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Exploring organisational support to apply best practice in the sick leave and rehabilitation process from a multiprofessional front-line perspective: a qualitative study

Märit Löfgren ,[1,2] Daniel Gyllenhammar ,[3] Dominique Hange ,[1,4,5] Lena Nordeman ,[2,6] Gun Rembeck ,[1,2] Cecilia Björkelund ,[1,4] Irene Svenningsson ,[1,7] Karin Törnbom [8,9]

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For numbered affiliations see end of article.

Correspondence to
Dr Märit Löfgren;
marit.lofgren@allmed.gu.se

ABSTRACT

Objectives To explore the experiences of organisational support to apply best practices held by front-line employees working with patients in the sick leave and rehabilitation process (SRP).

Design Qualitative study design. Data were collected with focus group interviews in Region Västra Götaland, Sweden. Participants discussed their perceptions of organisational support to apply the best SRP practice in a primary healthcare context.

Participants Purposive sampling was conducted to capture a range of experiences among various professionals, including general practitioners (n=6), rehabilitation coordinators, other primary healthcare professionals (n=13) and caseworkers from the Social Insurance Agency, Employment Agency and Social Services (n=12).

Results Informants perceived that their good intentions to work for the best interests of each patient were not enough to overcome inadequate organisational prerequisites. Identified themes described unequal care due to significant practice variation, conflicting messages, a situation where the patient loses control and mismatch between available support and patient needs. Perceived potential consequences for the patients included legal uncertainty of assessments, harmful passivity of the individual through misapplied sick leave and the risk of overlooking non-medical factors that could be managed in a safer and more well-adapted way.

Conclusions Neither guidelines on person-centred approaches, nor laws regulating the right to coordinated individual planning, seem to have fulfilled the intended purpose. The informants depicted an SRP obstructing individualised care, thus risking worsening patients' well-being and abilities. The opportunities to improve the quality of the processes within the SRP, and simultaneously make them more effective, appear to be extensive.

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ This study examined front-line employees' experiences with sick leave and rehabilitation across various public service organisations.
- ⇒ Researchers from diverse disciplines provided a broad perspective.
- ⇒ The qualitative design allowed for detailed, in-depth data collection.
- ⇒ Informants across different locations and organisations shared a surprisingly consistent view of the process.
- ⇒ Conducted in Region Västra Götaland, Sweden, the findings' applicability to other contexts requires professional judgement.

INTRODUCTION

The purpose of sick leave is to provide employees with time off from work when ill or injured, allowing them to recover and return to work (RTW) in a healthy state. Different healthcare systems have different organisational approaches to sick leave and rehabilitation, but problems and challenges are often similar. Research exploring patient experiences of being sick-listed has highlighted that the process can lead to feelings of shame, emotional distress and a sense of being disregarded.[1–3] Additionally, patients perceive the primary focus on disease and workability when assessing the right to sick leave conflicts with the complexity of their needs and their overall health interests.[2–4] From the professional perspective, studies have described the sick leave and rehabilitation process (SRP) as lacking in approaches that support high-quality medical assessments and prioritisation in overcoming barriers to RTW.[2 3 5 6] Furthermore, there needs to be more organisational prerequisites within the SRP for addressing persistent, ill-defined or complex conditions. This shortfall has been linked to professionals adopting a passive role[7] or, in some cases, even misusing sickness certification.[8]

Given that sick leave is both costly for society and a source of patient suffering, addressing and resolving process issues is a high priority.

In Sweden, efforts have been made to clarify stakeholder responsibilities in the SRP and to enhance the focus on person-centred approaches and rehabilitation.

Healthcare responsibilities within the SRP include conducting insurance medical assessments, providing healthcare and rehabilitation, and performing follow-up evaluations. Sick leave certificates are typically issued by general practitioners (GPs) in primary healthcare, where multiple licensed healthcare professionals and a rehabilitation coordinator are involved as needed. A guideline outlines a generic model for the healthcare SRP.[9]

Patients are encouraged to actively participate in the planning and implementation of their individual SRP plans. Employers are responsible for planning RTW strategies, making workplace adjustments and managing workplace rehabilitation. Occupational health services may be engaged if deemed necessary by the employer.

The Social Insurance Agency is tasked with assessing eligibility for sickness benefits based on medical certificates and coordinating the SRP. Critical factors in determining eligibility for sick leave benefits include the connection between diagnosis, impaired ability to participate in activities and the subsequent impact on work capacity.[10 11] A defined SRP timeline[12] specifies that after 180 days, entitlement to sick leave benefits depends on the individual's capacity to work in any job on the labour market. When patients are no longer eligible for sick leave benefits, the responsibility for work-oriented rehabilitation and SRP coordination shifts from the Social Insurance Agency to the Employment Agency, or Social Services if the patient is not entitled to unemployment benefits (as membership in an unemployment fund is voluntary). For more details, see online supplemental information 1.

For several years, the Swedish healthcare system has been undergoing a shift in focus from hospital care to primary healthcare, with an emphasis on greater patient involvement. Central to this transition is the adoption of person-centred care across all areas of healthcare, including the SRP.

Person-centred care is defined by a European standard,[13] which sets the foundation for involving patients in their care. In clinical practice, the patient-centred consultation continues to guide doctor–patient interactions.[14 15] Additionally, tools such as standardised written agreements[16] and control questions[17] are designed to enhance patient involvement in healthcare decisions and to provide assurance that support will be available when needed.

However, despite all efforts, the problems maintain. Swedish SRP patients report challenges related to a lack of person-centred care, process delays and inadequate coordination.[9] Further, a recent report from the Swedish National Board of Health and Welfare[18] reveals how physicians in primary healthcare struggle with their daily SRP assignments. It also highlights a lack of SRP governance at both national and regional levels, challenges in defining best practices and the generally low priority given to SRP.

A more efficient SRP could potentially reduce societal costs and individual suffering related to illness and compromised mental health.[19] However, despite previous pinpointing of SRP problems, there is no consensus on why problems persist or how to proceed.

Management research emphasises that achieving quality-driven improvements, reducing costs and making informed priorities requires a deep understanding of existing problems and their root causes.[20] Additionally, the combination of professional expertise, contextual knowledge and insights into improvement methodologies is essential for achieving positive outcomes.[21] This study is part of a larger project that adopts a holistic, multiprofessional and interdisciplinary approach to understanding the persistence of SRP challenges and identifying solutions. To our knowledge, this is the first Swedish study to include all professional parties involved in SRP, offering a comprehensive and contextual perspective on this area of research.

In a prior qualitative study, we explored professionals' experiences of creating a purposeful SRP that prioritises patients' long-term health. We found that careful problem analysis from a holistic perspective on the patient's health, addressing the patient's ability to solve situational problems, promoting participation in meaningful activities and ensuring relational continuity among all involved professionals were perceived to positively impact SRP outcomes.[22]

The purpose of the present study was to explore the experiences of organisational support to apply best practices held by front-line employees from different organisations within the SRP.

METHODS

Study design

This study is part of a larger, holistic project aimed at providing decision support for policymakers by addressing four predefined research questions: 'What are SRP front-line employees' experiences of factors influencing SRP outcomes?' 'How do SRP front-line employees perceive organisational support in applying best practices?' 'What potential process improvements do SRP front-line employees identify based on their experiences?' and 'What are SRP front-line employees' experiences with continuous improvement efforts in SRP?' The present study focuses on the second research question: 'How do SRP front-line employees perceive organisational support in applying best practices?'

A qualitative study design was employed, recognising the importance of professional perspectives and contextual knowledge.[23] The research aimed to delve into the lived experiences of informants, which were strategically selected to provide a comprehensive understanding of the research question from various angles.[24] Data collection was conducted through virtual and in-person focus group discussions, encouraging group interactions to elucidate and explore informants' statements and perceptions.[25 26] The study results are presented following the Standards for Reporting Qualitative Research checklist.[27]

Setting and informants

The study was conducted with informants from different organisations involved in the SRP in Region Västra Götaland, Sweden: primary healthcare, the Social Insurance Agency, the Employment Agency and the Social Service. Participants were purposively sampled to include individuals with profound knowledge of the SRP through regular direct interactions with its users, referred to as 'patients' in this study for clarity, despite variations in nomenclature across different SRP organisations. The sampling sought to encompass a broad range of experiences and perspectives, considering factors such as organisational affiliation, profession, role in SRP, age, gender, geographical location and attitude towards SRP. To facilitate geographically dispersed purposive sampling, rehabilitation coordinators who had completed a process manager training course were enlisted to recommend healthcare informants and contact persons in other relevant organisations. A total of 41 front-line employees were recommended. After obtaining managerial permissions, 36 employees were invited to participate, all wanting to participate. However, five were unable to join for logistic reasons. A final sample of 31 participants was secured, comprising caseworkers (n=12), GPs (n=6), rehabilitation coordinators and other healthcare professionals from primary healthcare (n=13). See table 1 for a description of participant characteristics.

Data collection

Four virtual and two in-person focus group discussions, the latter taking place on the university premises, were conducted between September and October 2021. Each interview included 4–6 informants and lasted 2 hours. There were two groups with two caseworkers from each of the Social Insurance Agency, the Employment Agency and the Social Services, one group with four GPs, one group with five rehabilitation coordinators and/or primary healthcare professionals, and two mixed groups with one GP and three and five rehabilitation coordinators and/or primary healthcare professionals, respectively. Notably, the rehabilitation coordinators were either licensed healthcare professionals, working as occupational therapists, physiotherapists, psychotherapists, psychologists, nurses and/or care managers for depression or had previous experience from work-oriented rehabilitation as caseworkers. The mixed focus groups, therefore, incorporated perspectives from different healthcare professionals and caseworkers. The discussions were audio recorded, transcribed and pseudonymised. A code key was established and stored separately from the transcriptions.

During the focus group interviews, the informants discussed their experiences of the SRP from their respective professional roles. The discussions were guided by a moderator and an observer, taking alternating roles asking questions, listening, taking notes and asking complementary questions (ML and DG). In the first three groups, there was also an additional observer supervising the procedure (KT). Group rules were established to foster open dialogue, maintaining a respectful and confidential environment. The introductory question was 'Could you tell us about your experiences of the sick leave and rehabilitation process?'. The interviews were semistructured (see online supplemental information 2 for the interview guide). However, since the interviewees required only the introductory question to spark lively discussions, the interviewers used the interview guide to ensure all research questions—factors influencing SRP outcomes, organisational support in applying best practices, potential improvements and experiences with improvement work—were covered in all focus groups. The order in which the questions were addressed varied across focus groups, depending on the direction of the discussions in each group. The moderators used open-ended and probing questions to ensure a comprehensive exploration of informants' experiences related to the SRP. To allow for optimising data collection, the observer made field notes during the focus groups, and the interview strategy was refined before the next focus group. The last focus group provided only variations on previous themes, which was interpreted as a sign of information depth and saturation. Two informants were contacted after the focus groups to decipher some aspects.

Data analysis

Data analysis used systematic text condensation, following the approach outlined by Malterud.[28] We chose this qualitative analysis method for its pragmatic, holistic, exploratory and reflexive approach, which we believe aligns well with our overall aim of providing decision support for quality-driven change management within SRP.

Data analysis was conducted collaboratively by ML, DG and KT, with oversight from the remaining authors who monitored every stage of the process, providing guidance for key analytical decisions. Anonymity was ensured through pseudonymisation.

First, two researchers (DG and ML) read the interviews to form an idea of the whole, independently identifying themes. The themes identified were similar, making it easy to reach a consensus about preliminary themes for the following analysis. In a subsequent second step, meaning units were grouped according to the preliminary themes using the NVivo program.[29] Throughout the analysis process, the definitions of the preliminary themes were refined following the researchers' growing understanding of the data.

During the analysis, it became clear that the researchers looked at data from different angles: the management scholar (DG) studied data from a 'Social Welfare System'

Table 1 Description of participants (n=31) in a qualitative study exploring experiences of organisational support to apply best practices held by front-line employees from different organisations working with patients in the sick leave and rehabilitation process (SRP) in a primary healthcare context

Participants' organisation, profession or role	Perspectives represented	Sex (men/women)	Experience from SRP relatively new/experienced	Number of PCCs and municipalities represented	Size of PCC patient population	Geographical representation
Caseworkers (n=12): Employment Agency (n=4), Social Insurance Agency (n=4), Social Services (n=4)	► Work oriented rehabilitation and coordination of SRP cases from the perspective of the Social Insurance Agency, the Employment Service and the Social Services. ► General practice, insurance medical responsiblity.	5/26	7/24	23 PCCs 5 municipalities	4 100–18 400	Big city, small city, urban area, sparsely populated area
General practitioners (n=6)	► Local management and local multiprofessional teamwork, within primary healthcare.					
Rehabilitation coordinators and/or primary healthcare professionals (n=13)	► SRP coordinator role within primary healthcare, occupational therapy, physiotherapy, psychotherapy/psychology, psychosocial team triage, care manager depression, work oriented rehabilitation.					

This table describes the characteristics of 31 front-line employees participating in virtual or in-person focus group interviews about the SRP. The informants came from primary healthcare, the Social Insurance Agency, the Employment Agency and the Social Services. They represented different professions and perspectives, were mostly experienced (>5 years working within the SRP) but also at the beginning of their working life and came from different primary care centres (PCCs) and municipalities. The PCCs represented included small and large centres, and PCCs from both urban and sparsely populated areas.

PCCs, primary care centres; SRP, sick leave and rehabilitation process.

perspective, and the GP/researcher from primary healthcare (ML) focused on 'What's best for the patients?' Two sets of codes with thematic subcodes were produced jointly to accommodate these research perspectives. After that, DG and ML took the main responsibility for the continued analysis of one set of codes each, but they continued to provide each other with interdisciplinary advice and data interpretation support. The management-oriented report was published in 2023.[30]

The analysis from a primary healthcare perspective began with sorting meaning units into three thematic codes: factors affecting SRP outcomes, a dysfunctional process and a systems perspective on achieving a person-centred and efficient SRP. The continued analysis was thereafter performed as separate processes for each thematic code, resulting in three separate articles from a primary healthcare perspective, each answering one of three predefined research questions: 'What are SRP front-line employees' experiences of what affects SRP outcome?', 'What are SRP front-line employees' experiences of organisational support to apply best practice in SRP?' and 'What potential process improvements do the SRP front-line employees identify based on their experiences?' This article focuses on the second question.

As a fourth step, quotes were integrated to refine and contextualise the condensates into a coherent analytic text.

Patient and public involvement

Awareness of negative patient narratives about SRP was the starting point of this study, but neither patients nor the public were specifically involved as the aim was to understand the patients' narratives by exploring experiences held by front-line employees.

Author reflexivity

ML, DG and KT, who were responsible for data collection and the initial qualitative analyses, each represented different research paradigms. ML, with clinical primary healthcare experience as a GP, and research focus on primary healthcare, contributed with the primary healthcare perspective, DG contributed with the management scholar perspective as a researcher focusing on how to improve organisational systems with multiple public service organisations and KT brought the social scientist perspective as a researcher focusing on person-centred perspectives of health and healthcare, and evaluation of processes and methods in healthcare and in health social work. The interviewers, ML and DG, discussed their preconceptions before conducting the focus groups to increase reflexivity and remind to avoid influencing the participants during the interviews, and KT, who supervised the first focus groups, provided additional guidance to optimise the data collection. Throughout the process, the discussions continued to make sure that the analysis stayed truthful to the data. All data were deliberated back and forth among the authors throughout the analysis, and ambiguities were thoroughly discussed from different perspectives until a consensus was reached.

Methodological discussion

The focus groups, comprising both profession-specific and mixed groups, proved beneficial. Single-profession groups enabled in-depth dialogue, while mixed groups fostered constructive exchanges between different perspectives. Although some tension arose in one of the mixed groups, overall interaction remained productive, allowing exploration of diverse viewpoints.

Embracing interdisciplinary research perspectives (primary healthcare, organisation and management and social science) in study design, data collection and analysis was a strength of the study. Filtering data through different research perspectives challenged our preunderstandings and enabled a broader and more in-depth understanding of data. Further, being forced to explain ones perspectives on a basic level refined the analysis and discussing both potential bias and findings from different angles until reaching consensus added to the quality of the analyses.

Interview data were analysed in three separate processes to answer three separate predefined research questions, which could be perceived as a fragmented publication. However, the data were incredibly rich, and three separate analyses were required to enable exploring each research question with sufficient analysis depth, and in such a way that the informants' experiences could adequately emerge. Additionally, coordinating data analysis for related research questions not only enhanced the quality of each analysis by providing deeper contextual understanding but also allowed for a stepwise analysis: first exploring the optimal scope of the SRP, then analysing the gap between the current and desired states, and, in a future article, offering recommendations on how to proceed.

RESULTS

A main finding was that informants, from both primary healthcare and other authorities in the SRP, experienced that they failed to care for the complex needs of patients with long-term sick leave or unemployment due to illness and poor health. Informants believed that this contributed to inefficient and costly work methods, unnecessary suffering for the patients, and unnecessarily high societal costs for sick leave. Four codes were identified: (1) problems persist if you do not draw the winning ticket, (2) conflicting messages, (3) a situation where the patient loses control and (4) mismatch between regulations and needs. See table 2 for the analysis structure and summary.

Problems persist if you do not draw the winning ticket

The informants perceived that the vast majority within their organisations do their very best to assist patients based on given conditions. All professionals at all levels were considered to have the desire to work towards the

Table 2 Analysis structure and summary of a qualitative study exploring experiences of organisational support to apply best practices held by front-line employees from different organisations working with patients in the sick leave and rehabilitation process (SRP) in a primary healthcare context

Aim	Code groups	Subgroups	Condensed findings	Implications of SRP practice
To explore the experiences of organisational support to apply best practices held by front-line employees from different organisations working with patients in the SRP.	Problems persist if you do not draw the winning ticket	▶ Employees' good intentions ▶ Unequal quality of care ▶ Fear and distrust	Despite front-line employees' desire to work towards the best interests of each patient, local organisational priorities affected resource allocation to the SRP, resulting in significant practice variation, quality loss and distrust in the process.	This qualitative study indicates that front-line employees in SRP have low confidence in the process. Neither guidelines on person-centred approaches, nor laws regulating the right to coordinated individual planning, seem to have resulted in the intended impact. The informants depicted an SRP obstructing individualised care, thus risking worsening patients' well-being and abilities. The room for process quality improvements and streamlining appeared to be extensive.
	Conflicting messages	▶ Insufficient problem analysis ▶ Unrealistic expectations ▶ Diverging interpretations	Patients' unrealistic expectations combined with inadequate assessments of their health problems from a biopsychosocial holistic perspective resulted in inability to provide patients with plausible explanations, diverging interpretations, insecurity and worse health outcomes for patients.	
	A situation where the patient loses control	▶ Lack of overall responsibility ▶ Shortage of interventions ▶ Financial unpredictability	Lack of overall responsibility for the individual's process led to short planning horizons and lack of plans. Shortage of interventions resulted in long waiting times and lost hope. Patients' fear of a personal financial disaster was perceived to steal focus from regaining health, function, and work capacity.	
	The mismatch between regulations and needs	▶ Illness and existential suffering intertangled ▶ Rigid regulations ▶ Impaired legal certainty ▶ Barrier to person-centredness	Rigid process rules and procedures in combination with difficulty distinguishing disease from existential suffering obstructed legal certainty and led to impaired, and unequal, prerequisites for tailoring the process to individual needs.	

This table describes the analysis structure and summarised results from the second of three qualitative analyses based on data collected with focus group interviews involving 31 front-line employees in the sick leave and rehabilitation process. Informants were from healthcare, the Social Insurance Agency, the Employment Agency, and the Social Services. The analyses were intended to provide decision support for managing quality driven change management within sick leave and rehabilitation process.

best interests of each patient. Nevertheless, the informants unanimously perceived that many of their SRP patients had to struggle hard to make it through the process. When discussing the process, it was clear that they, with their own experiences from the process, would not trust that they would receive help if getting ill;

> …the fear [of getting ill], I mean, what I've learned as a rehabilitation coordinator, it is like; 'I'm terrified of being on sick leave,' never in my life that I would have… that would be a nightmare (talking about the SRP as a non-patient-friendly system). Rehabilitation 16-4 (coordinator role)

The shared impression was that in well-maintained units, which prioritised and allocated time and resources to SRP, the process often functioned as desired. However, the informants described that overall, the minimum quality level is low, and there is a widespread lack of consistency in practice regarding how patients should be managed. This was considered to result in unequal care, both in primary healthcare and within the Social Insurance Agency, Employment Service and Social Services. The significant practice variation was described repeatedly:

> What determines the duration of a sick leave? Well, if you're sick, it's like… you go to the lottery, so to speak, and you draw a doctor, you draw an administrator at the Social Insurance Agency, you draw a rehabilitation coordinator and you draw an employer, who may or may not want to play ball [meaning cooperate] with you. And somewhere there, you can

> generate a [random] outcome, like 'How will this go? Will the doctors even involve the rehabilitation coordinator [implying unequal support]?' Rehabilitation 16-4 (coordinator role)

Conflicting messages

The informants described that a main part of the prevailing problems in SRP consisted of inadequate assessments of patients' health problems, together with a lack of consensus that contributed to conflicting information, uncertainty and an inconsistent process for patients.

The informants stressed that the early assessment to understand the patient's health problems was often insufficient or incorrect. As a result, there was a risk of overlooking underlying psychiatric illness or trauma/life events, which may indeed lead to somatic symptoms. Similarly, there was an identified risk of missing underlying somatic illnesses, which was initially interpreted as mental ill health. The informants also described that cognitive difficulties were sometimes not adequately recognised.

According to informants, all this uncertainty about the patient's actual health problems leads to conflicting messages, poorer medical care and failure to adjust demands and expectations that the patient could handle. All factors were believed to affect the patient's rehabilitation opportunities, and own ability to take responsibility in the process.

> One of the phenomena we frequently encounter is all perceptions regarding work capacity, often due to the absence of a properly conducted work capacity assessment. My experience suggests that without it, progress is hindered, you're not getting anywhere. A caseworker from the Social Services 6-S2

A general lack of knowledge within society concerning the extent to which psychosocial and societal factors may influence various health problems was identified as an important challenge to bridge when communicating with patients. Informants perceived that patients often adhered to medical explanatory models and found it more challenging to recognise the causes of their problems from a biopsychosocial holistic perspective. They also described frequently encountering an exaggerated belief in the value of merely resting through sick leave, which could be challenging to address and disprove. Overall, informants perceived difficulties in finding common ground with patients, about the origin of the ill-being being medical or non-medical, and about which problem-solving approaches are adequate.

Informants emphasised that even they, as professionals from different organisations involved in the SRP often defined and perceived the concept of work capacity in varying ways. This could have a central importance, both when determining who was entitled to sickness benefits and when identifying the responsible parties to advance the patient's process.

> We may judge that according to the regulations we work with at the Social Insurance Agency, someone is healthy enough [to work], but the Employment Agency may judge that the same person is far too sick [to work]. We follow different regulations. A caseworker from the Social Insurance Agency 27-5

When the health problem remained ambiguously defined, achieving a consensus among professionals was perceived as challenging. This applied not only to how the sick leave tool should be used in the patient's best interest but also to the expectations for the patient's efforts to improve their health. The lack of consensus around the causes of health problems, the allocation of responsibilities, the definition of work capacity and the purpose of sickness absence led to conflicting messages, insecurity and worse health outcomes for patients.

A situation where the patient loses control

Informants emphasised that for many patients in the SRP, there was no clear plan for investigation, care or rehabilitation. The lack of continuity among all professions led to short planning horizons, which was considered to result in patients often being referred between different levels of care, authorities and professionals, without anyone having an overview or responsibility for the entirety.

Informants further described that the absence of sickness and rehabilitation plans, together with inadequate coordination among different front-line employees, contributed to the risk of patients falling through the cracks. This, combined with financial unpredictability within the SRP, was perceived as causing patients to lose their footing during sick leave. This often led to a significantly worsening prognosis and thus longer sick leaves.

> There appear to be system-related gaps between these narrow perspectives [held by different authorities], which we try to juggle and see if we can resolve—sometimes it works, sometimes it doesn't work. […] The greatest frustration is the unpredictability, because while I can guess what's going to happen next, I don't really know… and that makes the task of coordinating patients' rehabilitation tremendously challenging Rehabilitation 16-4 (coordinator role)

Beyond the lack of plans, the informants described that a shortage of interventions could lead to difficulty adhering to a rehabilitation plan.

> …well, someone has thought this through, this is how we should work [based on a coordinated individual rehabilitation planning], but there are no resources to… What happens next? And we would need this, but there are no resources or places available to carry out this planning Caseworker from the Employment Agency 6-1

Long waiting times were perceived as leading to patients losing hope of ever being able to feel and function better again, which was thought to make it more challenging to overcome obstacles and to worsen the patients' prognosis further. For instance, it was mentioned that waiting times for psychotherapy and work-oriented rehabilitation could be long. It was also highlighted that practical support from the municipalities, such as easily accessible counselling support during life-crises, support for families with special needs or social rehabilitation measures, often was insufficient.

> …you get sick from being on sick leave… it's like, after two months, all parameters like sleep and self-confidence just crash… and the small conflicts that were at work, they grow over time Rehabilitation 16-2 (coordinator role)

Economic stress was often considered to hurt how well patients in the SRP could regain health, quality of life and work capacity. The informants further suggested that trust and economic considerations influenced the extent to which patients dared to honestly assess their capabilities as a basis for the ongoing rehabilitation plan. The informants stated that some patients had revealed that financial incentives could lead to cautiousness about endorsing work capacity simply because it could lead to further loss of control through the rejection of sickness benefits, worsening finances and obligations to seek new employment that they knew beforehand would fail.

> we are quite locked into a workplace, restructuring is costly, it is risky to be unemployed, it is difficult to find a new job and so on. So it's beyond what we [in healthcare] can influence, but I think it often prolongs and complicates sick leaves. GP 13–3

The mismatch between regulations and needs

Informants perceived that the rules and procedures in the SRP functioned with less quality in cases of long-term or more complex health problems. This led to difficulties in distinguishing reduced work capacity due to medical illness from suffering associated with psychosocial factors or poor life conditions. All of this affected the legal certainty in assessing entitlement to sickness benefits or adjustment support, resulting in unpredictability, frustration and insecurity for both patients and professionals.

> We are only humans, sometimes one [as a GP] might by mistake put someone on sick leave who perhaps shouldn't be, because the problem is something… yes, more work-related. But there are also those who come in with quite strong symptoms and you say 'no, it's work-related' [and deny sick leave] […] that boundary-drawing I think can be very, very difficult to make… and then it affects the patient a lot Rehabilitation 22-3 (coordinator role)

The SRP was perceived to pay insufficient attention to the patient's needs and what they expressed as important to them. A focus on objective findings, medical diagnoses and assessment of eligibility for sick leave, rather than on the need for support and rehabilitation, was described as contributing to long, passive periods of sick leave.

Informants further described that patients with similar medical needs received different treatment in primary healthcare depending on whether they were on sick leave from a current work or unemployed. Primary healthcare was perceived as less inclined to provide medical documentation to plan work-oriented rehabilitation and adjustments for unemployed patients, which informants believed led to unequal healthcare. Informants also described barriers to reopening a medical investigation, as part of a more thorough workability investigation, if there were setbacks to implementing a rehabilitation plan coordinated by the Employment Agency or the Social Services.

> People may need a medical certificate for reasons other than getting money from the Social Insurance Agency [refers to information in the medical certificate being used to tailor work-oriented measures to patients' needs]. We often encounter this view in primary healthcare: the medical certificate, you need that to get compensation from the Social Insurance Agency, and that's where it stops. What is the purpose of the doctor's medical certificate? A caseworker from the Social Services 6-S2

Finally, informants emphasised that it was often difficult to obtain permanent sickness benefits for patients, even when they probably would permanently need more work capacity. The consequence for the patients could be that they had to participate in labour market programmes, which were not expected to bring them closer to work, but were only a strategy to get compensation approved:

> Some people… shouldn't have to be in our systems [refers to people with permanent functional impairments], they should not be molested [with constant reassessments or activities] […] We have them on activity after activity and nothing happens and they are just there, just as you say [referring to another informant], to be entitled to their financial benefits […] obviously, one gets tired of just being in these systems. A caseworker from the Employment Agency 27-3

DISCUSSION

This qualitative study, exploring multiprofessional perspectives of the SRP, unveiled perceptions of suboptimal organisational support to apply best practices in SRP, resulting in process dysfunction and misalignment with patient needs and expectations. The findings revealed a pronounced gap between what the informants assessed as being the best for patients in SRP, which coincided with what was considered most effective for society, and how the SRP was perceived to work in reality. The informants depicted a process obstructing individualised care, thus risking worsening patients' well-being and abilities. Hence, the room for process quality improvements and streamlining was believed to be huge. Identified quality gaps were inadequate assessments, lack of overall liability, shortage of interventions and mismatch between regulations and needs.

Interpretation of results and comparison with previous work

As a first main finding, it was evident that informants perceived the SRP system as generally unequal, poorly coordinated and unpredictable despite their good intentions as professionals. For example, we would like to draw attention to the fear that was expressed by informants about the prospect of being personally affected by illness and being forced to participate in SRP. This result provides a vivid insider perspective. We concluded that the informants' narratives suggest real and extensive systemic issues within the SRP that need to be addressed fundamentally. We found no reason to perceive the notable and pervasive quality problems highlighted in this study, as solely due to isolated deficiencies in complex individual cases, local deviations or only for patient groups with specific needs. Our study aligns with previous Swedish SRP problem descriptions,[9 18] and with international literature[2 3 5–8] adding an in-depth, multiprofessional and front-line perspective to the reports from GPs, regional management and patients.

As a second main finding, we observed that informants described that inadequate assessments of patients' health problems from a biopsychosocial holistic perspective resulted in conflicting messages, insecurity and worse health outcomes for patients. Based on the results, it appeared that the SRP, and GPs, often place greater emphasis on assessing eligibility for sickness benefits rather than identifying and describing the need for interventions, both medical and non-medical, which is in line with prior international research.[2 3 5 6] The findings revealed that a lack of problem understanding leads to diverging interpretations, an inability to provide patients with plausible explanations, deficient problem-solving and inadequate planning around the patient. We concluded that though early assessments, careful SRP planning, process coordination and person-centredness are emphasised in current SRP guidelines,[9] they are not fully implemented in reality.

The results further showed a significant discrepancy between how informants perceived societal and patient expectations on one hand, and the functioning of healthcare and the SRP system on the other hand. Patients were described to have expectations, beliefs and concerns about the handling of SRP that were in conflict with both evidence-based practices and the regulations governing SRP. For example, informants depicted a clear and significant gap between their perception of patients' expectations of a diagnosis as an explanatory cause for their discomfort, and how the process actually unfolded. This finding is in line with previous studies highlighting how 'being able to work' is influenced by politics, media and the labour market,[4 31] and the need to educate patients and the public.[32] We concluded this finding indicates both insufficient health literacy[33] and insufficient social insurance literacy in society[34] from an SRP perspective. Further, our results indicated that a lack of problem analysis obstructs both clear answers to patients' health questions and may aggravate miscommunication at all levels in SRP.

Related to assessments, the findings also indicated that patients receive different quality of care in primary healthcare depending on whether they were employed or unemployed prior to the SRP. Given that both these groups have been described as having similar complex needs,[22] we find it difficult to justify these differences, if they exist. We concluded that there is a need for studying the effects of offering unemployed individuals with health issues, or unexplained difficulties in entering or re-entering the labour market, a biopsychosocial assessment in collaboration with healthcare providers, to avoid overlooking potential underlying medical issues.

A third main finding was that informants in the current study described how patients in the SRP express feelings of hopelessness and a desire to continue being on sick leave. Lack of overall responsibility for the individual's process was seen to lead to short planning horizons, lack of plans and lack of realistic alternatives to sick leave. Further, the shortage of interventions resulted in long waiting times and lost hope, and patients' fear of a personal financial disaster was perceived to steal focus from regaining health, function and work capacity. This finding aligns with previous research on patients' emotional stress related to SRP[1–3] while also providing an explanation for the underlying causes from a professional perspective.

The informants' description of how they perceived that their patients act irrationally in the SRP can be understood through existing research on health literacy,[33] sense of coherence,[35] the normal grieving process[36] and patient behaviour transitions in SRP.[37]

Becoming ill, and losing abilities previously taken for granted, is an unwanted turn in life. Different individuals have different abilities to cope based on health literacy.[33] It would be reasonable to assume that deteriorating health and an SRP that is perceived as incomprehensible, unmanageable and meaningless could, similar to other types of grief, trigger overwhelming emotions in patients. Based on the normal grieving process, which describes that it is normal to first mourn an unwanted change, then accept it and then reorient oneself based on the new conditions,[36] most individuals would eventually accept the new circumstances and reorient themselves.

Being able to shift goals is associated with positive feelings.[38] Interestingly, patients in SRP who experience ambivalence about returning to work have weaker sense of coherence and goal direction, while those who have reoriented themselves within the context of being sick regain stronger sense of coherence and goal direction.[37] We find it relevant to further investigate whether unpredictability in SRP, in combination with patient unawareness of other realistic options than sick leave, maybe a driver of patients reorienting themselves to identify with their sick role.

Patients losing control of SRP, as depicted by informants in this study, aligned with previous research from a patient perspective, which highlighted how SRP-related stress affects patients' mental health in a negative way.[2 3] Considering how the results indicated that the SRP puts patients in a situation where they lose control, it is relevant to compare the findings with previous research showing how prolonged loss of control due to external stressors can lead to fatigue and impaired cognitive function.[39] Based on the results, we found it reasonable to highlight the risk that over time, a dysfunctional SRP process may lead to or perpetuate stress-induced impairments or incite prolonged sick leave. We argue this needs to be further investigated.

A fourth main finding was that informants found it nearly impossible to distinguish symptoms of illness in a legally sound manner from what can be described as normal reactions to life events, which is required by SRP regulations. Rigid SRP rules and procedures, and a unilateral medical paradigm, were perceived to contribute to legal uncertainty and hinder person-centredness.

The importance of non-medical factors for the need for sick leave has been described in previous research.[4 31 40] However, this study indicated that the SRP system appears to need to be aligned with the available evidence. Our findings pinpointed that the combination of (1) difficulties distinguishing symptoms of illness from normal reactions and (2) suffering resulting from illness being valued highly in the Swedish social insurance system, carried the risk of medicalising common, non-medical, symptoms. In line with previous guidelines, research and position papers,[2 3 5 11 41 42] we concluded that uncalled for sick leave (overdiagnosis) could entail the risk of passivity of the individual (through misapplied sick leave), but also the risk of overlooking non-medical factors that could be managed.

Based on this finding, we also argue that neither eligibility for sickness benefits, nor the SRP as a whole, meet the requirements for person-centred care[17] as patients may need more confidence that support will be available when needed. Informants described deficiencies in the management of medical treatments and rehabilitation, impaired management of work-oriented rehabilitation, shortage of interventions, and lack of consensus and coherence of the process. Furthermore, the informants emphasised that the time to have a dialogue with the patients in the initial phase of the SRP about a person-centred and coherent SRP plan needed to be improved.

Overall, informants in our study described an SRP that was, in many respects, both dysfunctional and challenging for patients to navigate (with local exceptions). Notably, although our study examined the perspectives of professionals and not the perceptions of the patients, our findings are consistent with the results from previous qualitative studies with both patients[1–4] and professionals.[2 3 5–8]

We concluded that the informants perceived it a veritable challenge for most SRP patients with lingering symptoms to take responsibility for contributing to adequate care and support in their rehabilitation process under the present circumstances. If the patients also have a lower health and social insurance literacy, conditions become increasingly suboptimal.

Considerations for a purposeful SRP

Despite previous efforts, existing guidelines and laws, we found trust in the quality of the SRP could be more robust among the professionals. The findings indicated that front-line employees working with patients in the SRP experience multiple, and serious, barriers towards a person-centred process based on a holistic perspective on the patients' health. Process improvement potential was considered substantial, and patient benefits were perceived to coincide with what was most effective for society, thus simplifying priorities. Along with previous research, we advocate taking urgent measures to improve person-centredness and quality in SRP to enhance process outcomes. Specific recommendations from this study include improving the early biopsychosocial assessments, clarifying overall liability for the patients' SRP, ensuring access to adequate SRP interventions and to enable matching SRP regulations and needs. How such change may be concretised to allow realisation in practice needs to be further investigated.

Strengths and limitations

The chosen qualitative study design and data collection with focus group interviews were considered adequate to meet the purpose of the study. The focus group dialogues were sincere, dedicated and rich with details about personal experiences and contextual examples, thus allowing the researchers to comprehend the complexity of the SRP.

Front-line employees from various professions and organisations often described the same challenges differently. For example, one profession expressed frustration with another's handling of SRP tasks, while the criticised group explained they faced limitations affecting their performance. This contrast highlighted the complex interdependencies within the SRP and the importance of understanding challenges from multiple professional angles. Despite working in different locations and public service organisations, the informants depicted a surprisingly coherent holistic view of the process as a whole. Not every informant explicitly stated everything, but in cases where there was disagreement, it has been indicated in the results.

Considering the transferability of the findings in this article, it is system specific, that is, dependent on how a particular SRP is defined on organisational macrolevel, mesolevel and microlevel.[43] Our data suggested great local variation, which implies low transferability. However, the findings were to a large extent consistent with previous international studies, which indicates similar SRP challenges in differing contexts.

CONCLUSIONS

Based on the findings from this qualitative study, we concluded that the informants—front-line employees working with patients in the SRP—have low confidence in the quality of the SRP. Moreover, informants depicted a process obstructing individualised care, thus risking worsening patients' well-being and abilities. Potential consequences included legal uncertainty, harmful passivity of the individual through misapplied sick leave and the risk of overlooking non-medical factors that could be managed to alleviate symptoms. The room for process quality improvements and streamlining was believed to be significant. We concluded that our results point out SRP challenges that may be relevant in different contexts. Still, that transferability to a specific context needs to be determined with professional judgement in each case.

This study demonstrated that knowledge and guidelines on person-centred approaches, as well as laws regulating the right to coordinated individual planning, have not achieved the intended effects within the SRP system. Along with previous research, we advocate taking urgent measures to improve person-centredness and quality in SRP to enhance process outcomes.

Author affiliations
[1]Primary Health Care/School of Public Health and Community Medicine/Institute of Medicine, University of Gothenburg Sahlgrenska Academy, Göteborg, Sweden
[2]Research, Education, Development & Innovation Primary Health Care, Region Västra Götaland, Södra Älvsborg, Sweden
[3]Department of Technology Management and Economics, Centre of healthcare improvements, Chalmers University of Technology, Gothenburg, Sweden
[4]Region Västra Götaland, Research, Education, Development & Innovation Primary Health Care, Göteborg, Sweden
[5]Research, Education, Development & Innovation Primary Health Care, Region Västra Götaland, Skaraborg, Sweden
[6]Institute of Neuroscience and Physiology, Department of Health and Rehabilitation, Unit of Physiotherapy, Goteborgs universitet Sahlgrenska Akademin, Göteborg, Sweden
[7]Research, Education, Development & Innovation Primary Health Care, Region Västra Götaland, Fyrbodal, Sweden
[8]Department of Social Work, University of Gothenburg, Gothenburg, Sweden
[9]Department of Clinical Neuroscience, Rehabilitation Medicine, Institute of Neuroscience and Physiology, University of Gothenburg Sahlgrenska Academy, Gothenburg, Sweden

X Märit Löfgren @doktormarit

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Contributors All authors contributed to the study design. DG and ML alternated between the roles of moderator and observer during data collection with focus groups, while KT acted as an additional observer during the initial three focus groups. Data analysis was conducted collaboratively by ML, DG and KT. KT critically revised all manuscript versions and assisted with English translation. The remaining authors (DH, IS, CB, GR and LN) oversaw all process steps, providing guidance on crucial analysis decisions and critically reviewing manuscript drafts. All authors read and approved the final version of the manuscript. KT is the project guarantor. Language editing of this manuscript was performed using ChatGPT, an AI language model developed by OpenAI.

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ORCID iDs
Märit Löfgren http://orcid.org/0000-0003-0139-522X
Daniel Gyllenhammar http://orcid.org/0000-0001-8511-0820
Dominique Hange http://orcid.org/0000-0003-1114-4440
Lena Nordeman http://orcid.org/0000-0003-4691-9330
Gun Rembeck http://orcid.org/0000-0003-0097-5150
Cecilia Björkelund http://orcid.org/0000-0003-4083-7342
Irene Svenningsson http://orcid.org/0000-0002-7421-8171
Karin Törnbom http://orcid.org/0000-0002-7593-2051

REFERENCES

1 Skoglund I, Petersson EL, Hange D. A bridge over troubled water? A qualitative study of primary care patients' experiences of a rehabilitation program. *J Multidiscip Healthc* 2018;11:457–66.
2 Roberts-Yates DC. Examining the Role of Treating Medical Practitioners Practising in the South Australian Workers' Compensation System. *Aust J Rehab Couns* 2003;9:102–17.
3 Schnitzler L, Kosny A, Lifshen M. Healthcare providers' experience with the management of mental health conditions in the context of Workers' Compensation. *Work* 2018;59:449–62.

4 Ståhl C, Svensson T, Petersson G, *et al*. The work ability divide: holistic and reductionistic approaches in Swedish interdisciplinary rehabilitation teams. *J Occup Rehabil* 2009;19:264–73.
5 Nilsing E, Söderberg E, Berterö C, *et al*. Primary healthcare professionals' experiences of the sick leave process: a focus group study in Sweden. *J Occup Rehabil* 2013;23:450–61.
6 Edlund C, Dahlgren L. The physician's role in the vocational rehabilitation process. *Disabil Rehabil* 2002;24:727–33.
7 Bengtsson Boström K, Starzmann K, Östberg AL. Primary care physicians' concerned voices on sickness certification after a period of reorganization. Focus group interviews in Sweden. *Scand J Prim Health Care* 2020;38:146–55.
8 Hussey S, Hoddinott P, Wilson P, *et al*. Sickness certification system in the United Kingdom: qualitative study of views of general practitioners in Scotland. *BMJ* 2004;328:88.
9 National System for Knowledge Management Health Care Sweden's Regions in Collaboration. Generisk modell för rehabilitering och delar av försäkringsmedicinskt arbete - för klinisk verksamhet [Generic model for rehabilitation and elements of insurance medical work - for clinical practice], Available: https://www.nationelltklinisktkunskapsstod.se/globalassets/nkk/nationell/media/dokument/kunskapsstod/vardforlopp/generisk-modell-for-rehabilitering-och-delar-av-forsakringsmedicinskt-arbete_for-klinisk-verksamhet.pdf
10 The Swedish Social Insurance Agency. n.d. Hur skriver jag intyg som ger Försäkringskassan rätt information? [How do I write a certificate that gives the Social Insurance Agency the correct information.
11 The Social Welfare Board. *Hälso- och sjukvårdens arbete med sjukskrivning och rehabilitering Nationellt kunskapsstöd [Health and medical care's work with sick leave and rehabilitation National knowledge support]*. Stockholm: Socialstyrelsen, 2023. Available: https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2023-11-8831.pdf
12 The Swedish Social Insurance Agency. Rehabiliteringskedjan (The rehabilitation flowchart), Stockholm, 2023. Available: https://www.forsakringskassan.se/om-forsakringskassan/vart-uppdrag/om-socialforsakringen/rehabiliteringskedjan
13 European Committee for Standardization. Patient involvement in health care - minimum requirements for person-centred care. CEN-CENELEC Management Centre. 2020;17398:2020.
14 Levenstein JH, McCracken EC, McWhinney IR, *et al*. The patient-centred clinical method. 1. A model for the doctor-patient interaction in family medicine. *Fam Pract* 1986;3:24–30.
15 Van Dalen J, Bartholomeus P, Kerkhofs E, *et al*. Teaching and assessing communication skills in Maastricht: the first twenty years. *Med Teach* 2001;23:245–51.
16 The Swedish Association of Local Authorities and Regions. Patientkontrakt [patient contract]. n.d. Available: https://skr.se/skr/halsasjukvard/utvecklingavverksamhet/naravard/patientkontrakt.28918.html
17 The Swedish Association of Local Authorities and Regions. Metodstöd, uppföljning [method support, follow-up)]. Stockholm. 2022. Available: https://skr.se/skr/halsasjukvard/utvecklingavverksamhet/naravard/patientkontrakt/inforandestodpatientkontrakt/metodstoduppfoljning.28922.html
18 The Social Welfare Board. Hälso- och sjukvårdens arbete med sjukskrivning och rehabilitering. [Work with sick leave and rehabilitation in health care] Stockholm: Socialstyrelsen, 2023. Available: https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2023-6-8595.pdf
19 Stockholm. Samhällskostnaden för längre sjukskrivningar [The societal cost of longer sick leave]. Stockholm: Skandia, 2023. Available: https://www.skandia.se/globalassets/pdf/press-och-media/rapporter-och-debatt/230124_samhallskostnadenforsjukskrivning2022.pdf
20 Bradbury H, Lifvergren S. Action research healthcare: Focus on patients, improve quality, drive down costs. *Healthc Manage Forum* 2016;29:269–74.
21 Batalden PB, Stoltz PK. Quality management and continual improvement of health care: A framework. *J Contin Educ Health Prof* 1995;15:146–64.
22 Löfgren M, Törnbom K, Gyllenhammar D, *et al*. Professionals' experiences of what affects health outcomes in the sick leave and rehabilitation process-A qualitative study from primary care level. *PLoS One* 2024;19:e0306126.
23 Batalden M, Batalden P, Margolis P, *et al*. Coproduction of healthcare service. *BMJ Qual Saf* 2016;25:509–17.
24 Malterud K. Qualitative research: standards, challenges, and guidelines. *Lancet* 2001;358:483–8.
25 Malterud K. Kvalitativa metoder i medicinsk forskning [Qualitative methods in medical research]. Lund: Studentlitteratur. 2009.
26 Dahlin-Ivanoff S, Holmgren K. Fokusgrupper [Focus groups]. Lund: Studentlitteratur AB. 2017.
27 O'Brien BC, Harris IB, Beckman TJ, *et al*. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med* 2014;89:1245–51.
28 Malterud K. Systematic text condensation: A strategy for qualitative analysis. *Scand J Public Health* 2012;40:795–805.
29 QRS International. *NVivo, Version 1.4. Burlington Massachusetts*. 2021.
30 Gyllenhammar D, Eriksson E, Löfgren M. Value creation and destruction involving multiple public service organizations: a focus on frontline employees. *Pub Manag Rev* 2023;41:1–22.
31 Nordling P, Priebe G, Björkelund C, *et al*. Assessing work capacity - reviewing the what and how of physicians' clinical practice. *BMC Fam Pract* 2020;21:72.
32 Guzman J, Yassi A, Cooper JE, *et al*. Return to work after occupational injury. Family physicians' perspectives on soft-tissue injuries. *Can Fam Physician* 2002;48:1912–9.
33 Mårtensson L, Hensing G. Health literacy -- a heterogeneous phenomenon: a literature review. *Scand J Caring Sci* 2012;26:151–60.
34 Ståhl C, Karlsson EA, Sandqvist J, *et al*. Social insurance literacy: a scoping review on how to define and measure it. *Disabil Rehabil* 2021;43:1776–85.
35 Antonovsky A. *Unraveling the mystery of health. How people manage stress and stay well*. San Francisco: Jossey-Bass Publishers, 1987.
36 Cullberg J. *Kris och utveckling [crisis and development]*. Stockholm: Natur & Kultur, 2010.
37 Hansen Falkdal A, Edlund C, Dahlgren L. Experiences within the process of sick leave. *Scand J Occup Ther* 2006;13:170–82.
38 Ockander MK, Timpka T. Women's experiences of long term sickness absence: implications for rehabilitation practice and theory. *Scand J Public Health* 2003;31:143–8.
39 Åsberg M, Glise K, Herlofson J, *et al*. *Utmattningssyndrom - En Kunskapsöversikt Om Stressrelaterad Psykisk Ohälsa. (Exhaustion Syndrome - a Knowledge Overview of Stress-Related Mental Illness)*. Stockholm: National Board of Health and Well Fare, 2003.
40 Pransky G, Katz JN, Benjamin K, *et al*. Improving the physician role in evaluating work ability and managing disability: a survey of primary care practitioners. *Disabil Rehabil* 2002;24:867–74.
41 Hensher M, Tisdell J, Zimitat C. "Too much medicine": Insights and explanations from economic theory and research. *Soc Sci Med* 2017;176:77–84.
42 Roksund G, Sigurdsson J, Haas L, *et al*. *Position paper overdiagnosis and related medical excess*. Reykjavik: Nordic Federation of General Practice, 2017. Available: https://www.nfgp.org/files/8/position_paper_overdiagnosis.pdf
43 Bryman A, Bell E. *Business research methods, 4th edn*. Oxford: Oxford University Press, 2015:402.