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'You Need to be Healthy to be Ill': Constructing Sickness and Framing the Body in Swedish Healthcare

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Abstract

Recent trends have seen a move from 'welfare' to 'workfare' in Europe to increase labour flexibility and reduce state expenditure on sickness absence. This shift in healthcare logics has meant an increasing role for individuals to take an active part in the political process of managing their health and sickness absence. This paper draws upon empirical cases of observations of status meetings, in which the employee's medical situation and work capacity are evaluated, as well as interviews with participating actors. The study finds that governmental standards are, at times, incompatible with each other and this complexity allows for local strategies in managing the sickness absence process. These findings are discussed in relation to employment and it is concluded that local actors' translations of policies have important material consequences for employees' health, rehabilitation opportunities and access to sickness benefits. This contributes to our understanding of how political interventions to govern the population are appropriated locally to govern individual bodies.

Keywords

the body, discourse, Foucault, governmentality, sickness absence

The last two decades have seen a change in the central organizing principle of social policies in western liberal democracies from 'welfare' to 'workfare' (Dean, 2010; Walters, 1997), with the aim of increasing labour flexibility and lowering state expenditure (van Gestel & Herbillon, 2007, p. 324). Consequently, there have been reforms in the healthcare sector and to sick leave policies in order to optimize workability, minimize sickness absence, and accomplish a more 'efficient' healthcare sector (Bambra & Smith, 2010; Hasselbladh & Bejerot, 2007; van Gestel & Nyberg, 2009). For example, an employee in the Netherlands or Sweden is no longer sick or healthy, but rather healthy to a certain percentage, with both health and the percentage being contestable and negotiable. These types of policies have often included detailed recommendations on how to enact the policies in the form of standards and guidelines (Jacobsson & Sahlin-Andersson, 2006).

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The studies in organizational and management theory on the effects of health policy reforms and regulations in general, and sickness absence policies in particular, have focused mainly on macro political struggles (Doolin, 2002; Fotaki, 2006; Hasselbladh & Bejerot, 2007) or organizational practices (James, Cunningham, & Dibben, 2002, 2006), with limited consideration of their consequences for employees. Further, absenteeism usually is measured through large-scale surveys, which provide little information about the situations underlying the illnesses or work absence (see, e.g., Caverley, Cunningham, & MacGregor, 2007; Løkke Nielsen, 2009; Ramsey, Punnett, & Greenidge, 2008). Thus, while there are informative studies on the discourses of health policies and the programmes, calculations and techniques of managing health, recently there have been calls in *Organization Studies* for further examination of the 'performativity' of these discourses and technologies in local settings (McKinlay, 2010; Miller & Rose, 2010).

This paper aims to respond to these calls by investigating the link between societal political interventions of governing populations and the local conduct of governing an individual's body. The conceptual understanding of how the body is governed is developed by briefly reviewing the literature in management and organization studies that engages with how organizations discipline the population and the individual body. This is followed by an investigation of new sickness absence policies introduced in Sweden. The study is based on observations of status meetings in Swedish hospitals, in which an employee's medical situation and work capacity are evaluated, as well as interviews with participating actors (managers, HR specialists, doctors, state coordinators and employees). The cases of sickness absence management provide details of how the employee's health is governed according to standardized disease classifications used by medical doctors, and standardized time evaluations used by the National State Insurance Agency (NSIA) for determining sick leave benefits and rehabilitation. The findings show that the body is both an *object* that needs treatment, and a *subject* that needs sympathy and encouragement; both a body *at* work and a body *for* work. That is, for each employee at a status meeting, there are multiple bodies. The study also finds that the governmental standards are, at times, incompatible with each other and that this incompatibility provides room for local actors to manage the sickness absence process. These findings are discussed in the context of the employment relationship and it is concluded that the local translations of health policies have important material consequences for an employee's health, rehabilitation opportunities and access to sickness benefits.

Governmentality and the Body

Central to the discussion of the body in the broader field of management and organizational studies is Foucault's (1991a, p. 102; 1997, p. 82; 2007, pp. 192–193) notion of 'governmentality', which can be understood as processes of tactics, techniques and procedures of governments to define and direct individuals and populations. Essential to understanding the concept of governmentality is the nexus of power/knowledge relations, with power residing in the development and promotion of 'governmental apparatuses' in the form of programmes and regulations, and knowledge as particular ways to represent and order the population (Ezzamel & Reed, 2008; Foucault, 1991a). The practices of governmentality encompass power relations that make the objects known or categorized in order to be governed or managed by the state through local administrations, such as universities, schools and hospitals, as well as by private corporations (Ezzamel & Reed, 2008; Townley, 1993; Turner, 2008).

Governmentality is intrinsically dependent on representing or framing the population in order to control and discipline an individual's body. It thus 'ultimately refers to the ways in which bodies

are produced, cultivated and disciplined' (Turner, 2008, p. 3). Foucault further breaks this down to two central and interrelated areas for studying power over the body:

1. regulatory control of the population by supervision of and intervention in the biological processes surrounding the population's health (Foucault, 1990, p. 139; 2007).
2. discipline of the human body in the form of optimization of its capabilities, extorting its forces, and increasing its usefulness and docility into systems of efficient and economic control (Foucault, 1977; 1990, p. 139).

Research within organization studies has considered both these areas of governmentality of the body through studies on how public policies frame and transform discourses and how the body is optimized and disciplined within these discourses. However, as the brief review below will show, less attention has been given to the interconnection between national policies in governing population and the micro techniques of power in governing the individual body (Bröckling, Krasmann, & Lemke, 2011; Weiskopf & Munro, forthcoming).

In regard to the first area of governmentality, an international trend in the public health sector is the reform of public hospitals by increasing the transparency of diagnosis and treatment decisions (Dent, 2003; Doolin, 2002; Levay & Waks, 2009). These reforms aim to make professional conduct knowable and thus manageable, which 'commoditizes' the patient's body and works as a regulatory mechanism of the population. These control methods are typically introduced through 'soft' regulation that is not legally binding, such as guidelines, classification systems and diagnosis standards (Hasselbladh & Bejerot, 2007; Levay & Waks, 2009). This has, however, led to an increasingly contested boundary between managerial methods of control and medical professionals' expertise (Doolin, 2002), with medical professionals suspicious of initiatives and resistant to their implementation (Levay & Waks, 2009). Success in defending their professional authority is dependent on medical professionals convincing others that their core expertise is complex and not easily standardized (Dent, 2003).

Motion and Leitch (2009) argue that public policies act as discursive framings that can be utilized to legitimize practices and activities. This was further illustrated in van Gestel and Nyberg's (2009) case studies of legal firms in the Netherlands, which showed how national policies on sickness absence were translated into furthering organizational control. The policies, which were aimed at reducing long-term sickness absence, were used by HR managers to control short-term absences of administrative personnel, while long-term absent lawyers were not affected by the policies. Their study shows how governmental policies, standards and classifications can work as recourses in managing the sickness absence process, with technologies aimed at the broader population having implications for individuals.

This is an indirect political process where large-scale programmes, such as national policies, can shape individual activities (Foucault, 1991a, 2007). Between programme and application, governmental technologies are formed. To understand the connection between the government of population and of individuals requires analysis of this process of active appropriation of policies (Lemke, 2011). This study therefore uses a case study approach to examine how national political intervention has influenced the local process of sickness absence.

The second area of governmentality, in terms of the microphysics of the power of the body, has been emphasized in work on the disciplinary effects of team and electronic surveillance (Sewell, 1998; Sewell & Wilkinson, 1992). These studies also illustrate the effect of making activities known and managed by team norms, electronic supervision and subjective identification (Clegg, Pitsis, Rura-Polley, & Marosszeky, 2002). Similar to the mechanisms in Foucault's (1977) study of

prisons, the aim of the management techniques employed is to produce a docile and useful body (Mumby, 2005). For example, Townley (1994) provides a thorough account of how disciplinary techniques within organizations make the body knowable, and thus manageable, through surveillance and ranking of the population. The measurements, examinations, evaluations and comparisons of HRM practices become inscribed on an employee's body. These techniques for control of the body are mostly limited to gate-keeping and in-house keeping (Townley, 1994), while the main organizational interventions are aimed at governing the 'soul', 'psyche', or 'interior' of workers, in which employees participate in their own subjugation (Barratt, 2003; Deetz, 1995; Rose, 1989; Sewell & Wilkinson, 1992). The studies in organizational and management theory thus have shown how the 'objectivizing' of subjects happens through both 'dividing practices' that naturalize hierarchies and power imbalances, as well as how humans turns themselves into a subject through projects or technologies of the self (Foucault, 2000).

Recently we have seen calls to push the investigation of the 'body/work nexus' beyond linguistic constructions to account for the 'lived' body (see, e.g., Gimlin, 2007; Shilling, 2003; Wolkowitz, 2006, p. 1). The self-discipline in, for example, managing the body in order to be selected and retained informs the experiences of employment (Hancock & Tyler, 2000; Trethewey, 1999), and also the material body (Shilling, 2003; Wolkowitz, 2006). This literature attempts to reach beyond the 'grids of meaning imposed by discourse' (Shilling, 2001, p. 445) to understand how the body is 'moulded' by governmental regimes in the workplace, such as sex, food, diets, exercise and health (Weiss, 2005; Zoller, 2003). For sickness absence this suggests that the body is defined and classified by doctors, employers, health insurance agents, and so on, each with access to, and authority in, discursive regimes to order and discipline the 'ill' body. The body is socially produced in the mesh of these discourses, which influences how illnesses will be treated and rehabilitated (Freund, 1982).

However, while there are multiple accounts of discourses written upon the body and the plurality of these subjectifications is acknowledged (see, e.g., Hassard, Holliday, & Willmott, 2000; Hindmarsh & Pilnick, 2007; Trethewey, 1999), there is still a simple notion of the material body. Arguably, with the classifications written upon the body, dividing it as an examinable object and discursively marking it as a subject (Townley, 1994), there are multiple possible conceptualizations of the body (Mol, 2002; Nyberg, 2009). There is no single 'sick' or 'ill' body, but a plurality of bodies, reflected and formed by the discursive configurations at play (Twigg, 2006). In order to account for the often competing and contradictory discursive regimes, as well as the material consequences of these, this study examines how the body is produced locally and the material effects of this production.

Research Design

Context: sickness absence policies and classifications of diseases

Sweden's comparatively generous sickness absence policies have remained more or less the same since the 1960s, with everyone who works or lives in Sweden covered by social insurance. The employer pays 80% of the employee's salary as sick pay for the first 14 days of illness (with an exemption for the first day, which is a 'waiting day'). After 14 days, the costs are transferred to NSIA, which determines whether an employee is eligible for sickness benefits (National Insurance Act 1962). Since the 1990s, sickness absence has become both a major public health problem and an increasing economic burden for the Swedish welfare state. The number of people who are sick for more than 14 days has increased from 135,000 in 1997 to 296,300 in 2002 (Eklund, 2003), an

increase of 119% over five years. The expenditure on social insurance represents one-sixth of the Gross National Product in Sweden, with 25% of private consumption paid from social insurance money (NSIA, 2001). In 2003, the total cost was about 11.9 billion euros, an increase of nearly 50% in only four years (Hogstedt, Bjurvald, Marklund, Palmer, & Theorell, 2004).

With the sickness absence level twice as high as the European average (Mikaelsson et al., 2003), recent governments in Sweden have introduced a series of measures to decrease sickness absence. These started in 2003 with relatively small amendments to policy including, for example, introducing the requirement of a status meeting into the social insurance law (National Insurance Act 1962: ch. 3 § 8a). However, the major change in policy was introduced on 1 July 2008, when Sweden moved from having no time limit applicable to sickness benefits to a limit of one year (Ministry of Health and Social Affairs, 2008). With the new regulation, the government introduced a 'rehabilitation chain' with clear time lines and tests for managing sickness absence:

- Days 1–90: NSIA assesses the ability of the employee to perform the current job;
- Days 91–180: NSIA assesses the ability of the employee to perform another job within the same organization;
- Days 181–365: NSIA assesses the ability of the employee to perform any job in the external job market.

While these changes were introduced to the sickness absence policy, the National Board of Health and Welfare and NSIA (both under the Ministry of Health and Social Affairs) were commissioned by the Swedish Government to develop a more quality-assured and uniform sick leave process. A standardized diagnostic tool and classification of diseases was introduced in March 2008 (National Board of Health and Welfare, 2007). The classification of diseases also includes recommendations for the number of days of eligible sick leave. For example, if one has the flu the recommended decreased work capacity is less than one week. Another example is prostate cancer, for which there is recommended sick leave of six weeks after an operation. However, even straightforward injuries or diseases often have complications. This is partly acknowledged in the recommendations. For example, for carpal tunnel syndrome, a common strain injury, the suggested limitation of work capacity and recommended days of sickness absence is dependent on the type of work and seriousness of injury. Thus, if an employee's job does not involve straining of the hand, there is no need for sickness absence, but if the job involves heavy lifting, an employee may be on sick leave for up to four weeks.

These two standardized lists of sicknesses in the form of clear time lines and protocols, and classification of diseases for deciding sick benefits, were introduced during the same year. While neither of these amendments was directly aimed at the employment relationship, they provide an interesting case in trying to understand how governmentality of the whole population is administered locally and influences the individual employee's body. These programmes of conduct 'have both prescriptive effects regarding what is to be done (effects of "jurisdiction") and codifying effects regarding what is to be known (effects of "veridiction")' (Foucault, 1991c, p. 75). The opportunity to study the performance and effects of these standards and regulations was in the status meeting, in which both the employer and the employee were present.

Setting: status meetings and hospitals

The status meeting is regulated by a policy standard and considered to be an important tool in managing sick leave and sick benefits (Runnerstedt & Ståhl, 2005; Tollin, 2007). The employee is

called by a NSIA coordinator to take part and it is intended to stimulate the ill employee to return to work (Ministry of Health and Social Affairs, 2003). The participation of the ill employee is central to the meeting, but other relevant actors who can influence the situation are also invited (e.g. the medical doctor, the supervisor, a HR manager or specialist). The status meeting is voluntary for all actors except the employee, who can lose sick benefits if they do not participate. Thus, while the ill employee is required to participate in order to retain sick benefits (National Insurance Act 1962), the employer's presence is voluntary. The meeting is supposed to provide an opportunity for the actors to evaluate the employee's medical status, work capacity and rehabilitation needs in order to enable return to work (Hetzler, 2009; Runnerstedt & Ståhl, 2005).

This study examines hospital employees. Hospitals provide an interesting empirical setting for the case studies since they encompass employees in the midst of discourses, techniques and classifications of the body. Hospitals are also important empirical settings due to the public sector's relatively high degree of sickness absence and the large percentage of female employees, who are overrepresented within Swedish sickness absence (Nyman, Palmer, & Bergendorff, 2002).

Data collection and analysis

The research design was built around employees with long-term illnesses (more than six weeks) working in hospitals. The observed status meetings included in this paper are restricted to those where both the employee and a representative of the employer were present. This allowed in situ study of the administration of health within the employment relationship, since the meeting was concerned with the employee's ability to return to work for the present employer. Observing the meetings and conducting interviews afterwards allowed access to different interpretations and perspectives on the situation.

The status meeting with the NSIA coordinator(s), the employee, representative(s) from the employer and, at times, other actors (e.g. medical doctors or union representatives) were observed and recorded (see Table 1). The ten meetings lasted between 14 and 55 minutes, with an average of 35 minutes. Notes were also taken, for example, recording irony and facial expressions that could change the meanings of the conversations, but which are not captured well in recordings. The subsequent semi-structured interviews were conducted within a couple of weeks, using a topic list covering personal background, the sickness absence, the roles of the different actors and the actions undertaken by all involved. The 40 interviews lasted approximately 45 minutes and were all recorded and transcribed verbatim. Verbal consent from all actors was obtained before both observations and interviews.

The Foucault-inspired discursive analysis conducted for this paper studied the interplay between the political intervention (with its particular rules, standards and classifications) and the local production of health/illness (Foucault, 1991b, 1991c). The analysis did not aim to evaluate the effectiveness of the political interventions or how they can be optimized, but rather how the interventions unfolded locally and their effect (Bröckling et al., 2011). A very brief introduction to each of the ten cases can be found in Table 2 below. The transcripts of the status meetings and the interviews were coded along the four following dimensions.

First, the status meetings were analysed in terms of which concepts were introduced, when in the meeting they were introduced, and to what effect. Concepts were employed in terms of 'ideas, categories, relationships, and theories through which we understand the world and relate to one another' (Hardy & Phillips, 1999, p. 3). For example, common concepts introduced in the meetings were medical references to the body from both western and alternative systems; administrative rules of the new policies and classifications, but also local policies and practices; and more private and social ideas surrounding friendship and collegiality. The people in the meetings used the

Table 1.CC Summary of empirical material

Cases	Present participants in the observation of status meeting	Interviewed participants
Case 1: Angie	Employee, HR manager, HR specialist, supervisor, NSIA coordinator, and support person (for Angie)	Employee, HR specialist, psychiatrist and NSIA coordinator.
Case 2: Beatrice	Employee, supervisor, team leader and NSIA coordinator	Employee, supervisor, team leader and NSIA coordinator
Case 3: Danielle	Employee, supervisor and NSIA coordinator	Employee, supervisor and NSIA coordinator
Case 4: Fiona	Employee, supervisor and NSIA coordinator	Employee, supervisor and NSIA coordinator
Case 5: Marilyn	Employee, supervisor, union representative (Marilyn's) and NSIA coordinator	Employee, supervisor, union representative and NSIA coordinator
Case 6: Nina	Employee, supervisor, HR specialist and two NSIA coordinators	Employee, supervisor, HR specialist and NSIA coordinator
Case 7: Pia	Employee, supervisor and NSIA coordinator	Employee, supervisor and NSIA coordinator
Case 8: Susan	Employee, supervisor and NSIA coordinator	Employee, supervisor and NSIA coordinator
Case 9: Tilda	Employee, manager, supervisor, HR specialist, labour law specialist and NSIA coordinator	Employee, manager, supervisor, HR specialist, labour law specialist and NSIA coordinator
Case 10: Ulrika	Employee, supervisor, doctor and NSIA coordinator	Employee, supervisor, doctor and NSIA coordinator
Total	**Observations: 10**	**Interviews: 40**

concepts, opposed them, ignored them or emphasized them. The analysis then became a process of mapping out the different concepts, programmes and classifications introduced in the meeting.

Second, the different subject positions and their actions were identified. Speaking in the status meeting required the actors to adopt particular positions. Most of these were assigned before the meeting in terms of being a medical doctor, coordinator from NSIA, HR manager, patient, and so on, each with access to particular concepts that gave them legitimacy in relation to the meeting. Through their subject position they could then form new and alternative positions. For example, the coordinator from NSIA could introduce medical discourses that positioned the employee as a patient and/or referred to the employee's professional role. The effect of actors' articulations was dependent on the other subjects in the meeting. For example, if a medical doctor was present, the coordinators had limited authority in discussing medical concepts. Only certain people in the meetings had access to the medical and administrative discourses to form the situation. Depending on their access to, and authority in, particular discourses, the actors had a limited repertoire of tactics to shape the meeting (Foucault, 1991b).

Third, the analysis turned to the objectification of the subject by the different actors, drawing upon a range of discourses. The subject became a body, for example, needing care, rehabilitation, support, medication, rest, exercise, etc. The actors in the meeting constructed particular versions of the body that justified or legitimized certain actions. The technologies of the body have material effects in terms of whether, for example, the body is worthy of

rehabilitation or not. The meetings were performative in that the constructive effects inscribed and framed the body.

Fourth, the interviews were analysed in order to contextualize and further understand the activities in the meetings. The interviews provided descriptions and reflections of what happened in the status meeting, but they also contextualized the meeting. The interviews were treated as different representations of the empirical material compared to the observed meetings. They were analysed as further discursive activities to support, contradict, or be linked to the activities in the meeting. This brought to the fore the discrepancies and struggles in the situations as well as enabling further identification of differences and similarities between the actors' descriptions and reflections of the situation, both within and between the case studies (Mumby, 2005).

Table 2. Summary of the empirical cases

Case: Angie Age: 40–45 Occupation: Nurse Illness: 'Burnout' Sickness absence period: 3 years	The psychiatrist has not given a definite time frame for recovery from the burnout. The outcome of the meeting is for Angie to find a new career and occupation. However, Angie wants to continue to be a nurse, although she did not express this in the meeting, in which she was very quiet.
Case: Beatrice Age: 50–55 Occupation: Medical secretary Illnesses: 'Burnout'; breast cancer Sickness absence period: 1 year	Beatrice was first reported ill due to burnout, but is currently under treatment for breast cancer that she developed during her 50% sick leave. In the meeting the actors decided that Beatrice will start working 25%. The cancer treatment makes her joints hurt, but she will try working 25%.
Case: Danielle Age: 60–65 Occupation: Psychiatrist Illness: Work stress Sickness absence period: 1 year	Danielle's sick note does not justify further sick leave and her workability and illness are, according to her supervisor and the coordinator from NSIA, unclear in the sick note. In the meeting the participants agreed that Danielle will take early retirement instead of going back to work.
Case: Fiona Age: 60–65 Occupation: Medical orderly Illness: Carpal tunnel syndrome Sickness absence period: 3 months	Following an operation, there is a time difference between the sick leave granted on the doctor's certificate and the allowed sickness absence for the operation according to the medical diagnostic tool. This gap is negotiated and the participants agree that Fiona will start working 50%.
Case: Marilyn Age: 45–50 Occupation: Cleaner Illness: Carpal tunnel syndrome Sickness absence period: 6 months	Marilyn has carpal tunnel syndrome in both hands and requires an operation. She works 50% in an easier cleaning shift and Marilyn aims to work 100% after the operation. However, both the NSIA coordinator and her supervisor presume that her employment will be terminated.
Case: Nina Age: 60–65 Occupation: Medical doctor Illness: Back injury; breathing problems Sickness absence period: 10 months	Nina is able to work between 60 and 70% of full capacity, but the policy time frames are 25, 50 and 75%, which suggests that Nina needs to find another job for the other 50%. Nina will be evaluated by an occupational therapist in relation to what kind of work she will be able to perform.
Case: Pia Age: 55–60 Occupation: Medical orderly Illnesses: Breast cancer, anxiety hysteria, back problems Sickness absence period: 3 months	According to the doctor's certificate, Pia can do work that does not strain her back. In the meeting her supervisor suggests that Pia tries an administrative position in the hospital. However, after the meeting the supervisor cancel that, due to Pia being prone to illnesses, and suggests that Pia sees an occupational therapist to evaluate her work ability.

Table 2. (Continued)

Case: Susan Age: 45–50 Occupation: Psychotherapist Illness: Hypertension; angina Sickness absence period: 3 months	The stages of the rehabilitation chain have created problems, since Susan has not got a proper diagnosis of her illnesses. The meeting discusses how to ensure a good diagnosis within adequate time frames and the consequences of the time frames for Susan's situation.
Case: Tilda Age: 25–30 Occupation: Nurse Illness: Back problems Sickness absence period: 2 years	A second opinion organized by the employer suggests that Tilda can work in an occupation with no lifting, so she will no longer be granted sick benefits. She will do a work trial for three weeks, but all actors, including Tilda, suggest in the interviews that her employment will be terminated.
Case: Ulrika Age: 50–55 Occupation: Nurse Illnesses: Fibromyalgia; burnout Sickness absence period: 7 months	Ulrika is working 75% and in the meeting they discuss how they can schedule her 100% without overworking her. The meeting is mainly about particular shifts and departments within the hospital that would be beneficial to Ulrika.

Bodily Complexities

The body discussed in the meetings does not have *one* illness that needs treatment according to a straightforward plan. To the contrary, for each individual there are several bodies and illnesses introduced in the meetings (see also Table 2). For example, in the case of Pia, her illnesses were the first thing introduced by the NSIA coordinator:

NSIA: Well, you have been on sick leave since June, this time. Initially you were on sick leave for depression, and then it became breast cancer and sciatica. And you explained over the phone that you have had an x-ray, and then magnetic resonance imaging as well, and you have been to that, but you have not got any confirmations yet?
Pia: No. I have also been to computed tomography last Tuesday.
NSIA: Do you know when you will get further information?
Pia: No…

While the original medical certificate, or sick slip, said 'anxiety hysteria', in the meeting the discussion centred mainly on Pia's back problems and whether they could find work for her that would not strain her back. Her breast cancer and sciatica were only discussed in terms of the other actors showing sympathy. The body in the meeting was sliced, categorized and discussed in terms of the body on the sick slip with anxiety hysteria, the body at work with back problems, and the social and human body with breast cancer and sciatica. The attending actors discussed the body both at a distance as an object or a partial body in terms of 'the metastasis' that needs treatment, and as belonging to Pia in terms of 'your body'. The example shows that there were a multiplicity of bodies, body parts and illnesses discussed in the meeting.

These objects could be introduced by any of the present actors in the meeting and often reference was made to past, present or future bodies and illnesses. For example, in the status meeting surrounding Danielle's sickness absence, she referred back to previous illnesses, 'my whiplash, my broken arms, my back problems and everything…', in discussing the current work situation and the lack of support for her injuries. Similarly, Susan's supervisor referred to future problems with Susan's 'blood pressure' if she in the future 'works every day'. These objects are not easily disentangled, which is illustrated in the case of Beatrice. During radiation treatment for her breast

cancer, Beatrice acquired another injury to the elbow, which affected her job as a medical secretary. In the status meeting Beatrice explained to the other participants:

> And now I've got a problem with my elbow, since now at the end [of the radiation treatment], I have been in a particular position for five weeks with weights on my arms, so they won't move during radiation.

How the illnesses or diseases influence the employment relationship is dependent on how they are discussed in the meeting. After Beatrice introduced the problem with her elbow, the meeting became largely about her elbow: whether she needs massage or to go to a physiotherapist; who should fund this eventual massage or visit at the physiotherapist; whether she can do it during working hours; and how the elbow hinders her work capacity as a medical secretary. The introduction of one body part shaped the meeting and its decisions.

In the meetings, the employee, the body and the illness became 'known' beyond the few lines on the sick notes in the often technical discussions about illness and symptoms. However, rendering the employee knowable went beyond the medical discourse and illnesses, with often social aspects or private hardships discussed in the meetings. Mapping out the individual employee's workability also included aspects of the social life, their social body. How this happens was manifested in the case of Marilyn. In the status meeting about Marilyn's illness and rehabilitation, her coordinator from NSIA explained that the discussion would include:

> …the social part, it is about, well, are you married, living with someone, single, or whatever one is, children and all that, where you live and constraints you have in the home. As you said, you have problems with hygiene in the morning.

These may appear as valid considerations for a hospital cleaner with carpal tunnel syndrome, but, with her supervisor present, answering these questions might have consequences for the employment relationship. The employee takes part in providing knowledge, by making her health and private situation public, which can be used by the employer in governing the situation. In this case, Marilyn's problem with private hygiene in the form of washing herself and showering in the morning becomes part of the discussion of her workability. The private body was introduced to discuss the body at work.

Standardizing Bodies and Illnesses

All the different bodies, body parts and illnesses discussed in the meetings were not equally enacted. Some objects were pushed to the front, while others were left in the shadows. The actors in the meeting jointly gave shape to the sickness absence process. In all the meetings observed, one or both of the governmental programmes of the time-specific rehabilitation chain and classification of illnesses were introduced and used to frame the discussion of the sickness absence. These programmes did not determine the body to be enacted, but rather guided the conduct of the meeting.

The standards were introduced in the meetings by the actors when there was some form of contest, for example, what should be done, why things were as they were, or who was responsible. As outlined above, NSIA evaluate an employee's ability to hold any job after 90 days of sick leave. This can be problematic if the illness or injury is still hampering or hurting the employee. Fiona, suffering from carpal tunnel syndrome, was trying to get back to work after an operation, but her

right hand was still not fully functional. In the meeting, the actors discuss Fiona's right to sickness benefits considering that she can use other parts of her body:

Fiona:	But, I'm still ill.
NSIA:	Yes, but you don't have the right to get sick benefit if you can do another job, where you don't strain your hand.
Fiona:	Yes, I understand that, but what if that doesn't exist?
NSIA:	Well, then it is the employment agency's responsibility, since you have no right to sick benefits.
Supervisor:	Strange reasoning, I think, if you still don't have a working capacity after the injury or illness.
NSIA:	If I do a comparison with, for example, if you have problems with your knees in your occupation and then you cannot do your job as a medical orderly…
Fiona:	I understand that.
NSIA:	But you can still do another job where…
Fiona:	Yes, I get that too.
NSIA:	It is the same thing in this case, you are healthy except for your right hand and then you should be able to undertake some other kind of job.

The NSIA coordinator is questioning her right to sick benefits considering that potentially a job could be found where she does not use her right hand. The sick slip provided by the medical doctor in Fiona's case differs from the diagnostic tool used by NSIA. In the interview, Fiona described her illness and the situation:

> Well, the joints in my thumb are torn and it was very painful when the bones gnawed at each other. I was very bothered by it in certain situations as well as during the nights, and my fingers went to sleep. They decided that they would do surgery for it and I was operated on October 8. They have cut out this joint, added some tendons here, and ripped up this, so that my fingers won't go to sleep. The doctors say that is a sick period of 4–6 months, while the lady from NSIA looked up the diagnostic number and says it is 3 weeks.

Doctors need to provide clear explanations and justifications of why their sick leave is longer than the recommended time according to NSIA's diagnostic tool. Even so, NSIA may challenge the classification of disease, the recommended sick leave, and fundamentally the right to sickness benefits. A NSIA coordinator explained in an interview the importance of using the disease classification system, with its recommended sick leave periods:

> If [the medical doctors] recommend longer sick leave than the recommended time in the classification system they have to justify that medically in relation to the work capacity. But, well, there are not many who do this…the doctors themselves don't seem to understand their importance in sickness absence, in the process of sick leave, and the importance of what they write in order for the insured to be eligible for the right payment from us. It can be that, or I often feel like they don't really take it seriously.

Thus, although the medical doctors are rarely present in the status meeting, their written sick slip is often introduced, interpreted and discussed.

Similarly, in the case of Nina, the NSIA coordinator suggested in the meeting that the sick slip did not justify Nina's amount of sick leave. The NSIA coordinator explained in the meeting that she

had tried to get further information from the doctor as well as the potential consequences for the lack of details on the sick slip:

> The only thing [the doctor] has written is that you have problems with walking and that is what he has been writing all along… Based on [the doctor's slip] your right to sick benefits are a bit questionable. Because I can in principle ask your employer if they have a job where you sit instead and, if they do, you can have that and be allowed to get sick benefits. But if they don't, then you would be able to handle a sitting job that exists in the labour market and then you are not allowed to get sick benefits.

The sick note from the doctor provided a description of Nina's body and her abilities to work that was evaluated by the NSIA coordinator as not sufficient. In the meeting Nina opposed this evaluation. Nina, herself a medical doctor, introduced 'a few other illnesses as well' and further described why there was an insufficient sick note:

> I have an appointment with the lung doctor to measure my lung capacity, the 15th of October, I think. I have not heard anything back from the heart doctor. And then I have to wait for my back doctor and what he is going to find.

The sickness absence process then became more complex in trying to accommodate her back problems, which make it hard to sit down, her shortness of breath, which hinders her walking, and her different forms of medication, which make her 'a bit high' and unsuitable to see patients. Nina defended the doctor's lack of notation based on the fact that he is a doctor (with the basic assumption that they do not write much) and instead suggested that it is the standards that are the problem. Nina, with access to medical discourses and authority to enforce them, was able to influence the meeting towards other aspects of the situation. The discussion in the meeting was instead directed towards the different time lines for sickness absence administration.

The framing of the body and clinical evaluation further needs to be compatible with the introduced time lines of the sickness absence process. The sick note from the medical doctor thus needs to clarify what type of job, if not the current one, the employee can perform within the organization and the external job market. For example, Marilyn is waiting for an operation for her carpal tunnel syndrome; even so, the NSIA coordinator clarified in the meeting that:

> It is these first 90 days and then up to 180 days, you have a right to be on sick leave, if the employer cannot offer another job. At 180 days, then one evaluates the right to sick benefit, whether one can do another job, despite the disability…Today you are not allowed to get sick benefits for the type of disability you have in your hands. It is totally impossible.

The implication is that, even though Marilyn was waiting for an operation, she should still be evaluated as to whether she could do another job in the organization and subsequently in the whole labour market. This is not only problematic in terms of the time required in waiting for the operation, but also the period of sick leave after the operation, as shown by the example of Fiona above, who already had her operation and was rehabilitating her hand.

The possible incompatibility between illnesses and NSIA's time lines was commented on by a NSIA coordinator:

> Well, it feels like there is a bit of a distance between the [NSIA] rules and the health sector. I think it is good to have rules to follow, but there are quite a few who fall in between. For example, those who wait for an operation and it takes several months. They can perhaps go back to their job after the operation,

> while we make a judgement after six months that they should take another job. Then they say: 'but I can go back'.

Here the coordinator from NSIA suggests that the two standards are not compatible and that it is the employee who suffers as a result. The standards suggest that after six months an employee should be assessed for the whole external job market, even though employed. So, for example, if there is a long waiting list for an operation, an employee is supposed to find another job, which can be performed without the operation, regardless of whether the employee may be able to return to the current job after the operation. How the two programmes are introduced to guide the discussion of sickness absence in the status meeting can have consequences for the employee's sickness benefit.

The Politics of the Body

The multiplicity of the body, together with the often incompatible programmes of illness classification and administrative time lines, provided room for political manoeuvres. The actors did not apply the sickness absence rule, but rather appropriated the programmes strategically to shape the outcomes of the meetings. The actors had unequal access and authority to draw upon discursive regimes, such as medical or administrative discourses, or to introduce particular aspects of the sickness absence programmes. While any actor could introduce a concept in the meeting, it required certain subject positions for the concepts to be acted upon. It was often the employees who showed the least knowledge about the rules surrounding sickness absence and this could be used to shift responsibility for the situation. In the observed meetings, it was the employers rather than the employees or NSIA coordinators who displayed strategies in shaping the sickness absence process.

The employer has the responsibility to find a new job for the sick employee within the organization or to provide rehabilitation for the employee to return to the former job. However, there is nothing NSIA can do if the employer does not fulfil the rehabilitation duties. One of the NSIA coordinators explained this in the interview:

> Well [the employer] is supposed to have the big responsibility, but I think they get away too easily, without anything happening to them. There is no one telling them. Well, we cannot force them to take their responsibility. It feels like it is basically up to them.

With limited accountability, the meetings were used politically to evade responsibility and govern the individual body.

The politics was exemplified in Tilda's status meeting. In the meeting, the employer was represented by four people (Tilda's supervisor, Tilda's manager, an HR specialist and a specialist in labour law), who all took part in influencing the discussion. Even Tilda's manager, who in the interview acknowledged that she did not want Tilda back on her ward, thought the tactic of being four against one in the status meeting was a bit unfair:

> It wasn't good that Tilda was alone when we were so many from the employer and NSIA…We cancelled a meeting because [the labour law specialist] could not be there. And I think that we, or [the HR specialist], should have cancelled this meeting since Tilda was there by herself. It is the same situation. If we cannot have our labour law specialist there, why should we have a meeting when [Tilda] cannot have her union representative there. It is not right!

Cancelling an earlier meeting and choosing a time when Tilda's union representative could not attend influenced the dynamics of the meeting, since Tilda had limited knowledge about the

different concepts introduced by the actors. In the subsequent interview, Tilda explained that she got 'scared' when she saw that the labour law specialist was going to attend the meeting, since he was a specialist in 'firing' people. Tilda further claimed that her employer moved the status meeting back to ensure that Tilda would be tested for the external job market, rather than internally within the hospital. By doing this, the problem was shifted to Tilda herself to find another job. Prolonging the meeting can then result in shifting the responsibility from the employer to find the employee a job within the organization, to the employee to find a new job in the external job market.

Another example of how the employer could influence the outcome of the status meeting was to 'purchase' an alternative evaluation of the employee's illness or health. The HR specialist in the case of Nina explained in the interview how this works:

> We have the right to appoint a doctor, that is [employer-funded health service], to take over the sick listing, to have everything in one place. And it has been practical in certain situations where there have been two different [medical opinions], not totally different, but with different opinions on the situation and the treatment. In these instances we can get support from [employer-funded health service]. They come in and take over and provide the doctor's certificate.

The employer can thus 'hire' a doctor to support a particular diagnosis or provide an alternative medical certificate. New, supporting, or alternative evaluations of the illness and workability can then inform the activities taken in response to the sickness absence. A new diagnosis can provide a new version of the body to act upon, with a different classification and different needs for rehabilitation with different consequences for the ill employee.

An alternative strategy is for the employer to try to influence the current diagnosis. In the case of Susan, her supervisor declared in the meeting that she could influence the outcome of the diagnosis, saying that she could call the doctor to influence Susan's diagnosis. She also acknowledged that putting pressure on the doctor was perhaps not the moral thing to do: 'Sometimes, unfortunately, we can as employers give a signal to our dear [healthcare system] for these kinds of things. Right or wrong, I can use my resources.' In all cases, the supervisors were, or had been, a medical professional and thus had both knowledge and sometimes a professional relationship with the relevant doctor. Similarly, HR managers who engaged doctors to evaluate contested illnesses in the organization had an established relationship with these doctors.

The different strategies exemplified above emphasized how the actors brought in new or alternative framings of the illness or situation in the meetings to influence the meeting. The strategies acted upon the employee as an object to be known and categorized according to particular standards or frames. Another type of strategy used in the meetings was to influence the employee as a subject. These tactics involved the moral and social human being that is responsible for her or his illness. This was in line with the movement from welfare to workfare. One of the NSIA coordinators explained in the interview that this could be difficult for employees:

> The individual has a responsibility towards oneself, in regard to one's own interest and how one wants the future to look like. Not everyone recognizes this and that is partly to do with the age and the idea that one is employed by the same employer until retirement. Another aspect of this is, as people, we often identify with our jobs. When we meet a new person, we introduce ourselves with name and job title. This makes it hard to accept that the identity needs to change.

How the responsibility of the sickness absence process was shifted towards the employee was exemplified in the case of Angie, a nurse who was on sick leave due to 'burnout'. While Angie

wanted to return to her former work, her HR manager suggested in the status meeting that she should change career. The HR manager even gave the example of 'working with flowers' in the meeting. According to the regulations, the employer is responsible for rehabilitation and finding a new position within the organization. However, as the coordinator from NSIA suggested in the case of Angie: 'It will be interesting to see whether they find another job for her. They already [in the status meeting] said that there wasn't any. I don't think they have investigated it very carefully'. The NSIA coordinator said in the interview that Angie had said that she wanted to go back to her work, but that the employer might have convinced her otherwise: 'It appears like they have forced her to take this direction.' The employer instead introduced an alternative career in the meeting, which shifted the responsibility to Angie to manage her own situation. The HR specialist, in the subsequent interview, explained that this was a strategy planned before the meeting in order to terminate Angie's contract, since 'she takes a lot of time and resources from her colleagues'. Angie, who was very quiet in the meeting, explained that due to her illness she could not think straight and that her 'brain is a bit messy'. Being ill, Angie did not have the strength to oppose the shifted responsibility in the meeting. The weak and exposed position of Angie in the meeting was also noted by the HR specialist: 'I can only imagine how it feels for Angie sitting on her little chair with everyone around her looking at her.'

Similarly, in the case of Pia, the supervisor in the meeting introduced the possibility of an alternative career since, due to her back injury, she could not perform her work role any longer. Despite all the actors agreeing that Pia's back injury was work related, the supervisor shifted the responsibility to Pia:

Supervisor:	If you cannot handle the work, why should you still have the job as a medical orderly?
Pia:	I don't mean it…
Supervisor:	Perhaps take a course and be the boss's secretary.
Pia:	I don't know…

The supervisor led the discussion in the status meeting, interrupting Pia, and suggesting that it was her responsibility to plan for a second career, since very few people within the healthcare sector are able work to retirement age, due to strain injuries for example. Pia, on the other hand, appeared lost in her new situation. She was 57 years old, trained as a medical orderly, and no longer able to work in the profession due to her back problems. In the interview she declared, 'I'm a proud medical orderly, I have never wanted to be anything else.' A second, less physically demanding career did not appear plausible according to Pia, who suffers from breast cancer, back problems and sciatica. She explained this in the interview with the following words: 'I have eight years left to retirement, and I may not live eight more years.'

Other employees were more willing to accept that they needed to take ownership of the situation. For example, in the case of Ulrika, the actors discussed in the meeting how Ulrika was taking on too many responsibilities and worked too hard, which was why she became ill in the first place.

Supervisor:	This is where your own responsibility enters. This is where you should take responsibility for your illness.
Ulrika:	Yes I know, but…
Medical doctor:	So you don't get ill again.
Ulrika:	Yes. But I'm a bit like that, I have it within me that the patients are first priority. But, I know…

Medical doctor:	But is this the best attitude for your employer?
Ulrika:	No, perhaps it isn't if I'm really honest.
Supervisor:	No, and we really need her.

Thus, while the actors in the case of Ulrika agreed that work stress made her ill, it was implied that it was Ulrika's responsibility to manage herself to avoid illness. Employees were expected to be active in negotiating the complex situation surrounding their illness. Tilda's supervisor summed up the paradox of being enterprising while being ill: 'You need to be healthy to be ill'.

Discussion

The empirical material provided above illustrates how the regulatory control of the population through the sickness absence policies were locally connected to the individual body. The discussions in the status-meeting, as a form of governmentality, were aimed at administering the health of the employee (Rose & Miller, 1992). However, this was not a straightforward application of policies, in which the ill employee was categorized by the state or NSIA according to the standards of the political intervention. To the contrary, the findings showed how the various actors could influence the sickness absence process. The local appropriation of the governmental policies echoes Callon and Latour's (1981) concept of 'translation', with the actors locally transforming the policy for the situation while still expressing the intent of the policy (see also Cooper & Law, 1995; Czarniawska & Joerges, 1995; van Gestel & Nyberg, 2009). The local process of sickness absence is thus political in that the actors modified the policies to be aligned with their particular objectives in shaping the outcome of the meetings. This points to the importance of accounting for the power relations between the actors in understanding the sickness absence process.

The NSIA coordinators often introduced the policies in the meeting. These policies did not act directly on the individual and, beyond the requirement to attend the meetings, there appeared to be limited sovereign power on display. The governmental standards were introduced to indirectly influence actions and to make the actors reflect upon their situation in understanding why they should act in certain ways. The possibilities for NSIA coordinators to employ standards were dependent on their intimate knowledge of the subjects in the first place. The practice of status meetings connects detailed knowledge of the object with standards for the population in order to govern the subject. The NSIA coordinators' role was mostly just that, coordinating, and they had no responsibility for rehabilitation or changing the workplace to accommodate the ill employee. While the coordinators called the meetings and mediated some of the discussions, the return to work and access to rehabilitation was, subsequently, largely based on the relationship between the employer and the employee.

The findings suggest that the employers had a stronger position in the power relation with the employees. In the meetings, the employer representatives appropriated the governmental practices in governing the 'conduct of conduct' (Foucault, 2007, pp. 192–193), closing down certain paths and opening up others for the meeting and subsequent actions to take. The power relations were thus established through changing the procedures, evaluations, diagnosis and calculations of the illness and workability. Through these technologies they evaded responsibility for the object, in the form of rehabilitating the body or refitting the workplace, as well as for the subject as a moral and social being. The interventions were not directed towards the human being, but the 'rules of the game' as the field of possible actions (Foucault, 2000).

The exercise of power in influencing the game 'makes possible the introduction of new players into the game, the elaboration of new rules of the game, existing players finding new parts to play,

new relationships between the players, and new stakes of the game' (Burchell, 1993, p. 279). In managing the status meeting, the employers introduced, for example, new diagnosis and labour law specialists with legal resources, and involved ideas of the market as solutions to the problem of sickness absence. They also supported the role of the individual as an entrepreneur in cultivating his or her own human capital (Weiskopf & Munro, forthcoming), and argued for an economic rather than pastoral relationship. They offered limited support for long-term ill employees. The analysis of the technologies applied to the status meetings thus supports and reaches far beyond the categorizing and disciplining activities outlined in Townley's (1994) influential analysis. The categorization of employees to ensure their productivity was closely intertwined with the administration of their bodies in appropriating the regulations of sickness absence to administer efficient uses of employees.

Employees had somewhat contradictory positions in the meetings. In many instances they were victims, with other actors recognizing that the reason they were ill was because of inherent organizational or occupational problems. In this position, they were social beings who have faced hardships over a long period of time. On the other hand, they were responsible beings expected to be the entrepreneurs of their lives, including when ill. In this case, they have failed in their responsibility, with their failure evidenced by being ill in the first place. This latter position often dominated and the shift in healthcare logics from illness to health, from sickness absence to workability, has meant an increasing role for individuals in managing their well-being (Rose, 2001). This shift has also meant that individuals need to take an active part in a political process of shaping their health, not only in terms of patient choice (Mol, 2008) and private health insurance (Rose, 2001), but also in terms of being able to act on the diverse range of policies, standards and calculations that influence their situation. Failure to engage competently in the discussion, often due to illness, meant decisions were made for them.

With the employee ill and often lacking authority to access medical or administrative discourses, the policy guidelines and the disease classifications can be seen as 'devices for social control' (Suchman, 1994, p. 188). They can support or conflict with each other (Dodier, 1998), and the same standards can be used or drawn upon to provide several different versions of the body (Mol, 2002). In what Mol (1999) refers to as 'political ontology', the standards and classifications provide material realities and realities of the body. The instruments for controlling the population suggest what the population is and when these are enacted locally they become the chosen reality. With diseases and illnesses as the central topic in the status meeting, the discursive activities produce the employee's body. The standards form the body; they shape different versions of the material body (Barad, 2007; Nyberg, 2009), with different diagnostic tools and standards providing alternative own versions (Mol & Law, 2002). The discursive grids do not shape the representation of the body; the discursive grids produce the body. The body is an *object* that needs treatment, medicine or an operation, and a *subject* who needs sympathy and encouragement (Townley, 1994). It is a body *at* work with complication for its performance, and it is a body *for* work with, for example, need of a new job or career (Wolkowitz, 2006). There are thus multiple bodies in the meeting and which body that is emphasized or acted upon is politically negotiated.

Conclusion

The purpose of the paper was to understand the interconnection between, or translation of, national policies aimed at governing the population and the local techniques of power in governing the individual body. Using the case of sickness absence management, the paper illustrated how national political interventions were appropriated locally to manage ill employees. The empirical material

showed how the introduction of multiple bodies and standards allowed for political manoeuvring in influencing (a) the understanding of the conceptualization of the disease to be negotiated, (b) the subject position of the ill employee and (c) the ill body to be treated or rehabilitated. With a stronger position of power, the employer could strategically use this complexity to influence the sickness absence process towards particular outcomes. This had material consequences for the employees' situations resulting in, for example, unemployment or lack of sick benefits. This contributes to the understanding of the material consequences of regulations, policies and standards for the body (Rose & Miller, 1992).

The empirical support for the arguments suggests further investigations to understand the move from 'welfare' to 'workfare' in western liberal democracies more generally. First, it is worth considering the age and gender of the employees in the cases above. While the study lacks comparative elements, since all the subjects are women, the importance of access to influential discourses would suggest discrimination of disadvantaged groups, with implications for sexuality, gender, cultural background, age, etc. (see also van Gestel & Nyberg, 2009). The weaker subject positions of disadvantaged groups to negotiate their employment opportunity and rehabilitation, evidenced by less well-paid and prestigious occupations for these groups, would arguably explain the over-representation of women with long-term illnesses.

Second, there is a contradiction in the activation policies implemented across western liberal democracies in that they aim for mobilization and activity, while non-compliance suggests immobility and deactivation: cutting the benefits for lack of entrepreneurial activities results in restraint of individual capacity to activate oneself (Lessenich, 2011, p. 33). The risk associated with being ill is only supported if you are healthy. The increased complexity of healthcare regulations, policies and standards arguably increases inequality. This is due to different actors' access to resources and knowledge to influence the process associated with an illness, which favours certain occupations over others as well as employers over employees.

Third, in line with the marketization of social relations in neoliberal societies, the shift from welfare to workfare has replaced assistance and compassion from society with the duty of the enterprising self to organize the enterprise of one's life (Gordon, 1991). In healthcare, economic efficiency is upheld through giving the ill responsibility for their own rehabilitation and recovery. Homo economicus is no longer an ideal type or a theoretical figure, but a reason for political intervention. The ill employees' lack of influence in managing their health/illness in the case studies invites further studies to understand the limited individual autonomy when individual autonomy is the central principle of governmental policies.

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