rehabilitation is an interesting field as it incorporates several organisations, among them the medical system, the employers, social security and labour market authorities, each with their own special rules and routines.

Having first introduced the social policy context within which vocational rehabilitation takes place, the theoretical perspective of neo-institutionalism and its basic concepts will be introduced. Then, the different parties will be presented, along with their institutional contexts. Finally, the different forms of cooperation will be described and analysed, as well as the dilemmas and possibilities they bring with them. It is argued that cooperation between organisations is difficult to achieve when each sector of welfare becomes more strictly enforced, and when boundaries between each sector's duties become more and more distinct.

The social policy context

In most European countries, there has been a shift in emphasis from passive payment of support to active intervention, although both content and implementation from policy to practice have varied among countries (Geldof, 1999; Hvinden, 1999). The new activation policy contains two prominent elements. First, there are reduced levels of compensation for different allowances and more stringent requirements for awarding them. Second, there are clearer demands for active rehabilitation intervention and for more stringent work ethics, as well as expectations that the clients are work-motivated. From such a perspective, the function of vocational rehabilitation becomes to delineate the deserving from the non-deserving (Midré 1990). This function is explicitly formulated in the recent Swedish work policy, elaborated in the early 1990s, which emphasises that first and foremost it should be the long-term sick who should receive vocational rehabilitation, and where this is not possible, then early retirement (Lindqvist & Marklund 1995).

Another important characteristic of Scandinavian welfare policies is that benefits and services are delivered by an

array of agencies, acting within separate jurisdictions and according to different regulations. Consequently, boundaries also exist at the organisational level. In the field of vocational rehabilitation, inter-agency cooperation should be considered important, especially for groups who find it difficult to assert themselves in the prevailing, highly-sectored welfare model.

The system of vocational rehabilitation: players and regulations

Vocational rehabilitation is not explicitly defined in the Swedish social security legislation. It is a broad concept with two stated aims: "to prevent exclusion from the labour market" and "to shorten absence from work life" (Prop 1990/91: 141), encompassing measures that can help the person to return to his/her former job or to find another job. The most important players in this context, beside the sick-listed individual, are the medical doctor, the social insurance office, the labour market authorities, and the employers. The task of the doctor is first to assess the medical condition of the person, and second to assess the extent to which work capacity is reduced due to ill-health. However, the right to receive cash benefits because of illness and the need for rehabilitation services are issues decided by the social insurance office (Riksförsäkringsverket 1998:29).

The employer also has a significant responsibility, including examining the prospects for vocational rehabilitation and taking actions to rehabilitate an employee. This includes assessing possibilities for changed work tasks (with or without extra training) or re-placement. According to the Social Security Law, such an investigation must be sent to the social insurance office within 8 weeks from the begin-ning of the sickness period. Thereafter, the social insurance office is requested to cooperate with the employer in order to draw up an individual action plan for the person's vocational rehabilitation. Ac-cording to elaborate procedures, the so-called step-by-step model, the social insurance office has to figure out if the sick person can return to his/her former job, take on other work tasks at the same work place, take on another normally available job, or if the person's work capacity will be reduced for a con-siderable time. In the latter case, early retirement is the likely option. At each step, the need for rehabilitation must be considered. (Prop 1996/97: 28, p 13).

If after completing rehabilitation it turns out that the sick person cannot continue his/her employment, sick-leave should be terminated and the case turned over to the labour market authorities, the Public Employment Office (PEO), or special labour market institutes/rehabilitation units which provide more extensive examinations of work ability, such as work tests, psychological aptitude tests, and practical training. For the unem-ployed, the social insurance office is responsible for investigating and making

decisions about the need for rehabilitation, but otherwise it is the labour market authorities who have responsibility for rehabilitating those without employment.

In recent years, the concept of illness has become more narrowly defined in social security law (SFS 1962:381, amended in 1997). Considerations of education, previous activity, domicile, age and other factors may not be included in an assessment of the reduction of work capacity. The ideas behind this were to "define the limits for what should be compensated for by sickness insurance", and that "problems that are basically non-medical should principally be solved with labour market or socio-political means " (Prop. 1996/97:28, p. 9-10). The Swedish social insurance offices have been given a more distinct coordinating role in connection with vocational rehabilitation of the chronically ill (Prop. 1990/91:140 and 141). From 1998 on, social insurance offices have also been permitted to make agreements and use funds for joint action with local authorities, county councils and labour market authorities in joint projects; the purpose was to find better methods in rehabilitation work and to avoid contradictory priorities in work by "shortening the periods people are excluded from the labour market" (Prop. 1996/97: 63, p. 40-41).

After having been in force for about ten years, this reform can now be said to be a failure. Both long-term sick-leave and early retirement have increased dramatically since 1997 (SOU 2002:5, p 11). However, the number of sick-listed persons considered in need of vocational rehabilitation has hardly increased, whereas the waiting time until rehabilitation measures are decided by the social insurance office has become longer (Riksförsäkringsverket 2002: 89).

Data, method and research design

This article is a case study of vocational rehabilitation in an organisational context. The case study method gives an opportunity to more thoroughly depict a phenomenon and to explore its relations to other phenomena in a wider context (Yin 1994). In this article, the case method is used in a heuristic and exploratory sense. A theoretical framework within organisational analysis has been used to attempt to understand the possibilities and contradictions that are inherent in vocational rehabilitation of the long-term sick. Different types of data have been collected. Secondary data including public investigation reports, policy documents, social welfare legislation and annual reports from relevant authorities have been collected in order to grasp the intentions of the reform policy and the ways policies have been interpreted by the different organisations. In addition, semi-structured interviews were conducted in two studies to find out about dynamics on the inter-organisational level.

The first of these studies (Lindqvist 2000) included interview data from: 43 case-workers employed at the Social Insurance Office, Public Employment Offices, Labour Market Institutes/ Rehabilitation units and the Social Welfare administration; 9 Medical doctors employed at Health Care Centres; and 10 human resource managers at public and private agencies. Case-workers were asked if, and to what extent, there were goals, rules, regulations and work practices within the field of vocational rehabilitation that harmonise or contradict each other, and how they manage this. The medical doctors were asked questions concerning procedures and practices when sick-listing patients and about their knowledge of the patients' work conditions. Human resource managers were asked questions about the practice of vocational rehabilitation and co-operation with the other players.

In the second study (Lindqvist & Grape 1999), 39 case-workers and middle-managers participating in 14 local cooperative projects dealing with vocational rehabilitation for multi-problem clients were interviewed. The projects, geographically distributed throughout Sweden, each consisted of at least three cooperating state welfare agencies or health care units. The clients experienced at least two of the following predicaments: long-term unemployment, long-term sickness, psycho-social problems, or substance abuse. Case-workers were asked questions about the basic principles of their projects, why the projects were initiated, the role of the client, and about problematic and facilitating factors in efforts concerning cross-sector cooperation.

Institutions and organisations: a theoretical frame of reference

In order to identify dilemmas and opportunities that occur in the field between policy intentions and reform outcomes, I will take my point of departure in the neo-institutional perspective in organisational research. The essence of this perspective is that it focuses on the connection between an organisation and its surroundings. A central tenet is that organisations are permeated by their surroundings, which create (rather than influence) these organisations with certain structural traits and operational principles (Meyer, 1994:32; Scott 1995:xv). When organisations are seen as part of a greater whole, the 'environment' then acts as a set of determined modes of behaviour, patterns of action and cultural interpretative models. Organisations that embrace these institutionalised preconceptions within their formalised structure thus appear legitimate, gain access to increased resources, and improve their chances of survival (Meyer & Rowan 1977:352). Another important aspect is that individual organisations must adapt to a series of *separate* institutional sectors characterised by elaborated rules and requirements, if they are to receive

support and legitimacy from the environment. Such sectors can intrinsically be in conflict (cf. Scott, 1991: 167).

Instead of speaking of institutional sectors, Friedland & Alford (1991:248) distinguish between different (potentially contradictory) institutional orders. These are assumed to have a special 'logic', that is, a set of material applications and symbolic characteristics which create certain principles for organising. The institutional logic that applies for private companies (and many public bodies and authorities) is a rational, economic one that aims at maximising profits, and running the business as economically as possible. The logic that (welfare) bureaucracies apply is to fit individual situation-specific needs into routines and procedures which are reconcilable with the legitimate mission of the authority, and which make the needs manageable in a hierarchic decision-making model and a vertical division of work. A third logic is that of professional knowledge, here exemplified by the paternalistic standpoint of medicine, based on science and approved experience. According to this, the medical profession has the autonomy and legitimate right to make important decisions about diagnosis, treatment and care interventions, something that others must then comply with.

Situated in the midst of this power-field of conflicting institutional orders, it is not sufficient for organisations to adapt to technical demands linked to different kinds of work tasks. If such demands clash with institutional norms concerning what organisations should do, then the organisations must also create the impression that they have adapted to these norms as well. This can be done by 'de-coupling' the formal organisational structure from the practical performance of the work tasks, which can then be carried out in more or less pragmatic ways (cf. Weick 1976). The need for de-coupling probably increases depending on how institutionalised the organisation is, partly in order to uphold legitimacy in relation to the organisation, and partly because the practical work can be carried out more informally through different adaptation procedures, so that the purchasing interests are satisfied.

Organisational fields - claims and conflicts

The concept "organisational field" has been introduced to draw attention to the organisations which in a single field of activity have approximately the same tasks, and which thereby can be conceived to be subjected to the same processes of change. The term refers to such organisations that together comprise a recognised area of institutional life (DiMaggio & Powell 1983: 143). Vocational rehabilitation of the long-term sick, the functionally disabled and the unemployed can be analysed in terms of an organisational field in which a number of parties have much in

common, for instance through their working with the same clients, carrying out parts of the same work process, referring to, selling to and buying from each other, etc. (cf. Mallander, 1996). Belonging to the same organisational field may mean that cooperation will come about, but it can also be a source of competition because organisations with a similar structure and comparable tasks operate and compete to perform or avoid certain duties.

One vital 'domain claim' (cf. Scott 1992:126) for the social insurance office is that of deciding whether, and for how long, sickness allowance should be paid, and to initiate and coordinate interventions for vocational rehabilitation. In a corresponding way, the claims of medical care are to make diagnoses, and to decide on treatment and the degree of functional disability caused by illness, whereas the claim of labour market authorities is to assess whether an individual is 'at the disposal of the labour market'. Such domain claims however can change over a period of time, due to new guidelines and rule changes. One result of this can be territorial claims and demarcation disputes over client groups and helping actions, where both organisations and professions are involved (Hasenfeld, 1983: 60).

Organisations, then, can be seen as integrated into an environment that provides a set of rationalised patterns and models, whose concrete expression can be seen in legislation and statutes, the construction and missions of authorities, and scientific and professional patterns of thought. DiMaggio & Powell (1983) consider that the state and professions are the two most important sources of rationalisation in our type of society. This tendency for modern societies to become more rational, in the sense that our cultural norms expressly prescribe means-ends thinking, and that we create systems for controlling activities and their actors, are important elements which create new conditions for organising (Scott & Meyer, 1994: 3).

We can find concrete expressions of such a means-ends rationality in our thoroughly organised welfare state. At work, the boss has planning talks with each of his employees. The employment officer has individual action plans for the unemployed. The social insurance office, together with the individual and the employer, is supposed to draw up rehabilitation plans for the chronically ill, and the different care units are obliged to have care plans for their patients, something which is particularly important when the patient changes care settings or returns home. All this presupposes an increased number of organisations, but it is not however a necessary consequence that joint action, coordination and cooperation between them would increase.

Vocational rehabilitation in the power-field of different organisations

Three institutional spheres

Returning the long-term sick and functionally disabled to working life is an activity that involves several institutions and organisations whose driving forces are to some extent disparate. Here I will focus on three intrinsically related institutional sectors, which together have a considerable importance in the vocational rehabilitation of the chronically ill. The three sectors are: a) the medical care sector, b) the authorities who are to realise activation policies (the work policy), i.e. social insurance offices, labour market authorities, and to a certain extent, social services, and c) the production sphere of private and public employers, trade unions and occupational health services, etc.

Institution:	**Medicine**	**Vocational rehabilitation**	**Production**
Organisation:	Care system (Hospitals, care centres)	Welfare bureaucracy (social insurance offices, job centres, labour market institutes, social services, sheltered workshops, etc.)	Private and public employers
Logic (driving force):	Science , approved experience, professional self-regulation	Social security law, and negotiation (regarding social and occupational problems)	Profits, reduced costs
Domain claim:	Decisions on diagnostics, therapy, treatment (assessment of function and work capacity)	Decisions on the right to economic compensation, investigation of work capacity and vocational rehabilitation	Decisions on the volume and aims of the activity; size of workforce, management of work

Figure 1. The organisational power-field of rehabilitation.

Care system, medical profession and medicalisation

The powerful expansion of the welfare state has taken place parallel with another permeating process, namely the medicalisation of a number of personal and social problems. Medicalisation has been interpreted as a process where more and more general human conditions and areas of life, including feelings of insufficiency and frustration, adaptation problems, addiction and rehabilitation, become subject to medical decision-making and control measures (cf. Zola, 1975). This takes place on three levels, a) initially non-medical circumstances are classified in medical terms and are given diagnoses as a consequence of the 'progress' of medicine (conceptual level); b) different conditions are treated medically through the development of different therapies and care forms (interaction level); and c) through medical decisions steering administrative and socio-political conditions (institutional level), such as qualifying individuals for compensation in one form or another (Conrad, 1992).

The first two points can be said to deal with the essence of medical decision-making: namely, diagnostics, the definition of the concept of illness, and the subsequent therapy. Medicine has at its disposal a large number of diagnoses, and the accelerating rate of sub-specialisation indicates that development is likely to continue in the same direction. The other aspect means that diagnoses and medical labels for social problems have led to a search for solutions in the realm of medical treatments. The concept of illness has been extended, and care has been enlarged, as more and more illness symptoms have become treatable. Although the number of diagnoses is increasing, treatment times are becoming shorter, partly thanks to milder therapies. Now as care-service resources are shrinking, the problem instead seems to be to identify criteria for rationing treatment to patients, when treatment is not clearly indicated. Doctors in both somatic and psychiatric settings have to decide whether the patient needs round-the-clock medical care or other assistance, such as sheltered accommodation or social assistance.

The third aspect has to do with the scope of medicalisation at the socio-political level, where social benefits and services are provided and rehabilitation interventions are carried out on the basis of information in doctor's certificates about diagnosis and reduced work capacity. The construction of sickness insurance in Sweden, as in other countries, is in general based on the doctors' having a monopoly over the concept of illness and the right to assess the limiting effect of symptoms on work capacity.

Vocational rehabilitation – a counterforce to medicalisation?

Activation measures could be seen as a strategy to reduce the action radius of medicalisation. Activation policy as an

ideological principle consists of two elements: the obligation to earn a living, and the right to employment (Lindqvist & Marklund 1995). Whether the emphasis should be on the one or the other has varied over the years, but both elements are deeply rooted in key institutions in the areas of working life and social policy. The social insurance offices and labour market authorities, as well as the social services to some extent, are the most important of the existing organisations that apply activation strategy. The prevailing logic, at least in theory, is not on a single-minded focus on factors that make people ill, but rather a focus on factors that contribute to people staying healthy (cf. Antonovsky, 1987). However, compared to medicine as a social institution, vocational rehabilitation does not have nearly as large a volume of scientific knowledge or systematised approved experience. Assessment of work capacity and the design of rehabilitation strategies are carried out more or less by 'trial and error', where interpretation of the law and implementation of the rules take place in combination with negotiations with other parties (authorities and employers) on measures and the funding of those measures.

Although the work routines in these so-called welfare bureaucracies can sometimes be standardised and cases can be dealt with on a routine basis, case-workers are under considerable pressure to individualise service. It is through the encounter between the client and the welfare bureaucracy that the reform policy in question is given practical content (Lipsky, 1980). In such situations, case-workers often feel inclined to draw attention to the duty to earn a living through salaried employment and the will to regain work capacity. The strategies that thereby can come into play are either to reinforce the client's own determination to become rehabilitated or to try to motivate those who appear reluctant to rehabilitation (Jonsson, 1997). Case- workers then find themselves in a dilemma, as they must give each client adequate service, while at the same time they are expected to follow the established routines of bureaucracy and meet its demands for efficiency.

The production sphere – integration or outsourcing

Within the production sphere, profit and cost-efficiency are primary goals. According to the existing Work Environment Act, the employer is expected to continuously oversee that the working environment is satisfactory and also to rehabilitate employees, which presupposes that these functions are integrated in the main activities. The employees' claims for a secure and stable employment contract can however come into conflict with the requirement that the company is supposed to adapt to changing market demands. Flexibility and mobility are preconditions for survival, and can sometimes mean that an activity is discontinued or moved. Pfeffer

& Baran (1988) identify three ways whereby the employee's attachment to the employer can be supposed to become weaker: through work duties being carried out outside the companies premises via flexible arrangements such as 'cottage labour', through part-time and temporary employment, or through work duties being carried out by personnel employed in other companies, for instance a hired workforce.

Employers usually wish to rehabilitate personnel belonging to their core staff, even if it may be difficult to obtain resources to do this in periods of recession. One must also be aware that the social insurance system and its contract-based equivalents are used as an exit-route for employees whom the employer either cannot or does not want to retain. The existence of generous allowance systems facilitates such endeavours (Casey & Bruche 1983; Kohli *et al.* 1991). For many older employees with various degrees and types of ailments and a demanding work environment who wish to retire voluntarily, such possibilities can appear attractive. In such situations, the prospects of the social insurance office asserting an activation policy in cooperation with companies are often quite unlikely.

Vocational rehabilitation, then, takes place at the intersection between three different institutional spheres, each of which has been separately built up by several organisations, and each one characterised by different systems of values, different organisational principles and driving forces. The fact that several parties are simultaneously active in the area of rehabilitation also means that the different authorities must be familiar with the surrounding social environments of the organisations with whom they cooperate. The authorities need to take into consideration not only their own regulations but also those of other organisations, which means that collisions and 'boundary disputes' may arise. This is explored in the next section.

Boundary disputes between vocational rehabilitation organisations

Diagnosis, treatment, functional capacity - the domain of the medical system

The task of medical care is to diagnose illness and to prescribe treatment that can cure or relieve symptoms. However, in connection with the task of writing a sick note, the doctor will of necessity become involved in another assessment, namely whether and to what degree the illness constitutes a functional disability likely to reduce work capacity. According to the ideal model, the doctor first makes a diagnosis, then medical treatment begins, possibly followed by medical rehabilitation if the functional capacity needs to be restored in some respect, and after that the vocational rehabilitation begins. Social rehabilitation can also be

considered parallel to medical rehabilitation, if the insured person needs economic or curative support. The sick-leave is not infrequently seen as a direct consequence of a well-defined state of illness, and the degree of gravity of the illness is considered to guide the doctor's writing a certificate. When then the adequate treatment begins to produce results, the sick-leave terminates more or less of its own accord.

Let us begin by looking at the first phase of the ideal model, the diagnostic phase. It can be seen as the gateway to the sick-leave itself, and it determines to a large extent how the rehabilitation process takes shape. For several reasons, the ideal model described above does not correspond with reality. It is often difficult to say with 100% certainty that "this is the right diagnosis". Usually a preliminary assessment is carried out, wherein the patient's symptoms are compared with the established classical pattern from the medical literature. If the match is reasonable, a diagnosis can be quickly made, and treatment if available can begin. Riegelman (1991:4) considers that the following general rule can be applied to arrive at a correct diagnosis: The doctor must a) focus on what the patient presents as the main problems (the principle symptoms); b) formulate an early hypothesis of what the diagnosis might be; c) consider alternative diagnoses; d) identify the illness by testing the hypothesis; and e) make an assessment of likely underlying causes and relate the patient's symptoms to the identified illness.

These steps may appear to be a reasonable rule of thumb, but they are not always applied in a sufficiently cognizant way. Focusing on the patient's principle problems is not always easy, since the patient may have a number of different reasons for going to the doctor. Many patients describe incomplete or different symptoms compared with what is expected, or the patient denies or cannot persuade him/herself to express the symptoms. If it proves difficult to find a reasonable diagnosis in the process of identifying the illness, the doctor continues searching by further investigation, referral to specialists, or by making maximum use of different tests, physical examinations, etc. There may be cause to refer the patient if there is uncertainty, if the doctor feels insufficiently qualified and needs a second opinion, but the response from referrals is often the one expected before the referral. Often the occasional clinical discovery is also made, as most patients have in one way or another a somatic basis for their illnesses.

The second phase, beginning treatment, is also problematic. Even if it has been possible to make a diagnosis with great certainty, there may now be several treatment or therapy approaches or modalities considered to be possibly appropriate. Neither is it the case that treatment invariably be finished by the

time rehabilitation begins, since many times, rehabilitation may need to begin parallel with the diagnosis and medical treatment phases. The alternative may be a long waiting period. While considerable resources in the form of (often high-technological) apparatus, personnel, buildings, laboratories etc. are spent on diagnostics, considerably less is spent on following up choices of therapy or on supporting a process whereby doctors choose among the best of these (Weibull & Troëng, 1996:234-235). To refrain from treatment where beneficial effects cannot be expected is difficult if this is counter to the opinion of the patient or the patient's relatives. It can cause problems when ill-health cannot be explained with the help of standardised diagnostic criteria; the consequence can then be a circuitous route to different care providers, without the rehabilitation process advancing.

Stage three, that of sick-leave, is perhaps the stage that most of all rests on shaky ground. There is varied practice for recommending sick-leave among doctors when it comes to the effect of common medical diagnoses on work capacity. This may partly be due to the fact that most doctors (except company doctors) have little or no training in how to assess sick-leave, and often have scant knowledge of the demands made by working life. It has been observed that doctors are sensitive to the patient's labour market status, such that if the patient has exhausted her/his unemployment benefits, the doctor often feels pressured to write a medical certificate that would make the person eligible for illness cash benefits (Ds 1994:91, p 55).

To the extent that patients' subsistence problems are unsolved, a further limitation of the concept of illness might lead to extended medicalisation of social and occupational problems. If sick-leave is necessary for the individual from a subsistence point of view, one may entertain fears that patients may to a greater extent display symptoms that can be expressed in medical terms. The doctor is generally very loyal to his/her patients, and does nothing that could be perceived as injurious to the patient. But the doctor also pays attention to the pressure put on the patient by employers, in other words, the medical sector is permeated by the logic of the productive sphere.

In the context of the three different institutional spheres outlined here, the power, status and prestige bestowed upon the different professional categories differ greatly. Different weight is given to the doctors than to the case-workers at social insurance offices. Even if case-workers try to emphasise that there is sufficient residual work capacity to form a basis for vocational rehabilitation, the case-worker has little chance of defending this if the doctor is of another opinion. If the doctor says that there is hyper-mobility in the sacroiliac joint, or in a vertebra, or something else that can be thought up, then the social

insurance office must accept it. The doctor can apparently have many diagnoses "up his/her sleeve", if the social insurance office attempts to invade the domain of the doctor.

The rules that have applied for the last few years (that all cases of sick-leave must after 28 days be brought before the social insurance office's own consultant doctor, in order for the diagnosis to be studied and form a better basis for vocational rehabilitation) may be regarded as a way to dispel the potential for domain conflict that exists between the social insurance offices and doctors. One could also say that the function of the social insurance doctor is to bridge the differing kinds of logic prevailing within two important but dissimilar organisations in the same field. The doctor recommending sick-leave can occasionally need to defend the diagnosis, and the consequence is often that the doctor further expounds his views on diagnosis and functional ability on the certificate. It is less common for the social insurance office to discontinue sickness allowance. Counsellors and psychologists in primary care are other professional groups with a bridging function. These are often engaged as a sort of coordinator if it becomes apparent that a rehabilitation case will be a long-term one, requiring repeated and continual contacts with other parties.

There seem to be few studies that indicate that sickness allowance and permanent disability retirement should be connected with the degree of ill-health. This applies "both within a particular diagnosis, where measures of the degree of gravity of the illness have not proven to have any connection with work capacity, but also between different illness diagnoses, where more serious illnesses such as cancer and systemic illnesses have a better prognosis for an early return to work than bio-medically milder illnesses" (Englund, Tibblin & Svärdsudd, 1997:3). Instead, long-term sick-leave and lack of success in vocational rehabilitation can be explained with the help of a number of non-medical factors, such as for example the attitudes of the person on sick-leave towards his/her own health and work capacity, and different work-related factors. Motivation and job-satisfaction say more about whether the patient feels capable of working than do the degree and type of pain (Bigos *et al.* 1991). Other factors are socio-economic and demographic factors, factors that have to do with the possibilities of the care system to provide treatment, the aims and skills of the doctor, and the way in which the social insurance system is constructed (such as generous compensation levels, soft eligibility requirements).

In order to more easily limit or discontinue a dubious sick-leave, the doctor needs to know what the alternatives to sick-leave are based on the diagnosis. The doctor must often be

able to offer alternatives that are better than sick-leave, in order for the rehabilitation to be successful. As these alternatives are outside the medical care system, cooperation needs to begin among the other parties.

Testing the right to sickness allowance and work capacity - the domain of social insurance and labour market authorities

Within the vocational rehabilitation sphere, boundary disputes may occur between the two main agencies. The first step in a rehabilitation case is for a doctor's certificate to be handed in. The social insurance office then assesses whether the sick person is entitled to sickness allowance, that is, whether the person has the right to an allowance on the basis of the illness and on the basis of the job he/she does. It then becomes a question of whether the illness affects the person in his or her work to the extent that rehabilitation measures are needed. The most important criterium is the existence of an accepted medical diagnosis, as it acts as an entrance ticket to the social insurance system. Details of ongoing treatment and how long this might take, as well as the doctor's views on the rehabilitation needs of the patient, are also important information. A doctor's certificate considered ideal from the point of view of the social insurance office would contain the following: an assessment of the medical aspect and how it affects the person in his/her work, and what measures are planned, together with a prognosis. What is often missing in a doctor's certificate is information about working conditions and functional capacity. Such things often appear later in discussions between the doctor and the rehabilitation counsellor about concrete rehabilitation interventions.

Another important element is the employer's rehabilitation investigation. Such investigations are handed in only a small proportion of cases, which means that the social insurance office does not know the line of reasoning used concerning the rehabilitation question at the workplace (Riksförsäkringsverket, 1998). The diagnosis and rehabilitation investigation are important parts in the process whereby the individual acquires a client role, which does not necessarily mean that this is useful in solving the problems at hand. Many times it means just making a note of all the obstacles that exist. In order to make it easier to cross the sector boundaries created by rules, formalised procedures and disparate perspectives, mini-meetings are scheduled, where representatives of social insurance offices, the employer and sometimes also the doctor meet to present their assessments of the situation and possibilities for the person on sick-leave. This can be regarded as an arrangement designed to achieve domain consensus and to avoid conflicts. Such meetings also contribute to the creation of a heterogeneous and locally adapted implementation of rehabilitation policies and make it possible for the

organisation to de-couple from the formal organisational structure.

With regard to persons on sick-leave, the social insurance office tries to hand over the case either to the PEO or the labour market institute/rehabilitation unit. Demarcation with the labour market authorities works through the PEO considering itself to have the right to say 'no' to a client of the social insurance office, if the client has not 'completed medical rehabilitation' and if the person is not (theoretically) 'at the disposal of the labour market'. The difference in views between the labour market authorities and social insurance offices implies that labour market officials usually consider the number and character of vacant jobs in the (local) labour market and the demands that those jobs pose. The social insurance office, for their part, look at the residual work capacity of the long-term sick individual and how to make best use of this capacity.

If the unemployed person on sick-leave is not judged to be directly re-locatable in the labour market (when a suitable job has been announced), then normally a functional assessment is carried out, usually at a labour market institute or a special unit at the public employment office. A general demand made by the labour market institute is that the person on sick-leave should have 'completed medical treatment', and that he or she has a functional disability and is work-motivated. These questions (except the nature of the functional hindrance, which can often be confirmed with a doctor's certificate) can give rise to differing assessments. Social insurance office staff often optimistically want the person be functionally tested, while the labour market institute insists that the requirements be fulfilled. Sometimes such disputes end up in referring the client to another agency, for instance health care or social welfare authorities.

Efforts to solve disputes often take the form of a three or four-party meeting with representatives for the different authorities and often also the doctor of the person on sick-leave. The purpose is to determine whether the insured person is sufficiently motivated, has the stamina (functional and work capacity), and has settled circumstances, such as housing, in order to be able to benefit from a stay of up to six months at a labour market institute. Part of the ritual in connection with this is that the person admitted for a functional test at such an institute must have a 'handicap code', which the job centre can provide, if there is a documented functional disability. This act of categorisation works as an instrument for drawing boundaries, also with adjacent client categories, and from the point of view of the individual has the advantage of making more labour market policy measures available than would otherwise be the case. The disadvantage is that such measures can also seem conservational, that is, the functionally disabled can remain on a supplementary

pay allowance, in sheltered workshop employment, or in some similarly adapted form of employment.

There is, however, a 'grey zone' in the rehabilitation process, where neither the social insurance office nor the labour market authorities consider themselves to have the main responsibility, namely the question of strengthening the individual's motivation and self-esteem, measures that could be construed as 'preparatory vocational rehabilitation' (Riksrevisionsverket, 1996:82). One can say that there is a domain consensus that this is a 'no-man's-land'.

If the unemployed person is admitted to a labour market institute/rehabilitation unit, the first step is a stay at a practical training unit where a functional assessment is carried out on those who are on sick-leave and vocationally indeterminate. The person chooses the area or areas he or she wants to begin with, and with the help of occupational therapists and other personnel, the functional ability of the person is ascertained. There is additionally a vocational psychological investigation (APU) that can be used to identify interests and skills that can be incorporated in guidance talks with the person on sick-leave. If a work test at a workplace is called for, the careers advisory officer at the labour market institute can assist, but nowadays there is a large onus on the client him/herself to arrange a work placement. This is extra difficult if one is unemployed and on sick-leave.

During the probationary period at each workplace, the person in question is registered with the labour market authority. But continual contact with the social insurance office, which is responsible for coordination and which pays the rehabilitation allowance, is required if the registration is to remain valid. If the PEO consider that registration is to be extended by another four weeks, the social insurance office often agrees. But they can also insist that the labour market authorities take over, by using various labour market measures for the purpose of vocational rehabilitation, if the person is considered so healthy that he/she should be at the disposal of the labour market.

Such disputes may end up in a discussion among authorities concerning who should pay. The answer depends on whether the person in question is deemed to have completed vocational rehabilitation or not. If the rehabilitation has led to a recovery of functional capacity and work capacity, the case must be transferred to the job-centre, which then decides on subsequent measures: job application, re-training, or whatever is appropriate. If the expected job the person was trained for and capable to take on, is then not available, that does not matter. It is not easy to tell someone on sick-leave, who still has symptoms, that rehabilitation is

completed, that sickness allowance is being terminated, and that the person must get in the unemployment queue for the type of job he or she can manage, but which is not available.

Welfare agencies often find it difficult to assess the illness and ability to work of persons with multi-problem backgrounds, with diffuse and long-term illnesses. Therefore cooperation across the boundaries of welfare state agencies has been launched to find more efficient strategies for vocational rehabilitation. In the local projects, which form part of the empirical basis for this article, such cooperation was characterised by physical proximity and frequent face-to-face interactions among neighbouring agencies. Our interviews with case-workers participating in local projects with multi-problem clients revealed both positive and negative experiences of cooperation across sector boundaries (Lindqvist & Grape 1999). Among the positive experiences were: a) increased professionalism in vocational rehabilitation, by means of better knowledge of other participants' competencies; b) better assessment of clients' needs and higher accuracy in rehabilitation measures, due to increased quality of social histories and more precise targeting of clients' needs; c) increased client mobilisation (user-influence) facilitated by close and frequent interaction between client and case-workers; d) enhanced client motivation and self-esteem because fewer welfare agencies were involved, and those involved had first-hand knowledge of the client, which in turn minimised the risk of "falling between the cracks". The negative experiences voiced were a) difficulties to reach common goals and visions for the client because agencies defined key concepts such as "sickness", "work ability" and "vocational rehabilitation" differently; b) lack of economic resources and difficulties to pool resources of different agencies; c) too many different benefits based on different regulations, eligibility principles and compensation levels, which forced case-workers to piece together different kinds of measures, making vocational rehabilitation a "bumpy" journey to an uncertain destination. Experiences also demonstrate the importance of higher-level managers supporting the basic ideas and cooperative working models if such models are to persist.

Rehabilitation – employment: the employer's domain?

All employers are obliged under the Work Environment Act to have "organised adaptation and rehabilitation routines". Everyday rehabilitation work is performed by the line organisation, that is, by a work supervisor or work team who keep in touch with the person on sick-leave, arrange work-training opportunities and organise many other measures. If the problems are difficult to solve, the personnel department rehabilitation coordinator or the occupational health service is often engaged.

Among the most important of the employer's duties is to carry out the rehabilitation investigation as mentioned, in which the problems, needs and resources of the client are charted in relation to the work. This investigation is meant to form a basis for any further measures that need to be taken in order for the client to be able to return to work. The employer is considered responsible for financing and carrying out such measures that are aimed at returning the employee to work with his/her present employer, while the social insurance office usually assumes the responsibility for measures aimed at employment with another employer.

Where the boundary goes between the rehabilitation responsibility of the different parties is not precisely defined, and there are often long discussions over who should pay. However, it is clear that the employers have taken over some of the social insurance offices' previous duties regarding rehabilitation investigations, and are also expected to pay for specific and goal-related measures. The social insurance office usually finances more general rehabilitation costs (functional improvement, training, testing). The employers therefore to a certain extent have control over absence due to illness and the rehabilitation process. They also have the privilege of assessing when the possibilities for rehabilitation at the workplace are exhausted, and can thereafter give notice to the employee due to shortage of work. Internalisation of the rehabilitation functions can lead to an externalisation of parts of the workforce.

Several circumstances are pushing developments in this direction. The demands for rational operation from a strictly economic standpoint limit the room for rehabilitation, and the demands that the social insurance offices and labour market authorities should more distinctly delineate their activities towards employers (for instance, to not carry out that which is formally the employer's duty) make it difficult to overstep the boundary between the domains of different organisations. Let us look at these problems in turn.

One problem that several employers need to deal with is the fact that resources for rehabilitation usually have to be taken from the ordinary personnel budget, which means that a choice must be made between different areas of use. An investment in vocational rehabilitation can for example mean fewer stand-ins. Easy jobs may not exist any more, and it is unacceptable to have an employee hanging around who costs a whole salary, on top of what was budgeted. The jobs that remain have become more and more specialised, and typically require more and more capacity. This is the largest problem in many work places, and not the social insurance office's strict rules.

When an employee has completed rehabilitation, he/she has to be 'squeezed

into' the existing budget. This increasingly harsh climate forces a more distinctly economically-oriented rationality in recruitment and rehabilitation: the line between what are genuine work duties, such as employment, and what is rehabilitation (aptitude training and work training) becomes sharper, and the decision whether the person on sick-leave should continue to be employed or be given notice due to shortage of work comes earlier. There are, however, examples of how such difficulties can be overcome (Lindqvist 2000; Grape 2001). Some employers use a model whereby there is first an attempt to return to previous duties at the workplace, or alternatively a return to another workstation with the same employer, and if nothing else is possible, the solution is for the employee to consider another employer.

The employer often feels that the doctor writing the sick note (not the occupational health service doctor however) is too far from the employer's own reality. It is sometimes felt that doctors "give false hopes of what the employers can help with", that is, that there is a domain conflict expressed in the differences of opinion as to who should do what. The solution to this problem is to hand over the case to the occupational health service, which is expected to match the individual's functional disability with the work demands of various work settings. In this context the occupational health services perform an important cross-boundary function.

The cooperation between employer and social insurance office is partly characterised by the formal rules that stipulate the rights and duties of the different parties. The social insurance office adheres strictly to the employer taking care of the rehabilitation of his/her own employees. So when the course of rehabilitation is finished (in accordance with the rehabilitation plan) the employee is expected to be able to begin the employment referred to when rehabilitation began. If this employment is not available in the current work setting, in a situation when the individual, formally speaking, has finished rehabilitation, then the employer and social insurance office respectively must address two problems: whether the employee should be given notice due to shortage of work as there are no suitable (budgeted) work duties, and whether the person has the right to sickness allowance. Successful completion of a rehabilitation strategy can lead both to unemployment and to discontinuation of sickness allowance, or hopefully to a suitable job when the labour market situation improves. These strict demarcations can lead either to an exit from, or a 'lock-in' with, the current employer. The latter is a consequence of the fact that many employees do not wish to enter upon a rehabilitation venture, but attempt as long as possible to struggle on at their current workplace with a transfer and changed work duties.

The employer encounters correspondingly strict demarcations in dealing with labour market policy. The labour market authorities, like the social insurance offices, are of the opinion that it is the employer's duty to rehabilitate his/her own employees. Labour market policy measures, then, are not freely available to employers. It is not until the employee has been given notice that these measures can be used, and it is not until then that the job-centre and labour market institute can help. The discussion of the con-tradicting pressures in vocational rehabilitation is summarised in the figure below.

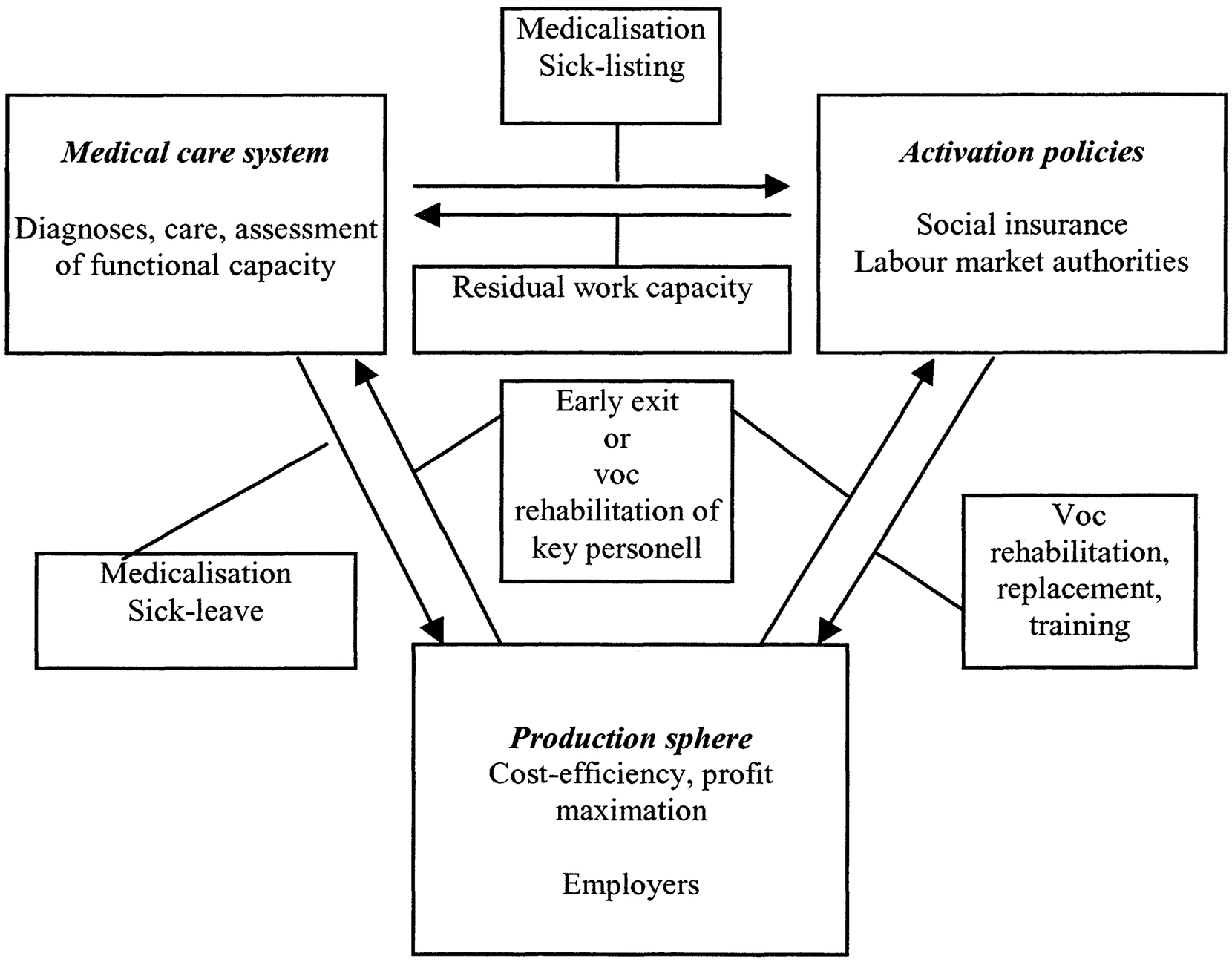

Figure 2. Contradicting pressures in vocational rehabilitation.

Conclusions

This article has asserted that vocational rehabilitation takes place in a power-field of different interests and separate organisations. The organisations dealt with here, the care system and the doctors, social insurance offices, labour market authorities and employers, must be seen as deeply embedded in larger institutional systems. The different organisations form something of a landscape, in which they can be seen as parts of each other's surroundings (cf. Ahrne, 1994). Therefore they often have reason to become involved in each other's activities, and thus form possibilities but also obstacles for each other. Sometimes they lay claim to control over the same field by making rival domain claims, and at other times they wish to hand over specific work duties and external demands to a neighbouring organisation. Different organisations, from their different perspectives, also expect different results.

As stated earlier, different institutional sectors (and the organisations belonging to them) are characterised by different driving forces, forms of steering, rules and procedures. Vocational rehabilitation of the long-term sick is a field that, to a high degree, is characterised by such differences. The recent activation policy reflects a series of conflicts between institutional sectors, and the practical actions and ambitions of medicine, social insurance and the labour market authorities, as well as those of the employers, differ on a number of points. Important areas where collisions and boundary disputes arise are: to what extent and in what way illness symptoms (interpreted as medical diagnoses) reduce the individual's work capacity; agreeing on how individuals manage specific rehabilitation measures; gaining access to rehabilitation measures that another organization has at its disposal, that is, when a case may be 'offloaded' on to someone else; and agreeing on whether all available measures have been exhausted.

Seen from the perspective of the long-term sick individual, such a state of the art as described in this article is very confusing. It is not unusual, for people like Charlie, to have the following players involved: the medical doctor and a physiotherapist at a health care centre, a hospital-based medical specialist, a social worker, a rehabilitation counsellor at the social insurance office and an officer at the public employment agency. In the middle of this crowd is the individual having difficulties orienting her/himself, probably listening to the expert that she/he met at the most recent meeting.

Most citizens who have well-defined, temporary problems in terms of sickness, unemployment and/or economic difficulty, benefit from the sector-based welfare model, while clients with diffuse and numerous problems are disadvantaged. They do not fit into the boxes of the

welfare agencies. Stimulating cross-boundary joint action between organisations in various sectors should be considered an important item on the socio-political agenda in the early 2000s. This would typically require the development of what Hvinden (1994:10) has called horizontal integration between organisations. In order to facilitate this, there is a need for "mutual awareness, and compatibility of perceptions and goals and interdependence between actors".

How these inter-organisational dynamics take shape is determined by what happens on several levels. On the cognitive level, which is most emphasised by neo-institutionalists, it is about how representatives for each organisation interpret key concepts such as illness, work capacity and rehabilitation, and how phenomena linked to these concepts are categorised. Another important factor is that of the normative prerequisites, for instance the basic values that are to be emphasised, and how to handle concrete rules for what should be done and how things should be done. It is evident that from a normative standpoint, the field of vocational rehabilitation has become more formalised: rights and obligations of the different parties have been made more distinct, and there has been a shift in the division of duties among the different parties. On the regulative level, this normative 'tightening up' has made itself felt in new legislation and directives as to what are instrumentally correct procedures. This increased goal-rationality, in the sense that more and more precise means are linked to more and more distinct goals, makes great demands on cooperation between organisations, which is not easy to achieve when each sector of welfare is becoming more rigidly defined, and when boundaries between each one's duties are becoming more and more distinct.

References

Antonovsky, A. (1987). *Unraveling the Mystery of Health.* San Fransisco, Jossey-Bass Inc.

Ahrne, G. (1994). *Social Organisations: interaction inside, outside and between organisations.* London, Sage.

Bigos, S.J. et al. (1991). A prospective study of work persceptions and psychosocial factors affecting the report of back injury. *Spine* 16: 9-14.

Casey, B.& Bruche, G. (1983) *Work or retirement?* Aldershot, Gower.

Conrad, P. (1992). Medicalization and social control. *Annual Review of Sociology* 18: 209 –231.

DiMaggio. P.J. & Powell, W.W. (1983). The iron cage revisited: Institutional isomorphism and collective rationality in organizational fields. *American Sociological Review* 48: 147–160.

Ds 1994:91. Rätten till förtidspension och sjukpenning (Ministry of Social Affairs: The right to disability pensions and sick cash benefits). Stockholm, Socialdepartementet.

Englund, L. & Tibblin, G. & Svärdsudd, K. (1997). *Litteratursammanställning, sjuk-skrivningsforskning* (Literature survey, sick-listing) Uppsala, Institutionen för allmänmedicin (1:a upplagan 1995).

Friedland, R. & Alford, R. (1991). Bringing society back in: Symbols, practices and institutional contradictions. In: Powell, W.W. & DiMaggio, P.J. (Eds.). *The new*

institutionalism in organizational analysis. Chicago, Chicago University Press.

Geldof, G. (1999). New activation policies: promises and risks. In: *Linking welfare to work.* Loughlinstown, Ireland, European foundation for the improvement of living and working conditions.

Grape, O. (2000). *Mellan morot och piska. En fallstudie av 1992 års rehabiliteringsreform* (Between the stick and the carrot. A case study of the rehabilitation reform of 1992). Umeå universitet, Sociologiska institutionen.

Hasenfeld, Y. (1983). *Human Services Organizations.* Englewood Cliffs, Prentice-Hall.

Hvinden, B. (1994). *Divided aganist itself. A study of integration in welfare bureaucracy.* Oslo, Scandinavian University Press.

Hvinden, B. (1999). Activation: a Nordic perspective. In: *Linking welfare to work.* Loughlinstown, Ireland, European foundation for the improvement of living and working conditions.

Jonsson, T. (1997). *Handlingsstrategier och maktsamspel i möten mellan handläggare och invandrarklienter. Studier av ett försäkringskassekontor* (Action strategies and power interaction in encounters between officials and immigrant clients. Studies of a social insurance office). Uppsala, Acta Universitatis Upsaliensis, nr 61 (diss.).

Kohli, M., Rein, M., Guillemard, A-M. & Gunsteren, H. (Eds.). (1991) *Time for retirement. Comparative studies of early exit from the labour force.* Cambridge, Cambridge University Press.

Lindqvist, R. (2000). *Att sätta gränser. Organisationer och reformer i arbetsrehabilitering* (Drawing boundaries. Organisations and reforms in vocational rehabilitation). Umeå, Borea.

Lindqvist, R. & Grape, O (1999). Vocational rehabilitation of the socially disadvantaged long-term sick: inter-organizational co-operation between welfare state agencies. *Scandinavian Journal of Public Health* 1: 5-10.

Lindqvist, R. & Marklund, S. (1995). Forced to work and liberated from work. A historical perspective on work and welfare in Sweden. *Scandinavian Journal of Social Welfare* 4: 224–237.

Lipsky, M. (1980). *Street-level bureaucracy. Dilemmas of the individual in public services.* New York, Russell Sage Foundation.

Mallander, O. (1996). *"Det måste se ut som en arbetsplats." Om interorganisatorisk samverkan för att yrkesrehabilitera gravt funktionshindrade* ("It must look like a workplace". On interorganisational cooperation for vocational rehabiliation of the severely disabled). Lund, Meddelanden från Socialhögskolan 1996:2.

Meyer, J. W. (1994). Rationalized environments. In: Scott, R.W. & Meyer, J.W. (Eds.). *Institutional environments and organizations.* Thousand Oaks, Sage.

Meyer, J.W. & Rowan, B. (1977). Institutionalized organizations: Formal structure as myth and ceremony. *Americal Journal of Sociology* 83: 55-77.

Midré, G. (1994). *Bot, bedring eller brød? Om bedømning og behandling av social nød fra reformationen til folketrygden* (Cure, improvment or bred? On the assessment and treatment of social poverty from the refomation until our days). Oslo, Universitetsforlaget.

Pfeffer, J. & Baran, J.N. (1988). Taking the workers back out: Recent trends in the structuring of employment. *Research in Organizational Behaviour* 10: 257–303.

Prop. 1990/91:140 *Arbetsmiljö och rehabilitering* (Government proposition: Work environment and rehabilitation).

Prop. 1990/91:141 *Rehabilitering och rehabiliteringsersättning* (Government proposition: Rehabilitation and rehabilitation allowances).

Prop. 1996/97:28 *Kriterier för rätt till ersättning i form av sjukpenning och förtidspension* (Government proposition: Criteria concerning the right to sickness benefits and disability insurance).

Prop. 1996/97:63 *Samverkan, social-försäkringens ersättningsnivåer och administration, m.m.* (Government proposition:

Cooperation, compensation levels and adminstration in the social security system)

Riegelman, R.K. (1991). *Minimizing medical mistakes: The art of medical decision making*. Boston, Little Brown and Co.

Riksförsäkringsverket, (1998). Försäkringskassornas handläggning av ohälsoförsäkringarna (National Social Security Board: The social insurance offices' implementation of health insurances). RFV Anser 1998:4. Stockholm.

Riksförsäkringsverket, (2002) *Social-försäkringen – årsberättelse för budgetåret 2001* (National Social Security Board: Annual report 2001). Stockholm.

Riksrevisionsverket, (1996). *Rehabilitering av arbetslösa långtidssjukskrivna* (The Swedish National Audit Office: Rehabilitation of the unemplyed long-term sick).

Scott, R.W. (1991). Unpacking institutional arguments. In: Powell, W.W. & DiMaggio, P.J. (Eds.). *The New Institutionalism in Organizational Analysis*. Chicago, Chicago University Press.

Scott, R.W. (1992). *Organizations: rational, natural and open systems* (third edition). Englewood Cliffs, NJ, Prentice-Hall.

Scott, R.W. (1995). *Institutions and organizations*. Thousand Oaks, Sage.

Scott, R.W & Meyer, J.W. (1994). Developments of institutional theory. In: Scott, R.W. & Meyer, J.W. (Eds.) *Institutional environments and organizations*. Thousand Oaks, Sage.

SFS 1962: 381 Lag om allmän försäkring (National Social Security law).

SOU 2002:5. Handlingsplan för ökad hälsa i arbetslivet (Swedish public investigations: Action plan increasing health in work life). Stockholm.

Weick, K. (1976). Educational organizations as loosely coupled systems. *Administrative Science Quarterly* 21: 1-19.

Weibull H. & Troëng, T. (1996). Det medicinska beslutet - faktorn bakom skiftande behandlingsresultat och sjukvårdskostnader (The medical decision – the factor behind varying treatment results and healt care costs). In: SOU 1996:163 *Behov av resurser i vården - en analys* (Swedish public investigations: Demand for resources in health care – an analysis). *Del B Bilagor.*

Yin, R. (1994) *Case Study Research. Design and Methods*. (Second Edition) London, Sage.

Zola, I. (1975). Medicine as a system of social control. In: Cox, C. & Mead, A. (Eds.) *A sociology of medical practice*. London, Collier-Macmillan.

The Author:

Rafael Lindqvist is professor at the Department of Social Welfare, Umeå University. Sweden

e-mail:

Rafael.Lindqvist@socw.umu.se