University of South-Eastern Norway

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Department of Health, Social and Welfare Studies

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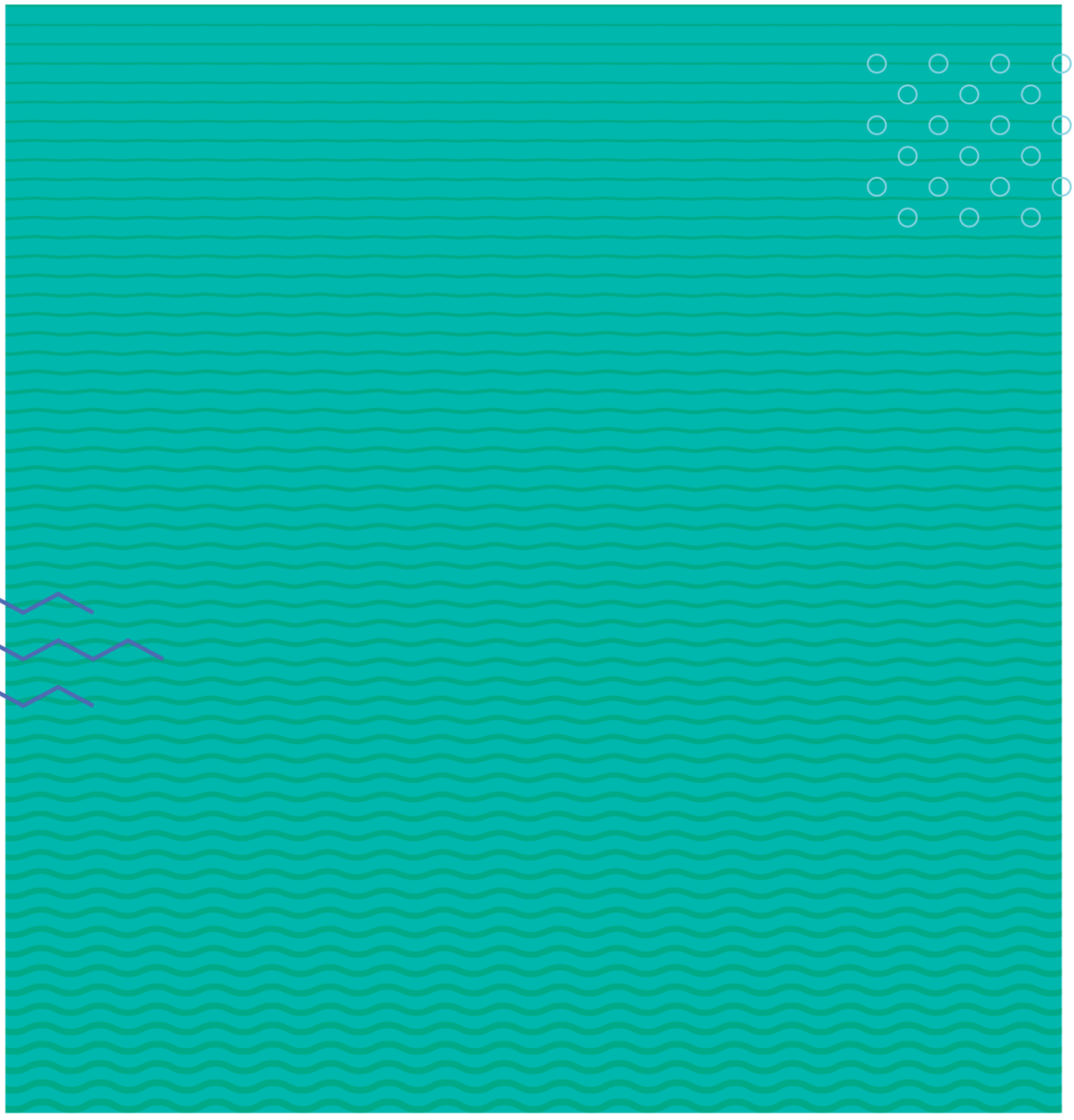
“I want to work; who can help me?”

An overview of work inclusion policies and practices for people with adverse health conditions in Norway

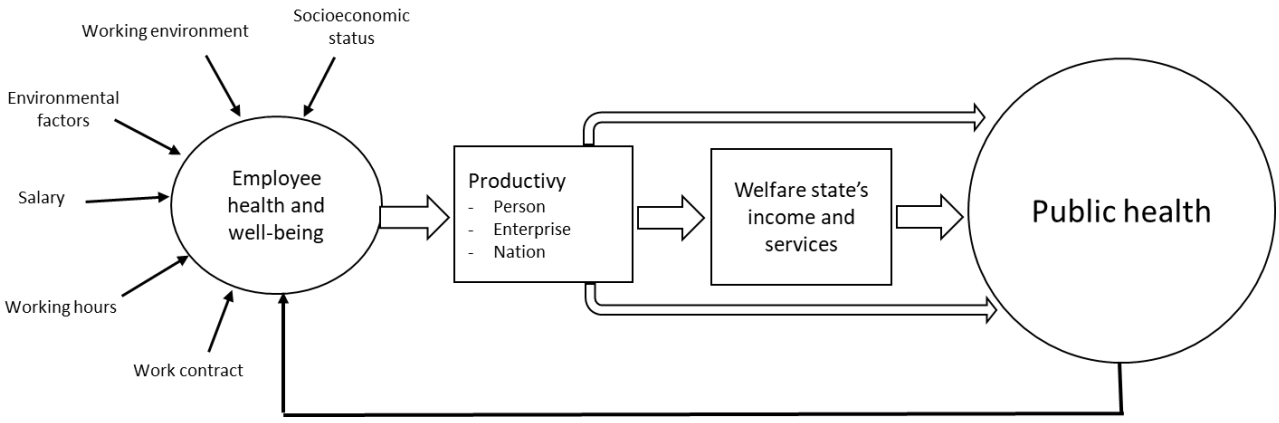


Content

1. Introduction – the importance of work

Work is generally regarded as positive for health (van der Noordt, IJzelenberg, Droomers, & Proper, 2014; Waddel & Burton, 2006). Nevertheless, a poor working environment may result in sickness and disease, whereas a good working environment may result in well-being and flourishing. Several studies have shown that the working environment is more important for social inequality in health than lifestyle factors (Borg & Kristensen, 2000; Landsbergis, 2010; Marmot, Bosma, Hemingway, Brunner, & Stansfeld, 1997). Therefore, occupational health promotion, disease prevention and rehabilitation are important not only for the individual employee but also for the entire society. Fig. 1 shows occupational factors important for health and well-being and how healthy and creative workers are important for productivity. High productivity secures income for the welfare state (through taxes) and thus contributes to welfare services for all citizens. Ultimately, all these factors contribute to good public health. One can also expect that a healthy population will have a positive spiral effect on the labour market.

Fig. 1. *Overview of relationships between working conditions, occupational health, productivity, welfare provisions and public health. Adapted from Schulte and Vainio (2010).*



For most people of working age, work is important to maintain their living standard and to uphold social contacts and self-esteem (Hakkart-van Roijen, 1998). For society, employing as many people as possible is not only important for productivity and economic reasons but also to prevent health-related socio-economic differences (Hanly, Soerjomataram, & Sharp, 2015). For people with health conditions, it is important to retain or return to work not only to secure income and living conditions but also to achieve some kind of normality in life (Peteet, 2000; Stergiou-Kita et al., 2014).

2. Aim

This report is written as part of the project anchored in Slovakia: I Want to Work; Who Can Help Me? Strengthening the Cooperation between Policy-makers and the Non-profit Sector in Return to Work of Persons with Health Conditions. The project is financed by Active Citizens Fund – Slovakia and the European Economic Area (EEA) Financial Mechanism 2014–2021. The aim of this project is to map out the situation in Slovakia regarding labour market integration and return to work of people with chronic health conditions. The target group is people with formally recognized (full or partial) disabilities. The project aims to analyse the Slovak legislative framework, identify stakeholders that are active or have a potential to retain work or facilitate a return to work of such people and their experiences with facing regulatory and practical barriers.

This report aims to describe labour market inclusion and return-to-work policies and practices for people with adverse health conditions in Norway. The content of the report is meant to serve as a benchmark for the project.

3. Norway

Norway has a population of 5.3 million and is one of the five Nordic countries (Denmark, Finland, Iceland, Norway and Sweden). The Nordic countries are rather similar regarding labour market, welfare and health, and the way these countries have organized their welfare states is often called the Nordic model or the Nordic welfare model. Norway is not part of the European Union (EU) but is closely linked to the EU through the European Economic Area (EEA) Agreement from 1992, an international agreement that enables the extension of the European Union's single market to Norway, Iceland and Lichtenstein governed by the same basic rules. These rules aim to enable the free movement of labour, goods, services, and capital within the European Single Market, including the freedom to choose residence in any country within this area.

Norway has a mixed-market capitalist economic system that features high degrees of private ownership, combined with a large number of state-owned enterprises and state ownership in publicly listed firms. The country's incomes rely largely on exploiting of natural resources such as petroleum, natural gas, minerals, lumber, seafood and fresh water of which the petroleum industry accounts for a relatively large part [approximately 25% of the gross domestic product (GDP)]. With about 7% of

the workforce, Norway has the lowest proportion of self-employed workers in Europe (Eurostat, 2017).

Norway ranks high on the World Bank lists regarding per capita income (The World Bank, 2020) and on the United Nations' Human Development Index ranking (United Nations Development Program, 2019). In addition, Norway rank highest in the world in social trust between citizens (Holmberg & Rothstein, 2017).

3.1. Norway's welfare and labour market model

In a comparative perspective, welfare provisions in Norway (and the other Nordic countries) are regarded as rather generous, with universal health care and a comprehensive social security system rooted in egalitarian ideals (Kuhnle, 2013). Most health care is public and funded by the state through tax income. More or less all treatment of diseases and disorders is free of user charges for residents, and private health and social security insurance are therefore not necessary.

About 30% of the workforce is employed in the public welfare sector, primarily the health care and education sectors. This proportion is higher than in most other European countries (Kuhnle, 2013). Many economists regard a large public sector and high public expenditure as counterproductive since this presumably weakens the incentives to innovate, save and work hard. Nevertheless, this does not seem to apply to the Nordic countries, since the economic growth in these countries has been about the same as in other European countries and in the United States. Norway generates a GDP per capita almost the same as that of the United States (which has a high GDP per capita) despite working less (1416 versus 1786 hours per year, respectively) (OECD, 2018).

It is believed that Norway's good economic performance results from a system comprising of well-organized employers and employees [about 50% of employees are members of trade unions (NOU 2019: 6)] engaging in coordinated wage and labour market negotiations at the national level and close collaboration with government representatives. Central coordinated labour market wage bargaining, a solidary wage policy and generous welfare services (education and health services free of user charges) are believed to result in wage compression, low social inequalities and high social trust between people and between people and the "system" (Barth & Moene, 2016; Uslaner, 2002.; Wilkinson & Pickett, 2018).

3.2. Employment, working environment and health

The following figures are mostly collected from the 6th European Working Conditions Survey (Aagestad, Bjerkan, & Gravseth, 2017; Eurofound, 2016). The employment rate of people 20–64 years old in Norway is 81% for men and 77% for women (average 79%). This is the third highest rate in Europe, and the difference between men and women is smaller than in any other European country. On average, Norwegians report that they work 35 hours per week, that is, slightly less than the average of the 28 EU countries as of 1 January 2020 (EU28) at 36 hours per week. As many as 45% report that they can influence their working hours, the highest in Europe (EU28 = 18%). The proportion reporting that their working hours fit well with family and social obligations is also the highest in Europe (87%).

Workers in Norway are more satisfied with work (94%) than in any other European country (EU28 = 86%). The satisfaction with the physical, chemical and biological working environment is about at the EU average, whereas the psychosocial working environment is rated better. Workers in Norway report higher work demands than the average in the EU but also report more decision authority and social support at work.

The physical health of workers in Norway is about the same as for the average of EU countries, whereas they report better mental health than the EU average. They are also more engaged in work than the average EU workers are. Nevertheless, Norway has the highest average sickness absence rate in Europe, about 10 days per year (EU28 average = 6.1 days per year), and about 6% of Norway's population (200,000 people) are registered with impaired work capacity (NAV, 2017).

4. Public rights and duties

4.1 Work, holiday and old-age pension

The ordinary working hours in Norway are 37.5 hours per week. All workers in Norway have 5 weeks of holiday per year. The ordinary pension age is 67 years. After 70–72 years (depending on the sector and occupation-specific regulations), the employer may decide whether the worker may continue working or not. All residents are ensured a minimum state old-age pension benefit. Benefits above this minimum benefit are based on residence time in Norway and the person's career and former

earnings. People may apply for early old-age pension at 62 years of age, but this reduces the benefits after the person reaches 67 years of age.

4.2 Health care

Most health-care services are public and free of user charges. General practitioners and physicians, physiotherapists, psychologists and other health-care personnel working outside hospitals are often private contractors but are largely funded by the National Insurance Scheme. Patients of such private therapists therefore have to pay a relatively small fee since the public sector covers most of the expenses. In addition to public rehabilitation clinics, the National Insurance Scheme supports some private clinics in which the patients do not have to pay for the rehabilitation.

According to Norway's Working Environment Act (Arbeids- og inkluderingsdepartementet, 2005), employers are obligated to provide an approved occupational health service for the employees when risk factors in the enterprise necessitate this. The occupational health service is free of charge for the employees whereas the employer must pay for all the services. The occupational health service must assist the employer, the employees, the working environment committee and safety representatives in creating safe and sound working conditions. In practice, the occupational health service must ensure primary and secondary prevention and *not* perform clinical treatment of employees and patients. About 70% of all employees in Norway are covered by the services of an occupational health service (personal communication from the Norwegian Labour Inspection Authority).

4.3 Sick leave

For all salaried employees in Norway, sick leave is granted from day one and for 1 year. After 1 year of sick leave, the employee must work full time in his/her original position for at least 26 weeks to be entitled to a new period with sick-leave benefits. The sick-leave benefit is equivalent to the regular salary or wage, with an upper limit of six times the national insurance base amount per year (2019: about €60,000 per year) (NAV, 2019a). Therefore, most salaried employees do not have reduced salaries while on sick leave. After 1 year of sick leave, the employee is either granted disability pension benefit or receives work assessment allowance or other forms of activation benefits (NAV, 2019b). Income in the form of disability pension and work assessment allowance is about 66% of annual income depending on the income in previous years and the number of children.

Employees must notify the employer on the first day of sick leave and can use self-certification for the first three days. After these three days, the employee must present a medical certificate from the employee's general practitioner or the treating physician. If the sick leave is related to musculoskeletal problems, chiropractors and manual therapists can provide the medical certificate.

The employer pays for the employee's full income the first 16 days of sick leave. After the employer financed period (1-16 days) until 1 year, the employee's full income is covered by the public insurance scheme. It is up to the doctor (together with the employee and employer) to decide whether the employee is 100% on sick leave or whether the employee can work part-time (up to 80%) with work tasks he or she may be able to perform by taking the residual working ability in use. Part-time sick leave is by NAV strongly considered the preferred form of sick leave. Regardless of whether the sick leave is 100% or part-time, the maximum sick leave period is 1 year. If an employee has a chronic disease that may result in many recurrent days or periods of sick leave, the employee and the employer may apply to the Labour and Welfare Administration (NAV) to cover the employers-financed period as well.

To receive sick-leave benefits, the employee is obligated to participate in necessary examinations, treatment and rehabilitation. In addition, the employee must take part in suggested arrangements (such as mandatory meetings) and adaptations of work offered by NAV and the employer (see below). The employer is not allowed to ask the employee about diagnosis and clinical symptoms. The employee is obligated to inform the employer about work ability. If the a sick listed employee does not contend with the means suggested by NAV, he or she risks losing the sickness benefit according to the "activity duty" in the National Insurance Scheme.

The employment protection regulations in Norway are rather strong. Employers are not allowed to terminate employees because of illness or being on sick leave within 12 months after the first day of sick leave (Working Environment Act, §15-8). Nevertheless, termination is allowed because of other reasons such as reorganizations and down-sizing. After 12 months, termination because of health reasons are only allowed if the prospects of returning to work is very little even after possible adaptations at the workplace or relocation of the employee.

4.4 Work assessment allowance

After 1 year of sick leave the worker can apply to NAV for work assessment allowance if the work ability is reduced by at least 50%. The aim of having a period with work assessment allowance is to

be able to keep or to find new work that the worker may be able to perform. The work assessment allowance period is up to 3 years, and the benefit is about 66% of the benefit received during the previous sick leave period.

To receive work assessment allowance, the worker must actively participate in the process initiated by NAV to enhance work resumption (called “activity duty”). This includes developing a specific plan for what to do to return to work; participating in meetings with NAV; delivering necessary information and documentation so that NAV can support the worker; and the worker following up on what has been agreed. Relevant actions are health services, (vocational) rehabilitation, work adaptation and gradual increase in working efforts.

When actions agreed between the worker and NAV entail extra expenses for the worker, he or she may apply for support for learning material (such as a required software and books) when taking a new education, travel expenses and expenses for childcare. Workers may apply for work assessment allowance for a certain period (up to 9 months) while establishing a company to start self-employment.

The worker must regularly report to NAV about (changes in) his or her work ability and work situation so that the worker receives the correct amount of support and benefits.

4.5 Disability pension

Workers 18-67 years old may apply for disability pension when their working ability is reduced by at least 50% because of illness or injury. Whether the worker is entitled to 100% or graded disability pension depends on the remaining work ability. The disability pension benefits are about 66% of the worker’s previous wage. People receiving disability pension benefits (100% or graded) may work as much as they want and can in addition to the benefit. The pensioner may earn 0.4 times the national insurance base amount per year (2019: about €4,000 per year) without this affecting the pension benefit. If the work income exceeds this amount, the pension benefit is reduced. Treatment and work activity measures must have been tried before the worker may apply for disability pension benefit unless the reduced work ability is because of a serious disease or injury with obvious long-lasting disability.

4.6 Occupational injury and disease

Workers who are injured at work or get a disease as a result of occupational exposure (and the disease is mentioned in the list of approved occupational diseases) may apply for occupational injury or disease benefits. Such benefits are often higher than the public disability benefits. Such benefits are not covered by the National Insurance Scheme and have to be granted through the employer's private occupational injury insurance for employees, which is compulsory for all employers.

4.7 Employers' and employees' responsibilities

The purpose of Norway's Working Environment Act (Arbeids- og inkluderingsdepartementet, 2005) is:

> "a) to secure a working environment that provides a basis for a healthy and meaningful working situation that affords full safety from harmful physical and mental influences…, ….,
> c) to facilitate adaptations of the individual employee's working situation in relation to his or her capabilities and circumstances of life,…..and
> e) to foster inclusive working conditions."

Further, the Act states that the employer is responsible for ensuring that the provisions laid down in and pursuant to the Act are complied with (§2-1). This includes the duty to organize and arrange work with regard for the individual employee's ability for work, proficiency, age and other conditions and to provide training if the work changes so that the employee is able to perform adequately (§4-2). This duty of adjusting the working conditions, referred to as "the adjustment duty" for employers, and equivalent to the employees' "activity duty". In addition, §4-6 states that:

> "1) If an employee suffers reduced capacity for work as a result of an accident, sickness, fatigue or the like, the employer shall, as far as possible, implement the necessary measures to enable the employee to retain or be given suitable work. The employee shall preferably be given the opportunity to continue his normal work, possibly after special adaptation of the work or working hours, alteration of work equipment, work-oriented measures or the like.
> 2) If, pursuant to the first paragraph, it is appropriate to transfer an employee to other work, the employee and the employees' elected representatives shall be consulted before deciding the matter."

Unless unnecessary, the employer must in consultation with the sick-listed employee prepare a follow-up plan for returning to work after 4 weeks of absence at the latest. The plan must contain appropriate measures by the employer, appropriate measures involving the assistance of the

authorities (such as NAV) and plans for further follow-up. The employer is also obligated to participate in dialogue meetings arranged by NAV (see below) and is motivated to make use of the support from NAV, the occupational health service and other relevant actors to enhance the employees' work resumption.

According to their "activity duty", employees must cooperate on designing, implementing and following up the enterprise's systematic work on health, environment and safety. Employees must take part in the organized safety and environmental work of the work place and must actively cooperate on implementing measures to create a satisfactory and safe working environment (§2-3).

5. Tripartite cooperation for a more inclusive working life (the IA Agreement)

During the late 1990s, the sick leave and disability rates in Norway increased. At the same time, there was increased focus on the demographic trend showing that the share of people of working age was decreasing. The government considered this development to be an economic challenge for welfare services in the future. The government therefore established an official committee mandated to investigate the causes of the increased sick leave and disability pensions and to suggest actions to reverse the negative trend. The results of this committee's work were presented in teh Norwegian official report "Sick leave and disability pensioning: an inclusive working life" (NOU 2000:27). The main conclusions of this official report were:

1) Necessary interventions have to be rooted in working life at the individuals' workplace.
2) Both the employer and the employee have to be made responsible to a greater extent.
3) More focus on function and work ability (rather than diagnosis).
4) Public measures should support actions and interventions made at the workplace.
5) The enterprises should not need to be in contact with more than one public agency when following up employees on sick leave; and NAV should be more active, supportive and advisory to the enterprises.

Because of this official report, negotiations between the government, the main trade unions and the employer organizations in Norway were initiated. In 2001, these parties signed the first Letter of Intent regarding a more inclusive working life (the IA Agreement) (2001–2005) (Ministry of Labour, 2001). The same parties have signed such agreements every fourth year since 2001. In accordance

with the official report, the aim of these IA Agreements (except for the last agreement in 2019 – see below) has been threefold:

1) to reduce sick leave rates;
2) to include more people with disabilities in working life; and
3) to increase the average pensioning age of workers.

Aims that are more concrete have been defined in the various agreements since 2001. To reach the aims, the enterprises that wanted to work within the IA framework could sign the agreement and thereby achieve some rights and support from the public (through NAV).

Overall, the IA Agreements and the measures associated with the agreements have been refined and developed, but the framework has been kept rather steady. The measures in the 2001 agreement were [as described by Ose et al. (2009)]:

1) Better follow-up of employees on sick leave
    a. Earlier interventions and qualitatively better follow-up.
    b. The interventions should be anchored at the workplace, and the employer and employees should be made accountable.
    c. More focus on functioning rather than diagnosis. The Medical Practioner Act was revised so that it would be impossible for a physician to sick list a patient without assessing function.
    d. Active dialogue between employer and employee.
    e. More targeted use of public support measures for more prevention and inclusion.
2) New incentives for employers
    a. To make it profitable to make adaptations at work so that employees can continue to work despite health conditions.
    b. To reward employers creating a more inclusive working life (see IA enterprises).
3) IA enterprises

    A framework agreement was developed for cooperation between the individual enterprises and the public authorities (NAV). Together with the agreement, a more specific guide was developed. The enterprises that signed the agreement got status as IA enterprises. To stimulate the IA work, the following actions and measures were possible for IA enterprises only:

    a. The enterprises could use part-time sick leave without discussing it with NAV.
    b. Each enterprise had a specific contact person at the NAV Inclusive Workplace Support Centre.

c. The occupational health service of the enterprise got a specific reimbursement form NAV for relevant IA work.
d. Self-certification for employees on sick leave was extended from 3 days to 8 days (with a maximum of 24 days per year).

The employer was obligated to contribute so that employees who could not continue in their previous work because of health conditions could get a new educational qualification to qualify for another job in the same enterprise.

The employee was obligated to contribute with information about work ability and function related to the sick leave and to engage in constructive dialogue with the employer about possible adaptations at work. Nevertheless, the employee was (and still is) *not* obligated to provide information about clinical symptoms and diagnosis to the employer.

The government was obligated to support the measures mentioned above. In addition, they increased financial support for vocational rehabilitation, financial support for enterprises to purchase health services for their sick employees and wage subsidies for enterprises employing employees with disabilities. In addition, they covered enterprise expenses for pregnant employees on sick leave and reduced the employer tax for employees older than 62 years.

In accordance with suggestions from several governments before and after the IA Agreement in 2001, the official report suggested changing the regulations for sick leave: that is, full wage compensation for the employees from day one of sick leave and the 16-day period during which the employer is responsible for covering the sick employee's wages. The argument was that Norway's system lacked economic incentives for both employees and employers to return to work during the first year of sick leave. In the first agreement and in all the following agreements, the government agreed *not* to change the existing scheme for sick-leave benefits. For the trade unions, the main argument for keeping the system has been that reduced wages during sick leave would punish the employees with the weakest health and lowest wages (that is, a social equity argument). The employers have argued to keep the employer-financed period of 16 days to keep their share of the costs low.

Ose et al. (2009) evaluated the IA Agreement process from 2001 to 2009. The study used registry data (Statistics Norway) at the enterprise and individual levels, questionnaires and qualitative interviews with managers, health & safety personnel, healthy employees and employees on sick leave.

No later studies of the whole IA reform were conducted after that study except for minor IA-related interventions. The study concludes that the IA Agreement resulted in better collaboration between the parties (employers' organizations, trade unions and the government) at the national level. The study shows further that the main reason for the enterprises to sign the IA Agreement was to reduce sick-leave rates (subgoal 1). Overall, the enterprises experienced the collaboration with NAV as very good and the IA Agreement contributed to more and better collaboration between stakeholders within the enterprises (health & safety personnel, managers, employee representatives, occupational health service etc.) regarding the IA goals.

Nevertheless, the study concludes that the national goal of reducing the overall sick leave by 20% (compared with the 2001 sick-leave rate in Norway) was not reached (subgoal 1). Nevertheless, the sick leave rates in the IA enterprises were reduced and by significantly more than for the non-IA enterprises. The effect was greatest in private and municipal enterprises, whereas the IA Agreement had virtually no effect in state and county (regional) enterprises.

Regarding subgoal 2, including more people with disabilities in working life, the enterprises seems to have taken responsibility to include employees with a working contract who have disabilities or develop them. This is expected to result in preventing premature exit from the labour force, but this is difficult to measure because it is so closely related to subgoal 1 of reducing sick leave. For including employees with disabilities without a contract, the study concludes that the IA Agreements did not contribute to including more such employees. One reason for this may be that (small) private enterprises regarded this not to be their responsibility. Still, large state-run enterprises claimed that they were better suited than other enterprises to include employees with disabilities.

Subgoal 3, increasing the average pension age by 6 months compared with 2001, was reached in 2009. The increase was highest among men. The study shows that the focus on recruiting older employees and retaining older employees increased during the investigated period. This development may also be viewed in relation to a change in the general pension scheme, making postponed retirement more profitable for the individual worker. The private sector was the sector that worked the least with subgoal 3.

Since this evaluation in 2009, the IA Agreement has been renewed three times even though the sick leave has not been overwhelmingly reduced. In 2019, the government was rather sceptical about continuing the collaboration because the results had not been good enough at the national level.

Nevertheless, an agreement was reached, but subgoals 2 and 3 were excluded and only the sick-leave goal was retained. In addition, all enterprises in Norway were offered the same support from NAV that only the IA enterprises had had before. Consequently, from 2019, all Norwegian enterprises are IA-enterprises, and the measures of signing an IA-agreement have lost its exclusivity.

6. The role of the Labour and Welfare Administration (NAV)

NAV is a public organization responsible for supporting citizens with social security and welfare provisions and guidance. As a result of the NAV reform of 2006, NAV comprises three former welfare service offices – the state insurance office, the state employment office and components of municipal social services (Stortingsproposisjon 46 (2004-2005)). These three entities were merged into one organization to prevent fragmentation of welfare support and to ensure seamless treatment of clients, who should be able to have their case treated (and closed) in only one office regardless of their needs and the development of needs he or she would have. One main aim of the NAV offices is to reduce the number of passive economic transfers by promoting better coordination and increased effectiveness through the international trend of active labour market policies (Johansson & Hvinden, 2007). The NAV Inclusive Workplace Support Centre that was established to support IA enterprises (see above) is not part of this NAV reorganization that focuses on serving individual people with health or social problems.

After the NAV reform was implemented, several economic incentives and support services have been implemented to enhance NAVs activation work: the task of motivating, compelling and assisting people having difficulty in participating in the labour market. The activation policy includes an approach focusing on enabling people of working age, and the benefits offered depend on the applicants' fulfilment of activation obligations. In addition, employers are obligated to make reasonable adjustments to enable labour market participation despite reduced ability to work. Part of this activation venture has been to change the NAV officers' duties from being casework administrators to being guidance counsellors. This shift includes a shift from discretionary judgements about legal benefits to also include discretionary judgements about goals and about activation measures to achieve the identified goal, such as training, vocational rehabilitation, work-integration programmes or education, assistive technology (to compensate for reduced ability to work) or other kinds of reasonable adjustments of work tasks and working hours (Andreassen, 2019; Røysum, 2013).

The NAV counsellors constitute a mix of employees with different backgrounds and educations. Some have years of on-the-job training, but two thirds have education at the university level, primarily from the social and health professions (NAV, 2015). Health and social work education is definitely relevant for supporting clients with health problems, but few of these educations include work integration issues (Terum, 2014). The NAV counsellors therefore receive training in activation work and assessing work ability (Andreassen, 2019).

6.1. Following up sick-listed employees

Fig. 2 gives an overview of relevant health service agencies and a timeline for returning to work for people with health conditions and sick-leave spells. The role of the health services and clinical rehabilitation is not the focus of this report and is therefore not elaborated on here, but it is important to provide a context for what happens at the workplace. The timeline shown is described below.

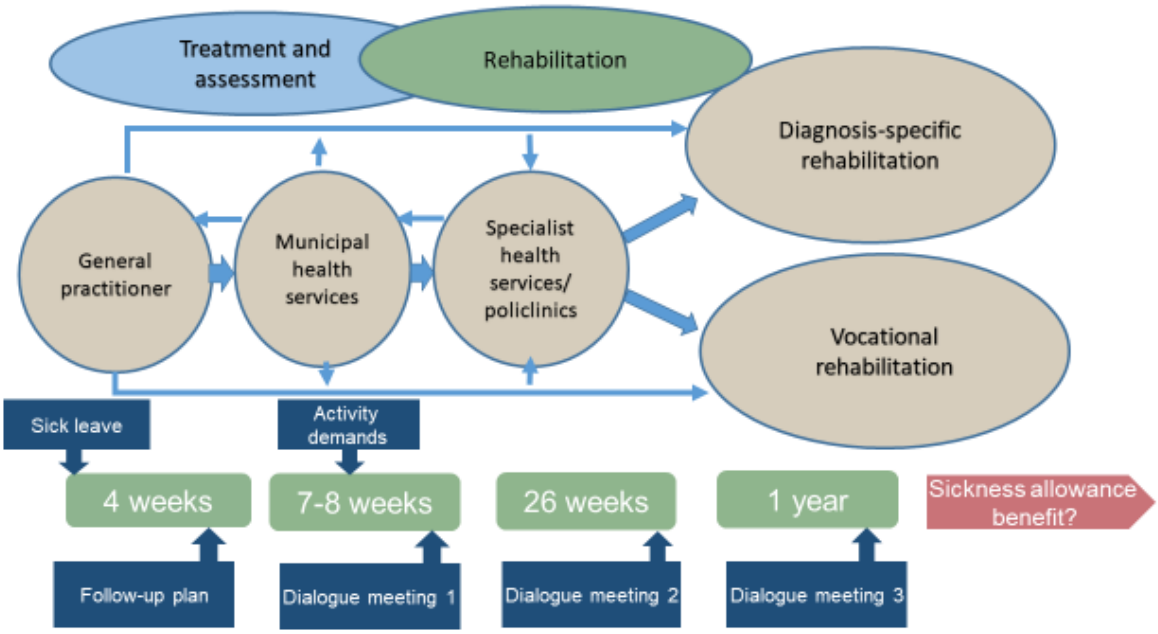


Fig. 2. *Overview of agencies and deadlines relevant for returning to work when sick (adapted from Øyeflaten I., 2019)*

The employer is given an important role in supporting employees to return to or stay at work when experiencing reduced work ability from sickness, fatigue and disabilities. Both the employer and the employee must get necessary support in close collaboration with the NAV counsellors and other relevant agencies. Table 1 provides a more detailed overview of actions, responsibilities and

deadlines for sick-listed employees, employers, NAV and doctors at the workplace and where NAV is more involved in the processes than the health services are.

1–8 days: When an employee calls in sick, he or she can use self-certified sick leave the first 3 days in accordance with the National Insurance Act (Arbeids- og sosialdepartementet, 1997). After that, he or she needs to get this sick leave certified by a doctor (or manual therapist, chiropractor or dentist depending on what health condition the employee has). From 2019,
employers and employees can make an agreement that self-certified sick leave may last up to 8 days. The employer may contact the employee if he or she does not contact the employer when sick listed. Within 4 weeks, the employer and employee should develop a follow-up plan unless it is obviously not necessary. The employer must send this plan to NAV.

Up to 8 weeks: The activation policy is based on the fact that most employees on sick leave are more or less sick: in other words, more or less able to work. If the employee is able to work in some way or another, the sick-listed employee should be in some activity related to work within 8 weeks. If the employee is still 100% on sick leave, the employer must take responsibility to organize dialogue meeting 1 between the employer, the employee and, if necessary, other relevant parties such as the occupational health service, NAV, employee representatives (trade union representative or safety representative) and/or the certifying doctor. The employee is obligated to attend the meeting (except if medical reasons make participation impossible) and collaborate actively in finding good solutions for returning to work. If the employee cannot participate in some kind of activity at the workplace, the doctor must provide a medical certification stating that this is impossible for the employee. If the employer cannot adapt work in some way for the employee, the employer must inform NAV about this.

Table 1. *Overview of involved agencies, actions, responsibilities and deadlines in supporting returning to work for sick-listed employees. Adapted from NAV (2015).*

Deadlines, roles and duties	Self-certified sick leave 1–8 days*	Sick leave** 4 weeks	Sick leave 7 weeks	Sick leave 8 weeks	Sick leave 26 weeks	Sick leave 1 year
Employer has responsibility to include employees early Must document follow-up of sick-listed employees	Keep self-certification forms Contact worker if on sick leave several days	Develop a follow-up plan with employee Inform doctor and NAV (if NAV support is needed)	If 100% sick listed, take initiative for dialogue meeting 1 with employee NAV, occupational health service, doctor and employee representative may participate		Participate in dialogue meeting 2 together with NAV, employee and others Send NAV updated follow-up plan 1 week before meeting	Participate in dialogue meeting 3 if summoned Can initiate dialogue meeting 3
Employee must collaborate and be active in finding solutions for early return to work***	Contact employer Inform about expected time for sick leave	Participate in developing a follow-up plan with the aim of returning to work if possible	Participate in dialogue meeting 1 (if medically possible) Inform employer if other parties are wanted in the meeting	If not in work-related activity, a new sick-leave certificate from doctor is needed	Participate in dialogue meeting 2 Participate in finding solutions for returning to work	Participate in dialogue meeting 3 Can request dialogue meeting 3 Before 1 year: together with doctor, consider help from NAV Apply for work assessment allowance or disability pension
Certifying doctor must motivate the person to return to work 10% or part time if medically sound		Consider part-time sick leave on an ongoing basis Receive follow-up plan	Participate in dialogue meeting 1	Certify whether the employee cannot participate in relevant work activities	Participate in dialogue meeting 2 if summoned	Participate in dialogue meeting 3 if summoned Can request dialogue meeting 3
NAV must support the employer and employee Pay sick leave benefits Suggest means for returning to work		Send general information to all sick-listed employees		Consider whether the demands regarding work activity have been fulfilled	Organize dialogue meeting 2	Organize dialogue meeting 3 if necessary or if one of the parties requests it Consider whether more work-related actions or work assessment allowance are relevant
Employee representatives	Contribute to preventing sick leave through the systematic health and safety work. Give advice to the sick-listed worker and contribute to the dialogue with the employer. Participate in dialogue meetings if the employee requests it.					
Occupational health service	Contribute to the systematic health and safety work and in follow-up work with the employee and employer. Take part in dialogue meetings if the employer and/or employee request it.					
Labour inspectorate	Supervise and oversee enterprise health and safety work to prevent sick leave. Oversee that enterprises or employers follow up workers in accordance with the directives mentioned above.					

* 1 – 3 days if there is no agreement between employers and employees regarding 8-day self-certification. **Certified by a doctor.

Up to 26 weeks: If the employee is still not working after 26 weeks, NAV summons the employee, the employer and the doctor to dialogue meeting 2. It is organised either at NAV's office or at the enterprise. This meeting is particularly important in the process of returning to work, and is mandatory for both the sick listed employee and the employer. If any of the parties want other parties such as trade union representatives and the occupational health service to attend, they are also invited. The employee's personal NAV counsellor leads the meeting, takes responsibility for the meeting protocol (based on an updated follow-up plan sent to NAV by the employer 1 week before the meeting) and writes the minutes of the meeting, including a new follow-up plan.

The employee describes first his or her situation regarding ability to work and relevant adaptations made at the workplace, the employer does the same based on its experience and the doctor gives his or her opinion about the employee's ability to work. Then the involved parties discuss further solutions for the employee to return to work. In addition to relevant adaptations at work (such as working hours, work tasks, physical and ergonomic adaptations and collaboration with co-workers), the parties must consider further help from the health services and financial support from NAV to the employee and/or the employer. For instance, NAV can provide financial support for the employer to hire an external ergonomist or physical therapist to make a workplace assessment and guidance for the employee. It is also relevant to consider whether NAV should buy (vocational) rehabilitation services from a rehabilitation clinic for the employee.

Up to one year: Sick-leave benefits end after 1 year (52 weeks). If any of the involved parties want, they can ask for dialogue meeting 3. This meeting resembles dialogue meeting 2. The employee should contact NAV at the end of the 1-year period to discuss the possibility of applying for work allowance benefits after the sick-leave period (or to apply for disability pension benefits). In some instances, NAV is proactive and sends a letter to the employee if it is reasonable to believe that he/she will not return to work within 1 year.

These measures to prevent sick leave, including NAV's role in supporting employers and employees in this process, were evaluated in 2015 (NAV, 2015). This evaluation concluded that NAV does not live up to the expected ambitions related to sick-leave follow-up. The follow-up does not reach all employees, is initiated too late and most sick-listed employees get the work ability assessment too late. The collaboration with the NAV Inclusive Workplace Support Centre is not good enough (see the IA Agreement above), and the NAV counsellors know too little about the relationship between work-related actions and treatment. The evaluation group anticipates that some clients would benefit

from improving the integration of health- and work-related interventions from the health service and NAV and enterprises.

It is also concluded that the doctors' contribution to the return-to-work process is not optimal, since many of the doctors do not assess ability to work or at least do not inform NAV about the results. Thus, the NAV counsellors find it challenging to implement sound work-related adaptations and actions because they lack sufficient information about the employee or patient. The Norwegian College of General Practice argues that the doctors are in a dilemma; if they are too optimistic regarding ability to work, their patient may lose the possibility of work assessment allowance. In addition, assessing the ability to work on a general basis is difficult. They therefore argue that they need concrete questions from NAV or the enterprise as to whether their patient will be able to perform specific work tasks.

Overall, the evaluation is unclear as to whether the results can be regarded as good (enough) in preventing long-term sick leave and disability pensioning. Nevertheless, a later controlled registry study (Markussen, Røed, & Schreiner, 2017) showed that compulsory dialogues (measured using dialogue meeting 2) between NAV, the employee and the employer (and other parties) reduce sick-leave duration considerably and the estimated benefits exceed by far the estimated costs.

As in many other countries, return to work has until rather recently not been a particular interest of most treating doctors (Lelliott et al., 2008; Wainwright, Wainwright, Keogh, & Eccleston, 2011). Therefore, instructions to hospitals and general practitioners from the Ministry of Health and Care Services have lately underlined the importance of including return to work as an important measure for (successful) treatment and that increased collaboration with NAV is necessary (Meld. St. 7 (2019 – 2020)).

6.2. Following up sick-listed self-employed people

Self-employed people in Norway are granted sick-leave benefits from day 17 and for 1 year. The benefit is based on 66% of the past 3 years' average income reported to the tax authorities on which the sickness benefit is based. Furthermore, for self-employed people, the upper limit of the sickness benefit is six times the national insurance base amount per year. Self-employed people may buy an insurance policy from the National Insurance Scheme to receive better compensation if they become sick listed, but only 11% of self-employed people buy such insurance (Grünfeld, Salvanes, Hvide,

Jensen, & JF, 2016). The regulations regarding unemployment, work assessment allowance and disability pension benefits are more or less the same for self-employed people as for employed people.

Much of Norway's follow-up programme is based on the employers' responsibility to adapt work in accordance with the workers' ability to work. The definition of a self-employed person is that he or she does not have an employer. Therefore, NAV has special responsibility to support self-employed people in returning to work. Very little research has documented how this group is followed up in Norway, but two studies on self-employed cancer survivors document that this group encounters great financial problems when sick-listed (Torp, Syse, Paraponaris, & Gudbergsson, 2017) and that the support from NAV during the first year of sick leave is more or less non-existent (Torp, Brusletto, Withbro, Nygaard, & Sharp, 2020). Another study on cancer survivors claims that Norway's support system is especially weak for self-employed people (Becken, Eriksen, Solheim, Lien, & Wedde, 2015). One reason for this may be that Norway has few self-employed people (7%) compared with other European countries (EU= 15%) (Eurostat, 2018) and therefore do not get the attention they might deserve.

6.3. Following up marginalized groups in the labour force

For both individual and societal reasons, including as many people as possible in the labour force is important, including groups that are marginalized, such as young unemployed people who are not in an educational programme (NEETs), immigrants who do not speak Norwegian, people struggling with alcohol addiction or substance abuse problems and people with physical, mental, social and cognitive disabilities. Including such groups may prevent social inequity, improve public health and decrease the burden of public funding (Organisation for Economic Cooperation and Development (OECD), 2019). In the IA Agreement, this has been a focus and is partly expressed in subgoal 2 regarding including people with disabilities. Compared with other countries, Norway does not perform very well in including people with disabilities. According to Statistics Norway (2019), 43.8% of the people with disabilities are working (Statistics Norway, 2020), that is, a lower proportion than in the EU (47.3%) [comparable data from 2011 show 47.3% for EU and 42% for Norway) (Eurostat, 2014; Statistics Norway, 2020). In relation to this finding, it is interesting to observe that managers in Norway are less willing to employ young people who have problems with entering the labour force than managers in other countries (Imdorf et al., 2019).

NAV has several measures to help these groups into the labour market. First, NAV counsellors assess the person's ability to work and develops, together with the client, an activation plan. The aim of this

plan is to make the client able to work, 100% or part time. Depending on the needs of the individual client, NAV offers either practical or financial support. The support measures can be divided into two main categories: educational programmes and labour market initiatives.

Examples of educational programmes may be short courses in how to write CVs and job applications and how to search for jobs; courses to qualify for various jobs (up to 1-year course); ordinary secondary-school educational programmes (2 years) or higher education at the university level (up to 3 years).

Examples of labour market initiatives are work training in sheltered enterprises (to qualify for ordinary work); work training in ordinary enterprises with NAV paying the wage and the employer having the opportunity to determine whether the person may be suitable for an ordinary working contract; work in ordinary enterprises with the employee having a working contract and NAV and the employer share the wage expense (for a limited period or as a permanent scheme); and Supported Employment, in which the person gets an ordinary job and contract in an enterprise while NAV pays the wage for a period and provides both the employee and the employer support and close follow-up by a specially trained supervisor (key account manager).

In Supported Employment, the supervisor is responsible for finding a good job match for both the employee and the employer, for ensuring good dialogue with both and to have knowledge about and access to relevant support mechanisms in NAV and other agencies (Frøyland & Spjelkavik 2014). Studies in Norway have shown that Supported Employment and the variant called Individual Placement and Support (IPS), are more effective in helping marginalized people get work than other initiatives (such as the ones mentioned above) (Nøkleby, Blaasvær, & Berg, 2017; Reme et al., 2019). The controlled study by Reme et al. (2016) also shows that the IPS participants reported better quality of life, less depression and better functioning than the control group 1 year after the intervention started.

So far in this report, work has been implicitly defined as some kind of paid work (the manifest function of work) in the ordinary labour market. This definition of work is contested. Work may also be defined as work not resulting in income such as homemaking or family work and volunteer work. This last category is also work for people who are far from the ordinary labour market, such as people with a disability pension (and support from NAV) but who still need the other positive effects of work such as feeling mastery, social support and contact and increased self-esteem (the latent functions of

work). According to Heen (2008), if paid work is regarded as the only way to achieve social integration and a meaningful life, this may further marginalize the people who already are marginalized. Norway's policy and Norwegian official reports (such as NOU 2016:17 "On an equal basis") therefore increasingly focus on the latent functions of work in addition to the manifest functions. Thus, both public and private enterprises include workers who have their income from NAV but are offered work in sheltered workplaces with the aim of providing them an opportunity to experience the positive effects of being in work and thus prevent further disability.

7. The role of non-governmental organizations (NGOs) and vocational rehabilitation enterprises

As described above, the state work and welfare agency NAV is responsible for most of the work inclusion activities in Norway. Nevertheless, private agencies are also involved in vocational inclusion and rehabilitation but they get primarily their funding from NAV and other public agencies. Three different types of enterprises constitute this group: private enterprises, municipality-owned enterprises and NGO-owned enterprises. According to law (Arbeids- og sosialdepartementet, 2015), these enterprises are not allowed to obtain profit from the services paid by NAV. Their income comes partly from fixed transfers from NAV, from winning tenders among vocational rehabilitation enterprises and from products and services the enterprises produce and sell.

For both societal and individual reasons, Norway has had strong political focus since the 1950s on including as many people as possible in work (the so-called "work-line policy" under which everyone should have the opportunity and duty to work) and on reducing passive transfer payments. The first vocational rehabilitation enterprise was the state National Institute of Vocational Rehabilitation, but also some private individuals and organizations operated enterprises with the goal of including more people with disabilities in the labour market. Since then, the number of vocational rehabilitation enterprises has increased, supporting people with various forms of disabilities and other groups of people that may be marginalized in employment. There has been a particular increase in the support measures for people with mental disorders. The first enterprises offered primarily sheltered employment. Lately there has been a steady increase in the focus on employing people in ordinary jobs with ordinary wages. The latest focus is mapping the needs of the employer and focusing more on the abilities of the people with disabilities rather than on the opposite – in accordance with Supported Employment and Individual Placement and Support as described above.

Overall, NAV and the enterprises take care of employees and self-employed people who experience health conditions that reduce their ability to work. For people who have difficulty in entering the labour force, the private and public vocational rehabilitation enterprises (mostly through funding from NAV) play a more important role. Some primarily focus on supporting people in entering the ordinary labour force and a "normal" life; others mainly focus on sheltered employment and the latent functions of being in work. An example of an NGO engaged in work inclusion activities is the Church City Mission, an inclusive non-profit organization that works in towns and cities across Norway among people who face challenges in life for various reasons. A recent evaluation (Lien, 2020) of their activities within work inclusion concludes that they especially focus on groups far from being part of the ordinary labour market and with weak ambitions of being part of it. Examples of such groups are poor people with alcohol addiction and substance abuse problems. The organization's main focus is on care rather than on income (although some income is offered) and thus focusing on offering social inclusion, self-esteem and coping through work.

8. Homelessness and work

Adverse health conditions, addiction problems, lack of work and homelessness are all highly correlated. Norway belong to the lower end of the scale when it comes to homelessness (Dyb, 2017). Still, the problem of homelessness is highly relevant as in other countries and public policy has therefore had an ambition of preventing, reducing and even abolishing homelessness (Ministry of Local Government and Regional Development, 2006; Norwegian Ministry of Labour and Inclusion, 2007; Norwegian Ministry of Local Government and Regional Development, 2004).

For most people, and in many countries, homeless people are mostly understood as rough sleepers and people staying in facilities for homeless. Nevertheless, there is little consensus on how to define homelessness. In Norway, a person is regarded as homeless if he/she has no privately owned or rented accommodation and is in one of these situations: Reliant on occupational or temporary lodging, lives temporarily with friends, acquaintances or relatives ("sofa surfers"), lives in an institution or in a correctional facility and is due to be discharged or released within two months without access to accommodation (e.g. prison), or sleeps rough/has no place to sleep. Using this definition, Norway surveys every fourth year (since 1996) the prevalence of homelessness in the country. As in most other countries in Europe, homelessness has increased since 2000 but in 2016 this negative trend changed (from 1.26 homeless person per 1000 inhabitant in 2012 to 0.75 in 2016) (Dyb, 2017). It is

believed that this positive trend is a result of systematic efforts to reduce homelessness and promote social integration of vulnerable citizens.

In a review of the Norwegian housing policy the past two decades Dyb (2017) highlight the following issues as important for a relatively successful housing policy reducing homelessness in Norway:

1) Using a rather wide definition of homelessness.
2) Routinely measuring homelessness and surveying the profile of the homeless population to guide interventions.
3) Focussing on prevention of homelessness in addition to provide housing for those without a home.
4) Moving from a "staircase of transition" model to a "housing led" model.

According to Dyb (2017), the change from a staircase of transition model to a housing led model (point 4) is probably the most important action. The former demands changes in lifestyle before the person with health or addiction problems will get a tenancy whereas the latter does not demand anything in that way. "Project homelessness" was (and is) lead by the Norwegian State Housing Bank and thus embedded in the housing sector on a state level. In addition, social workers were trained in "social housing". Dyb underlines that Housing First philosophy (Tsemberis, Gulcur, & Nakae, 2004) is included in the Norwegian housing led approach but the approach goes further than Housing First.

In Norway, there is no clear linkage between working with homeless and simultaneously working with employment of homeless. One reason for this may be that most persons are provided with a place to live through relatively generous public welfare arrangements giving income and housing. People falling out of this public system are people with very complex issues and are very far from being part of the labour market. For most of these people it is primarily a question of finding a social benefit that may ensure a stable income and a home. Embedded in the housing led philosophy a stable life with housing and income may be a point of departure for being able to tackle complex challenges related to for instance diseases and drug addiction - and employment. The governmental and non-governmental employment initiatives described above would then be of relevance.

9. Examples of interventions to reduce sick leave and to promote work inclusion.

9.1. atWork

Subjective health complaints such as back pain and mild mental disorders (such as feeling anxious and depressed) are prevalent among workers in Norway and the main causes of high sick-leave rates. The atWork intervention (Johnsen, Indahl, Baste, Eriksen, & Tveito, 2016; Odeen et al., 2013; Werner, Laerum, Wormgoor, Lindh, & Indahl, 2007) was developed by health personnel in a public rehabilitation clinic at a large hospital in Norway. atWork is a group intervention using the workplace as a setting for distributing evidence-based knowledge about musculoskeletal and mental health problems and thereby reducing the negative effects of subjective health problems and reducing sick leave.

The intervention has a theoretical foundation in the Cognitive Activation Theory of Stress (CATS) in which coping is defined as positive response–outcome expectancies and a belief that a person's actions and strategies will lead to positive results. The intervention was first created for preventing negative results from low-back pain but has been modified to fit musculoskeletal disorders in general and also mental health problems. The original model consists of the following components.

Workplace sessions. Three workplace sessions are for all employees and managers at the workplace. The prevalence of problems, what the relevant problems are and what the atWork intervention includes are part of the first workplace session. In addition, a peer-support person is selected among the employees. The second session is more about the disorder and symptoms and underlines the importance of staying active (both in private and at work) while experiencing pain and symptoms. The third session focuses especially on dispelling myths about the disorders and symptoms related to inactivity and bedrest and what X-rays and magnetic resonance imaging can actually tell about functioning and pain.

Peer support. The selected peer-support person or peer adviser participates in two outpatient clinic courses and thereby obtains more in-depth knowledge about anatomy, the health problems and guidance on how to function as a peer adviser at the workplace. This person gives support and uses local knowledge of the working environment to help colleagues to stay at work when they have symptoms or pain.

This original atWork intervention has shown positive results in reducing sick leave among employees with low-back pain (Werner, Laerum, Wormgoor, Lindh, & Indahl, 2007; Odeen et al., 2013). In a later intervention, the focus was on employees with both musculoskeletal disorders and mental health disorders. The use of peer support was omitted (Johnsen 2016) because the peer support role collided with the role and responsibility of the manager or supervisor. Instead, a new version of the workplace sessions was introduced. In that version, the first and fourth sessions are exclusively for managers, health and safety representatives and union representatives. The fourth session especially focuses on how to create an inclusive culture at the workplace and what further assistance they may need (from within the enterprise or from other agencies such as NAV) to achieve this goal. The second and the third workplace session are for all employees, including the managers and representatives, with largely the same content as the original atWork sessions. A randomized controlled trial (Johnsen et al., 2019) did not show any significant differences in sick leave between the two models of intervention.

9.2 Ripples in Water

Ripples in Water (NHO, 2020) was a project initiated by the employers' organization the Confederation of Norwegian Enterprises (NHO), an organization whose main objective is to create and sustain the competitiveness and profitability of business and industry. The objective of Ripples in Water was to increase the level of employment for people with disabilities and marginalized people who are far from participating in the labour market. It is a collaboration between NHO-organized vocational rehabilitation enterprises (enterprises whose main service is to help clients into work by various initiatives) and other production enterprises in NHO. The methods used are based on Supported Employment and Individual Placement and Support, with the "place and then train" approach (in contrast to the "train and then place" approach).

A trained key account manager is a key factor in this process. Most personnel in vocational rehabilitation enterprises have their education within pedagogy or the health sciences. The key account manager's most important competency should be knowledge about the local industry and businesses and being able to sell the methods and candidates to these local businesses.

The first phase in Ripples in Water is to assess the needs of the production enterprise and then find the best suited candidate the rehabilitation enterprises have available. Thereafter, the candidate gets training either at the rehabilitation enterprise (such as necessary formal education) and training for the specific work tasks at the workplace. Practical work tasks should start early, and the evaluation

after a period determines whether the candidate obtains an ordinary working contract. The key account manager gives close follow-up to the candidate and to the employer. His or her services may also continue after the candidate is employed at the enterprise.

An evaluation of Ripples in Water (Bråthen & Lien, 2015) underlines that the strength of this particular project is that it is organized by the employers' organization NHO, which gives the project legitimacy and is a door opener for recruiting relevant production enterprises to which the candidates may be recruited. It is also relevant that both the rehabilitation enterprises and the production enterprises are organized in the same employers' organization. In addition, this has promoted more collaboration between the rehabilitation enterprises by establishing a network between the rehabilitation enterprises and thereby made it easier, across rehabilitation enterprises, to find suitable candidates for the specific production enterprise's needs and also jobs for the individual candidate's interests and competencies.

9.3 The fast track for newly arrived refugees

Refugees who need basic qualifications to enter the labour force in Norway are offered an introduction programme (Directorate of Integration and Diversity, 2020). The municipality in which the refugees settle offers the programme, and all participants receive benefits for daily living as long as they participate in the programme. The programme usually lasts 2 years, and the participants have to participate 30–37.5 hours per week. The programme includes training in Norwegian and social studies related to living in Norway. The programme also includes practice in working life and training for relevant jobs. The training and initiatives must be adapted to the interests and needs of the refugee and set out in an individual plan for every refugee. The refugee services, NAV and educational services are jointly responsible for the introduction programme for refugees. Ordinary labour migrants from Europe are not entitled to take part in the introduction programme. The effects of the introduction programme have been thoroughly discussed. Questions have been asked as to whether the participants learn Norwegian well enough to participate in working life, and it has been asked whether the training for working life has been good enough. A programme called "The fast track for newly arrived refugees" has therefore been developed (The Directorate of Integration and Diversity, 2019).

The fast track resembles Supported Employment, with close follow-up by mentors or supervisors, thorough assessment of the refugee's competencies and interests, early introduction to working life and enterprises and a clear focus on the enterprises' labour needs. The idea is that learning Norwegian

will be easier if the refugee is in work. Thus, the programme is more "place and then train" than the more traditional introduction programme, which resembles a "train then place" model. The aim is to identify refugees who already have the competencies Norwegian enterprises need within defined geographical regions and to provide necessary training early so that they relatively rapidly can participate in working life. The traditional teaching in Norwegian is somewhat challenged by this model, since the teaching must be more flexible than before. Thus, the refugee services, NAV and educational services need to collaborate better and more closely.

10. Conclusion

In an international perspective, Norway has rather good welfare provisions for people with health conditions or other disabilities who need support for entering the labour market or for returning to work after sick leave. The policies in work inclusion are governed by the idea that it is best for individuals and for society that as many people as possible are in the labour market and contribute as much as their ability allows. Nevertheless, Norway struggles with high sick-leave rates, and the proportion of people in the labour market with disabilities is rather low. The reasons for this are not known, and the state, employers and unions make joint efforts to disentangle this difficult question and try out different strategies.

Currently, the trend for work inclusion and activation policy seems to be in accordance with Supported Employment, focusing on early activation at the workplace, close follow-up and encouraging employers to be socially responsible by focusing on the enterprises' needs for competencies and labour. Therefore, the collaboration between NAV and the enterprises must improve, and public incentives through NAV must be readily available for employers (Mandal, Midtgård, & Mordal, 2019). The recent Norwegian official report (NOU 2019:7, 2019) "On work and benefits – measures to increase employment among people with reduced work ability or others who struggle with entering the labour market" suggests the following main measures to increase employment in Norway:

1) *A new sick leave benefit scheme.* Increase the use of incentives for employees to use graded sick leave and thereby increase the sick-leave period from 12 months to 18 or 24 months. In addition, increase the employers' financial responsibility for long-term sick leave.
2) *A work-oriented disability pension*. To increase employers' interest in employing people receiving a disability pension, it is suggested to implement a health-adjusted wage. The employers will then pay full wage adjusted for the reduction in productivity. The disability

benefits will then be given as compensation for the reduced wage per hour or reduced working hours.

3) *Increased follow-up but reduced work assessment allowance for young people*: Young people with benefits earn relatively much compared with young people in work. It is expected that reducing benefits will motivate more young people to make efforts to enter the labour force. Often, the disability of young people is more a social problem than a health condition. It is important to prevent the medicalization of vulnerable young people.
4) *Increased measures to increase employment among older people*. Increase the competencies of older people to meet the challenges in current working life. In addition, increase the opportunities to work longer than the set age limits (70–72 years), with adjusted wage and work terms to benefit both employees and employers.

Currently, it is not known whether these suggestions will be initiated, but it seems reasonable to believe that some of these measures must be implemented, since the inclusion and activation policies have not had overwhelmingly good effects in the past 20 years. Nevertheless, Norway's labour market is doing rather well, and the health and job satisfaction of employees is very good compared with other countries. New measures taken to increase work inclusion and activation should not interfere with these important and positive aspects of working life in Norway.

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