

Facilitator or enforcer, ally or enemy? Claimant's perceptions of insurers' roles in occupational rehabilitation

Ally or enemy

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Abstract

Purpose – This study aims to deepen the understanding of insurers' role within the return-to-work (RTW) process by uncovering and categorizing the multiple roles assumed by the insurer based on the claimant's perceptions and identifying the underlying mechanisms that explain the relationship between perceived insurer roles and occupational rehabilitation outcomes.

Design/methodology/approach – The author used a qualitative approach with theory-guided content analysis to examine 24 semi-structured interviews with occupational rehabilitation claimants who had undergone occupational rehabilitation within the earnings-related pension insurance system in Finland.

Findings – The author uncovered three perceived insurer roles in relation to other stakeholders in the rehabilitation network: financier, coordinator and leader. These roles have different perceived responsibilities and influences on rehabilitation outcomes. Additionally, the author found four perceived insurer roles in relation to the claimants, which varied according to their democracy and activity levels: ally, facilitator, enforcer or enemy. Based on this study, the author recommends that insurers adopt democratic and participatory actor roles (ally and facilitator) to promote the RTW process in occupational rehabilitation.

Originality/value – This inaugural study applied role theory to insurers within the RTW process, developing a new framework of insurer profiles. This study reveals the dynamic nature of insurers and enhances the understanding of the connections between perceived insurer roles and rehabilitation outcomes.

Keywords Return to work, Insurers, Disability insurance, Occupational rehabilitation, Qualitative research, Insurance companies

Paper type Research paper

Introduction

Disability is a major public health problem, and both researchers and practitioners have recently become more interested managing it. Previous studies have identified a significant number of sociodemographic, medical, economic and psychological factors that affect the probability of an individual returning to work once they have faced disability (Cancelliere *et al.*, 2016). However, few studies have addressed the role of insurers within the return-to-work (RTW) process. This qualitative study contributes to this research gap by uncovering

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and conceptualizing the different roles of insurers within the RTW process and identifying the underlying causal mechanisms that explain the relationship between perceived insurer roles and occupational rehabilitation outcomes. Notably, this study focuses purely on the perspectives of disability claimants.

Literature review

Several studies (Franché *et al.*, 2005a; MacEachen *et al.*, 2010; Nielsen *et al.*, 2013; Sager and James, 2005) have acknowledged the vital role of insurers in the RTW process, referring to them as key stakeholders. Traditionally, the role of the insurer has been limited to the administration of compensation claims (e.g. the assessment of eligibility, cost management and claims fulfillment), but recent developments in disability management and occupational rehabilitation have expanded their activities and roles throughout the RTW process (Franché and Krause, 2002). Today, many insurers are vital when it comes to managing compensation claims, coordinating occupational rehabilitation and overseeing the RTW process, for example, through case managers (Franché *et al.*, 2005a; MacEachen *et al.*, 2010). The literature has often presented the objectives and incentives of disability claimants and insurers as conflicting with one another. Under this paradigm, claimants seek a successful and sustainable RTW process, whereas insurers are supposedly motivated to deny claims (valid reasons permitting) and complete the RTW process at a minimum expense (Franché *et al.*, 2005b). These conflicting objectives frequently frame insurers as workers' foes rather than as their friends. Indeed, the literature has offered evidence of complicated procedures, poor communication and a lack of professional expertise among insurers (Black *et al.*, 2019; Dean *et al.*, 2019). Furthermore, insurers often come across as rulers with the power to dismiss claims or force tests, treatments and rehabilitation measures upon claimants without either listening to or respecting their thoughts and wishes (Lynøe *et al.*, 2011; Strunin and Boden, 2004; Thornthwaite and Markey, 2017). Finally, the literature has reported that claimants can suffer from psychological, financial or social consequences because of the failures in the compensation system (Beardwood *et al.*, 2005; Kilgour *et al.*, 2015) [1].

However, academic research has also indicated that insurers differ significantly in terms of their responsibilities and actions within rehabilitation networks and their encounters with disability claimants (Kilgour *et al.*, 2015; MacEachen *et al.*, 2010). Although most studies have negatively described the encounters between claimants and insurers (Sager and James, 2005; Strunin and Boden, 2004; Upmark *et al.*, 2011), others have reported smooth process flow, customer-oriented approaches, friendly customer service attitudes and active guidance, leading to a supportive process with positive outcomes (Hubertsson *et al.*, 2011; Klanghed *et al.*, 2004; Müssener *et al.*, 2008).

Current theories also suggest that more positive relationships between insurers and disabled workers promote successful RTW outcomes and vice versa. According to empirical studies, negative encounters with insurers are correlated with poor recovery and lower self-rated mood, health and ability to work (Lynøe *et al.*, 2013; Nordgren and Söderlund, 2016). On the contrary, positive claims experiences are associated with positive RTW outcomes (Collie *et al.*, 2019; Lynøe *et al.*, 2013; Nordgren and Söderlund, 2016; Pasanen and Luoma, 2021).

Overall, earlier studies have conceptualized the role of the whole insurance system within the arena of disability risk management (Franché and Krause, 2002; Franché *et al.*, 2005a; Friesen *et al.*, 2001), summarized claimants' views and experiences related to interactions with insurers within RTW processes (Beardwood *et al.*, 2005; Black *et al.*, 2019; Dean *et al.*, 2019; Hubertsson *et al.*, 2011; Kilgour *et al.*, 2015) and connected insurers' actions with

rehabilitation outcomes (Lynöe *et al.*, 2013; Nordgren and Söderlund, 2016; Collie *et al.*, 2019; Pasanen and Luoma, 2021).

Following these reported claimant experiences, we can assume that the perceived roles of insurers within the RTW process are diverse. However, little research has been done on these roles. Despite acknowledging that insurers are not a homogenous group, earlier studies have either discussed the roles of insurers in vague terms or generalized them based on the case studies of individual insurers. This indicates that a comprehensive conceptualization of the perceived roles of insurers is missing from the literature. The author argues that to clarify the dynamics of occupational rehabilitation and reveal opportunities for insurers to promote RTW, greater attention should be directed at the various roles of insurers and possible consequences of the particular roles in the RTW process.

Application of role theory

To understand the perceived roles of insurers in the RTW process, the author applied role theory; and proposed that insurers, as actors, may assume multiple roles. Although its roots are in sociology, role theory has been widely applied, for example, to service research in business contexts (Broderick, 1998; Solomon *et al.*, 1985). Organizations can be seen as the social systems that are formed by individuals; they perform certain roles through the actions of the individuals within them (Katz and Kahn, 1966). In the current study, the author has specifically focused on the social roles enacted by insurers as actors.

Solomon *et al.* (1985) investigated interactive service encounters from the perspective of role theory; they claimed that service interaction can be better understood by considering the specific roles enacted by consumers and service providers as they interact with one another. In their research, they introduced the service script, which is determined by the role expectations that individuals place on both themselves and other actors in a given situation. Crucially, Solomon *et al.* (1985) argued that the adopted roles affect consumer service satisfaction. Broderick (1998) applied the approaches of Biddle (1986) and Solomon *et al.* (1985) to examine the potential importance of role theory to service performance; she explored concepts such as role congruence, which refers to the mutual understanding of role expectations and behaviors, and role discrepancy, which illustrates the differences between planned and actual services (Broderick, 1998).

Since the 1990s, the roles of organizational actors have been studied particularly in network contexts, and studies have identified various network roles, such as architect, leading operator and caretaker (Harland and Knight, 2001; Harland and Knight, 2005; Heikkinen *et al.*, 2007; Snow *et al.*, 2000). On a theoretical level, the role of an organization or individual leader in a network can be very clear. However, on a practical level, a single network player can assume several different roles or fulfill several roles simultaneously (Heikkinen *et al.*, 2007). We can assume that this is also valid in occupational rehabilitation networks.

Disability insurance system in Finland

Although the research has largely targeted the RTW-related roles of insurers within cause-based workers' compensation systems (Kosny *et al.*, 2011; Lippel, 2007), some studies have focused on social insurance officers within disability-based insurance systems (Hubertsson *et al.*, 2011; Lynöe *et al.*, 2011; Lynöe *et al.*, 2013; Müssener *et al.*, 2015) [2]. In Finland, disability insurance is part of statutory social security, which means that the contents of the insurance, including covered loss events and compensation amounts, are specified in legislation. Finnish disability insurance is divided into two social insurance systems: cause-based workers' compensation insurance that is handled by nonlife insurance companies and

disability-based insurance that is overseen by both the Social Insurance Institution and pension providers.

If the illness or injury causing the disability is not work related, the disabled worker is entitled to disability benefits from the Finnish pension insurance system. The pension system relies on national pensions and earnings-related pensions. The national pension covers all people residing in Finland if they meet the minimum requirements related to their time of residence, whereas the earnings-related pensions cover people with earned income. Although the Social Insurance Institution of Finland is responsible for implementing the national pension system, the administration of the earnings-related pension scheme is decentralized. In the private sector, earnings-related pensions are mainly handled by pension insurance companies, which are responsible for the coverage of long-term disability compensation, including occupational rehabilitation [3]. Altogether, four pension insurance companies in Finland take care of the administration of long-term disability compensation claims (e.g. assessment of eligibility for benefits and rehabilitation measures, cost management and oversight of the RTW process). Furthermore, these pension insurers are responsible for coordinating occupational rehabilitative activities. In light of this context, the current study targeted pension insurers and the disability-based insurance system of Finland.

Purpose of the study

The first objective was to create a framework of insurer profiles by examining claimants' perceptions of insurers' roles within the RTW process. The second objective was to gain a deeper understanding of the underlying causal mechanisms that can explain the relationship between perceived insurer roles and occupational rehabilitation outcomes. The research questions were as follows:

RQ1. What roles do claimants perceive insurers to carry out during the RTW process?

RQ2. What underlying causal mechanisms exist between perceived insurer roles and occupational rehabilitation outcomes?

The author created the second question specifically to explore the perceived impact of the insurers' role on rehabilitation outcomes, not to establish or test this assumed causal relationship.

The present study applied role theory to insurers within the RTW process and contributes to the literature in several ways. First, to the best of the author's knowledge, there are no earlier categorizations or conceptualizations of different insurer roles in the literature. Thus, to the best of the author's knowledge, for the first time, the present study uncovered and conceptualized the different insurer roles perceived by claimants within the RTW process. Consequently, the current study assumed the existence of multiple insurer roles, creating a novel framework for perceived insurer roles. This framework enlarges earlier theories related to the role of insurers in the RTW process, demonstrates insurers' ability to act in various roles and facilitates the comparison of different insurers. Second, the current study deepens our understanding of the causal mechanisms that explain the relationship between insurers' actions and rehabilitation outcomes. Furthermore, it illustrates how claimants perceive certain roles and their characteristics as affecting the outcomes of the RTW process.

In practical terms, the current study clarifies the dynamic nature of insurers and shows how insurers can promote RTW by assuming certain roles. Thus, the present study may be particularly useful for insurers who are trying to manage the permanent disability risks of

their clients. Furthermore, the use of role theory enables the evaluation and development of the service script and role expectations within the RTW process. Ultimately, the current study has the potential to help reduce the costs of permanent disabilities for insurance companies, employers and society at large. In 2020, almost 130,000 individuals received disability pensions from the earnings-related pension system in Finland (2.6% of the employed persons), and pension insurers paid disability pensions of almost €1.72bn (0.7% of gross domestic product, GDP) for these individuals (FCP, 2021; OSF, 2021). Furthermore, disability to work has high indirect costs for employers and societies. Rissanen and Kaseva (2014) calculated the potential loss of work contribution because of disability pensions to be €8.0bn per year in Finland (3.4% of GDP), which describes the loss of potential labor input. These high numbers illustrate the need for academic research in this area.

Materials and methods

Participants and data selection

The data consisted of semi-structured interviews with 24 disabled workers who had completed occupational rehabilitation in 2015. The interviewees were selected from the respondents who answered a questionnaire distributed in 2017. This questionnaire was sent to 1,427 individuals who had undergone the occupational rehabilitation process, resulting in 668 responses, with 447 individuals consenting to be contacted for future research. The author obtained basic information on these disabled workers from the KuntoutuNET online service for occupational rehabilitation customer data processing. This online service is used as a communication tool between the subscribers (pension insurers) and producers of rehabilitation services. KuntoutuNET is maintained by a service network of occupational rehabilitation in Finland.

The author used criterion-based, purposive sampling to obtain claimants with different sociodemographic backgrounds and rehabilitation experiences to ensure that the data were detailed and relevant for the research questions (Jupp, 2006). Because it was important to explore both failed and successful rehabilitations, the author used the outcome of occupational rehabilitation as the main selection criterion. The author evaluated rehabilitative success with two variables: “self-assessed work ability” and “employment situation immediately following rehabilitation.” First, the author considered the rehabilitation to be successful if the claimants’ self-rated ability to work remained unchanged or improved during rehabilitation and if they also found employment afterwards. Second, the author considered the rehabilitation to be partly successful if the claimants’ self-rated ability to work improved during rehabilitation but did not find employment afterwards. Finally, the author determined that the rehabilitation failed if the claimants’ self-rated ability to work did not improve during rehabilitation. In addition to these occupational rehabilitation outcomes, the author also used the following factors in purposive sampling: life situation before rehabilitation, age, sex, diagnosis and pension insurance company.

The author selected the interviewees through an open and flexible process, and did not decide on the final number of interviewees in advance. As is typical for qualitative research, the current study’s objectives and research questions determined the required number of interviewees, and the author applied the concept of data saturation. According to Fusch and Ness (2015):

Data saturation is reached when there is enough information to replicate the study, when the ability to obtain additional new information has been attained, and when further coding is no longer feasible.

Initially, the author roughly estimated that 15–30 interviewees would be required based on similar study designs (Beardwood *et al.*, 2005; Black *et al.*, 2019; Hubertsson *et al.*, 2011; Müssener *et al.*, 2015) and method-related literature (Boddy, 2016; Green and Thorogood, 2018; Malterud *et al.*, 2016) that suggested anywhere from 5 to 50 participants as adequate for this kind of qualitative analysis. The final number of 24 claimants fell into this range.

Table 1 displays the descriptive data of the interviewees. Because of the sensitive nature of the data, the author only has permission from the interviewees to link their age, gender and outcome of rehabilitation to their answers. The age range was 28–61 years, with a median age of 52. Most of the interviewees were women (62.5%) and suffered from musculoskeletal disorders (54%). Although their life situation before rehabilitation varied, most (54.2%) were on sick leave. Furthermore, the interviewees had experience with different insurance companies; all four pension insurance companies in Finland (Ilmarinen, Varma, Elo and Veritas) were represented in the sample. Consequently, the purposive sample included claimants with different sociodemographic backgrounds, life situations, rehabilitation experiences and rehabilitation outcomes to ensure a full range of complexity related to the perceived roles of insurers.

The author was specifically interested in the claimants' experiences with the flow of occupational rehabilitation and perceived insurer roles during the different phases of the process. Consequently, the author did not concentrate on understanding the insurers' or other stakeholder's experiences of the RTW process. Thus, they were not interviewed.

Data collection

The author intended the interviews to produce material that was as conversational and narrational as possible, focusing on the claimants' experiences of occupational rehabilitation and the role of the insurer. The author chose semi-structured interviews as the research method to balance the interests of the researcher and participants with predefined themes while still permitting both parties to remain responsive and flexible. Thus, both parties could move across themes, add new themes and ask new questions about emerging topics (Nathan *et al.*, 2019). The interview guide covered the entire rehabilitation process in chronological order (Table 2) to make it easier for the interviewees to remember the different stages and their emotional states during rehabilitation. Consequently, the insurer's role was also thoroughly described at different stages of the rehabilitation process.

The interviews were conducted by telephone in July 2018. Because the claimants lived all over the country, the author chose to conduct telephone interviews. Furthermore, the research interviews were preceded by three pilot interviews. Because these pilot interviews made no major changes to the interview guide, the author eventually included them in the

Informant number	Rehabilitation succeeded		Informant number	Rehabilitation partly succeeded, partly failed		Informant number	Rehabilitation failed	
	Age	Gender		Age	Gender		Age	Gender
1	30	Female	9	28	Male	17	38	Female
2	34	Male	10	33	Female	18	46	Male
3	37	Male	11	47	Female	19	47	Female
4	45	Male	12	52	Female	20	56	Female
5	46	Female	13	53	Male	21	57	Male
6	52	Female	14	53	Female	22	58	Female
7	53	Female	15	53	Female	23	60	Male
8	56	Male	16	61	Female	24	61	Female

Table 1.
Description of the claimants of the study

Theme	Subtheme/Question
Background information	Level of education? Career and occupation before the rehabilitation?
Before the occupational rehabilitation	The cause of disability? The rehabilitation initiative – How, when, who was involved? – The content of the initiative? – The role of the insurer? Rehabilitation motivation, expectations and goals? Compensation decision – Thoughts, pros and cons?
During the occupational rehabilitation	Rehabilitation plan – How, when, who was involved? – The content of the plan? – The role of the insurer? Rehabilitation measures – How, when, who was involved – Evaluation: pros and cons – The role of the insurer? Follow-up control – How, when, who was involved – The role of the insurer?
After the occupational rehabilitation	Life situation? Employment situation? Ability and motivation to work?
Evaluation of the occupational rehabilitation	How would you describe the role of the insurer in occupational rehabilitation as a whole; why? How would you rate the success of the occupational rehabilitation for you; why? On your opinion, what explains the outcomes; why? How would you describe the role of the insurer in terms of outcomes; why? Where did the insurer succeed/failed; why? Comments, development suggestions, questions?

Table 2.
Interview topic list

actual research material. The claimants were contacted about a week prior to the interviews. The author told them how and why we had obtained their contact information. In addition, she briefed them on the most important aspects of the research, its objectives, its use of data and its guaranteed anonymity. All of the contacted informants agreed to the interviews.

All interviews were conducted by the same author, who has extensive knowledge of the cause-based disability insurance system and occupational rehabilitation in Finland, in addition to experience conducting telephone and in-person interviews. The interview duration ranged from 19 to 61 min (with an average duration of 43 min), and the interviews were recorded and transcribed verbatim (with minor corrections made to improve readability).

Data analysis

The author selected qualitative theory-guided content analysis as her analytical method, and the analysis process followed the examples presented in [Gläser and Laudel \(2013\)](#) and [Krippendorff \(2013\)](#). Analysis of the transcribed interview data consisted of three overlapping steps: classification, analysis and interpretation. Initially, the author listened to

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the recordings and repeatedly read the transcripts to ensure accuracy during transcription and achieve an overview of the data. Data classification began with the identification of the relevant sentences and phrases, which were then sorted into meaningful units and labeled with codes. The author used a bottom-up coding scheme to analyze the interview data. The first step was to find relevant text passages from the transcribed data, which were then paraphrased in the second step and combined into third-level categories. Table 3 contains a few examples to illustrate how the data classification was executed to form the third-level categories.

The first two steps of this process (finding meaningful text units and paraphrasing them) were purely data driven. In the third step (forming the third-level categories), the role theories were used, and the process evolved into a theory-driven analysis. Crucially, the third step revealed two contexts related to the insurer's role. First, the claimants described certain insurer roles within the rehabilitation networks. That is, they outlined these roles in relation to other rehabilitation stakeholders, such as employers, health-care staff and rehabilitation service providers. The author classified these roles as network roles (which is the term used later in this study). Second, the claimants described unique insurer roles in relation to themselves. Specifically, the claimants focused on the insurer's actions and attitudes toward them and narrated their feelings in response. The author classified these roles as actor roles (which is the term used later in this study). Thus, we divided the text passages, their paraphrased versions and the third-level categories into two groups, illustrating the twofold roles insurers play in occupational rehabilitation.

The next step of analysis was the generation of second-level categories within which various contradictions related to the role descriptions were clearly present (Table 4). The final step was to form the first-level categories (i.e. the final insurer roles). At this point, the author determined that it was necessary to delve into the individual interviews again and combine the previously formed categories within each interview.

The analytical steps formed an iterative process, which is typical of qualitative research. Likewise, and which is typical for qualitative analysis, the data and research questions were in close dialogue with each other. Hence, the author applied her ever-increasing familiarity with the data to refine the analytical questions. During the classification phase, she

Table 3.
Example of forming
the third-level
categories

Meaningful text passage	Paraphrased text passage	Third level category
The goal should be to genuinely rehabilitate and employ the person. That should be the objective. This is not the case now. They (the insurer) don't concentrate on the claimant or consider the things he would need or from what he could benefit from (18)	The insurance company does not acknowledge claimants with their individual needs	Ignorance of the needs and wishes of the claimants
Well, the insurers should pay more attention [...] If they would've been at all interested in my life situation [...]. You know, like "what should we do, if we would actually want to rehabilitate and employ this person". But no, they were not interested at all (9)	The insurance company is not interested in claimants' life situation	
My ability to work was by no means sufficient. It was totally the wrong time to start the work trials. Rationally, they should have waited for another year, but no one listened to me (23)	The insurance company does not listen or hear the claimants	

systematically reviewed the interview data according to the research problem and key concepts using theory-guided content analysis (Elo and Kyngäs, 2008; Gläser and Laudel, 2013; Hsieh and Shannon, 2005; Krippendorff, 2013).

The author confirmed the context, as well as the credibility, of our analysis with continual cross-references between the original transcripts, study objectives and data interpretations. Furthermore, she identified and included quotes in the manuscript to both clarify the labels and increase the credibility of the analysis.

Results

The analysis of the data revealed a substantial variety of perceived insurer roles. One major finding was the twofold perception of insurer roles. The author found three network roles of the insurers, followed by the four actor roles. Figures 1 and 2 illustrate the identified insurer roles and conceptualize them in a new framework of insurer profiles. The author also identified the connections between network and actor roles and explored the underlying mechanisms between perceived insurer roles and occupational rehabilitation outcomes. These results are presented in the last two sections.

Perceived insurer roles in relation to other rehabilitation stakeholders

Occupational rehabilitation networks include numerous stakeholders, such as employers, occupational health-care staff, rehabilitation service providers and insurers. Although pension insurers generally wield the most responsibility for organizing, financing and

Third-level categories	Second-level categories
Respectful treatment, consideration of the needs and wishes, participatory methods, flexible attitude	Democratic approach
Disrespectful treatment, ignorance of the needs and wishes, claimant exclusion	Autocratic approach
Enthusiastic involvement, pushing forward, quick action, unprompted communication	Active approach
Detachment, irregular communication, lack of initiative, avoiding responsibilities	Passive approach

Table 4.
Generating the second-level categories of insurer's actor roles

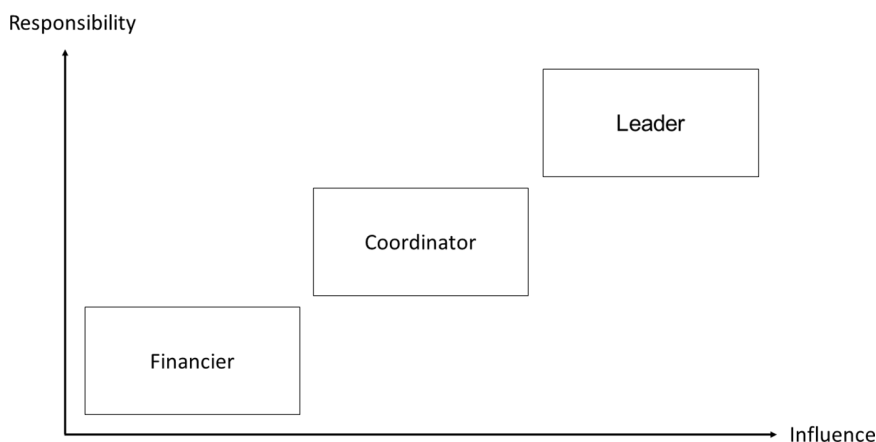


Figure 1.
Perceived insurer roles in relation to other rehabilitation stakeholders

coordinating occupational rehabilitation in Finland, our analysis revealed that their perceived network roles were more diverse in practice. Based on the interviews, the author formed three perceived roles for insurers in the rehabilitation network. In [Figure 1](#), these roles are positioned in relation to the two axes of their overall responsibility for the rehabilitation process and their influence on rehabilitation outcomes. As also shown in [Figure 1](#), the author analysis suggested that these network roles were cumulative in nature: the more responsibility was linked to a role, the greater its influence on the outcome would be.

The author labeled the first perceived network role as “financier.” Many claimants considered the role of an insurer to be limited to claims handling and financing vocational rehabilitation. The tasks of the financier insurers included compensation decisions, the approval or denial of rehabilitation plans and fulfilling compensation payments. According to the claimants, financier insurers were more involved in the early stages of rehabilitation than in the later stages. Following the initial decisions, the claimants described financier insurers as alienating themselves from rehabilitation planning and implementation, effectively remaining in the background as authorities and the payers of compensation. As one claimant put it, “The only role was that of the money payer” (Claimant 14). Another stated, “They really had no other role than deciding to rehabilitate and then financing it” (Claimant 12). Thus, the claimants represented financier insurers as having only little responsibility for and limited influence over rehabilitation outcomes.

The author labeled the second perceived network role as “coordinator.” In addition to the financing function, the claimants asserted that the coordinators had “administrative and coordinative tasks” (Claimant 13). They were in closer contact with the rehabilitees and the other rehabilitation stakeholders, acting as a link between them throughout the rehabilitation process. The claimants described coordinators as coordinating tasks between different stakeholders and actively participating in the planning and implementation of occupational rehabilitation. Thus, the claimants considered coordinators to have more responsibility for and influence over rehabilitation outcomes than the financier insurers.

The author labeled the third perceived network role as “leader.” According to the claimants, leader insurers not only financed or coordinated tasks between different rehabilitation stakeholders, but they also took full responsibility for controlling and overseeing the RTW process. Furthermore, leader insurers established and maintained contact with stakeholders and rehabilitees throughout the process; they actively oversaw the planning, implementation, reviewing and monitoring of rehabilitation measures. In addition, they showed interest in the effectiveness of rehabilitation and provided follow-up controls and guidance. The claimants usually assumed that out of all the network roles, leader insurers had the most influence over rehabilitation outcomes because they were closely involved in each step of the process and wielded the power to set goals, define boundaries, control actions and review results.

Perceived insurer roles in relation to claimant

The second dimension of perceived insurer roles focused purely on the relationship between the insurer and claimant. The author found four actor roles based on the analysis and labeled them as follows: “ally,” “facilitator,” “enforcer” and “enemy.” [Figure 2](#) conceptualizes these roles in the form of a four-fold diagram. In the figure, roles are determined within the two axes of democracy versus autocracy and activity versus passivity. In the present study, the claimants described insurers with democratic approaches as customer oriented. These insurers appreciated the views of rehabilitees and actively involved them in decision-making. Conversely, the claimants described autocratic insurers as emphasizing their own

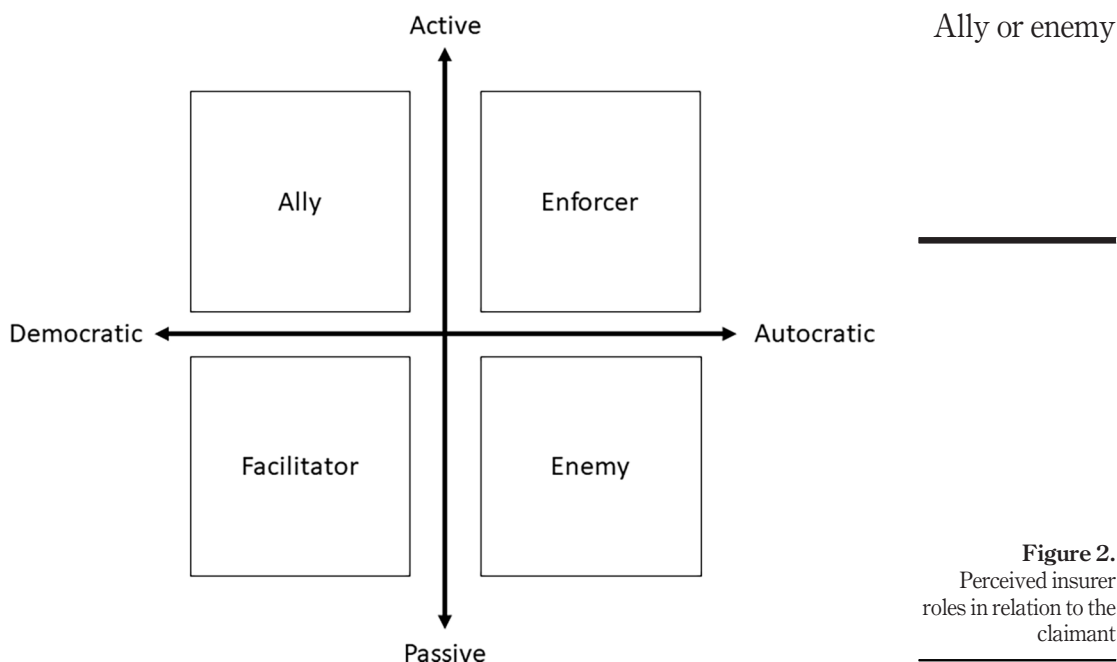


Figure 2.
Perceived insurer roles in relation to the claimant

expertise and failing to involve rehabilitees in the process. As demonstrated by the second axis, the claimants reported that active insurers made spontaneous and regular contact with them, encouraging them throughout the process. Correspondingly, the claimants described passive insurers as aloof and remaining in the background, thus leaving the promotion of the rehabilitation process to other actors.

The first perceived actor role, “ally,” occupies the upper left corner of [Figure 2](#). According to the claimants, ally insurers clearly took on a democratic and participatory role because of their appreciation of clients. The claimants with ally insurers felt that they were treated with respect. As one claimant put it, “As such a small citizen, I felt important. And it was pretty great” (Claimant 4). In addition, ally insurers were said to have listened to and genuinely considered the needs and wishes of their claimants: “It was really great how they were able to look at my path so personally and plan things directly for me” (Claimant 4). The claimants with ally insurers also reported that they had been included in the decision-making and preparation of their rehabilitation plans.

Furthermore, the claimants perceived ally insurers as active players in the rehabilitation process, as evidenced by their willingness to promote the process: “I informed the insurance company, and they were so enthusiastic about it right away, arranging my interviews immediately” (Claimant 3). Moreover, the claimants described how ally insurers stimulated and encouraged them:

The trigger for me was the ultimatum of the insurer that they would invent me a profession if I didn’t do it myself. You know, when somebody kicks your ass and urges you to do something. Ultimately, it gave me direction, made me work for my future. (Claimant 8)

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Overall, the active role included unprompted and regular communication with claimants and other stakeholders throughout the rehabilitation process. The claimants also remarked that ally insurers remained in contact with them, even after the rehabilitation measures had ended.

The second perceived actor role, “facilitator,” occupies the lower left corner of [Figure 2](#). Like ally insurers, facilitator insurers were said to use participatory and customer-oriented methods. This customer orientation was reflected in the respect with which these facilitator insurers treated their claimants:

I felt like a well-received customer; it was customer oriented. I didn't feel as I usually do at agencies, you know, when you are a bit like a customer only, but now they treated me very nicely and didn't disparage me (Claimant 7).

The claimants also asserted that facilitator insurers listened carefully to their wishes and views, as well as those of other rehabilitation stakeholders. In addition, the claimants felt that facilitator insurers included them in the decision-making and planning of their rehabilitation: “They asked if I had any thoughts on what I would like to start doing and how” (Claimant 11).

In contrast to ally insurers, facilitator insurers were described as passive actors who remained in the background. According to the claimants, facilitator insurers operated under the assumption that rehabilitees and other rehabilitation stakeholders were responsible for promoting the rehabilitation process. Some encounters between the facilitator insurers and claimants may have lacked any human contact, with these insurers offering no active help or support. Some claimants criticized this dynamic:

So they just send you the forms, like fill them in and mark what you want to study[.] [. . .]. There should've been some human contact in the beginning and a little more help[.] [. . .]. And then at follow-up after the rehabilitation, all I got was a piece of paper saying that it was now over (Claimant 5).

Nevertheless, help was available to those who sought it, though the claimant had to be the active party:

As soon as you realized that you can ask and that there are no stupid questions, everything started to work. And every time I called and asked something, it was always ok, they arranged it, and things were fixed (Claimant 1).

The third perceived actor role, “enforcer,” occupies the upper right corner of [Figure 2](#). Unlike allies and facilitators, enforcers were described as autocratic actors. The claimants felt that autocratic enforcer insurers disdained and disrespected them. Moreover, the claimants determined that these insurers perceived them as ignorant, unreliable or lazy: “She treated me as if I were a hypochondriac[.] [. . .] I felt a sense of inferiority because I was sick and could not work” (Claimant 14). This disrespect caused some claimants distress and mental strain: “The insurance company has definitely made me cry[.] [. . .] with all the nasty comments I have received” (Claimant 24). This autocratic attitude was also clearly seen in the decision-making process and rehabilitation planning. The claimants noted that enforcer insurers had their own views that they pushed through, despite any objections. Moreover, the claimants felt that enforcer insurers failed to consider their previous skills, work experience, capabilities or wishes when deciding which measures were appropriate for occupational rehabilitation. In addition, some of the claimants felt excluded from the decision-making and planning of their rehabilitation. As one claimant put it, “It was totally the wrong time to start work trials. Rationally, they should have waited for another year, but no one listened to me” (Claimant 23).

In addition to their autocratic behavior, enforcer insurers were considered active participants in the RTW process. They were described as regularly contacting the claimants based on their own initiative to ensure that a rehabilitation plan was completed on time and that the rehabilitation process proceeded as quickly and efficiently as possible: “Well, with a super-fast schedule, a kind of work trial was put together with the insurer. It was only a couple of weeks before it started” (Claimant 24). Like ally insurers, enforcer insurers were portrayed as “kind of pushing forward” (Claimant 15) while guiding claimants throughout rehabilitation. Overall, several claimants felt that the rehabilitative progress was prioritized over their own views. Moreover, enforcer insurers were seen as merely looking for profit: “They weren’t interested in my situation at all, only in paying as little money as possible” (Claimant 19).

The fourth actor role, “enemy,” occupies the lower right corner of [Figure 2](#). Like enforcer insurers, enemy insurers are described as autocratic and arrogant. They were criticized for their machinist behavior and “lack of humanity” (Claimant 18). In addition, they were perceived as acting as if they were superior to the claimants and other rehabilitation stakeholders, ignoring their opinions. As a result, claimants with enemy insurers felt excluded from the decision-making process and planning of their rehabilitation. Consequently, they felt oppressed and forced to participate in inappropriate rehabilitation measures. These claimants often considered the authoritarian decisions made by enemy insurers to be biased, causing frustration and opposition: “Even though I tried to send all the different documents there, it didn’t help. So the whole winter was spent fighting with them” (Claimant 22).

In addition to their autocratic behavior, enemy insurers were represented as passive actors. The claimants reported a lack of any human contact or activity in the compensation process. Thus, the word most used to describe enemy insurers was “distant.” As one claimant said, “Well, they weren’t that interested in me. I didn’t have much contact with them” (Claimant 13). Another claimant remarked, “They were as inactive as possible” (claimant 18). Enemy insurers also reportedly left responsibility for the overall rehabilitation to rehabilitees or other stakeholders. The most prominent feature associated with enemy insurers was their tendency to complicate matters and slow down the rehabilitation process. Therefore, the claimants felt that the actions of enemy insurers first hindered their access to occupational rehabilitation and then blocked the fulfillment of their wishes, eventually destroying the possibility of their re-employment. As one claimant put it, “Most of all, they failed in customer service and destroyed my motivation. A weaker-minded person would’ve stopped trying long ago” (Claimant 19).

Connection between network and actor roles

In response to the twofold role of insurers, the author investigated the possible connections between network and actor roles. As [Table 5](#) illustrates, coordinator insurers could fulfill all actor roles, whereas financier and leader insurers could fulfill only some. Insurers in

The actor/network roles of insurers	Financier	Coordinator	Leader
Ally		x	x
Facilitator	x	x	
Enforcer		x	x
Enemy	x	x	

Table 5.
Connection between
the network roles and
the actor roles

network positions with more responsibilities and influence were more likely to be associated with active roles and vice versa.

The claimants reported that financier insurers acted as either facilitators or enemies. In a rehabilitation network, financier insurers were described as tending to retreat into the background and act aloof during the planning and implementation of rehabilitation. This tendency toward passivity explained the connection between the facilitator and enemy roles. In contrast, the claimants viewed the leader insurers as either allies or enforcers. In a rehabilitation network, leader insurers were described as highly involved in the rehabilitation process, from the initial steps to aftercare. Therefore, leader insurers were seen as usually possessing the active touch of an ally or enforcer, which explains the connection between these roles. Finally, the claimants viewed the coordinator insurers as able to perform all actor roles. Overall, although the network role of an insurer did not determine its actor role, it may have imposed limitations on it.

Perceived insurer role and rehabilitation outcomes

All claimants expressed that the perceived insurer role either promoted or hindered the progress of their rehabilitation and directly affected their rehabilitation outcomes. However, only actor roles and rehabilitation outcomes were connected in the interviews. The success and failure of rehabilitation were relatively evenly distributed across network roles. Because the claimants did not connect any network roles with rehabilitation outcomes, we concluded that insurers could play any network role and still promote successful rehabilitation. This finding can be explained by the variable role structures of other stakeholders in the network. Although the claimants highlighted the need for a coordinator and leader during the rehabilitation process, the insurers were not obligated to take on either of these roles if they were fulfilled by other stakeholders. However, when no one assumed responsibility for coordinating or leading the process, the claimants struggled to plan and implement their own rehabilitation, which often resulted in undesired outcomes.

In contrast, actor roles were strongly associated with rehabilitation outcomes. The claimants proposed that the determining insurer factor of the outcomes was the level of democracy in the decision-making, planning and implementation of rehabilitation. Whereas the autocratic roles of enforcer and enemy were clearly associated with negative outcomes, the democratic roles of ally and facilitator were associated with positive rehabilitation outcomes. All the claimants with ally or facilitator insurers eventually returned to work, and they shared the common feeling of being included in the search for new jobs or professions and in preparing their rehabilitation plans. Although some plans were only drawn up after lengthy negotiations, meaning that the outcomes may be attributed to compromise, each claimant was able to commit to their plan and follow the process through to achieve a positive outcome. Nevertheless, in cases with facilitator insurers, success also seemed to require either active participation from other rehabilitation stakeholders or strong-minded, self-determined and motivated claimants.

Most claimants with autocratic enforcers or enemy insurers did not return to work. At the time of the interview, half of the claimants were receiving sickness allowances or disability pensions. Only two had found permanent employment, while the rest of those who could work were unemployed or engaged in temporary work. The main insurer-related reasons for rehabilitative failure were the neglected views of these claimants and their forced acceptance of autocratic decisions. These claimants usually felt obligated to participate in unnecessary and unsatisfying rehabilitation measures:

For some reason, they just wouldn't support the retraining I wanted. I told them that their rehabilitation measures would not help me in any way and that the whole thing really did not make any sense (Claimant 9).

Most of the claimants felt that their ability to work could have been restored with appropriate measures and timing. These beliefs were supported by the fact that several claimants had later retrained themselves for new jobs at their own expense, implementing the original occupational rehabilitation plans that had been rejected by their insurers. These claimants eventually returned to work, at least temporarily. Nevertheless, a few claimants reported that because their health status prevented their returning to work, any effort on the part of their insurers would have been useless; they claimed that instead of rehabilitation, they should have been granted a disability pension at the outset of their disability.

Overall, those claimants with enforcers or enemy insurers were usually unsatisfied with the occupational rehabilitation system and did not expect it to restore their ability to work. Some faced the painful experience of being disparaged and despised by their insurers, which may have led to bitterness and worsened depression. The claimants concluded that had enforcer or enemy insurers listened to them more carefully and shown genuine interest in them returning to work, the results of their rehabilitation would likely have been better.

Discussion

The first objective of the current study was to explore claimants' perceptions of insurers' roles and to conceptualize a new framework of insurer profiles within the RTW process. The author discovered that perceived insurer roles could be divided into network and actor roles. Namely, the claimants described insurer roles in relation to other stakeholders in the rehabilitation network and themselves as rehabilitees. The claimants separated the different network roles (financier, coordinator and leader) based on their perceived responsibility for and influence over rehabilitation outcomes. The claimants viewed financier insurers as handling limited tasks dealing with claims and compensation, coordinator insurers as administering the process and acting as intermediaries between claimants and other rehabilitation stakeholders and, finally, leader insurers as having full responsibility for controlling and overseeing the RTW process.

Earlier studies have treated insurers as a whole and analyzed insurers' activities from the theoretical viewpoint that they must play a singular role in the RTW process (Franché *et al.*, 2005a; Sager and James, 2005; Strunin and Boden, 2004; Thornthwaite and Markey, 2017). However, the present study has shown that insurers can take on diverse roles, even some that are conditional on other actors within the rehabilitation network. Indeed, the author determined that although the occupational rehabilitation networks seemed to benefit from actors in the roles of financier, coordinator and leader, these roles may be performed by different actors depending on the circumstances. Earlier studies of organizational roles recognized this dynamic network of organizations. For example, Heikkinen *et al.* (2007) reported that actors may take on several roles in a network.

The results of the present study have revealed that regardless of the network role played by an insurer, they may still fulfill several actor roles in relation to their claimants. The perceived roles were shaped by two factors: democracy and activity. Whereas the democratic actor roles of ally and facilitator were linked with customer orientation and participatory methods, the autocratic actor roles of enforcer and enemy were associated with business orientation and dominating methods. Correspondingly, the active roles of ally and enforcer insurers were associated with continuous contact and forceful methods, while the passive roles of facilitator and enemy insurers were associated with limited contact and detachment. Previous studies have described the encounters between insurers and disabled

workers as hostile (Beardwood *et al.*, 2005; Kilgour *et al.*, 2015; Strunin and Boden, 2004; Thornthwaite and Markey, 2017), and data from these encounters may confirm the role of the enemy insurer. Yet other studies have provided evidence of positive interactions between these parties (Hubertsson *et al.*, 2011; Klanghed *et al.*, 2004; Müssener *et al.*, 2008), reflecting the additional roles that insurers may occupy.

The results have also highlighted that insurers' role expectations clearly differed between the claimants. Most expected insurers to take on the network role of the financier or actor role of the facilitator. Generally, these roles seem both natural and effective for insurers in occupational rehabilitation. However, some claimants felt that their insurers were trying to avoid liability by merely adopting the financier role, thus distancing themselves from the planning, implementation and review of the RTW process. These claimants expected their insurers to play a more involved role. Thus, the service script for occupational rehabilitation appeared incoherent because there was no mutual understanding of the role expectations and role behaviors between the claimants and their insurers. Consistent with role theory (Broderick, 1998), the current study suggests that failure to meet role expectations usually leads to customer dissatisfaction. Consequently, in the future, special attention should be paid to the actor roles of insurers. To avoid conflict between expected roles and actual behaviors, network members and claimants should clearly understand how insurance companies interpret their own roles.

Notably, the current study represented insurers and their roles in the actions of individual customer service representatives. Therefore, the same insurer might be interpreted as an ally insurer by one claimant and an enforcer insurer by another. As the previous literature has illustrated, organizations perform certain roles through the actions of individuals (Katz and Kahn, 1966), and it is vital that insurers understand and take note of this dynamic. In addition, the perceived roles presented in the current study were based purely on customers' perceptions of their insurers. As a result, the present study sheds light on the roles of insurers in RTW processes from only one perspective. Future research should examine the perspectives of other rehabilitation stakeholders (e.g. occupational health-care staff, employers and rehabilitation service providers) and the insurers themselves to form a more complete understanding of the subject.

The second objective of the current study was to explore the underlying causal mechanisms that explain the relationship between perceived insurer roles and occupational rehabilitation outcomes. The results linked the actor role and, more specifically, the democracy level of the insurer with rehabilitation success. The claimants described how their involvement in rehabilitation planning motivated and committed them to rehabilitation programs. In the end, all the claimants with facilitators or ally insurers returned to work. In contrast, the results showed that autocratic decision-making and neglected claimant views usually resulted in dissatisfaction and negative rehabilitation outcomes. Because the level of democracy appears to be the decisive factor in determining the role of an insurer, we can conclude that insurers with different network roles can effectively promote RTW by adopting democratic methods in their actor roles.

The main theoretical contribution of the current study is the identification and conceptualization of different insurer roles within the RTW process. Furthermore, the present study provides insights into the underlying mechanisms between insurers' actions and rehabilitation outcomes. Thus, the study complements earlier theories related to the role of insurers in the RTW process (Franche and Kraus, 2002; Franche *et al.*, 2005a; Friesen *et al.*, 2001).

The practical implications of the current study are useful for insurers, especially because the claimants concluded that the assumed roles of their insurers clearly impacted their rehabilitation outcomes. According to the results, insurers would benefit from applying democratic and participatory methods related to ally and facilitator roles. Insurers can exploit this knowledge in the permanent disability risk management of their clients. In a broader sense, the results have the potential to promote RTW and prevent permanent disability, which would benefit not only the insurance system but also workers, employers and society at large.

Limitations

It is essential to note that the chosen qualitative study approach has its limitations. Although this qualitative study identified the underlying mechanisms explaining the relationship between insurers' actions and rehabilitation outcomes, it cannot establish a causal relationship and its range of validity between insurer roles and occupational rehabilitation outcomes (Gläser and Laudel, 2013). Thus, the current study does not offer general determinants or generalizations; instead, the objective is to enhance the understanding of the phenomenon and contribute to theory development.

Notably, the current study explored only claimants' views of the perceived roles of their insurers. A study with a larger perspective may identify even more or different roles if including the views of insurers themselves and/or those of other rehabilitation stakeholders. Furthermore, although the purposive sampling method produced a wide range of rehabilitation experiences, the interview responses depended on the individuals and their own contexts, so the experiences of claimants from other insurance systems may differ.

Some critique could also be directed at the telephone interviews. This method can be seen as a hygienic convenience technique. In addition, telephone interviews may foster less of a rapport between the researcher and interviewees than face-to-face interviews (Trier-Bieniek, 2012; Shuy, 2002; Stephens, 2007). However, some scholars have suggested that telephone interviews can be beneficial in studies of sensitive subjects and may result in more honest data, particularly as people have become more accustomed to "virtual" communication (Trier-Bieniek, 2012). The author determined that telephone interviews were appropriate because they enabled the acquisition of the interviewees around the country, offered a cheap and convenient option and resulted in an excellent response rate.

Furthermore, it should be noted that this was a cross-sectional study. The interviews were conducted following the completion of rehabilitation measures, so the ultimate outcome may have affected the interviewees' interpretations of the roles of their insurers. For instance, claimants who were satisfied with the outcome might have praised all the stakeholders and individuals involved in the process, even when such praise was undue. Consequently, it is possible to question whether the role-based behaviors of the insurers explained the successful rehabilitation outcomes or vice versa.

The author sought to minimize such bias by concentrating on every phase throughout the rehabilitation process. During the analysis, the author prioritized the chain of events and the views of the interviewees on the roles of their insurers. The results that are based on the association between insurer roles and rehabilitation outcomes agree with those of earlier studies, indicating that positive encounters with social insurers can promote RTW among long-term sickness absentees (Lynøe *et al.*, 2011; Olsson *et al.*, 2016; Collie *et al.*, 2019).

Conclusion

First, the current study conceptualized the different roles enacted by insurers within the RTW process from the perspective of disability claimants. The author determined that the

insurers enacted different roles in relation to the other stakeholders in the rehabilitation network and the claimants themselves. She uncovered three perceived insurer roles within the rehabilitation network (financier, coordinator and leader) and four roles in relation to the claimants (ally, facilitator, enforcer and enemy).

Second, the present study has provided a deeper understanding of the underlying causal mechanisms that explain the relationship between perceived insurer roles and occupational rehabilitation outcomes. The perceived network role did not seem to affect rehabilitation success if one of the stakeholders (e.g. insurer, health care or workplace) took responsibility for coordinating or leading the process. On the contrary, the perceived actor role was seen as a decisive determinant of the success of the RTW process. Above all, the study revealed that a high level of democracy in planning and implementing occupational rehabilitation could promote the best outcomes. Correspondingly, the author associated the ally and facilitator roles with positive rehabilitation outcomes.

Third, the current study determined that the expected roles of insurers differed between claimants, indicating that the stakeholders' roles in occupational rehabilitation networks were either poorly established or inadequately disclosed to the claimants. In the future, stakeholders should address this issue to avoid conflicts between expected and perceived roles and to ensure high customer satisfaction. Based on the current study, the author recommends that insurers adopt democratic and participatory methods to promote RTW. Nevertheless, future quantitative studies should investigate the potential causal relationships between insurer roles and rehabilitation outcomes to draw general conclusions about the phenomenon.

Notes

1. Because these previous studies were done from the perspectives of claimants, the reported experiences may differ from those of insurers. For example, even if an insurer only complies with the insurance's terms and conditions, a claimant may view the encounter negatively, especially if they feel that their wishes were not fulfilled.
2. More information about cause- and disability-based insurance systems can be found in the work of [Lippel and Lötters \(2013\)](#).
3. The earnings-related pension scheme in Finland covers all employees, self-employed persons and farmers whose employment exceeds the minimum requirements as defined by law.

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