

Assessing sick-listed clients' work ability: A moral mission?

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Abstract

Judging the extent to which sick-listed clients' disabilities qualify them for sickness benefits is increasingly part of frontline work. However, we lack knowledge about the discretionary process of assessing work ability. Institutional ethnographic research of caseworkers in the Norwegian Labour and Welfare Administration revealed that they emphasised clients' residual work ability - meaning what clients could perform despite their medical diagnoses - as well as their inner motivations and work ethic. We argue that frontline praxis is influenced by efforts to fit clients into a category of the deserving 'sick-listed yet work-capable client'. Because caseworkers lack guidelines to combine health and work, they increasingly apply their 'moral selves' in the assessment process resulting in scepticism towards clients' feigning, or exaggerating symptoms to obtain financial benefits or avoid work. We question whether our findings represent a shift of the Norwegian universalistic welfare model to a more liberal and incentive-strengthening type.

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Introduction

Comparative studies from both Continental European and Nordic welfare states show an increasing trend of introducing and expanding sick-leave schemes that enable partial benefit receipt to be combined with part-time work or gradual return to work (Leoni, 2021). This aspect of the ‘active turn’ in neo-liberal welfare states entails an expansion and intensification of obligations for those who receive state benefits as compensation for not working, working part-time owing to health issues, or for being sick listed. However, whereas researchers have often focused on the target groups of activation policies – i.e. clients’ experiences (Gründelová, 2020) – less is known about how such policies are interpreted, negotiated, and implemented at the street level (Berkel, 2020). In this article, we direct our attention to how frontline workers in the Norwegian Labour and Welfare Administration (NAV) assess sickness benefit applicants’ so-called *residual work ability*. Our findings suggest that frontline workers seek to realise this practical enforcement through reinterpretation of clients’ subjectivity and fitting clients into categories that appear to harmonise with official activation policies. By use of an Institutional Ethnography (IE) research approach, we argue that this part of frontline everyday work can work as a prism for studying broader institutional changes in the Norwegian welfare state: At the street level, we investigate how the contradiction emerging from these ruling relations influences frontline constructions of clients. At the structural level, we illuminate the process whereby a universalist, rights-based welfare regime invests more heavily in conditionality. We question whether the new conceptualisation of citizens and welfare policies hidden within a moral discourse of *the sick-listed yet work-capable client* reflect even deeper transformations in the Norwegian welfare state that represents a shift of the universal Nordic welfare state to a more liberal, incentive-strengthening regime (Vike, 2018). Because activation measures and strategies are shared cross-nationally, these findings may resonate beyond the Nordic countries.

Frontline workers as policy and moral mediators

From previous research, we learn that frontline workers serve both as gatekeepers of benefits and implementers of activation policies (Lipsky, 2010).

This type of work includes ensuring the principle of equal treatment on the one hand, and tailor-making services to citizens' individual needs on the other. Frontline work thus entails a considerable amount of discretion, understood as the perceived freedom of street-level bureaucrats in making choices concerning the type, quantity, and quality of sanctions and rewards on offer when implementing a policy (Tummers and Bekkers, 2014). An increasing development within frontline work is related to 'conditions of conduct' (Watts and Fitzpatrick, 2018: 18–19). For benefit applicants, this means that getting support from the state is made conditional upon behaving in specific ways or performing compulsory activities. On the part of frontline workers, conditions of conduct imply monitoring and assessing if, or to what extent, clients fulfil the required behavioural standards. Although frontline work is viewed as non-political, Rose (1996) points out that such regulatory strategies form citizens' experience of modern power. In this sense, frontline workers delivering social benefits are not neutral 'agents of the state' (Berkel et al., 2018), but *policy mediators* conducting the state's welfare governance (Lipsky, 2010). Due to a growing influence of psychology ('psycho-policies') in street-level bureaucracy services, frontline workers even tend to undertake individual responsibility for the sustainability of the welfare state (Mik-Meyer, 2017: 91).

In parallel, an increasing stream of research addresses frontline workers' role as *moral mediators* because they assess and judge not only clients' individual needs, resources, and state of health but also their motivation and work ethic (Hasenfeld, 2010; Keinemans and Kanne, 2013; Pors and Schou, 2021; Zacka, 2017). This argument rests on a view of the state as not only a distant entity but how frontline workers act as agents of the state based on their values, affects and dispositions in a 'moral ecosystem' (Zacka, 2017: 246). In studying these aspects of frontline work, previous research has related to the theory of un/deservingness to identify perceptions underlying the distribution of welfare benefits. This research is largely summed up in the question of 'who should get what and why?' (van Oorschot, 2000) and has been addressed in both public opinion and among frontline workers (Kallio and Kouvo, 2015; Misje, 2021; Senghaas, 2021). As such, deservingness theory explains how caseworkers' discretion is affected by their judgements of clients' moral standards.

Drawing on Rose (1996), Mik-Meyer (2017: 6) further asserts that the construction of clients as moral subjects who are active and responsible render certain actions and perceptions among frontline workers as 'natural' and others not, according to dominant norms in society. One dominant norm in contemporary western societies is the urge to work despite health issues (OECD, 2010). Clients who fail, or resist living up to this norm for reasons well-known from moral hazard research, have historically been accused of feigning or exaggerating symptoms to obtain financial benefits or

avoid work (Goldberg, 2021). Thompson (2021) even argues that a key theme in the history of anxieties about malingering is that women, People of Color, and disabled people are more likely to be accused of feigning illness. Despite little agreement on its definition, The American Psychiatric Association defines *malingering* as ‘the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives, such as avoiding military duty, avoiding work, obtaining financial compensation, avoiding criminal prosecution, or obtaining drugs’ (Bass and Halligan, 2014: 1427). Recent studies of Norwegian General Practitioner (GP)s’ encounters with NAV officials make it relevant to ask whether suspiciousness of malingering is emerging as an integral, but unspoken part of Norwegian activation policies. Rasmussen (2020) studies GPs who treat patients suffering from medically unexplained symptoms. He shows how GPs invest considerable time and effort in persuasive strategies vis-à-vis NAV, as they experience NAV officials to be suspicious towards benefit applications from clients whose health issues are not supported by objective evidence. Similarly, Aarseth (2019) demonstrates how GPs undertake persuasive strategies when writing medical certificates, i.e., emphasising patients’ worthiness, appealing to the NAV-officials compassion, or willingness to be realistic or pragmatic, to ensure support from NAV to the clients’ benefit claim. These studies indicate that suspiciousness towards clients’ potential malingering circulates within NAV and potentially shape how frontline workers approach clients.

The dual roles of policy and moral mediators are highly relevant for Norwegian frontline workers allocating sickness benefits, the group with whom this article is concerned. This work entails revealing and separating sick-listed employees’ work ability and disabilities, to detect their residual work ability. More specifically, frontline workers are to judge to what extent the clients’ remaining capacities may be objectified as labour, or, on the contrary, if the lack of such capacities may qualify them to receive sickness benefits. Therefore, we explore how frontline workers interpret and assess long-term sick-listed clients’ work ability in the context of Norwegian activation policies.

The Norwegian context: Activation through multi-stakeholder dialogue

In Esping-Andersen’s (1990) classic welfare state typology, Norway is regarded as a social-democratic regime founded on core principles such as universalism and equality. Extensive social rights are granted relatively unconditionally *qua* citizenship and financed through taxation, and all public benefits are administered by NAV. Support and public welfare spending in Norway is among the highest of the OECD countries (OECD, 2009). Sickness benefits

have been especially controversial because sick-listed employees receive 100 percent wage compensation for up to one year, of which employers are only financially responsible for the first 16 days. After that, the state becomes responsible. The reduction of sickness absence in the Norwegian labour force is therefore a common political goal, founded on concern for the sustainability of the welfare model and has affected activation policies in several ways since the end of the last millennium. Hagelund (2016) concludes that the general trend is a movement towards conditionality, gatekeeping, and individual assessment.

Traditionally, the Norwegian model is based on improving the capacity, knowledge, and skills of out-of-work citizens (e.g. through vocational training), and thus it is often referred to as an enabling and universalistic type (Barbier and Ludwig-Mayerhofer, 2004). This type is contrasted with more liberal, incentive-strengthening approaches, designed to ‘make work pay’ by reducing the duration and levels of benefits to make them less desirable (Johansson and Hvinden, 2007). Although the levels of benefits and employers’ share of the costs have remained largely untouched, the Norwegian benefit regime has undergone major reforms in recent decades. In addition to an increase in New Public Management governance strategies, a prominent characteristic of these reforms is related to a parallel conception of the relationship between work and recovery (Fossetøl and Andreassen, 2014; NOU 2019: 7). This approach has taken the form of a widespread belief in the benefits of being active despite health issues, resulting in a move from the use of diagnostic categories to functional assessments for sickness benefit applicants.

Another characteristic of recent reforms is the expansion of the activation setting from a dual relationship between the client and the NAV caseworker to a multi-stakeholder relationship that includes the client’s employer and his/her GP. The Dialogue meeting (DM), from which the empirical data in this article are drawn, is the most resource-demanding activation measure in this respect. However, the sanctions vary considerably between stakeholders. Whereas clients risk losing sickness benefits if they do not participate in return-to-work activities, employers’ strategies resemble carrots rather than sticks, or ‘dialogical nudging’ (Hagelund, 2014). Certainly, the reforms can be viewed as a silent establishment of new governance relations that have not only built consensus but also depoliticised an otherwise conflict-ridden area of politics (Hagelund, 2014).

Dialogue meeting: An arena for assessing sick-listed clients’ work ability

The DM is a mandatory multi-stakeholder meeting between the sick-listed employee (now a NAV client), the NAV caseworker, the client’s employer,

and his/her GP. The DM occurs when the sick-listed employee has been absent from work – full time or partially – for six months. At that time, the caseworker routinely invites the stakeholders to a meeting to discuss how each stakeholder can assist the client's return to work, assess whether obligations have been met, and determine when the client can resume work. The DM is usually held at the NAV office; although consistent with the intent to collaborate closely with employers, NAV caseworkers are encouraged to conduct these meetings at the workplace. Meetings also occur at the GP's office. The NAV caseworker's role is to facilitate the meeting, to consider the implementation of NAV's various measures, and to write the subsequent report.

Institutional ethnography as a research approach

To study how individual and institutional conditions intertwine, we apply elements of IE research. IE is considered both a theory and a methodology of inquiry, acknowledging people's everyday activities as the point of departure for discovering the social (Smith, 1987). From the standpoint of the street-level institutional informants – in our setting, NAV caseworkers—IE aims to reveal how local activities are co-ordinated translocally. The 'translocal level' refers to how everyday work is co-ordinated across time and space by the workings of power manifested in discourse, bureaucracy, or institutions. To highlight these structures' capacity for co-ordination, Smith (2005) terms this translocal organisation *ruling relations*. Ruling relations are the objectified forms of consciousness and organisation, constituted externally to particular people and places, creating and relying on textually based realities (Smith, 2005: 227). The IE approach thus offers a relational perspective in acknowledging that co-ordination takes place in *institutional circuits*; people co-ordinate their activities and thus change institutional relations. Equally, institutional relations involve the co-ordination of people's activities (Nilsen, 2017). Unpacking NAV caseworkers' everyday work of assessing sick-listed people's work ability is also an entry to investigating Norwegian activation policies.

Because governments can only rule at a distance, authoritative texts (termed 'boss' texts), play a co-ordinating role in organising institutionally mandated courses of action (Smith and Turner, 2014). These texts provide guidelines, procedures, and indicators by which workers are held accountable, thus regulating frontline practice. In our setting, frontline work in the sickness benefit area relies on a hierarchy of texts ranging from Norwegian white papers and social legislation via NAV's internal procedures and guidelines, including clients' sick notes authorised by GPs. The overall aim of IE analysis is discovering and making observable how these texts enter, organise, shape, and co-ordinate people's doings as they participate in the objectifying of relations of ruling (Smith and Turner, 2014).

Data collection and analysis

According to the IE research approach, we combine ethnographic fieldwork with in-depth interviews, observation, tape recordings of DMs, and documents to map the complexity of the institutional setting from a ‘bottom-up’ perspective. Data were collected at two NAV offices in two regions in the south-eastern part of Norway. The observational data consisted of informal interviews with caseworkers, observations of their ‘backstage’ work, staff meetings, and other activities, i.e. two streamed public meetings (coffee mornings) held by NAV authorities and published on social media such as Facebook and YouTube. Informal interviews took place individually, in shared offices with several caseworkers, walking or driving to external DMs, or during lunch in the canteen. In total, the first author interacted with 15 caseworkers and later conducted in-depth interviews with nine of these caseworkers (all women) who worked in the relevant departments at the time. Their ages ranged between 27 and 62 years, and their tenure in NAV was a median of nine years. In terms of education, one of these nine had a social work qualification, whereas the others had various educational backgrounds in healthcare, business and administration, and human relations. Two of the caseworkers had upper secondary education, whereas the other reported a bachelor’s degree as their highest qualification. Previous research on NAV has shown a rather similar distribution regarding age, organisational tenure, and educational background among NAV caseworkers (Sadeghi and Fekjær, 2019) with the exception of our sample having a less balanced gender distribution and fewer caseworkers with social work qualifications. In addition to fieldwork and in-depth interviews, we recorded 10 DMs.

Regarding research ethics, because the aim of the study was to explore the caseworkers’ discretionary assessment work, the clients’ diagnosis was not of particular interest. However, being sick listed is considered being in a vulnerable position for many reasons, and attending a mandatory meeting with NAV, your employer, and GP is regarded as an extra burden (Juritzen et al., 2019). Our caseworker informants, therefore, asked clients whom they had already scheduled for a routine DM whether they would participate in the study, without any researcher interference. The caseworkers underscored that rejecting participation would not affect the benefit application process. The clients who consented then had the option of requesting their employers to participate themselves or having the first author contact him/her. All clients chose to inform the employers themselves, and no employers declined participation. The clients’ GPs were informed either by the client before, or by the first author when arriving at the meeting. All GPs consented. One client declined to participate, citing a conflict with his/her employer. This case, we argue, illustrates that rejecting participation appeared as a legitimate

option. In the meeting, the first author briefly introduced the study to the participants, collected written informed consent, and facilitated the recordings but did not otherwise participate. This choice was made from consideration for the client, to remove the burden of having yet another person present in the room. In addition, this strategy reduced the caseworkers' feeling of being monitored and evaluated, although this was explicitly stated by the first author as not an aim of the study. All recordings were transcribed (verbatim). To protect the confidentiality of the caseworkers, we use pseudonyms throughout the article.

According to an IE approach, analytic strategies are knowledge organisation *processes*, rather than knowledge organisation *products*; therefore, theorising IE is a research approach with three main procedures (Smith, 1987: 166–167). The first explicates the actual work of the subjects of inquiry, so we reviewed the data on caseworkers' task performance, efforts, intentions, and reflections on their everyday work of assessing sick-listed clients' work ability. This is reported as two dimensions in the Findings section. The second procedure locates the informants' work in the local and translocal social relations in which it is embedded. This includes 'keeping the institution in view' (McCoy, 2006), and entailed asking analytical questions of the data, such as where the term 'residual work ability' came from. Through this dialogical strategy, we analyse how the caseworkers' work is related to the boss texts framing their work. The third procedure concerns how ideologies and discourses co-ordinate those relations. More specifically, we investigate how Norwegian activation policies activate and are activated in institutional circuits starting in the caseworkers' assessment of clients' work ability. These issues and implications are discussed conclusively.

Findings

Questioning clients' abilities despite their medical diagnoses

The themes of recorded DM conversations were dominated by clients' health issues, i.e. the client elaborating on his or her health problems. The caseworkers had access to clients' sick notes, which revealed the current diagnosis. However, the caseworkers maintained that judging working ability on this basis alone was insufficient. Kirsten elaborated during the in-depth interview:

The diagnosis says something about the medical judgement on which the doctor bases the sick note. It says nothing about what you can do despite that diagnosis. Because most people can do something. And that approach is missing a bit, and I

think it is undermined by the idea that when you are sick, it is a private matter involving you and the doctor exclusively. Then one doesn't ask: 'What can we get out of you despite the fact that you face some health challenges?'

She later added, humorously, that this perspective is more obvious to herself and her colleagues at NAV 'than to other groups that have not been indoctrinated with this view on a daily basis'. Therefore, the caseworkers shared strategies for revealing what sick-listed clients could still do – their residual work ability – among themselves in staff meetings. Addressing both male and female clients, Ingrid recommended asking the client what he/she was doing at home in terms of mundane housework. She referred to transferring such activities to workplace tasks because these abilities could be used as arguments for urging clients to work if they were reluctant to do so: '(...) and if they say that they can't do anything, we can move on to what they are doing at home'. Her colleague Karen shared how she had interpreted a client's sick note, which described an injured arm: 'But does the *other* arm work, I wonder?'

However, the caseworkers do not always find these strategies sufficient or appropriate. In a DM recorded in a kindergarten, Ingrid meets with a sick-listed client, a female educational supervisor in her early 60s, and her employer. The woman suffered from a rare diagnosis causing fever and infection during physical activity. After a description of her health issues, supplemented by the employer, Ingrid is heard asking how the woman manages at home – specifying housekeeping activities such as cleaning the house, doing laundry, and cooking. The woman answers that she is barely capable of cooking, but that her husband has to vacuum. Eventually, Ingrid concludes that: 'Well, then, I guess that it is not very relevant to talk about adjustments and return-to-work activities ...'.

The demand to be active despite health issues was also expressed in coffee mornings held by one of NAV's senior medical consultants (SMCs). SMCs are former GPs employed by NAV to support caseworkers in judging medical issues. All NAV regions employ several SMCs, and in general, their experience is highly respected and valued because most caseworkers lack a professional medical background. In one NAV unit coffee morning, about 200 managers and human resources staff gathered in a large conference room. The meeting was also advertised, streamed, and posted on the NAV unit's Facebook site and launched on YouTube. The SMC talked enthusiastically from the stage about the importance of employers having the right focus in following up sick-listed employees:

Again, it's all about focus. Once a loss of function, or sickness, or whatever you choose to call it, is reported – what can you do? The focus should not be what you cannot manage, but on what we can have you do. What are you able to manage

and take – right now? We are totally uninterested in what you cannot do; we want you here. We want to take advantage of your residual working ability. (Streamed coffee morning, 7 September 2018)

The caseworkers at NAV B apparently saw this meeting. In a staff meeting shortly afterwards, one caseworker impatiently requested that the SMC's PowerPoint presentation be sent to her and her colleagues. She emphasised that these slides would provide a 'formal' version of a message they had repeatedly promoted in the DMs, but which had largely fallen on barren ground. Later, some of these slides on a NAV template were observed pinned up over the printer in the back office. The presentation had the intriguing title: '*Do we need the doctor to sick list?*'. It contained an explicit argument for an allegedly much-needed distinction between the medical authority and that of NAV. The main argument was that health care services' approach to sickness absence focused on illness as defined by the literal, straightforward interpretation of medical conditions, whereas NAV's approach relied on clients' functional ability in relation to their work. According to the SMC's prints, the clients' GP played a central role. One slide included the following two bullet points under the heading: '*Avoid the doctor!*'

- Take hold of the patient before the doctor does!
- If the doctor gets his hands on the patient, it's all over!

(Field notes, NAV B, autumn 2018)

The main bullet points were elaborated in subordinate points containing arguments that a sick note provides the patient with the 'key solution' and 'undermines the employee's motivation to take alternative work'. Another subordinate point maintained that a sick note provides the patient with an 'alibi for not participating in return-to-work activities and labour participation in general'. When presenting these slides 'online' from the stage during the gathering, the SMC introduced a humorous and self-ironic dimension to the presentation because the SMC is a former GP. The SMC maintained that clients' GPs were generally ill-equipped to judge the patient's functional ability for work, presumably owing to too much theoretical education and too little experience with the practicalities of the real world. These statements sparked general amusement in the audience. From the stage, the SMC also shared the preferred point of departure for an alternative and successful follow-up process:

I usually put it this way: If the patient stays away from work because his nose is blocked, it is only the blocked nose that the patient is not supposed to use. The

rest of the body is at your disposal. The question is: Are you able to find a job or something he can do, despite the blocked nose? (Streamed coffee morning, 29 March 2019)

As the SMC underscores, assessing clients' work ability also entails matching key properties of workplaces and the clients' state of health. However, caseworkers at both offices maintained that conflicts and collaboration problems – with managers and between colleagues – were important factors behind sickness absence. The lack of good relations between the employer and the sick-listed client was sometimes described as the cause of not only the initial sick-leave but also the reason for failure to return to work after recovery.

Stressing the client's motivation and work ethic

When describing clients' working ability, caseworkers frequently referred to personal and inner qualities such as motivation, willingness to work, and work ethic. Some even claimed that a client's work ability is to some extent situated in the head, whereas others maintained that some sick-listed clients only suffered from '*vondt i vilja*', which can be loosely translated as a 'will that is hurting' or a 'hurt will'. The meaning of the expression is entirely negative, and it suggests a lack of motivation with resulting inaction or active avoidance of action. However, the caseworkers were careful to draw distinctions between different categories of clients and diagnoses. Especially at NAV B, a common example used by caseworkers was that seriously ill clients such as cancer patients receiving chemotherapy were more willing to attend work than clients with more subjective illnesses or mental health conditions. Nina explained:

In my view, there are very few people who do not have the ability to work. I see this proven many times when I meet seriously ill people who have only one focus, and that is to get back to work. And then you meet those who ... well, have a hurt will, as I say, who do not want to return to work, and there are actually quite a few of them. (In-depth interview)

Particularly at NAV B, the caseworkers gave the impression of suspecting clients because of their potential to misuse benefits. Some caseworkers explicitly attributed this potential to attitudes signifying moral decay, particularly what they perceived as the gradual undermining of the work ethic with which the caseworker identified. Discussing these trends, the NAV B caseworkers extended their sense of personal involvement, using their personal experiences as a measure. In staff meetings, during fieldwork, and in interviews, they shared examples of personally attending work despite illness because their

employer (most often NAV) had adjusted their working conditions to accommodate them, or just due to their strong work ethic. Covering a range of issues such as death in the family and break-ups to managing the ‘time crunch’ associated with combining work, family care, and an active social life, they compared the situation of their clients to their own circumstances. Minela shared her experience of being a single mother:

Ok, there has been periods in my life too... having small children (...), when I had to say no to things (...) There are choices to be made all the time, you have to make priorities. You have to make yourself a priority (...). And then maybe you have to skip some social gatherings until like three am on a Saturday night (...) But I feel like people are kind of like, “No, but that’s my right.” Is it though? Is it right that the Norwegian population should be paying for you to be able to socialize, like during your afternoons and weekends? (In-depth interview)

These views were typically related to diagnosis the caseworkers characterised as ‘trendy’ health conditions or ailments among their clients. According to the caseworkers, such attitudes rested on an outdated definition, or (mis-)understanding, of illness, whereby normal reactions to difficult life situations and challenges appeared to be less common than previously. Such conditions were exemplified by the abbreviation ‘P-diagnosis’, which referred to various mental health diagnoses such as ‘acute stress reactions’, ‘malaise and fatigue’, or the controversial ‘burn-out’, or chronic fatigue syndrome in the International Statistical Classification of Diseases and Related Health Problems (ICD-10) (WHO, 1994). In general, the caseworkers viewed these conditions as individuals struggling to manage the common challenges of life. However, the caseworkers were surprised that many clients were able to obtain such diagnoses from their GPs, and that they seemed so easily accessible. In their opinion, many diagnoses lacked credibility because they often consisted of self-reported symptoms and were not evidence-based. One afternoon, as two caseworkers at NAV B waited to be picked up after work outside the office, they discussed the example of chronic fatigue syndrome. One explained that five to 10 years ago, fatigue had commonly referred to the after-effects of chemotherapy and was taken very seriously. However, recently, they experienced that the status of the diagnosis has been diluted along with other subjective health issues. Ellen said:

(...) But it becomes an epidemic, right? So, one can see that ... (...) that it is another condition based on self-reported symptoms, which tends to get diluted after a while. It’s a little bit like crying wolf. And we keep on doing what we do—with one diagnosis after the other.

To the caseworkers, it appeared that the lack of critical values and standards had become a personal burden. Walking back to the NAV office from a DM at a sick-listed clients’ workplace, Ingrid elaborated:

The truth is very difficult to find! What is true? Because experiences are so individual ... Is it true that your work is that stressful, in a way? (...) Nevertheless, it is difficult to make demands. Well, it is. To others. Because in the end, it's all up to you. What you do, and how much you do, what you can take, and what you find stressful, and what you do not find stressful. And that is perhaps where we, in our societal development, have come too far, and that we leave it too much up to each individual. (Walk-along interview)

The caseworkers' reflections covered a wide range of views of how individuals and society may suffer from unhealthy dynamics, and how this may be manifested in attitudes and approaches to the work ethic. In general, they seemed to conclude that people's attitudes to work were changing for the worse and that clients failed to appreciate the overall benefits of work. Conclusively, the sustainability of the welfare state were under pressure if attitudes towards work do not change.

Tracing the ruling relations of Norwegian activation policies

According to Norwegian welfare legislation, sickness benefits are granted to employees whose ability to work has been reduced by their 'own illness, injury or impairment' (National Insurance Act, 1997). Furthermore, the law states that eligibility for a sickness benefit depends on the effect of a medical condition on a client's work ability rather than the condition or diagnosis itself. This approach is characterised by judging 'what the individual can do, despite ill health and sickness' (White paper 2001–2002: 29, 11). By similar reasoning, the Norwegian Governmental Commission on Employment recently concluded that in prospective national income security schemes 'it is necessary to break with the notion that the working life is only for the healthy' (NOU, 2019: 7, 3). Notably, a thread in the chain of these boss texts is the explicit focus on activity despite sickness and disability.

Based on our empirical findings, there seems to exist a similar strong belief throughout the organisation of NAV that anyone, regardless of subjective factors and diagnosis, can do *something*. According to the caseworkers, work ability relies on the client's capacity after the illness or injury has been adjusted or compensated for. This capacity amounts to what functions the client retains that can be utilised by the employer despite health issues and are enacted and made meaningful to caseworkers by the use of the term '*residual working ability*'. As such, the caseworkers' interpretations of the relationship between work ability and state of health appear to comply with dominating discourses within Norwegian activation policies.

Such policies underscore that because health problems rarely dominate lives completely, there are always residual aspects that may be emancipated as labour. The law, circulars, and institutional framing of *the sick-listed yet work-capable client*, we argue, constitutes an institutional category of deserving benefit recipients that appears to harmonise with Norwegian activation policies.

However, in client encounters, the caseworkers learn that attending work with health problems is a more complex issue. The reasons behind clients' absence from work seldom relate to a blocked nose or a specific part of the body that can be singled out and temporarily set aside, as the SMC suggests. Complex and psychosocial issues affecting both work and the domestic domain dominate such circumstances – a view that is supported by the return-to-work literature (Aronsson et al., 2015). Nevertheless, the Social Insurance Act clearly states that disability attributable to social or economic issues does not entitle someone to sickness benefits, further stressing that only diagnosed health conditions should be considered in eligibility for sickness benefits (National Insurance Act, 1997, § 8–4). However, many symptom-based and self-reported health issues in the ICD-10 diagnosis hierarchy appear to lack credibility among the caseworkers, due to the scarcity of measurable standards or observable symptoms. This leads to frustration related to the absence of factual evidence in their process by which to judge clients' eligibility for sickness benefits. Hence, the caseworkers' adoption of the SMC's streamed guidance of investigating clients' housekeeping activities – or questioning whether the other arm works – can be seen as an attempt to solve this dilemma. Our findings reveal that clients suffering from e.g. exhaustion or other diagnosis triggered by psychosocial related issues, are regarded as less deserving of sickness benefits. The nature of the *diagnosis* thus appears as an increasingly important factor in the judgement of clients' deservingness of benefits (Rasmussen, 2020).

The mismatch or gap between caseworkers' experiences and the practical institutional realities imposed by NAVs regulatory frames represent a classic frontline dilemma and an institutional disjuncture (Smith, 2005). On the one hand, the caseworkers are 'indoctrinated', as one caseworker puts it, with an institutionally mandated course of action based on the view that everyone can always do something. On the other hand, when facing stakeholders around the meeting table, this course of action appears less appropriate. For example, how can conflicts between the sick-listed person and his/her employer, affecting the client's sleep and general well-being, be 'blocked out' in practice? Failing to incorporate these potentially incompatible aims results in a resignation over citizens' moral approach to work, followed by a concern about the sustainability of the welfare state. Assessing clients' sickness benefit eligibility by considering it a moral mission thus boils down to making a reasonable attempt to solve a recurring caseworker dilemma.

The sick-listed yet work-capable client: A moral mission

Because the objective of IE is to ‘find and describe social processes that have generalising effects’ (DeVault and McCoy, 2006: 18), we argue that frontline praxis constitutes a category of the *sick-listed yet work-capable client* that reflects Norwegian activation policies. This category is based on a moral discourse manifested in a particular form of governance. NAV’s attempt to implement governmental activation policies involves very few praxis guidelines to align the extensive client rights moored in the universalist and capacity-building welfare state model with the conditionality representing the neo-liberal approach (Skjefstad et al., 2019). The caseworkers thus seek various strategies to reduce the complexity of the discretionary process and align the two approaches. The concept of ‘residual work ability’ and caseworkers’ struggle to apply it in their client encounters demonstrates this ambiguity. It affords a logical and promising approach to a discretionary dilemma, but it is still left to individual caseworkers to explore, define, and operationalise its implementation to extend the boundaries of conditionality. We argue that beneath the surface of a rhetoric that speaks of possibilities and capabilities despite illness, lurks a scepticism towards medical diagnosis as providing legitimate and viable reasons for being absent from work.

Drawing on Smith’s concept of ruling relations (2005), we argue that caseworkers’ suspiciousness of clients’ malingering indicates a new institutional aspect developing in NAV. As such, the boss texts in indirect ways pave the ground for an institutional circuit of suspecting clients’ feigning or exaggerating symptoms to obtain sickness benefits. These processes, we argue, are fuelled by the fact that NAV offers few, practical guidelines for judging essential issues in combining work and recovery for sick-listed clients at the organisational level. Although staff meetings and the DM are collaborative arenas for this purpose, the caseworkers are largely left to themselves to judge and negotiate these considerations. The caseworkers, therefore, turn to themselves and each other to discuss strategies to acknowledge, access, and mobilise the inner qualities concealed behind the clients’ image of ill health, thereby institutionalising this scepticism. Tracing sick-listed clients’ ‘residual work ability’ is NAV’s attempt to implement this disclosure process, however, the caseworkers’ understanding of what clients’ residual work ability actually consists of and strategies to detect it, vary.

One aspect of this variation might be related to gender. The concept of *rationality of care*, introduced by Sørensen (1982), suggests that women more often make use of their personal experiences from the domestic domain in rationalizing and decision-making at work. Because the group of caseworkers was relatively homogeneous, including a large preponderance of female

workers in the 35–55-year age group, their health problems – and prescribed solutions – typically related to ailments affecting middle-aged women. Moreover, because these women had mostly performed office work, they had less personal experience with more manual types of work. We thus argue that gender-specific dispositions contribute to producing specific moral strategies towards sick listed, i.e. by comparing clients' health situation with the caseworkers' own health situation. These gendered strategies potentially display how frontline workers' personal experiences and background are becoming central points of reference for judgements of clients' eligibility for benefits. As such, ruling relations institutionalising scepticism towards whether clients are unable to work is paired with an individualised and moralising approach.

This resonates with Mik-Meyer's (2017) analyses of how frontline work in modern street-level bureaucracies is simultaneously influenced by bureaucratic principles, principles from the market, and psychological and therapeutic ideals. Although the discourse of malingering can be seen as a result of the adjustment of frontline practice to ideals of the market ('everyone is able to work, and this is beneficial for the individual as well as for the society and economy'), the references that frontline workers make to their own, personal experiences resembles what Mik-Meyer identifies as the new role-pair of coach–coachee in welfare encounters:

Similar to the market approach, an individualized psychology-inspired approach regards the citizen as someone who is able to voice his or her problems and knows (or will learn to know) how to solve them in a manner consistent with the evaluation and judgements of the welfare worker (2017: 86).

We suggest that this mechanism may explain both why activation and other neo-liberal measures re-introduce moralism as a guiding principle in welfare state governance, and why this aspect remains so unexplicated in political intentions and institutional governance. It emerges as an unintentional side-effect of frontline workers' attempts to embrace and realise values of a higher order. This complies with the American anthropologist Kelly McKowen's (2020) fieldwork among unemployed citizens in Norway. He identified a dominant moral work orientation emphasising the moral duty to become a part of the labour force and pay taxes, as a general approach to work and as a criterion for achieving status as 'normal'. McKowen refers to this type of morality as an 'employment ethic', distinguishing it from the well-known Protestant work ethic. In our interpretation, the employment ethic illustrates how the morality of workfare has drawn nourishment from conventional forms of conformity in Scandinavia; the latter aptly described in Henrik Stenius's chapter 'The good life is a life of conformity' in his 1997 book *The Cultural*

Construction of Norden. Increasingly, failing to take part in the workforce is understood as a problem of character and lacking the will to join the community of solidarity (1997: 124). This employment ethic thus may explain why the NAV caseworkers ‘moral selves’ are so strongly mobilised, taking on the role of *moral mediators* (Pors and Schou, 2021) and conducting *moral bordering* (Misje, 2021). The caseworkers’ engagement in their clients’ moral character emerges as a response to the contradictions inherent in the moral discourse, which undermines the potential of professional discretion while considerably expanding the scope of judgement of a more private character.

Conclusion

As caseworkers strive to unite different roles – gatekeepers of benefits, advocates for the government’s activation policies, protectors of conventional morals, and defenders of clients’ rights – they must craft new solutions for recurring dilemmas. Caseworkers seem to approach these dilemmas by seeking to adjust and improve the client’s subjective understanding of her/his situation, identify the hidden potential, and propose an assessment that may put the clients’ residual work ability into circulation (as labour). However, it seems that the solution instead creates new dilemmas due to new institutional discourses about sickness. To achieve results in the institutionally prescribed manner, they can only attempt to transform the relationship with the client and legitimise this by applying an egalitarian moralism drawn from the private realm. This approach mirrors the political visions behind activation: to restore society’s sustainability by mobilising sufficient labour. Failure to work equals a failure to commit to solidarity.

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