Vocational Rehabilitation in Norway: a Dutch perspective
Statements and Comments

Rienk Prins
ASTri Research & Consultancy Group

1. Introduction

The official paper from the government and the discussion paper prepared by Dr. Inés Hardoy inform us about a country with a well developed set of benefit arrangements as well as medical and vocational rehabilitation measures. Moreover, the country introduced various adaptations and reforms to improve the system, a feature which also is very familiar to the Dutch reader. Further, policy makers and other stakeholders in Norway, have a high quality data base and statistical sources at their disposal and a - comparatively - rich tradition of evaluation research. These characteristics make the Norwegian experiences interesting and relevant for other countries, which struggle with similar problems.

2. Context

Before focussing on the context and transferability of the Norwegian rehabilitation policy it may be good to summarise the Dutch situation, which also faced many reforms. Moreover, our experiences affect our comments and suggestions and – more general – the relevancy of foreign experiences for domestic problems.

2.1 Paradigm changes in Dutch sickness and disability policies

Also in the Netherlands government made agreements with employers’ organisations and trade unions to combat high sickness absence and growing disability dependency rates. Reforms should address basic ideologies and leading principles. Measures taken reflected:

a. a shift in responsibilities of major actors involved, including ‘privatization and competition’ in the administration of benefits and the provision of rehabilitation (return to work) services;

b. consequently: increase of financial incentives to employers, e.g. by introducing or increasing wage payment periods, self insurance options, experience rating in contributions or imposing penalties when many employees became dependent on disability benefits;

c. but also: financial consequences for employees, e.g. by reducing benefit levels, or by making the duration of benefit payment age dependent, or increase of duties (e.g. as to partial work resumption);

d. strengthening of programme administration, e.g. by introducing periodical reassessment of disability benefit beneficiaries, improving reporting and accountability policy for social insurance agencies, or merging of public service providers.
2.2 Long term sickness and return to work: new actors and responsibilities

From March 1996 all Dutch employer were legally obliged to pay full wage of their sick employees for maximally 52 weeks (1994: an own risk period of two or six weeks of continued wage payment had been introduced). As Dutch labour law prohibits dismissal during sickness, the only way to limit the employer’s financial risk is to try to have the sick employee returned to work as quickly as possible.59

A special law on labour reintegration was created, with extra incentives for employers, to retain persons with disabilities. Furthermore, support in the management of sickness absence, check of work incapacity and initiatives for return to work measures was laid in the hands of occupational health services. Employers were by law obliged to contract such a service, either in-company, or as an external service. Further a market of private service providers (“labour reintegration services”) was created of providers helping the employer and employee with work resumption, transfer to another job/employer or for getting benefit recipients from the benefit rolls (into employment).

Due to its positive impact on sickness absence rates, in 2004 the compulsory wage payment period (in case of sickness of an employee) has been extended to maximally 2 years.

2.3. Early intervention and integration of recovery and work resumption

Two years earlier the “Improved Gatekeeper Law” came into force; it prescribed in a detailed and stepwise way the actions employer and employee (who now have the main responsibilities) should take in case of (prolonging) sickness absence. Major elements regard “early intervention” and an active approach in recovery and work resumption (not: work resumption after recovery but work resumption supporting recovery). The basic steps in a case of prolonging sickness absence regard:

1. on the first day of sickness absence: the employee should notify work incapacity to the employer or supervisor;
2. the latter should report immediately to the occupational health service (OHS); depending on the contract the service (immediately or later) checks eligibility to wage payment, the need for additional measures, etc.60;
3. within six weeks of sickness absence: the OHS makes a ‘problem analysis’, which clarifies the chances for recovery and work resumption;
4. in case recovery is feasible: employer and employee together make a work resumption plan, advised by the OHS;
5. in case work incapacity continues: in the 13th week the employer should inform the social insurance agency;

59 The employer can insure the financial risk in the private insurance market, but he is also free to pay the costs himself.
60 In the Netherlands GPs do not (actually: “refuse”) to certify sickness absence at the onset of work incapacity.
6. When sickness absence continues: employer and employee regularly meet to discuss progress, need for adaptation of the plan, etc.; the employer further creates a ‘reintegration file’;

7. Before week 52: employer and employee evaluate the work resumption plan, eventually revise it, etc.;

8. In case in work incapacity still exists: in week 87 the employee receives documents for claiming a disability benefit. The OHS makes an assessment of the situation, of measures taken (e.g. work adaptations), etc.;

9. In week 89: employer and employee make a ‘reintegration report’ which reports on the activities attempted, which is sent to the social insurance agency;

10. Week 93: the agency checks whether all measures have been tried by employer and employee to resume work, and starts claim evaluation procedure.

Evaluations of this programme and analysis of sickness absence rates indicated that (short and long term) sickness absence dropped substantially, although the economic cycle also may play a role. Furthermore, employers showed to pay more attention to return to work measures, whereas employees became aware of the need of an active attitude towards recovery and work resumption. Furthermore (some categories of) physicians supported the relevancy of (partial) work resumption; finally also the inflow in the disability scheme dropped considerably.

3. Relevancy

Both the official paper and the discussion paper give an insight into the regulations (and changes), the quantitative developments, as well as conclusions from studies on utilization of programmes and transfer to the labour market. The papers identify relevant features of the programmes as well as questions that can not fully be answered, despite extended research efforts.

When one tries to understand the description of the Norwegian system three questions arise. The first two issues are not explicitly discussed in the documentation, or do not seem to be subject of research, whereas the third is connected to a basic feature of the programme. These three topics are: the role of the employer, the experiences of administrative stakeholders (social insurance agency, VR providers, employment office, others?) and the strict distinction (in time) between medical and vocational rehabilitation.

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61 This was also affected by a reform in the disability benefit scheme (2006).
3.1 The employer: a neglected factor?

From a Dutch perspective the role of employers seems to be restricted. This not only regards:

a. their obligations as to the long term sick, or on employment of disabled (except what is said about wage payment during sickness absence), or

b. their sickness absence management policies and practices (e.g. openness to partial work resumption? dismissal of long term sick?), but also:

c. their attitudes towards recruitment of persons with disabilities or with reduced health;

d. evaluations of employers attitudes and utilization of facilities or incentives to keep persons with reduced health in employment (e.g. wage subsidy).

In the Netherlands many measures have been attempted to improve RTW (Return to Work) of persons with short term or long term reduction of work capacity and to prevent disability pension claims. Substantial effects, however, were noted from the moment that regulations were introduced that gave more financial responsibilities (obligations but also tools, e.g. OHService) to employers (extended wage payment period, obligation to find adapted work, experience rating in social security contributions). Then – after some years - employers noted that actions in an early stage of work incapacity may be cost reducing.

Also cross-national studies showed the crucial role of the employer: continuation of an (employment) relationship with the employer is a positive condition for successful work resumption of the (long term) sick listed workers.62

3.2 Insight into provision of services?

In the discussion paper some remarks are being made about waiting periods for VR. Dutch experiences show that it might be relevant to focus also on the service delivery aspect of the regulations: what lessons can be learned about VR programme utilization (“creaming”) and impact, e.g. by analysing the operation/administration of the programmes? Staff and providers opinions on the quality of implementation and efficiency of new programmes may give insight into relevant factors that show to facilitate or complicate the system, e.g.:

- tools, working methods and procedures applied, or cooperation with other stakeholders;
- back ground of waiting periods, client motivation, sub groups (needing special attention);
- placement in employment, employers attitudes;
- which VR service providers do better than others?

3.3 Separation or integration of medical and vocational measures?

The discussion paper describes the strict separation of medical and vocational rehabilitation.

This structure evokes some questions. Traditionally employers, workers and physicians use a two step approach:

a. first *full* recovery,

b. then back to work (with or without vocational measures).

In the light of the time lost (also due to waiting periods), changing morbidity patterns (growing frequency of chronic diseases), and the creation of passive attitudes in clients, we wonder whether policies to intertwine (integrate) medical and vocational rehabilitation measures, would not be feasible. This seems in particular relevant for mental health related sickness absence and disability.

4. Transferability

Our *preliminary* conclusions on transferability of Norwegian policies and practices mainly regard the rich evaluation research conditions in the country. The content or benefit regulations as well as the organization of vocational rehabilitation measures reminds of the Dutch situation of 15 years ago with a predominance of actions by public stakeholders and lack of responsibility taken by employers and employees.