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Cross-sectoral frontline delivery of welfare-to-work services for young adults with complex problems in Norway

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Abstract

Activation policies have increasingly targeted new and 'hard-to-serve' clients with complex needs, often deprived of the labour market experience, health, skills, and competencies that employers look for. The role of the health sector as a partner for welfare services has thus become more important. Cross-sectoral frontline delivery of activation is seen as crucial in succeeding with activation and labour market integration in general and especially for young adults with complex needs. The current study aims at contributing new insights on such cross-sectoral coordination by investigating how various actors within the welfare and health services experience interagency collaboration in the context of activating young welfare clients in the Norwegian Work Assessment Allowance scheme (WAA). Our data consist of 33 interviews with frontline workers in the two sectors in six different municipalities. Our data suggest that cross-sectoral work in Norway directed at young WAA-clients is hampered by a lack of coordination and communication between frontline workers in the two sectors, leading to tension and inefficiency in activating these young clients. We do, however, find that in-house medical advisers in the welfare services have a potential to act as boundary spanners, but that seem to be an underused asset in this regard.

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We conclude that frontline workers' opportunities for cross-sectoral coordination seem to be constrained by narrow and insufficient spaces for integration and collaboration, possibly due to organisational and administrative barriers.

KEYWORDS
activation policy, cross-sectoral frontline work, disability, fragmentation problem, frontline workers, work assessment allowance, young welfare clients

1 | INTRODUCTION

European welfare states have increasingly turned towards active labour market policies to solve the financial and welfare challenges associated with demographic change, new social risks and post-industrial labour markets (Esping-Andersen, 1999; OECD, 2017). A key ambition in the expansion of activation has been to better integrate disadvantaged citizens in the labour market by means of economic incentives, conditionality, and sanctioning on one hand, and rehabilitation, up-skilling and education on the other.

However, this shift from 'passive' to 'active' labour market policy soon led to calls for welfare service reform. As activation policies increasingly targeted new and 'hard-to-serve' clients, the 'fragmentation problem' in welfare service delivery became steadily more salient (Champion & Bonoli, 2011). The new client groups often had challenges beyond not being able to find work, frequently lacking the labour market experience, health, skills, and competencies that employers demanded, so-called complex problems. The traditional public employment services, embedded in 'departmentalism' and New Public Management governance structures (Christensen & Lægreid, 2007), were not set up to meet these challenges. In response to this, scholars and policy makers argued that different health and welfare services needed to collaborate and coordinate their efforts to provide the necessary help and increase service efficacy (Heidenreich & Aurich-Beerheide, 2014; Larsen & Caswell, 2020; van Berkel et al., 2012).

The fragmentation problem in social policy delivery has been widely acknowledged (EU., 2014; OECD, 2015), and recent welfare and organisational reforms have been launched to aid successful labour market integration. These include major reforms such as the Hartz-reforms in Germany (2003–2005), the Dutch SUWI-reform (2002) and Job Centre Plus in Great Britain (2002) (Champion & Bonoli, 2011). In Norway, the 2006 NAV-reform is yet another expression of this reform-wave (Askim et al., 2011; Minas, 2014).

With the expansion of activation policies to beneficiaries with complex problems, the role of the health sector as a partner for welfare services has become more important (Caswell, Larsen, et al., 2017). However, the two sectors have different institutional aims, professional values and understandings, as well as separate institutional logics, internal governance and technical infrastructure that may hamper coordination and cause inefficiencies (Andreassen & Fossestøl, 2014; Loyens, 2019; Saikku & Karjalainen, 2012).

While the preconditions and consequences of welfare reform and organisational change can be observed in aggregate studies, welfare reform arguably takes place locally and depend on frontline workers' practices and the resources and abilities available to them (van Berkel et al., 2017). To better understand the nature of integrated service delivery, including possibilities, hurdles and bottlenecks, a local cross-sectoral perspective is pertinent. Yet, a recent review established that there is a lack of knowledge on how frontline workers in different public-sector organisations are related, interact and cooperate in their work with clients who have complex needs (van Berkel, 2017).

This article addresses this gap, using activation of young adults in Norway as a case. Young adults outside the labour force often have complex needs, such as (combinations of) health problems, little education, lack of work

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experience, sleeping problems, low self-esteem and mental health issues (Ose & Jensen, 2017). The transition to adulthood is a critical life-stage that exposes existing inequalities and vulnerabilities and strongly shapes future outcomes. Research shows that critical life events and disadvantaged family backgrounds increase the risk of marginalisation, ill health and benefit receipt in adulthood (Dunlavy et al., 2021; Kauppinen et al., 2014). Although Norway ranks low in international comparison regarding youth not in employment or training and on youth unemployment (OECD 2022), a large proportion receive welfare benefits, and health-related benefits in particular (Carcillo et al., 2015, p. 43). Hence, in addition to serving as an example of the type of clients networked services in Norway were meant to aid, young adults on welfare also represent an important and prioritised target group in this context.

Our data consist of 33 interviews with frontline workers in the welfare and health services in six municipalities, engaged in work ability assessment and activation for young adults in the temporary disability benefit scheme: The Work Assessment Allowance (WAA). The introduction of the work assessment allowance (WAA) in 2010 was a key element of the NAV reform in Norway, as it specifically aimed at providing 'holistic' and coordinated work assessment, rehabilitation and activation services to users with complex needs.

In the assessment of eligibility for the allowance and in organising and executing activity requirements, frontline workers in the Labour and Welfare Administration (NAV) interact and coordinate their work with professionals in the health services, General Practitioners (GPs) and in-house medical advisers in particular. In this article we address this collaboration between frontline workers and ask; How do frontline workers in the welfare services and the health care sector experience collaboration and joint assessments of work ability in relation to achieving activation for young clients with complex problems? The paper proceeds by presenting previous research and describing the study context, before presenting and discussing our empirical findings.

2 | THEORETICAL BACKGROUND

Cross-sectorial collaboration or networked services has been studied extensively, but different scholarly traditions use different concepts and frameworks. Andreassen et al. (2020), in a recent review, distinguish between four different conceptualisations focussing on governance, organisation, service innovation and professions, respectively. The first conceptualisation uses terms like 'New Public Governance', 'post-New Public Management' and 'collaborative governance' to emphasise new modes of decision making and management that transcend sectorial boundaries and increase horizontal collaboration. The second approach views networked services as a form of organisation in which actors engage in 'inter-organisational' or 'intersectoral' collaboration and form relations across service sectors. Third, the service innovation approach is interested in how networked services can shape new practices ('collaborative innovation'), involve service users in development and service delivery ('co-production') and how this can create added value for the user ('co-creation'). Finally, a fourth approach considers the relationship between professionals in different organisations with distinct disciplinary backgrounds and jurisdictions that engage in joint activities. This includes an interest in the relationship between different forms of professional knowledge in 'inter-professional collaboration' as well as how and to what degree the collaboration is embedded in a coherent model of integration, for example, the 'integrated care' literature in health services research.

The literature on cross-sectoral frontline delivery of welfare-to-work services may have relevance to all these conceptualisations, but is scarce as most micro-level studies have taken singular organisations as their unit of analysis, rather than interlinked or networked services (Loyens, 2019; van Berkel, 2017). Multiagency modes of governance arguably constitute distinct contexts for frontline workers which in comparison to single-type-of-agency are less influenced by formal rules, hierarchies, and control regimes, and more dependent on inter-agency trust, partnership, shared understanding, and joint action (Loyens, 2019; Saikku & Karjalainen, 2012). These features may also make network governance more prone to conflict, inefficiency, lack of legitimacy and breaches in equal treatment and transparency principles (Loyens, 2019), and may raise questions about accountability (Saikku & Karjalainen, 2012).

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Related to this, previous research on cross-sectorial services has emphasised the role of 'boundary spanners' in service co-ordination and collaboration. Boundary spanners, often employed in standard positions in a multiagency landscape, can create trust and relationships across institutional and professional barriers. In doing so, they facilitate new modes of networked collaboration (Williams, 2002). For instance, Lindsay and Dutton (2012) identify boundary spanners in the UK National Health Service engaging employees at Jobcentre Plus and other stakeholders in collaborative efforts to improve outcomes for incapacitated service users. The boundary spanners facilitated multi-agency partnership through engaging with the values and interests of other agencies and by their openness to new ways of working, that is, practices uncommon within medical domain.

Boundary spanners can occupy different positions in an organisation, some of which may be boundary spanning by 'design', but also managers and frontline workers in traditional positions may take on boundary spanning roles and functions (Williams, 2013). The boundary spanner role can be divided into four components. The retuculist component is about tending inter-personal relationships and networks, making use of cognitive, managerial and political competencies. The entrepreneurial role is about creating new solutions to complex problems through opportunism, creativity and innovation, and building coalitions and negotiate deals between disparate interests. The interpreter/communicator role involves having knowledge on the various cultures, motivations, gazes and practices shaping the cross-sectoral field. This is acquired through listening and understanding the various actor's positions and interests. The boundary spanner uses this knowledge in conflict resolution, negotiation and consensus- and trust-building between the different actors. Finally, the coordinator role involves organising, planning, servicing and administrating the collaboration and network activities.

Although the importance of individual personal traits and relationships is emphasised in the boundary spanning literature (Ingold, 2018; Williams, 2013), programmes that specifically aim at collaborative innovation between various services can also be a way of cultivating boundary spanning, as found by Lindsay et al. (2020). This is contingent on preconditions that empower managers and key frontline workers, like distributive leadership, professional autonomy, and absence of outcome-based funding regimes. Other barriers to effective boundary spanning are networks with few links, task overload, heterogenous partners and structural limitations such as legal constraints and an unequal power balance (Kousgaard et al., 2015; Long et al., 2013; Pearson & Watson, 2018).

In the face of conflicting institutional logics and organisational barriers, welfare-to-work caseworkers and general practitioners may instead resign to various strategies for promoting their own views and decisions. For instance, as found in a Norwegian study, frontline welfare workers tend to see GPs as constrained by a medicalised view on health and work, focussing on disease and limitations and work and activation as damaging to health (Håvold et al., 2018). The caseworkers also worry that the market-based funding regimes for GPs incentivises them to accepting and advocating the patient's views rather than basing their advice on professional judgements. In response to this, the welfare frontline workers engage in creative institutional work to promote an 'asset-based' ideology of activation, where work and activation is seen as salutary rather than health-damaging. This work included *defining*, such as getting second opinions from in-house medical advisers; *constructing normative networks*, for example, arranging dialogue meetings and exchanging information; *educating* GPs in activation policy and regulation; and *changing normative associations*, that is, trying to re-orientate the GPs attitudes towards the 'asset-based' view of activation by involving them in the preparation of individual work inclusion plans and presenting and discussing opportunities and solutions (Håvold et al., 2018).

The GPs on the other hand, particularly when faced with mentally ill patients, or patients with musculoskeletal complaints, who have little or no work experience, feel ill equipped in making qualified professional judgements about individuals' work ability (Krohne & Brage, 2008). The inherent conflict between the medical ethos of being the patient's advocate and making professional judgements under great uncertainty, seem to result in various rhetoric strategies in medical certificates, ranging from emphasising the patient's 'worthiness' or positive character, like their willingness to work; making pleas for sympathy and understanding; to displaying professional uncertainties and doubts (Aarseth et al., 2019).

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Håvold et al. (2018) also note that compared to frontline welfare workers, the medical profession ranks high in the occupational hierarchy, with more education and a strong professional organisation. This is reflected in the strong position 'objective' medical assessments has in the social insurance system, although GPs may often find it hard to live up to these expectations (Aarseth et al., 2019; Krohne & Brage, 2008).

3 | STUDY CONTEXT

Norway's solution to the fragmentation problem was first and foremost the NAV-reform which established the new Labour and Welfare Administration (NAV). The NAV-reform was a major public administration restructuring which merged the previously separate welfare, labour and social services, although the latter remained a separate municipal branch within the otherwise state-funded services. A key ingredient was the establishment of local 'one-stop-shops' where users would find all three services behind one door, and where services would be delivered in a user-oriented, 'holistic' and integrated fashion to improve quality and efficiency (Askim et al., 2011). The ambition of service integration in the reformed organisation was not restricted to the internal services; the local NAV-offices were also responsible for coordinating and collaborating with external services, such as health care services (Andreassen & Aars, 2015, p. 49).

In international comparison, Norwegian activation strategies have emphasised human capital development rather than "work-first" approaches (Minas, 2014). While most countries have developed more active/integrated policies over time while cutting back on cash benefits, another defining feature of Norwegian policies has been the maintenance of relatively generous benefits (Böheim & Leoni, 2018). Norwegian activation services have also increasingly adopted the belief that by changing perspective from social problems, illness and disease to abilities, opportunities and motivations, users with complex needs can more effectively be included in the labour market, that is, the 'asset-model' of activation (Håvold et al., 2018).

As noted several places in the research literature, activation programmes increasingly target not only the traditionally unemployed but also users with complex needs, such as disabilities, mental health problems and addictions (Minas, 2014). In Norway, the main benefit scheme for activation of such groups is the work assessment allowance (WAA), a temporary health related benefit. WAA is one of three health benefits in the Norwegian National Insurance, the others being sick leave benefit and permanent disability benefit. To be eligible for WAA, a work ability reduction by at least 50 per cent due to illness, injury, or defect is required. The maximum benefit duration was 4 years but was reduced to 3 years in 2018 (Lovdata, 2017).

People under the age of 30 are a high-priority target group and youth frontline workers at the NAV offices have fewer clients and more time to each client. At the time of the interviews, youth guarantees applied to provide young people with services more quickly than older persons. The youth guarantee entitled those under the age of 20, the right to work, study or attend work-oriented measures, those between 20 and 24 an activity plan within 1 month, and a general guarantee ensuring at least 90% of clients below 30 an approved activity plan (Thorbjørnsrud, 2018).

All clients, regardless of age, are entitled to an individual assessment of employment prospects and service needs (NAV Act §14a) and placed into either of four service groups. 'Standard efforts' and 'situation specific efforts' are both assessed as able to get an ordinary job without or with assistance from NAV, respectively. 'Specially adapted efforts' are clients with reduced working capacity and more extensive assistance needs, and WAA-clients are mainly in this group. 'Permanent adapted efforts' are clients with small prospects to get and keep an ordinary job.

The local NAV offices and their frontline workers are responsible for carrying out the activation policy, but they depend on input from the health care sector to do so. As part of the work assessment process and the elaboration of an activity plan, the NAV frontline workers need a medical assessment and a treatment plan, if applicable. With the medical certificate, typically provided by the GP, the client receives one or more diagnoses and an assessment of how the illnesses affect the client's ability to work. Hence, successful activation in the WAA in part hinges on a productive inter-sectoral and inter-professional co-operation, which is what we will delve into in this study.

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4 | METHODS

The qualitative data in this article consists of 33 interviews with key actors, who worked with young clients in the work assessment allowance scheme, conducted during spring 2016. Key Actors in this study were: NAV frontline workers (17), NAV office managers (7), GPs (3) and medical advisers (6).

The selection of municipalities/NAV offices was based on the 2015 annual work assessment allowance rates for young clients produced on request by NAV for the purpose of this study. In the age group 18–29 these rates ranged from 1.9% of the population to 8.5%. For this study, we selected six municipalities ranked high, in the middle and low within this range to ensure sufficient variation in our data.

We interviewed all NAV office managers, NAV frontline workers working with young work assessment allowance clients and medical advisers at the six selected NAV offices. This resulted in seven interviews with office mangers as one office had dual leadership and 17 interviews with NAV frontline workers.

The recruitment of general practitioners was difficult as they were reluctant to take part in the study due to busy time schedules. This weakness was partly accommodated by the inclusion of the six medical advisers. The medical advisers also hold a medical degree and they had worked or worked part time as GPs. In total, our material covers a total of nine medically educated interviewees. In addition, these interviews were rich, so we argue that the medical perspective is adequately covered in this study.

Frontline worker and office managers in NAV were interviewed face-to-face, whereas the interviews with general practitioners and medical advisers were recorded over the phone. Semi-structured interview guides were applied, and the interviews lasted between 40 and 70 min. The interviews were fully transcribed and coded systematically. The semi-structured interview guide consisted of core themes that were adapted to the different stakeholders. The interviews were coded in accordance with the following core themes: cross-sectoral collaboration, descriptions of the client group, the different stakeholders' experience with work assessment allowance and their perception of activation policy. The interviews were analysed in search for tendencies. The analysis revealed no systematic differences between the NAV offices in the core themes.

The Norwegian Centre for Research Data (NSD) approved the study. Participation was voluntary, and all interviewees received information letters about the study in advance.

5 | SAMPLE DESCRIPTION

The Labour and Welfare Administration and the health care sector are represented in this study by the NAV frontline workers, NAV office managers, NAV medical advisers and general practitioners. The NAV offices managers are responsible for strategic management and finances, development, and results at the local NAV offices. They have little or no direct contact with clients. The medical advisers are employed by NAV to make statements and to give expert assessments on a case level and seldom have direct client contact. The NAV frontline workers' main tasks are to follow-up, guide and assess the young clients, process cases and collaborate with, for example, employers and GPs. The GPs do the medical follow up and treatment of the young clients.

The NAV frontline workers and office managers displayed great variation in educational backgrounds, as nursing, law, economy, sociology, teaching, business management, tourism and management. Social work and child welfare backgrounds were most common. The GPs and medical advisers all held medical degrees.

About 70% of the WAA-clients aged 18–29 are diagnosed with a mental illness (Sutterud, 2017). In line with this, the interviewees reported that the majority of their young WAA clients were diagnosed with a mental illness most often in combination with complex problems. Complex problems were referred to as beyond joblessness, and included personal and social matters, such as financial issues, school-drop out, complex family problems, homelessness, substance use disorders, loneliness, bullying, low self-esteem and lack of confidence in school and work-related

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matters. Some of the young WAA clients had been diagnosed quite late with learning difficulties like dyslexia or ADHD, which had had negative impact on their learning outcome in school.

6 | RESULTS

6.1 | Cross-sectoral coordination and communication

The medical certificate is a key element in the assessment of the young clients in the work assessment allowance scheme as it conveys medical information from the GPs to the NAV frontline workers, who uses this information in deciding on the timing and type of activation measures. We find examples of the needs of the NAV frontline workers not being met in the medical certificates, as they do not convey sufficient information. One NAV frontline worker said:

> In the medical certificate, the general practitioners often tend to repeat the patient's own words and descriptions. So, if the patient claims to be unfit for work, that is what it [the certificate] says. And without any explanations or elaboration of causes.

The NAV frontline worker in this case expected a medical explanation and not only a parroting of the client's own words and is hence left with little information to guide any decisions on activation.

Another issue that may hamper activation, is when the medical certificate states clearly that the young client is not ready for activation measures. Then the result could be that young clients resign from activation measures without further discussion between the GP and NAV.

From a NAV frontline workers point of view this can be frustrating especially in the initial phase of assessing the young clients:

> They sometimes tell me that the young clients need to be left in peace and receive only treatment and no activation.

The NAV frontline workers also reported that medical certificates can be used to intervene in ongoing activation measures. One NAV frontline worker expressed:

> It's quite challenging with young WAA clients as they might ask their GP for a medical certificate. And then, they are excused from taking part in activation measures. The GP did perhaps not get the intention of why I initiated participation in the first place. So, a closer dialogue with the GP would have been wise.

The NAV frontline workers described the available activation measures as flexible and adaptable to the clients' situation as they cover a wide range of activities from attending a walking group to placement in ordinary work. However, they felt that the medical professionals were not fully informed about the range of activities.

The GPs, on the other hand, find it difficult to give an assessment of a young person's work ability in an activation context. They emphasise that the young clients most often lack work experience, which makes it hard to relate any health limitations to specific tasks, occupations, or employers. They also bring up the complexity introduced in the work assessment by the frequent mix of vague (i.e., non-organic) mental illnesses, financial difficulties and longstanding social problems in their patients. As one GP put it:

> Almost all diagnoses we see are psychiatric. There's a grey zone between drug addiction and financial problems, but there are very few – well, of course there are some [patients] with organic diagnoses,

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> which are also sort of psychiatric, it depends a bit on how you define it - but there are very few organic, somatic causes of reduced work ability in this group of young people. It's almost exclusively psychiatric diagnoses and social problems.

The GPs, however, express that they sometimes do not understand what NAV wants from them when they ask for medical certificates. A general practitioner said:

> Some of the young clients do not know why they are coming to see me. They may not have consulted a GP before, because they do not have a somatic problem. I hardly know them. (…). They consult me only because their NAV frontline worker has told them to. Probably because they need a medical certificate. But the young clients do not know themselves what NAV wants. (…). When NAV frontline workers do not ask specific questions, they will not receive good answers.

Cross-sectoral frontline delivery of activation in our material seems to be hampered by a lack of communication between NAV and the GPs. Although the GPs seem to share an understanding of the youth as having 'complex problems', collaboration between the two sectors is further obstructed by a lack of mutual understanding. The GPs seem unaware of the wide spectre of available activation measures, some of which should be compatible with most functional limitations experienced by this group, and the NAV frontline workers (erroneously) seem to presuppose such knowledge in the GPs.

6.2 | Boundary spanning

Cross-sectoral collaboration may benefit from 'boundary spanners' which facilitate organisational learning, mutual understanding, and value exchange across agencies, as well as new modes of networked practices (Lindsay & Dutton, 2012; Williams, 2002). These boundary spanners typically hold standard positions in one of the involved agencies. When designing this study, we expected that the medical advisers, with one foot in each camp, so to speak, would be well placed to assume such a role.

The interviews revealed great variation in how much the medical advisers were involved in the work assessment allowance scheme, despite all medical advisers expressing that they would like to be more involved. At one NAV office, the medical adviser was involved in all decisions about work assessment allowance. Three NAV offices involved the medical adviser only in the difficult cases. Two NAV offices did not involve the medical advisers in the decisions about work assessment allowance at all, but they were involved in decisions about sick leave and disability benefit.

One reason for this variation may be related to the significant autonomy of the NAV offices in organising their work. The medical advisers point to the importance of the NAV office manager. One medical adviser said:

> Current [political] signals are that NAV offices need to be forceful and independent and that's why the NAV manager is so important;(…) the NAV manager [needs to be] aware of these things and (…) create a well-functioning culture at the NAV office. Then we're automatically invited to review relevant cases. Some [NAV offices] do it systematically and others do it less systematically. This is highly dependent on the awareness of the manager.

This quote emphasises that for boundary spanning to happen, there need to be a space for cross-sectoral interaction. If medical advisers are not invited in, there is no space.

On the other hand, our data shows that in the cases where medical advisers are used, their roles do resemble that of a boundary spanner. The medical adviser that participated in all work assessment allowance cases at the NAV offices in his county elaborated on his role:

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> We're primarily concerned with what would be the most appropriate activity [for the client] or conducting a medical assessment if this has not already been done or if we feel that the medical basis isn't strong enough. There may be some old documents from the educational and psychological counselling service, but really no proper assessment. Then we try to arrange that, and we're also eager to get the adolescent going in some kind of activity, something meaningful to do. We consider whether it [the activity] should be a [labour market programme] measure or WAA or something else.

The quote reveals that the medical adviser in no way is restricted by a 'medical' perspective or by the goals of the health-services, but rather aligns with the goals and methods of NAV, that is, emphasising a holistic approach, individual tailoring and activation. Moreover, the medical advisers frequently show in the interviews that they possess in-depth knowledge on activation and recent developments and trials, such as Individual Placement and Support. The following excerpt even suggests that the medical advisers to some extent see themselves as activation experts and proponents as compared to (some) NAV offices:

> [NAV frontline workers] often sees the patient as being sicker and more often limits… [stops himself] well, they are far behind in exploring opportunities, but things have changed the past three years since we started working on the activity requirements. There has been a change of attitudes [among the frontline workers], but they often blindly accept the GPs' description of [the patient's] limitations. (…). Traditionally, NAV's been more concerned with patient's limitations than I ever was as a GP, but things are slowly changing.

The 'interpreter/communicator' function that boundary spanners can take on (Williams, 2002) seem to fit the following quotes which show how medical advisers help NAV frontline workers in understanding and critically assess the medical certificates from an activation point of view:

> Interviewer: "What about the NAV frontline workers then? Do you find that you often disagree with them when it comes to assessing what a client can tolerate of activity and such?"

> Medical adviser: "No, not really. Some ask, 'is it safe to attempt placing the client in work based on what the GP has written [in the medical certificate]'. Then we help finding grounds for that when interpreting [the certificate]. So, no - on the contrary. They [the frontline workers] are very humble and dare to ask. There are few frontline workers who actually even try to overrule a GP. What the GP has written, they usually accept."

This quote also hints to the possible occupational hierarchy in the field of activation, and the dominant role of medical knowledge. The medical advisers seem to be able to empower NAV frontline workers in pursuing their activation goals by translating and interpreting field-specific knowledge. Another medical adviser also elaborates on the role of medical knowledge in pursuing activation:

> In the absence of knowledge, it's easier to accept an application for [passive] benefits than to ask questions and require activation. You need a certain level of confidence about the state of things, and I believe we [the medical advisers] have been able to provide the NAV-offices with that confidence because they now understand the medical information. This is crucial for NAV in having a proactive attitude to activation. They need to understand what they're doing, and to understand that they need to speak with a medical adviser and possibly a work psychologist (…).

Furthermore, the medical advisers even seem to help NAV frontline workers challenge the GPs' medical certificates:

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Interviewer: "When it comes to the assessment of the client's health and ability to work, do you often disagree with the GP?

Medical adviser: "There are several times when we disagree, when diagnoses are diffuse and there has been a lack of treatment. Then we say; 'where's the medical perspective in this?'. What I demand from a [medical] statement is not much, there are four points. There actually need to be a diagnosis or a hypothesis about a diagnosis; it must say something about the treatment one has provided or plan to provide; it also needs to say something about the doctor's expectation on the likely outcome for the patient, i.e. a prognosis; and we also want a description of how the diagnosis limits the patient's functional abilities. Then we've got something about both severity and duration."

7 | DISCUSSION

The successful integration of services—the aim of several major welfare reforms—rests on the ability and organisational opportunities of frontline workers to collaborate and coordinate their work effectively. The current study aimed at contributing new insights on such interagency coordination and add empirical knowledge to the scarce literature on cross-sectoral frontline delivery of welfare-to-work. We used the Norwegian WAA, which depends on collaboration and coordination between labour and welfare sector and the healthcare sector, as a case, and included perspectives from different stakeholders in the two sectors.

Our study finds that the cross-sectoral space for delivery of welfare-to-work services for young clients in the work assessment allowance-scheme seems to be narrow and weakly integrated. Among the frontline workers, we rarely find signs of inter-professional exchange, shared understanding and cross-sectoral engagement in common aims that could have contributed to the build-up of a shared culture and mutual trust. The frontline workers, who represent the labour and welfare services in charge of the activation process, experience that health care professionals make decisions that affect the activation process without reaching out to them for information and coordination. The general practitioners, on the other hand, express that they do not know what NAV wants and why young WAA clients attend their clinic and seem to have limited insight into activation services. The frontline workers in the two sectors solve the strain of missing information and insecurity using different strategies. The NAV frontline workers seem to postpone activation if they do not feel confident that they have medical support, while GPs write medical certificates and statements that may correctly reflect the young patient's wishes, but with limited value or even obstructive effects on the activation process (Krohne & Brage, 2008). Thus, our empirical material shows few signs of truly 'intersectoral' collaboration that could have sparked innovation and created added value for the users (i.e., co-production and co-creation) (Saltkjel et al., 2022). Rather, it seems, communication between the two frontline services more resembles a two-way monologue.

The lack of communication further seems to fuel distrust between the representatives of the two sectors. The NAV frontline workers' stories about health professionals 'shielding' their young clients from the activation of the welfare services and not actively engaging in providing useful medical certificates are examples of this. This is also expressed in our data by unexpected medically assessed exemptions from planned activation, and GPs parroting the young WAA client's own words in the medical assessment, rather than providing specific advice on how to proceed with activation measures. This is in accordance with previous research showing that frontline welfare workers tend to see general practitioners as constrained by a medicalised view on health and work, focussing on disease and limitations and work and activation as damaging to health (Håvold et al., 2018). While the main objectives in the welfare services are activation and work integration, the health care sector is primarily concerned with treatment. The GPs actions may well be understood in line with this aim, and even as an expression of the principle of client complicity in activation. However, as also noted by Håvold et al. (2018), caseworkers tend to be aware of the potential conflict of interest inherent in the role of GPs as financially dependent on keeping their patient lists while sometimes having

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to make unpopular decisions on their behalf. In any case, whether GPs are unwilling to engage with the shared goal of activation or are better understood as subject to market or professional logics, the lack of communication may be an obstacle to the build-up of cross-sectoral trust.

Håvold et al. (2018) also note that compared to frontline welfare workers, the medical profession ranks high in the occupational hierarchy, with more education and a strong professional organisation. This is reflected in the strong position 'objective' medical assessment has in the social insurance system, although GPs may often find it hard to live up to these expectations (Aarseth et al., 2019; Krohne & Brage, 2008). We find few stories, however, about NAV frontline workers actively educating GPs on activation and an 'asset-based' ideology of health, as found by Håvold et al. (2018). This too suggests that the two professions in the frontline delivery of welfare-to-work sometimes lack a mutual understanding that could have facilitated a more collaborative environment. Instead, the frontline workers seem to be captured by conflicting institutional and professional logics.

One possible explanation for the weak integration that we observe, may be the relative absence of boundary spanners or cross-sectoral spaces where boundary spanning can happen. Previous research (Lindsay & Dutton, 2012) has emphasised the important role of boundary spanners in efforts to integrate services 'on the ground'. These boundary spanners, through their openness and interest towards other agencies, can facilitate multi-agency partnerships and mutual trust. At the outset of this study, we hypothesised that the medical advisers would serve as boundary spanners, often having one foot in each camp. We found some support for this in our data, although considerable variation in the local NAV offices' use of medical advisers is present. Several medical advisers do seem to engage in activity resembling the interpreter/communicator boundary spanning role (Williams, 2012), such as supporting NAV frontline workers in pursuing activation in ambiguous cases or challenging GPs to improve the usefulness of medical certificates in the context of activation. They also exhibit in-depth knowledge about activation and seem to share and understand the political goals and methodologies in NAV. Sometimes they even see themselves as 'activation experts' vis a vis NAV-offices. Hence, to a large extent, the medical advisers have adopted the 'asset model of activation' (Håvold et al., 2018). Nevertheless, our findings suggest that the boundary spanning potential of the medical advisers is underused at many NAV offices. The medial advisers explain this by pointing to the autonomy of the NAV offices and the key role of the NAV managers in deciding to involve the medical advisers or not, echoing the importance of personal traits and relationships emphasised in the literature (Ingold, 2018; Williams, 2013). Further, we do not find indications of any of the interviewees in any of the sectors or at any level engaging in other functions of the boundary spanner role than the interpreter/communicator role, such as the retuculist, entrepreneur or coordinator roles (Williams, 2012, 2013). In principle, NAV-leaders, GPs or NAV frontline workers could have taken on such roles. In the Norwegian cross-sectoral field of activation, there is thus much untapped potential in accommodating such engagement, to achieve better coordination, co-production, innovation and added value for the users. As noted by Lindsay et al. (2020), organisational factors, like leadership models, professional autonomy and funding regimes, may also be important in fostering boundary spanning. Previous literature has also emphasised organisational/structural factors such as task overload, professional heterogeneity and power imbalances (Kousgaard et al., 2015; Long et al., 2013; Pearson & Watson, 2018).

8 | CONCLUSION

Cross-sectoral frontline delivery of activation is seen as crucial in succeeding with activation and labour market integration of users with complex needs (Heidenreich & Aurich-Beerheide, 2014; Larsen & Caswell, 2020; van Berkel et al., 2012). Our study finds that such cross-sectoral work in our data from Norway is hampered by a lack of coordination and communication between frontline workers, leading to tension and inefficiency in activating the young WAA clients. We do find that in-house medical advisers in the welfare services can play an important role in empowering NAV frontline workers in interpreting and improving the GPs' medical certificates, and that they often see themselves as proponents of an 'asset model of activation' (Håvold et al., 2018). The potential role of the

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medical advisers as boundary spanners (Lindsay & Dutton, 2012), and frontline workers' opportunities for cross-sectoral coordination, however, seem to be constrained by narrow and insufficient spaces for integration and collaboration, possibly due to organisational and administrative barriers (Fossestøl et al., 2016; van der Wel et al., 2021).

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DATA AVAILABILITY STATEMENT

Data available on request due to privacy/ethical restrictions.

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