Assessment and recommendations

Norway combines a unique mix of a favourable economic and labour force situation and very high investments in education and health with a pervasive exclusion of people with health problems from the labour market. While the Norwegian system has generated a high and stable employment rate over the last decades, one-fifth of the population receives income supports due to health problems, and spending on disability and sickness benefits amounts to around 5% of GDP, by far the highest level in the OECD. The causes for this combination cannot be found either in a lack of vocational rehabilitation policies or a lack of elaborated support structures; both are well developed. Rather, the reasons lie in a political reluctance to revise a very generous social protection system; to implement effectively far-reaching changes introduced in the past decade; and to enforce new obligations rigorously.

Blocking the exclusion perspective

For many people with a mental disorder, the welfare-driven strategy has the contrary effect of exclusion and inequality: people with a severe mental disorder have a nine-fold unemployment rate compared with the national average and, more generally, Norwegians with a mental disorder did not benefit from the favourable labour market situation in the period leading up to the recent crisis, as reflected in falling employment and rising unemployment rates for this group. Relatively easy access to long-term or permanent work incapacity benefits not only plays to some typical characteristics of mental illness like, for instance, fear avoidance, withdrawal and passivity, but also isolates people with mental disorders from the world of work.

To improve labour market access and job retention of people with a mental disorder, perspectives should be changed. Employees with a mental health problem are more frequently taking long-term sick leave compared with people with a physical health problem, and their sickness rates have steadily increased, despite an elaborate system of sickness absence monitoring. Similarly, the drop-out rate of clients with a mental disorder

from vocational rehabilitation programmes is high despite a strong work-first approach and a broad range of supports over several years. Finally, disability benefit claims are seldom rejected and, once awarded, rarely reassessed, although beneficiaries with a more moderate mental disorder typically have a fluctuating work capacity. To improve the effectiveness of existing measures, the perspective of long-term sick leave and permanent disability benefit should in many cases be blocked from the beginning.

Matching responsibilities and funding structures

Responsibility for sickness and disability benefits is very unequally distributed, with the bulk of the costs covered by social insurance. Employers have a key role in preventing sick leave and supporting the return-to-work process, but are financially involved in short-term absences only, reducing their efforts to avoid harmful long-term sick leave. Employees also face limited incentives to avoid sickness absence, receiving compensation equal to 100% of their previous wage for up to one year. Co-workers represented by their unions, and the physicians' certification behaviour also influence workplace dynamics and return-to-work, but unions and doctors do not bear any of the financial costs of their decisions. Finally, the municipalities – responsible for health, education and rehabilitation services – have much impact on the rates of exclusion, but are not involved in health-related work incapacity funding either. Although it is difficult to quantify the responsibility of each actor, new ways of co-financing should be discussed to improve their commitment to labour market inclusion of people with mental ill-health.

Reconsidering sickness absence policies

Norway has, by far, the highest rate of sickness absence in the OECD. Despite a recent focus on partial sickness leave, full-time sick leave is still the rule. General practitioners (GPs) are responsible for sickness certification, but they find it difficult to assess the duration, degree and future development of functional capacity. Sickness absence regulations are quite elaborate but there is no early identification of sick leaves due to mental illness. Medical and vocational professionals come in too late in the process, if at all, and the elaboration of a return-to-work plan is left to the employer and the employee. Managers and human resource professionals are not trained sufficiently to identify and intervene in mental health problems. The strong focus of existing services such as occupational health services or the labour inspection authority on sickness prevention and health promotion, results in a lack of targeted early intervention and support to employers.

Revising disability assessment procedures and eligibility criteria

The eligibility criteria for a disability benefit are strict in Norway requiring a permanent loss of work capacity and excluding social problems or milder mental disorders. Nevertheless, common mental disorders like mood and neurotic disorders are the main reason for a disability benefit in people with mental health problems, especially in older age. The strict eligibility rules do not always seem to be followed. Moreover, around one-third of the new beneficiaries have never sought treatment for their mental health problem. The possibility to receive a disability benefit after several years of vocational rehabilitation undermines the seriousness of the integration efforts. Another potential problem lies in the disability assessment process itself, which is influenced significantly by the claimants; often takes place without the involvement of a mental health specialist; and lacks a focus on periodic reassessment.

Improving the outcomes of vocational rehabilitation

The many different vocational rehabilitation services in Norway support an increasing number of clients. However, education and training are still the most frequently used measures despite a modest effectiveness, and they are used mostly as re-education measures for persons with higher education rather than to up-skill people with low education. Conversely, wage subsidies to employers, which are rather effective, are hardly used. Finally, the large group of people at risk of dropping out of the labour market but still at work is not reached by vocational rehabilitation. The existing employer support centres could offer a basis for support to employees struggling in work provided these centres would be expanded; turned into multidisciplinary services; and given responsibility for individual follow-up.

Strengthening health care integration

The disintegration of mental health care and employment services, as well as the fragmentation within the mental health system itself with municipal primary care and regional specialist care, is a main barrier for labour market inclusion. The pioneering Norwegian strategy for work and mental health has tried to build a bridge between the Labour and Welfare Administration (NAV) and the health care sector. In order to yield sustainable improvements, however, structural measures are needed. For instance, the few insurance physicians in the NAV offices are not allowed to see the claimants; when in treatment, the significance of the patient's employment situation is undervalued; and many people on sick leave have an undetected mental disorder indicating a need for improved co-operation between general and specialist care. A more integrated approach is also hindered by a lack of inter-sectoral routine data. Finally, while people with a

severe mental disorder and more generally all those who can afford private psychotherapy seem to have good access to mental health services, the majority of people with moderate disorders and working problems have long waiting times for psychiatric treatment.

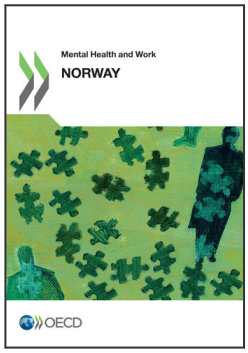
Due to the early onset of most psychiatric disorders and the importance of a good education for future performance in the labour market, mental health problems in pupils should be tackled in concerted action. This would be important because non-completion of upper secondary education is common in Norway, especially in apprenticeships. There are a number of obstacles: pedagogical and psychological services are not obliged to co-operate with health services; general health services often do not refer young patients to specialists; and teachers do not receive enough support. In case of inward-oriented mental disorders not associated with difficult behaviours or emotions, the chance to get specialist treatment is low. Finally, there are no services and no integrated concepts to systematically secure a successful and sustainable transition to work.

Summary of the main OECD recommendations for Norway

Key policy challenges	Policy recommendations
1. There is a lack of incentives to avoid sick leave or to support early return-to-work	• Increase the duration of the sickness payment obligation for employers, or introduce co-financing for the entire sick-leave period. • Reduce the replacement rate in case of sickness absence from 100% to around 80%. • Discuss a co-financing of health-related work incapacity costs by unions and municipalities.
2. Employers are not equipped to deal with mental health problems in the workplace	• Develop criteria for rapid intervention by NAV and the treating physician in case of mental health-related work problems or sick leave. • Expand resources and responsibilities of the Employer Support Centres to secure earlier intervention, support for employers and follow-up of employees in need of help. • Develop integrated processes for employers, NAV professionals and physicians to co-operate in case of employees' non-compliance.
3. GPs feel uncertain in assessing sickness absence duration and work capacity	• Assure as little and short sick leave as possible for common mental disorders. • Train physicians in dealing with workplace problems of patients, and strengthen sanctions for systematically non-compliant physicians. • Base long-term sickness certifications on an interdisciplinary assessment which involves a specialist and a NAV professional.
4. Strict disability benefit eligibility is not applied in practice	• Expand explicit social and medical exclusion criteria for a disability benefit. • Request an adequate specialist treatment before awarding a disability benefit on the grounds of a mental disorder. • Strengthen the requirements on compliance with rehabilitative measures and apply them rigorously in practice. • Base disability benefit awards on an interdisciplinary assessment rather than merely the existing medical record.
5. There is no outflow from disability benefits into employment	• Introduce periodic reassessments of disability benefit entitlements. • Provide better incentives for municipalities and enterprises to offer jobs for disability beneficiaries and provide long-term follow-up to employers and beneficiaries.

Summary of the main OECD recommendations for Norway *(cont.)*

Key policy challenges	Policy recommendations
6. Vocational rehabilitation measures are not as effective as possible	• Provide more workplace-oriented job retention services targeting employers and employees. • Decrease the share of education and training measures for people with mental disorders in favour of the provision of wage subsidies. • Provide education measures above all to people with low education (up-skilling). • Define rehabilitative programme packages for relevant target groups.
7. Mental health care and employment support are not integrated	• Develop collaboration between NAV, local GPs and District Psychiatric Centres. • Install NAV professionals in the District Psychiatric Centres. • Partly integrate GPs into the NAV offices.
8. The mental health sector has no systematic focus on employment	• Establish work-related issues as a core competence in the District Psychiatric Centres. • Implement employment as a main outcome in mental health care and develop work-related health care quality indicators. • Develop an employment and workplace-related mental health training curriculum for GPs. • Develop a screening tool for doctors to detect mental health problems in general practice.
9. High rates of school dropout and increasing disability benefit rates among young adults	• Increase the resources of school-based health services and ensure an integrated approach with the Pedagogical and Psychological Services. • Establish a close contact between vocational education, NAV professionals and municipal health services. • Expand the Qualification Programme explicitly to youth with mental health problems and secure identification and treatment.



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