Received: 26 April 2021 | Revised: 3 January 2022 | Accepted: 6 January 2022

DOI: 10.1111/spol.12790

ORIGINAL ARTICLE

WILEY

Sanctioning the sick: Do perceptions of activating the sick and diagnosis matter?

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Funding information
This work was supported by the Research Council of Norway's Welfare, Working Life and Migration (VAM) program (257603/H20).

Abstract

The recent inclusion of behavioural conditionality in health-related benefit programmes raises questions about frontline workers' (FWs') discretionary use of sanctioning. Using an experimental vignette design in a survey of 824 FWs in the Norwegian Labour and Welfare Administration (NAV), we investigated whether FWs' perceptions of diagnosis and sick recipients' obligations affect their propensity to sanction for non-compliance. We find that the recipients' diagnoses did not influence FWs' propensity to sanction for non-compliance. Recipients with a symptom diagnosis (ME/CFS) were sanctioned to the same degree as those with a diagnosis based on objective medical evidence (Bekhterev's disease). However, FWs who generally found it difficult to impose activity requirements on recipients with health-related problems were also less prone to enact sanctions. Our results support the notion of competing approaches to activating and sanctioning the sick. FWs who agree that it is difficult to activate the sick also tend to avoid sanctioning, whereas the propensity to sanction is more widespread among those who disagree that activating the sick is difficult.

KEYWORDS
activation, behavioural conditionality, disability, health problems, sanctions, sick role, subjective symptoms, vignette experiment

[The copyright line for this article was changed on 30 March 2022 after original online publication]

1 | INTRODUCTION

A trend in European welfare policies is the turn towards activation and behavioural conditionality (van Berkel et al., 2017). The policy aim is to steer the client's conduct towards activity and return to work. Hence, recipients of benefits are increasingly obliged to behave in prescribed ways in accordance with activity requirements. The recipient must actively contribute to the process of returning to work, including work training and other activities. Failure to comply may result in reduction or termination of the recipient's benefits. Although initially restricted to recipients of unemployment benefits, the target group for behavioural conditionality has been expanded to include recipients of health benefits, that is, those not working because of sickness or disability. This expansion creates new challenges for frontline workers (FWs) that have scarcely been examined (Geiger, 2017).

A central challenge in this regard, is FWs' assessment of the recipients' health issues and their ability to meet the expectation of participating in activity requirements and work. However, few studies have examined how FWs' conception of what Talcott Parsons (1951) called the clients' *sick role* affects their propensity to impose sanctions. The sick role refers to when a person is declared sick and is thereby exempt from normal obligations and from blame for their present state (Parsons, 1951). However, the sick person is also expected to seek qualified help and to cooperate with physicians or other qualified therapists "in the process of trying to get well" (Parsons, 1951, p. 456). What, then, are FWs' perceptions of whether sick recipients can legitimately be required to participate in activity and work? And does their propensity to sanction vary with the recipient's diagnosis? Different diagnoses are valued differently, affecting how patients are understood by doctors (Album et al., 2017) as well as lay persons (Geiger, 2021; Grue et al., 2015). There has, however, been scant investigation of whether diagnoses are also important at the welfare administration's frontline.

This article examines FWs' discretionary administration of welfare conditionality for recipients of health benefits. Previous studies indicate that FWs' perceptions of welfare reforms, as well as recipients' attributes, affect their assessments and decisions (Schram et al., 2009; Torsvik et al., 2021). Our study explores the importance of workers' perceptions of both the sick recipients' attributes and obligations within the context of an activation scheme.

To that end, we conducted an experimental study with a vignette design in a survey of 824 FWs in the Norwegian Labour and Welfare Administration (NAV). FWs in NAV are the day-to-day implementers of a scheme called Work Assessment Allowance (WAA)—a time-limited maintenance scheme for clients with reduced work capability. The eligibility criterion for WAA is that impaired work capability must be primarily due to illness, injury or defect. However, the receipt of benefits is conditional on the recipient's active contribution to the process of returning to work. The importance of FWs' perceptions of sick recipients' attributes and obligations for their sanctioning practices is therefore of great interest.

2 | DISCRETION, SICKNESS, AND WORK

In this study, we examine how FWs respond to recipients' health issues when they assess non-compliance with activity requirements. As street-level bureaucrats (Lipsky, 2010), FWs interact directly with citizens and have discretion in the execution of their work. To have discretion means to have some freedom of choice delegated by a higher authority. FWs' "space for discretion" (Molander, 2016) is restricted by political aims, legal rules and professional standards. Within this space, however, there is an expectation that FWs act in accordance with their best judgement, which also includes their preferences, attitudes and interpretations of clients' attributes (Baviskar & Winter, 2017; Jilke & Tummers, 2018).

The role of street-level bureaucrats in implementing behavioural conditionality differs somewhat from that of assessing eligibility and administering social protection. The aim of behavioural conditionality is to steer the recipient's conduct towards activities with the aim of returning to work. Three key characteristics are: *behavioural requirements* (skill-enhancement courses, trainee work, etc.) are a condition for continued receipt of benefits; compliance with the requirements is assessed through *monitoring and verification processes*; and *sanctions* are indicated for

non-compliance (Watts & Fitzpatrick, 2018 p. 31). The street-level bureaucrat is expected to choose activity requirements adjusted to the individual recipient, conduct "surveillance" of the recipient's fulfilment and assess whether breaches of activity requirements should be sanctioned or not. An important question is to what extent the introduction of welfare conditionality differs depending on whether the recipient is perceived as "sick" or "unemployed".

The literature on conditionality and sanctions is mainly about social assistance and unemployment schemes, and can be grouped into studies of political reforms, implementation, and effects. Most studies are of changes and variations in welfare schemes (Clasen & Clegg, 2011; Eichhorst et al., 2008; Langenbucher, 2015; Watts & Fitzpatrick, 2018), but there are also studies of whether sanctions improve the transition from welfare to work (e.g. Arni et al., 2013; McVicar, 2020; Van der Klaauw & Van Ours, 2013). This study examines challenges related to implementation in the frontline, which has received less attention.

2.1 | Sick versus unemployed

The expansion of behavioural conditionality to include sickness and disability is part of a more general ambition to align health-related benefits with unemployment benefits (OECD, 2010). A criticism of health-related benefits, with its focus on medical diagnosis and loss of function, is the emphasis on claimants' lack of work capability. Rather, it is claimed, attention should be directed towards their remaining work capacity. Like the unemployed, recipients of health-related benefits should be required to participate, for example, in training and job-search activities (OECD, 2010). The overall aim is promotion of labour market participation, and the political ambition is to reduce the difference between being unemployed and being out of work due to health problems.

This ambition may blur important differences between unemployment and sickness. For instance, the unemployed are often considered more or less responsible for their predicament, and are expected to demonstrate motivation and willingness to participate in activities and work (Dunn, 2014). When someone is declared sick by a doctor and enters the sick role, however, they are considered blameless for their condition (they cannot just decide to get well) and are exempt from their normal obligations. Instead, they are obliged to do what they can to get well and seek appropriate (medical) assistance (Parsons, 1951, pp. 455–456). Sickness is therefore more ambiguous with regards to norms of activity and work, and FWs might consequently feel less inclined to sanction the sick. Moreover, FWs' inclinations may vary according to *types* of sickness (diagnoses) since the different types may be found more or less compatible with activity and work.

Generally, there is a lack of knowledge about how the FWs in the welfare administration handle those who are out of work and have health problems. Research indicates that the main challenges for FWs working with sick recipients are capacity assessment and setting reasonable activity requirements (Geiger, 2017; Gjersøe, 2016), and it is assumed that implementing conditionality for this group is experienced as more difficult than for the unemployed (Geiger, 2017). Regarding the latter, previous studies indicate that FWs' perceptions of recipient attributes and attitudes—such as ethnicity, unfavourable behaviour, and personal responsibility—affects their decisions approach to conditionality and sanctioning (De Wilde & Marchal, 2019; Schram et al., 2009; Terum et al., 2018; Torsvik et al., 2021). Less is known, however, about the importance of health-related factors on FWs' decision making.

To further our understanding of the recent inclusion of behavioural conditionality in health-related benefit programmes, we examine FWs' propensity for sanctioning in light of whether the imposition of activity requirements is perceived as compatible with the sick recipient's obligations, as expressed in the sick role. Moreover, we examine whether sanctioning practices depend on the type of medical diagnosis that the FWs encounter.

2.2 | Does frontline workers' perception of activating sick recipients' matter?

All recipients of the WAA have health issues. Our first objective is to examine whether FWs' perception of activating sick recipients of WAA affects their propensity to sanction non-compliance with activity requirements.

The recent inclusion of behavioural conditionality in health-related benefit programmes can be framed as a transition from welfare to workfare, or from *decommodification* to *re-commodification* (Papadopoulos, 2005). Decommodification "refers to the degree to which individuals, or families, can uphold a socially acceptable standard of living independently of market participation" (Esping-Andersen, 1990, p. 37). In a decommodified scheme, diagnosed impairments are grounds for exemption from labour market participation. This approach has been criticised for overemphasising diagnoses and taking sickness as indicative of a complete rather than gradual loss of capacity for work (Mabbett, 2003; OECD, 2010). Recommodification, in contrast, aims to enhance recipients' employability and stimulate increased labour market participation (Papadopoulos, 2005). The key concern is to activate the sick recipient's remaining work capacity, which challenges the traditional view of the link between sickness and work capacity. Making use of the individual's residual working capacity is considered important for society and a contribution to make sick and disabled people's lives better (Geiger, 2017; WHO, 2011). Accordingly, benefits should be made conditional on training and activity requirements, and entitlement to alternative decent income maintenance should be restricted.

Despite the growing political emphasis on recommodification (activation policy) in Norway, the eligibility criteria in benefit schemes have only marginally been adjusted and social protection is still comprehensive (Molander & Terum, 2019). Furthermore, general practitioners (GPs) and medically driven reasoning remain important in the assessment of entitlement to benefits (OECD, 2019; Rasmussen, 2020). What we do not know, however, concerns the degree to which different approaches at the policy level coexist among non-physicians at the street level, and whether various perceptions of activating the sick affect their sanctioning practices. In line with recommodification, imposing activity requirements matches the overall goal of encouraging labour market participation, while, in line with decommodification, the imposition of activity requirements on sick recipients would be more ethically challenging. Our assumption is that those taking the latter position will be more reluctant to sanction for non-compliance, too.

2.3 | Does diagnosis matter?

As all recipients of the WAA have a diagnosis at entrance to the scheme, our second objective is to examine whether the type of diagnosis affects FWs' propensity to sanction non-compliance of activity requirements.

In a medical context, diagnoses are important. They classify not only diseases, but people, and are awarded different status and prestige (Album et al., 2017). Among other factors, high prestige is typically given to diseases that have objective diagnostic signs, meaning that, on average, objective complaints are held in higher regard than subjective complaints (for a more elaborate list of criteria, see Album et al., 2017). Objectivity and physical evidence hold a central place in modern medicine by marking the line between conjecture and fact (Album et al., 2017; Meershoek et al., 2007). Without any objective findings, the credibility of the patient's complaint may be questioned (Meershoek et al., 2007; Rasmussen, 2020).[1] In such cases, doctors may doubt the legitimacy and severity of a patient's complaint and possibly their own professional competence (Howman et al., 2016; Woivalin et al., 2004). Patients may also feel distrusted and struggle to convince their doctor that the symptoms are real (Aamland et al., 2013; Werner & Malterud, 2003). The objective/subjective dimension is therefore also, empirically speaking, a moral dimension; it is a matter of trust, credibility and responsibility. Whereas physical evidence can relieve patients of the burden of their predicament, a lack of evidence may raise questions of blame and responsibility (Scambler, 2009).

Vignette studies have shown that GPs are more reluctant to grant sick leave for patients with a "psychological" diagnosis (Werner et al., 2016). Generally, the diagnosis is an important predictor of certified sick leave and symptom diagnoses imply shorter sick leave (Starzmann et al., 2015). Deciding the level of work-related limitations to functioning may be especially difficult for patients with symptom diagnoses and physicians are divided in their initial assessments of these patients (although research suggests the potential for reaching a broader consensus) (Weerdesteijn et al., 2017).

The importance of the diagnosis for the GP's assessment notwithstanding, it is not given that this would apply to non-physician assessments in the welfare administration. In addition, physicians have a more pivotal role in the entitlement to benefits than in the assessment of sanctions. Even though diagnoses are important for determining eligibility, therefore, they are not necessarily important when non-physicians decide whether to sanction.

To examine whether the type of diagnosis affects non-physician FWs' inclination to sanction, we differentiated between two vignettes in a survey experiment: one recipient with a subjective somatic complaint (ME: myalgic encephalomyelitis/CFS: chronic fatigue syndrome) and one recipient with a diagnosis based on objective medical findings (Bekhterev's disease: ankylosing spondylitis). If FWs, like physicians, accord less credibility and more responsibility to people with subjective complaints, the assumption is that the ME/CFS vignette is treated more strictly than the Bekhterev's vignette; that is, the recipient diagnosed with ME/CFS will be sanctioned more often than the recipient with Bekhterev's disease.

2.4 | The legal and institutional context

Introduced in Norway in 2010, WAA is a time-limited maintenance scheme (3 years) for people whose work capability is impaired by at least 50% due to health problems. Receipt of WAA is conditional on recipients' active contribution to the process of returning to work by: participating in preparing an activation plan; completing activities specified in the plan; and attending meetings with NAV employees. Our study's topic is the 2018 amendment which permitted FWs to impose sanctions. Specifically, they may decide to make a minor (1 day) benefit reduction when recipients, without reasonable grounds, fail to comply with the requirements. Termination of the allowance is possible but a more comprehensive process that requires authority beyond the local office. Our study is limited to the minor benefit reduction that can be decided by FWs at the local level.

While on paper WAA in Norway has been characterised as one of the most activating disability schemes worldwide (Geiger, 2017), it seems to be "softer" in practice. FWs must balance the imposition of activity requirements and sanctions with the fact that the recipients have reduced work capability due to health problems. In a comparative study, implementation of WAA in Norway has been classified as a "passive system" with low conditionality and weak links between conditionality and rehabilitation. This contrasts with "active systems" that have high conditionality and a strong rehabilitation link, such as the Danish and Dutch schemes (Geiger, 2017).

Administration of the WWA is delegated to NAV, which also administers sickness, disability, and unemployment benefits, as well as the social assistance scheme. Every year, approximately 20% of the working-age population (16–66 years) in Norway receives benefits administered by NAV, 16% are recipients of health-related benefits and 4% are recipients of unemployment benefits (Kann & Sutterud, 2017). A large proportion of WAA recipients experience subjective somatic complaints, and nearly 30% of recipients aged 30–49 years have a muscular and/or skeletal disorder as their main diagnosis (NAV, 2017). Enforcing sanctions on these recipients is challenging partly because FWs are unsure about the recipient's work capacity and what is the right thing to do, and because they fear undermining the relationship with the recipient (Gjersøe, 2016).

FWs in NAV are gatekeepers of social rights and obligations. Most have higher education (minimum three years from the university level), mainly in the social sciences. The WAA Act delegates to them the authority to decide which activity requirements should be made and when non-compliance should be sanctioned. Medical experts have a central influence on entry into the WAA, but they have only a peripheral role in assessing activity requirements and sanctions.

3 | DATA AND METHODS

In general, few quantitative studies have been conducted on those who administer welfare-to-work programmes (van Berkel, 2017). Our study was designed as a survey distributed online to 3228 FWs from a representative sample

of 107 NAV offices in Norway. The same sample of offices participated in surveys we conducted in 2011 and 2015. Permission was granted by the Directorate of Labour and Welfare. Respondents were informed that one of our aims was to study discretionary decision-making. The response rate was 51% ($N = 1646$). Only those who confirmed having experience administrating WWA ($N = 824$) got access to the vignette, which constitute the analysed sample. In addition to decisions in vignette cases, attitudes towards behavioural conditionality, educational background and other demographic factors were included in the survey.[2] Statistical analysis was performed using STATA software (version 15.1; STATA Corp., College Station, TX, USA).

3.1 | Perceptions of activating sick recipients

The FWs' propensity to sanction might be affected by their view of what to expect of sick recipients, and by extension, their basic understanding of the relationship between the recipients' sick role, on the one hand, and work and activity, on the other. Varied perceptions of what should be required of sick recipients are a complex phenomenon and, ideally, we would have preferred to study this issue using a validated index. In this explorative study, however, we make a first attempt to examine this phenomenon by asking the respondents whether they agree with the statement: "It is difficult to impose activity requirements on recipients of WAA when you know they have an injury or illness". The answer categories range from 1 (*strongly disagree*) to 5 (*strongly agree*).[3] Although this cannot tell us what FWs generally think is required of sick recipients, it does provide an indication specifically of their perception of activating such recipients.

In the analyses in Tables 2 and 3, the independent variables are not randomly distributed. Hence, we control for the following independent variables: *sex* (0 = female, 1 = male), *age* (range 20–70 years),[4] *tenure at NAV* (0 = <2 years, 1 = 2–5 years, 2 = 6–10 years, 3 = 11–20 years, 4 = >20 years), *office size* (range 2–214 employees), *percentage of WAA recipients in the municipality* (range 1.1%–5.1%) and *municipal centrality* (geographical position seen in relation to urban settlements, 0 = low degree of centrality, 6 = high degree of centrality[5]).

3.2 | Diagnoses: Experimental design

Using experimental methods in studies of street-level bureaucrats is uncommon (but see De Wilde & Marchal, 2019; Jilke & Tummers, 2018; Schram et al., 2009). In vignette experiments, respondents are asked to read and respond to a case story that describes a person or social situation. The vignette design allows one to manipulate potential causal factor(s) within the framework of a traditional survey. While the method cannot be used to determine the occurrence of sanctioning, it is suitable for studying conditions that may affect how likely street-level Bureaucrat's are to impose sanctions. In our study, the vignette described a case of a WAA recipient (Marianne) who was required to participate in work training, arranged as a follow-up measure by an external contractor (see Box 1). We constructed two versions of the vignette, which were identical except for the recipient's diagnosis and related symptoms. The two versions were randomly assigned to the respondents.

Randomisation is a clear advantage of vignette studies in that all respondents have the same chance of receiving the different vignettes. On average, this makes the respondent groups similar except for the factor altered. Hence, causality claims are more robust than in traditional survey research. At best, vignette studies combines the internal validity of experiments and the external validity of representative population surveys. However, since one cannot be sure that the participants' vignette responses reflect their real-life attitudes and actions, the external validity can be questioned (Barabas & Jerit, 2010). For example, publics discourse can make FWs especially sensitive to cases with contested diagnoses; consequently, they may provide "correct" answers if they recognize such diagnoses in a vignette. However, social desirability bias is probably less prevalent in experimental vignette studies than in studies of sensitive subjects using more traditional methods (Janus, 2010). Our case also had the advantages of exploring a

BOX 1 WAA vignette

Marianne Haugen has received the Work Assessment Allowance for the past 22 months. She is 41 years old and has previously worked in kindergartens and as a personal assistant. She has often been absent because of sickness in her previous jobs. Diagnostic tests have been performed, including blood tests and MR imaging **[but no medical cause has been found // which has shown radiological changes in the pelvis and vertebral column]**. Marianne was diagnosed with **[ME/CFS (chronic fatigue syndrome) // Bekhterev's disease]**. After having her third child 4 years ago, Marianne has not worked. She has gone through work capability assessment and the conclusion was that a close follow-up measure, directed towards the labour market, would benefit her. She now participates in follow-up work training, and the counsellor has arranged work training at an office. Marianne has contacted you and says that it has been difficult for her to attend because she has been **[lacking energy, tired and unfocused because of the ME/CFS // stiff, sore and experiencing hip and back pain because of Bekhterev's disease].** However, you have not received a medical certificate. The GP has sent a dialogue message after being asked by NAV and has confirmed that Marianne is **[powerless and unfocused // stiff and sore]**, but also writes that NAV must decide whether she should continue the work training. As the NAV counsellor, you have been informed by the work training organiser that Marianne has not attended training in the past weeks as agreed, even though the work training has been adjusted to her situation.

specific situation that was well known to the respondents and using a relatively simple case wherein the alternatives were limited to sanctioning or not sanctioning.

Half of the respondents received vignette version (a), where the recipient is diagnosed with ME/CFS (coded "A04" in the International Classification of Primary Care), while the other half received version (b), where the recipient is diagnosed with ankylosing spondylitis, better known as Bekhterev's disease (coded "L88"). Both diagnoses are widely represented among WAA recipients (NAV, 2019), and both are characterised by a sizeable variation in symptom severity (Chu et al., 2019; Sieper et al., 2002). In version (a) (ME/CFS), no objective medical evidence was found, and Marianne is described as lacking energy, tired and unfocused. In version (b) (Bekhterev's disease), radiological changes were identified, and Marianne is described as stiff, sore and with hip and back pain. The vignette is displayed in Box 1, and the alternative wording of versions (a)/(b) is highlighted in bold.

Each respondent was given only one vignette and were asked to decide whether to impose a sanction (i.e., reduce Marianne's benefits). Because the method requires that respondents take the time to consider before responding, we excluded six respondents who took less than 30 seconds to evaluate the vignette and the following question about their certainty about their decision (cf. Kootstra, 2016).

We also asked how certain they were about their decision to sanction or not. About 30% reported that they were uncertain about their decision, independent of which vignette they received (see Appendix S1 for details). This indicates that the presence of a clinical diagnosis may cause some uncertainty regarding the expectations that can be set for sick recipients. However, it is important to note that the majority reported no uncertainty about their decision, even though the described recipient had health problems.

The recipient in our vignette had already received an official diagnosis and been granted the WAA, which may signal approval of the health problem and reduce the uncertainty often associated with subjective somatic complaints, such as ME/CFS. Information about diagnosis may also affect respondents' assessments of what ought to be the consequence of failure to meet the activity requirement. Based on previous findings among physicians (Album et al., 2017; Woivalin et al., 2004), our assumption in constructing the vignettes was that information indicating a symptom diagnosis (ME/CFS) would increase the FWs' inclination to sanction.

3.3 | Analyses

In Table 3, we use a linear probability model (LPM) to estimate the relationship between *perception of activating sick recipients with health issues* and *probability of sanctioning*. The interpretation of the coefficients from the LPM is akin to that of an OLS model. Although LPM have several limitations (Long, 1997), the results from LPM models are easier to interpret compared to a logistic regression and bypasses the problems of using a logistic regression model described by Mood (2010). For our models, logistic regressions, average marginal effects and LPM offer substantially equivalent findings. In Table 2, we use an ordinary least square regression model (OLS).

We generally did not find systematic differences in the background characteristics of the respondents who received the different versions of the vignette. This is as expected because they were randomly distributed across the two versions of vignettes, and the background characteristics were assumed not to interact with the experimental manipulations (Mutz, 2011). There was one exception in that male respondents received the Bekhterev's disease version of the vignette slightly more often. However, because the sex of respondents did not correlate with the tendency to sanction, this was not likely to have affected our results. Generally, we found low correlations between the background variables and the tendency to sanction. Hence, inclusion of control variables was not considered to be necessary (see the Appendix S1 for details).

4 | RESULTS

First, we examine FWs' propensity to sanction breaches of activity requirements considering their perception of activating sick recipients. We then look specifically at whether sanction practices depend on the type of medical diagnosis FWs' encounter.

4.1 | Importance of perception of activating sick recipients

NAV FWs are far from unanimous in their decisions. In our study, 43% of respondents decided to sanction, while 57% did not. This is not surprising given that the vignette was designed to describe a case where the decision to sanction was not clear-cut, which should ensure variation in the responses. What we found is that FWs' decisions varied widely in this case, and more importantly, that their decisions correlated with their position on activating sick recipients. Table 1 shows that NAV FWs are divided with respect to imposing activity requirements on recipients with health issues. While almost half of the respondents (48%) perceived this as difficult (answer categories 4 + 5), 44% did not find this especially difficult (answer categories 1 + 2). Only a minority (7%) chose the middle category 3, reflecting a neutral or undecided perception of imposing activity requirements on the sick and injured.

Next, we examine whether the perception of activating sick recipients varies according to the FWs' individual characteristics and/or characteristics of the office and municipality.

Table 2 shows that the older FWs and those who work in larger offices find it less difficult to impose activity requirements on recipients with health issues. However, the differences are small. For example, when asked whether

TABLE 1 Frontline workers' perception of activating sick recipients

Answers to the question "It is difficult to impose activity requirements on recipients of WAA when you know they have an injury or illness" ($N = 558$)				
1 strongly disagree	**2**	**3**	**4**	**5 strongly agree**
12.7%	31.7%	7.2%	41.0%	7.3%

it is difficult to impose activity requirements on recipients with health issues, a 50-year-old FW is likely to score 0.4 points lower than a 30-year old on a scale from 1 to 5. None of the other characteristics were significant. This means that neither sex, age, proportion of WAA recipients in the municipality or municipal centrality, correlated with the perceptions of activating sick recipients.

Our next question is whether FWs' perception of activating sick recipients correlates with the propensity to sanction. Table 3 shows the results of a logistic regression of attitudes towards imposing activity requirements on the propensity to sanction recipients.

Table 3 shows that FWs who generally found it difficult to impose activity requirements on sick recipients also chose to sanction less often when confronted with non-compliance with activity requirements (model #1). In model #2, we can see that this pattern is also present when we compare individuals with similar background characteristics. The background variables generally provide quite few significant findings: sex, age and tenure do not correlate with the tendency to sanction the recipient. However, FWs in areas with a large proportion of WAA recipients chose less often to sanction recipients who failed to meet the activation requirements. Moreover, those who are working in more central areas tend to sanction more often. There is also a tendency towards those working in larger offices sanctioning more seldom, but this difference is small.

TABLE 2 Perception of activating sick recipients dependent on individual and office characteristics. OLS regression ($N = 612$)

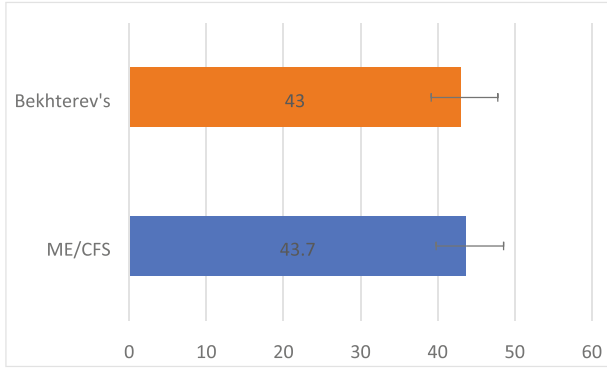
	Coeff.	95% CI
Sex (0 = female)	−0.08	−0.32 to 0.16
Age	−0.02***	−0.03 to −0.01
Tenure	−0.04	−0.14 to −0.05
Office size	−0.003**	−0.01 to −0.00
Proportion of WAA recipients in municipality	−0.02	−0.15 to 0.18
Municipal centrality	0.01	−0.10 to 0.11
Constant	3.29**	0.65 to 1.25

Note: Adjusted $r^2 = 0.05$. *$p < 0.05$.
**$p < 0.01$; ***$p < 0.001$.

TABLE 3 Probability of sanctioning dependent on perception of activating sick recipients with health issues and background variables

	Decision to sanction model #1		Decision to sanction model #2	
	Coeff.	95% CI	Coeff.	95% CI
Perception of activating sick recipient	−0.05**	−0.08 to −0.02	−0.05**	−0.09 to −0.02
Sex (0 = female)			0.04	−0.07 to 0.14
Age			−0.00	−0.00 to 0.01
Tenure			−0.03	−0.07 to 0.01
Office size			−0.001**	−0.00 to 0.00
Proportion of WAA recipients in municipality			−0.11**	−0.18 to −0.04
Municipal centrality			0.05*	0.01 to 0.10
Constant	0.52	0.44 to 0.60	0.78***	0.47 to 1.12
N	539		530	

Abbreviation: LPM, linear probability model.
*$p < 0.05$; **$p < 0.01$; ***$p < 0.001$.



N = 421 (ME/CFS), 401 (Bekhterev's disease). $t(820) = 0.163$, $p = 0.871$.
Note: The horizontal lines at the right side of the bars show 95% confidence intervals.

FIGURE 1 Decision to sanction according to the recipients' diagnosis. Percentage of respondents who decided to sanction. $N = 421$ (ME/CFS), 401 (Bekhterev's disease). $t(820) = 0.163$, $p = 0.871$. The horizontal lines at the right side of the bars show 95% confidence intervals [Colour figure can be viewed at wileyonlinelibrary.com]

4.2 | Importance of the diagnosis

Figure 1 shows that the recipients' diagnoses did not influence FWs' decision to sanction, which is somewhat unexpected. About 43% of FWs chose to sanction regardless of the diagnosis. Both the overlapping confidence intervals and the *t* test results show that the difference between the two groups was not significant.

5 | DISCUSSION

As street-level bureaucrats, FWs in NAV have a "discretionary space", which is surrounded by political aims, legal rules, and professional standards. Within this space, FWs are expected to act in accordance with their best judgement, which also includes their preferences, attitudes and interpretations of client attributes.

5.1 | Perception of activating sick recipients

The political decision to align health-related benefits with unemployment benefits implied an expansion of behavioural conditionality to include sick recipients. As street-level bureaucrats in NAV, this makes FWs' understanding of the sick role in the context of behavioural conditionality an important issue, and with it, their notion of what should be required by sick recipients in terms of activity and work.

Our results indicate that FWs are divided in their perception of whether it is appropriate to impose activity requirements on recipients with a known injury or illness. Interestingly, relatively few of the FWs placed themselves in the middle of our scale (Table 1): 93% either disagreed or agreed that it is a difficult choice, thereby splitting respondents into two relatively even groups. This might be taken as empirical support for the notion that there are two competing approaches to activating the sick among FWs (Bonoli & Natali, 2011; Papadopoulos, 2005; van Berkel et al., 2017). Agreeing that activation of the sick is difficult is more in line with the assumption that sickness gives legitimate reasons for exemption from participation in the labour force (decommodification). Disagreeing is more in line with the assumption that making use of the remaining work capacity contributes to improving the lives of the recipients and the productivity of society (recommodification).

Alternatively, and in light of findings that FWs struggle to determine work capacity and appropriate measures in individual cases (Geiger, 2017, Gjersøe, 2016), our respondents might simply be expressing their struggle to determine the appropriate activity requirements for sick recipients. Counter to such an interpretation, however, are two factors. First, the vignette story emphasised that the choice of activity requirement was carefully adapted to the recipients' situation and that the doctor does not oppose this measure but leaves to the FW to decide whether work training should continue. Thus, the choice of activity requirement does not seem to be the issue. Second, our finding of a correlation between respondents' perception of activating sick recipients and their propensity to sanction. Those who agreed that it is difficult to activate the sick were also less willing to sanction for non-compliance. Correspondingly, those disagreeing were more likely to sanction.

It is our assumption that these approaches live side by side among the FWs. This means that the FWs operate with opposing views on what to expect from recipients occupying the sick role, corresponding to two analytically distinct approaches to welfare policy. While the sick person's obligation to do what one can to get well is what legitimates exemption from their normal duties (Parsons, 1951, pp. 455–456), that obligation, our findings indicate, can be framed both within a social protection frame and an activation frame. The framing, furthermore, has implications for FWs' sanctioning practices. Future research should critically examine our interpretation by using an index that better manages to measure FWs' various normative perceptions of activating sick recipients.

5.2 | Medical diagnosis

Unlike their views on activating the sick, the type of diagnosis does not seem to be important for the FWs' propensity to sanction. Influenced by previous studies from a medical context, we expected that the subjective diagnosis would be sanctioned more, because of the known association between absent objective evidence, on the one hand, and doubts, uncertainty and moral blame, on the other (Album et al., 2017; Howman et al., 2016; Woivalin et al., 2004). A study of lay perceptions of disability benefit claimants' relative 'deservingness' also suggest the importance of diagnosis: Based on a vignette study with Norwegian (and UK) laypersons, Geiger (2021) constructed a "hierarchy of deservingness" in which "medical legitimation—both a sick note and a diagnosis—strongly raises deservingness perceptions (…), while describing claimants as blameworthy for their symptoms/impairments strongly reduces them (…)" (p. 11). In our study, however, the results showed no difference in the degree of sanctions proposed between recipients with a symptom diagnosis (ME/CFS) and those with a diagnosis based on objective findings (Bekhterev's disease). Given the evidence that uncertainties and contestation are associated with a lack of objective medical evidence (Scambler, 2009), this finding is surprising. Why, then, did we not find a difference?

One possible explanation may be that diagnoses are of varying degrees of importance for decision-making for different kinds of FW. Unlike physicians, it does not seem important to NAV's FWs when imposing sanctions. From the perspective of the FW in this context, the more important question is what one might expect from the recipient *despite* the diagnosis.

However, the relative unimportance of diagnoses for decisions about sanctioning does not mean that diagnoses are generally of scant importance in the assessment of entitlement to benefits. Granting of the WAA, which requires medical legitimation, can serve to remove or limit the doubt that is typically associated with subjective somatic complaints. That is, receiving WAA implies medical approval of the recipient's health problem. The fact that the recipient in our vignette had already passed this hurdle may explain why we found no difference. In other words, as long clients have not yet been granted a benefit that requires medical legitimation, FWs are quite possibly as doubtful of subjective complaints as doctors and the general public have been found to be. Further studies of the importance of the diagnosis at the initial stages of WAA and other welfare benefits may help to resolve this matter.

Another possible explanation is that perceptions about the ME/CFS diagnosis have improved either because of the work of NGOs promoting the diagnosis and patients' rights or that of medical doctors and associations that promote the legitimacy of the patients' symptoms. In Norwegian mass media, several documentaries have focused specifically on

the sickest patients diagnosed with ME/CFS. Recipients with ME/CFS may be increasingly seen as incapable of working and in need of total rest, rendering nonapplicable the primary motivation behind sanctioning, namely behaviour conditioning. If adjustment of work conditions and a soft introduction to work are not possible, why sanction?

5.3 | Municipality characteristics

It is noteworthy that FWs in areas with larger proportions of WAA recipients were less prone to sanction. It is unlikely that a low sanction rate in an area will attract citizens to the WAA scheme. It is more likely that a large proportion of WAA recipients might affect FWs' practice. But how?

One interpretation is that, generally, FWs in areas with a high incidence of WAA recipients involve themselves less in individual cases (Zacka, 2017). When they are less involved, the probability of sanctioning also decreases. An alternative, and perhaps complementary interpretation, is that FWs find sanctioning to be time-consuming (Beer et al., 2007). This notion is supported by existing research.

Also noteworthy, FWs in central areas tend to sanction more often than those in less central municipalities. One possible explanation is that sanctioning is harder when you share a community with the recipients. Workers in less central areas have a greater risk of knowing the recipients, knowing somebody who knows them, or run into them at the store. This could make them more hesitant to impose sanctions.

5.4 | Strengths and limitations

A potential weakness of our study is that the two diagnoses differ in a number of ways, for example, in the assumed functional level of people with these diagnoses. Although this would be the case with any experimental diagnostic set, it limits the reliability of our findings. One way of addressing this in further research is to use multiple factorial experiments (Auspurg & Hinz, 2015; Wallander, 2009). Including more vignette manipulations would give further knowledge of which differences between the recipients the FWs are sensitive to (if any). Interesting factors to manipulate include functional level, symptom severity and GP validation. In addition, testing more outcome variables (e.g., the perceived severity of the illness) could shed light on the reasons why the FWs choose (not) to sanction when confronted with different diagnoses.

Additionally, vignette experiments may be criticised as having limited external validity; we do not know whether FWs' real-life decisions would differ from the answers they provide when confronted with a constructed vignette. However, we note that studies from other professions report high validity of vignette studies compared with real-life decisions (Krolak-Schwerdt et al., 2018).

The main strength of our study is the vignette design, which allowed us to draw causal inferences about the importance of the diagnosis and described symptoms (the only condition that varied between vignettes). Another strength is that we were able to survey welfare administrators, an influential group who make decisions that affect clients' everyday life and who are seldom studied using quantitative methods (van Berkel, 2017). Finally, we believe that the case itself—the extension of activation policies to include the sick and disabled—is important and warrants attention, both because of this group's vulnerability and needs, and based on the amount of public spending on benefits. Our study may serve as a starting point for further research on activation of the sick and disabled.

6 | CONCLUSION

The expansion of behavioural conditionality to include sick recipients is part of a more general political ambition in the OECD area to align health-related benefits with unemployment benefits. We investigated FWs'

implementation and thus shed light on the 'missing middle' of welfare policy. First, the study discusses to what degree norms of activity and work directed at the sick are different from those directed at the unemployed. We argue that the sick role is ambiguous with regards to whether activity requirements and work are consistent with being sick or disabled. This ambiguity makes the expansion of behavioural conditionality challenging for the frontline. The study puts forward an argument that competing views on activating the sick exist among FWs, affecting their sanctioning practices. There is a need for further studies of how different perceptions of recipients' rights and obligations affect discretionary practices where "the state meets the street" (Zacka, 2017).

Second, the study examines the meaning of diagnoses, when FWs assess sick recipients' non-compliance with activity requirements. Although we found no effect, further studies of the significance of diagnoses are needed, both at the entrance of health-related benefits and in the administration of conditionality and sanctions. NAV has been publicly accused of discriminating against, and exhibiting a distrustful attitude towards, clients with an ME/CFS diagnosis (Osland, 2019). Although we found no support for this claim in the propensity to sanction recipients, our study involved only one specific situation, that is, the decision to sanction WAA recipients for non-compliance with activity requirements.

Finally, our study suggests that FWs' broader conceptions of just, fair, or reasonable welfare provision affect their decision-making. Given the pivotal role that discretion has at the welfare state's frontline, the current lack of knowledge about the how this discretion is exercised is a major challenge. This study is a response to the demand for more research into FWs' discretionary decision-making practices.

ACKNOWLEDGEMENT

The authors wish to thank Dag Album, Andreea Alecu, Heidi Moen Gjersøe, Gaute Torsvik and members of the career-group at the Centre for the Study of Professions for helpful comments. This paper is part of the project *Between Income Maintenance and Activation: the legitimacy, implementation and outcomes of social security policies* (TREfF2), funded by The Research Council of Norway.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

ETHICAL APPROVAL

The study was approved by NSD - Norwegian Centre for Research Data. The procedures used in this study adhere to the tenets of the Declaration of Helsinki.

DATA AVAILABILITY STATEMENT

The data that support the findings will be available in the data archive of NSD - Norwegian centre for research data (https://www.nsd.no/en/find-data). Due to privacy and ethical restrictions, the data will be anonymized.

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ENDNOTES

[1] The point is not that a client's condition must be fully corroborated by evidence, but that doubt tends to ensue when there is *no* corroborating objective evidence.

[2] The question "It is difficult to impose activity requirements on recipients of WAA when you know they have an injury or illness" was only presented to FWs who had experience administrating the WWA scheme and were working as counsellors/case workers. This extra filter was used because the question was placed in a battery of questions which included queries about a recent change in law, which only those working as counsellors/case workers were considered qualified to

answer. Hence, this question was presented to 629 respondents, out of which 622 (99%) answered. Descriptive statistics for the control variables including non-response is included in Appendix S1.

[3] We note that this question is significantly correlated with the FWs' reports of their own sanctioning practise. Those who find it more difficult to impose activity requirements on recipients who are sick or injured, report that they less often sanction WAA-recipients who fail to comply with the requirements (Pearson $Chi^2 = 19.48$, $df = 8$, $p < 0.05$).

[4] We have also tested a quadratic term of age (age^2) to check for non-linearities in the effect of age, but this turned out not to be significant.

[5] Statistics Norway has classified the municipalities based on geographical proximity to service functions and jobs. Centrality is coded from 0 to 1000 (the Capital city Oslo) and divided into six levels.

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How to cite this article: Bringsrud Fekjær, S., Børve Rasmussen, E., & Terum, L. I. (2022). Sanctioning the sick: Do perceptions of activating the sick and diagnosis matter? *Social Policy & Administration*, *56*(5), 726–741. https://doi.org/10.1111/spol.12790