

The Inclusive Workplace Agreement: Past Effects and Future Directions

An interim OECD assessment
November 2005

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FORWARD

In June 2005, the OECD started a new *thematic review on sickness and disability policies* to improve work incentives and employment rates of persons with health problems. The review will cover 10-12 countries in total. The main focus will be to explain why so many sick people end up receiving disability-related benefits and to identify policies that work best in terms of retaining and reintegrating people with health problems in work.

The first round of the review covers Norway, Poland and Switzerland; the two subsequent rounds will cover Australia, Denmark, Finland, Ireland, Luxembourg, Spain, the United Kingdom and probably the Netherlands. The outcomes of the review will include one comparative publication each year and a synthesis report containing a more general discussion of the key issues and policy lessons from this project.

In addition, the OECD was invited to express an opinion on a major issue in the current political debate in Norway, namely the *Inclusive Workplace Agreement* (IW-agreement), which is currently under evaluation. The purpose of this paper is to respond to this request.

This assessment of the IW-agreement is *preliminary*, and it does not refer to other elements of Norway's sickness and disability policy system more broadly or other ongoing reforms such as the mandate of the Disability Pension Reform Commission. The overall OECD assessment of Norway's sickness and disability policy will be presented in a forthcoming comparative report on Norway, Poland and Switzerland which will be published in Autumn 2006.

The Inclusive Workplace Agreement: Past Effects and Future Directions

An interim OECD assessment

Summary of the main points

1. The bottom line of this preliminary assessment is the following:
 - a. It is not clear to what extent the recent decline in sickness absence is due to the IW-agreement or rather to the reform to the sick pay scheme adopted in mid-2004 – though the timing of the latter reform seems to match that of the decline in sickness absence. However, this question seems sterile and narrow. Indeed, these measures reinforce each other, which is why social partner-driven actions directed at the workplace should always be complemented by enforcement of adequate legal systems.
 - b. The agreement between government and social partners seems to have facilitated the adoption and implementation of the 2004 reform of sick pay. However, the tripartite agreement in and of itself is neither a necessary nor a sufficient condition for measures taken at the workplace. Indeed, it is often the individual cooperation agreements between employers and their county national insurance offices which lie behind recent successful developments.
 - c. Moreover, the tripartite agreement should not become a hindrance to change. If the tripartite agreement was to be continued or a new agreement be signed, the government should not accept a veto against government intervention. A new agreement should follow a number of principles, including a stronger focus on people currently outside the labour market (which by definition are not well represented by social partners), measurable targets for all its objectives, and consequences for the different actors of not achieving these targets.
 - d. More generally, to reduce the outflow from work into disability benefits and to raise the employment rate of people with health problems, additional reforms are needed. Reform experiences from other OECD countries – e.g. as regards incentives for employers, employees and gatekeepers, including doctors – might provide useful in this regard.

The current situation in Norway in an international perspective

2. In examining the situation in 20 Member countries around the year 2000, in early 2003 the OECD published a ground-breaking study on disability policy for the working-age population, entitled *Transforming Disability into Ability*. This study developed comparative disability policy indicators and compared these with the outcomes of policies (e.g. in terms of employment rates, income levels and benefit dependency) with the aim to identify successful systems, or components of systems, and directions for reform.

3. This study concluded that most OECD countries are facing similar challenges. For some, disability benefits have turned into benefits of last resort, while in other countries, the disability route has become an attractive route to early retirement. Hence, disability benefit recipiency and long-term sickness absence rates are increasing in many countries; the causes of disability are shifting away from physical towards mental conditions everywhere; and growth rates for women tend to be higher than for men. At the same time, employment rates of persons with health problems are low. In all these aspects, Norway is not an exception. However, Norway is exceptional to the extent that it has one of the highest number of working days lost due to sickness, twice the OECD median, as well as one of the highest disability benefit recipiency rates in the OECD. The study further concluded that Norway belongs to those countries with considerable emphasis on employment integration the impact of which, however, is weakened by a generous and easily accessible benefit system. Among the 20 countries studied, Norway has the 4th most comprehensive integration policy but also the most generous compensation policy of all.¹

4. Having found more problems than solutions, the 2003 OECD study concluded that a comprehensive transformation of policy towards disability and sickness is needed in most countries – so as to turn disability benefit schemes from passive benefit programmes into active programmes promoting integration into employment and hence society. Key elements of such a new approach are: to introduce a culture of mutual obligations, also involving employers; to promote early intervention and to emphasise tailored activation measures; and to remove disincentives to work. A number of OECD countries have since undertaken or at least started major reform attempts in the right direction. Norway is one of them.

1. This classification is based on a two-dimensional policy typology, with each of the two main dimensions (*integration* and *compensation*) being broken down into ten sub-dimensions. Each sub-dimension measures one important aspect of the countries' integration and compensation policies, based on a predefined quantitative and/or qualitative scale.

The objectives of the Inclusive Workplace Agreement

5. In response to the high sickness absence and disability benefit inflow rates over the 1990s, various reform proposals have been under consideration – such as the Sandman Committee’s recommendation to introduce respectively raise sickness benefit co-payments for employees and employers. The Norwegian government, however, decided on a different and – in international perspective – quite unusual route, namely to shift parts of the responsibility for solving these issues to the social partners. With the aim of reducing the outflow from the labour market into health-related benefits and early retirement schemes, a tripartite agreement was signed for the period 2001-2005 between the government and the social partners to cooperate on strengthening active measures at the workplace – the IW-Agreement. The main idea behind this is that the workplace is the main arena where progress could and should be made.

6. The three specific objectives of this tripartite agreement are:

- to reduce sickness absence by at least 20% from the level observed in the second quarter of 2001;
- to secure employment for a larger number of people with disabilities; and
- to increase the actual retirement age i.e. to prolong working life.

7. Several measures were implemented so as to achieve these objectives. However, there is a strong bias towards the *first* objective, in terms of measures taken and policy issues discussed by the Norwegian authorities. This bias is also reflected in the much vaguer objectives on employment of people with disabilities and on prolonging working life.² Similarly, the mid-term as well as the final evaluation of the agreement is largely looking into the question as to whether sickness absences had been reduced in line with the policy objective.

8. The most important recent policy instrument appears to be the possibility for enterprises to enter into a cooperation agreement with the National Insurance Administration (NIA). IW-enterprises, which by now cover some 60% of the labour force, benefit from a number of special regulations (including, for instance, a possibility for longer periods of self-certified sickness absence for their employees) and from support by the newly-established Workplace Centres of the NIA, which were set up in each county. Service from these Centres can be comprehensive and include, for instance, tailored management and organisational development assistance.

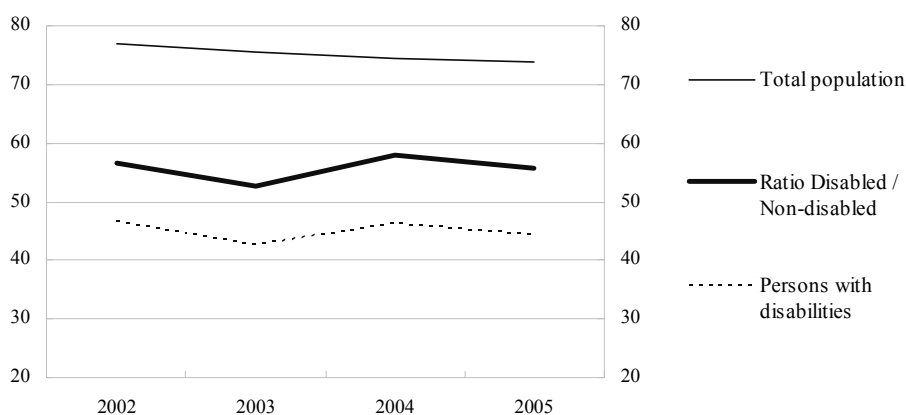
2. In this paper the focus is on sickness and disability policy. Recent and ongoing reforms addressing retirement policy are not described. The issue of how to improve employment opportunities of older workers so as to prolong working lives has been the subject of another OECD report published in 2004 (*Ageing and Employment Policies: Norway*).

Available evidence on the objectives of the IW-Agreement

9. The IW-agreement was signed for a trial period of four years, effective from 3 October 2001 until 31 December 2005. A mid-term evaluation was carried out after the 2nd quarter of 2003; this showed that the objectives were far from being reached. However, as the IW-concept has gained considerable support in the Norwegian workplace, the government and the social partners agreed to uphold the IW-agreement for the agreed period and to undergo a more comprehensive evaluation (which is soon to be completed) by the end of 2005. The future of the agreement will in part depend on the results of this evaluation.

10. What are the outcomes thus far? First of all, both the average age of retirement and the employment rate of persons with disabilities have not changed during the past years. Rates of employment of persons with health problems fluctuate at 50%-60% of those without such problems (Figure 1), for both men and women. This finding is not surprising because of the overriding emphasis in the IW-agreement itself and in the political debate on the first objective, the reduction in sickness absence. But it is unfortunate as the other two objectives should be treated as every bit as important as sickness absence.

Figure 1. **Employment rates of persons with disabilities and of the total population and relative employment rates for disabled people, 2002-2005**

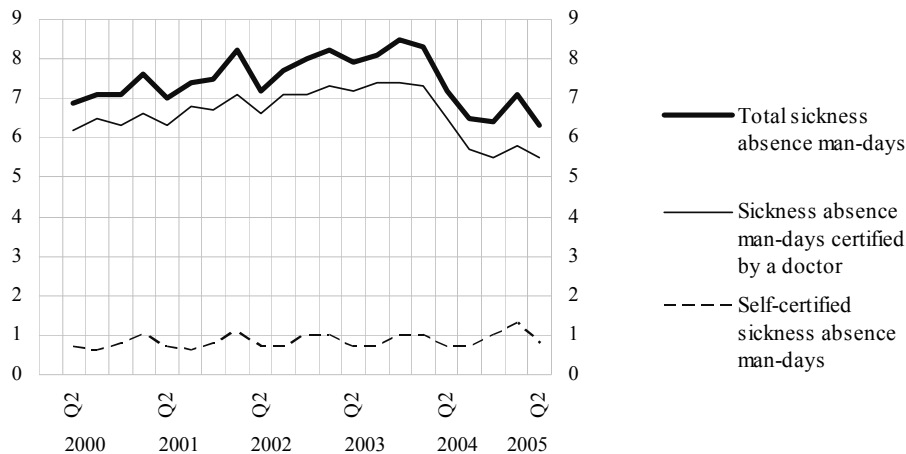


Source: Statistics Norway, www.ssb.no, subject 06.01 Labour force survey, Ad hoc modules; data refer to the second quarter in each year.

11. Trends in sickness absence rates show an irregular pattern. By and large, total sickness absenteeism continued to increase rapidly in the first two years after the tripartite agreement was signed, i.e. in 2002 and 2003, but dropped sharply in the second half of 2004. Sickness absence has, however, been fairly stable since the last quarter of 2004. Due to the decline through 2004, the level of sickness absence in the 2nd quarter of 2005 was about 12% below the level in the 2nd quarter of 2004 (Figure 2, Panel A). The extent and

direction of change varies, however, when looking at different indicators: long-term and short-term sickness absences have *not* changed in parallel.

Figure 2. **Total, self-certified and doctor-certified sickness absence man-days for Norwegian employees, quarterly figures 2000-2005**



Source: Statistics Norway in cooperation with the National Insurance Administration, www.ssb.no, subject 06.02 Working conditions, sickness absenteeism.

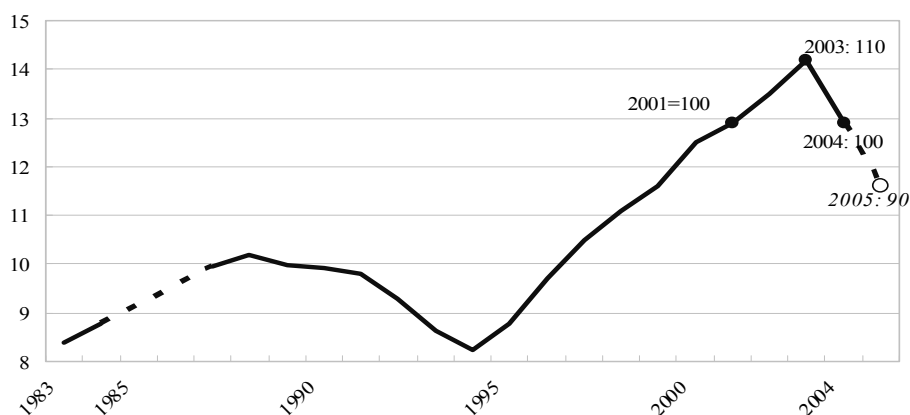
12. Self-certified sickness absence has changed only marginally over the years for which such data are available, except for a significant *increase* in the first two quarters of 2005 (Figure 2, Panel B).⁵ Doctor-certified absence rates (absences longer than three days in companies without and eight days in those with IW-status) have increased in every period up to the first quarter of 2004, when these absences started to fall (Figure 2, Panel C). Compared to the 2nd quarter of 2001, the benchmark period for the objective of the IW-agreement, by 2005 (2nd quarter) doctor-certified absences had fallen by 13%. Due to the increase in self-certified sickness absences over the same four-year period, however, the corresponding fall in *total* sickness absence was only 10%.

13. The situation is again somewhat different if only longer-term sickness absences were considered. Figure 3 shows that sickness days per employee reimbursed by the NIA (i.e. absences of a duration of more than 16 days) also fell in 2004, after a continuous very steep and gradual increase over the decade

5. It is surprising that such increase has not occurred earlier, since workers in IW-firms can have longer periods of self-certified sickness absence.

1994-2003 (from around 8 to around 14 days per employee).⁶ However, the decline from 2003 to 2004 was merely compensating the continued increase in the period 2001-2003.

Figure 3. **Annual sickness days per employee reimbursed by the National Insurance Administration, 1983-2004 and estimate for 2005**



Notes: Doted lines correspond to (1) interpolated years in 1985 and 1986 and (2) to an estimate for 2005 assuming that the decline 2004-2005 is equal to the observed decline in 2003-2004. Numbers shown in the chart are indices (2001=100).

Source: Data supplied by the national administration and OECD secretariat estimates.

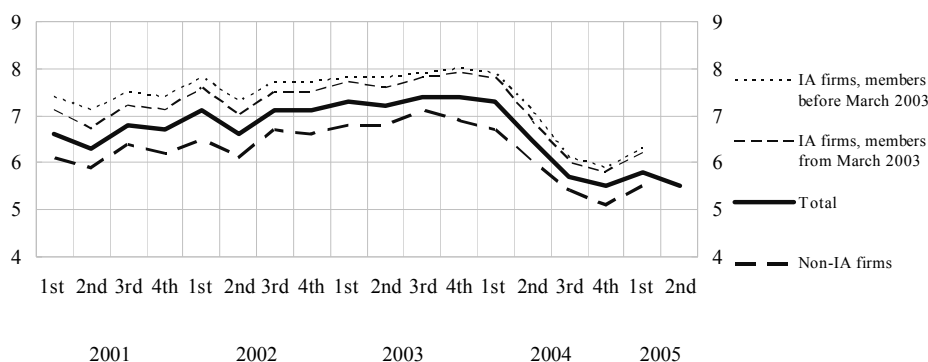
14. Would the decline continue at the same speed in 2005, which is likely even without a further drop in absences in the 2nd half of 2005, sickness days reimbursed by the NIA could fall by yet another 10% by 2005 – back to the level in 1999 and a 10% decline as compared to the benchmark year 2001. Thus, while the recent trend is very encouraging, absence is going to have to fall much further if it is to get back to what used to be normal in the 1980s and early 1990s.

15. Finally, available data also allow to distinguish trends in sickness absence rates in IW-enterprises and those enterprises which have *not* signed a cooperation agreement with the NIA. While overall absenteeism is higher in IW-enterprises than in others during the entire observation period, there is virtually no difference in trends between the different types of enterprises: In the 2nd quarter of 2004, doctor-certified sickness absence rates started to fall very suddenly in all enterprises (Figure 4).⁷

6. Until the year 2000, only data on longer-term sickness absence (i.e. sickness absences reimbursed by NIA) are available.

7. These data refer to doctor-certified absences. Self-certified absence tends to be more frequent in IW-enterprises, thus further reducing the very small

Figure 4. Trends in doctor-certified sickness absence man-days for employees by type of enterprise, quarterly figures 2001-2005



Note: No enterprise-specific data were available for the second quarter of 2005.

Source: National Insurance Administration; www.trygdeetaten.no, Sykefravaersstatistikk.

16. Concerning different sectors of the economy, the decline of sickness absence (total, doctor-certified and self-certified) has been strongest within manufacturing industries (-18%) and construction (-13%). However, the trend affected all industries, with, by and large, larger declines reported in sectors where sickness absence levels were relatively high. These were also the industries that entered into an IW-Agreement at an early stage.

Evaluating the success of the Inclusive Workplace Agreement

17. The objectives of raising employment of people with disabilities and prolonging working life have obviously not, or at least not yet, been achieved. While effects in these areas are likely to need more time to become visible, the lack of improvement is worrying.⁸ Much more will have to be done in the future to achieve the necessary changes in employment practices (see below).

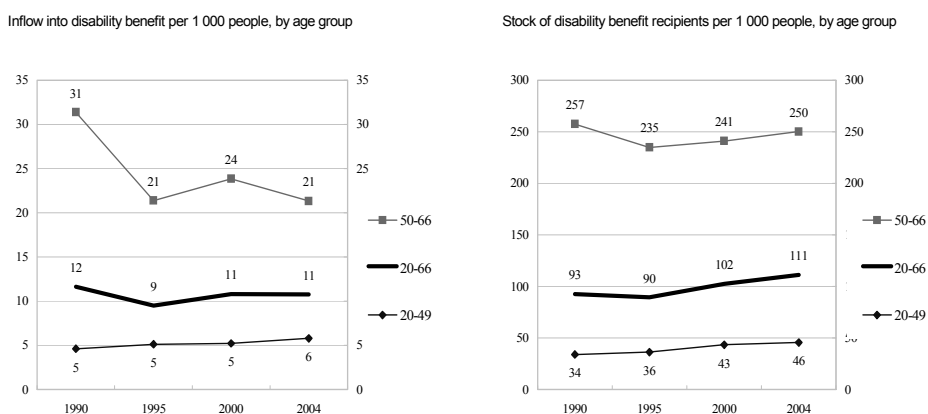
18. The first objective of the agreement, to reduce the level of sickness absence by 20% vis-à-vis its (high) level in the 2nd quarter of 2001, has been achieved at least partly. However, not only is it difficult to say to what extent it has been accomplished, but also whether that success had been due to the tripartite agreement or other factors. As to the *extent* of achievement of the objective, the following observations are noteworthy:

difference between IW- and non-IW firms in the size of the observed decline in sickness absence rates.

8. Ideally, the recent success with the first objective, i.e. the decline in sickness absence, could trigger success with objectives two (lower disability benefit inflow) and three (longer working lives) in the long term – as was hoped for when the tripartite agreement was signed. This, however, remains to be seen.

- The definition of this objective leaves room for interpretation. Which indicator of sickness absence is to be taken as the correct benchmark? Doctor-certified sickness absence rates appear to have fallen most, suggesting that two-thirds of this objective might have been reached. Total sickness absence rates and measures of longer-term sickness absence (i.e. days reimbursed by the NIA) suggest that, despite the turnaround and the steep decline in sickness absence since late 2003, only about half of the targeted decline has been accomplished.
- Indeed, the key issue for policy makers should be to reduce outflow from work. Previous analysis has shown that people on long-term sickness absence are far more likely to end up on disability benefits and far less likely to return to work. Of all benefit careers starting with a health problem, some 11% end up with a disability benefit. After a period of one year of sickness, that proportion has increased to 40%.⁹ Reducing long-term absences due to sickness should therefore receive particular attention.
- The decline in sickness absence rates has not had any effect on the rate of inflow into disability benefits, which remained rather stable during the last ten years – thus contributing to a continuous albeit gradual increase in the stock of disability benefit recipients. This conclusion holds for older as well as for prime-aged workers (Figure 5).

Figure 5. Trends in disability benefit inflow and recipiency rates, 1990-2004



Source: Data supplied by the national administration and OECD secretariat estimates.

9. These results refer to a study on gateways into disability benefits undertaken by the Frisch Centre. Results are based on benefit careers from 1993 to 2000.

19. As to the actual *causes* of the recent decline in sickness absence rates the picture is quite complex:

- That similar sick leave reductions are observed in firms both with and without cooperation agreements with the county NIA, and also for the self-employed who did not have the possibility to enter into such an agreement, can be taken as a partial proof that this is predominantly *not* an effect of the tripartite agreement itself. Instead, changes in sick pay regulations as of July 2004 are more important in explaining the turnaround in sickness absence rates. In that year, some restrictive amendments were made to the sick pay scheme which included:
 - the introduction of an activity requirement within eight weeks of granting the latest sickness certificate (unless medical reasons clearly exclude workplace attendance);
 - an evaluation of the functional capacity by a medical practitioner after eight weeks at the latest; and
 - stricter sanctions on medical practitioners who do not comply with the new rules for sickness absence certification.
- The timing of the decline in sickness absence rates indeed suggests that this regulatory amendments have played the key role. However, it is not known which element of the 2004 sick pay reform has triggered the decline in absence rates. Moreover, the reform may not have played the only role: while trends in IW-enterprises and other companies were indeed very similar, the decline in absenteeism was somewhat larger in those enterprises that have signed a cooperation agreement with the NIA in an early stage (15% decline in the period 2001-2005) than in those without an agreement (10% decline over the same period) – when measured on the basis of trends in doctor-certified sickness absences.¹⁰ However, the IW-enterprises had, on average, higher initial sickness rates, and thus also a larger potential for improvement.¹¹
- The increase in self-certified sickness absences is probably related to the possibility of longer periods of self-certified absences in IW-firms.

10 . The fact that the decline started one quarter before the new regulations came into place is likely to be an announcement effect, at least partly.

11 . In any case, differences between IW- and non-IW firms, or rather the lack of such differences, have to be interpreted with caution; information campaigns and public debates in recent years are likely to have influenced behaviour of all employers and employees.

However, it is unclear why such effect has not appeared prior to the second half of 2004. This particular change, with a 30% increase in self-certified absences from the first quarter of 2004 to the first quarter of 2005, has apparently also been caused by the regulatory reform in mid-2004 or, in other words, the subsequent decline in doctor-certified sickness absences. Patients seem to go round the stricter doctoral assessment by extending self-assessed periods of leave. This trend will have to be monitored very closely.

- Finally, it remains to be seen to what extent the recent trend is at least partly a cyclical effect. A fall in the rate of unemployment could well push the rate of sickness absences upwards. In the past (i.e. until around 2000), Norway has been shown to be one of those OECD countries with a very close relationship between the trends in unemployment and sickness absenteeism. But in recent years this relationship has become more complex; an issue that will have to be investigated in the years to come.¹²

20. What overall assessment does all this detail imply? A larger part of the decline in sickness absence since the 2nd quarter of 2004 was observably caused by the restrictive changes in regulations. These changes, however, have not overruled but *supplemented* certain developments brought about in the course of the tripartite agreement. Or, to put it differently, the consensual climate around the agreement has greatly helped to efficiently implement policy change.

21. The cooperation agreements of enterprises with the county National Insurance Administration have indeed initiated a broad cultural change, admitting that such change is difficult to measure empirically. In contrast to just a few years ago, sickness absence no longer seems to be a private matter between the employee and his or her doctor. Today, employers can engage in a dialogue with their employees on health problems and possible solutions at the workplace. This can be seen as an almost revolutionary managerial change with considerable long-term potential. Indeed, as the description of a good-practice example in the transport sector in the Box below shows, the basic driving force is a change in management practices.

22. In this process, human resource managers can rely on the competent support from the new county Workplace Centres of the NIA, which are well

12. Another question that goes beyond the scope of this interim assessment is the impact of changing working conditions on sickness absence and, eventually, disability benefit inflow. Research suggests that the general health and living conditions in Norway have not deteriorated, rather the opposite, but also that firm reorganization and downsizing – phenomena that have increased in recent years – have a negative impact on absence rates. However, this does not help explaining the recent ups and downs in sickness absence rates.

received by these managers. Importantly, these potentially costly services are entirely free to the employer. Despite being fully funded from public sources, however, the total costs of these Workplace Centres are small vis-à-vis the potential savings they produce: The total direct costs in 2004/2005 were close to 200 Million NOK, some 20% of which was transformed from previous PES centres. This compares with NIA costs for one day of sickness absence in the order of around 400 Million NOK. Thus, the additional costs of the Workplace Centres are offset by merely a half-day reduction in total sickness absence across Norway (not taking indirect benefits through increased production and productivity into account).

Box. New management practices can bring down sickness absence

The example of the Bjørkelangen branch of *Norgesbuss Bærum og Romerike AS* shows how a new management style and the support from the county Workplace Centre can influence the behaviour of employees.

The success story of this small branch of a large company, with some 50 workers, which is running a school bus service in the east of Norway and an hourly express service from Lillestrøm to Oslo, is flattering: in 2002 the branch was undergoing a very difficult time, including a merger with another company. At this time, working conditions and the relationship between staff and management were very poor; “it was hell going to work”, as some of the workers said. In the last quarter of 2003, the company recorded total sickness absences of 15.2%, which is, however, quite normal in the transport industry. During this year, a completely new management style was introduced to improve relations with the workforce and to raise the quality of work. This new approach was initiated by a joint exercise for all employees (in which they practised for a catastrophe situation) and further on characterised by an open door policy so to shorten the distance between staff and management: they take up matters immediately as they arise. Another important element was that all managers were required to drive a bus themselves every day (even if only for two hours or so).

Within a year, management and its employees has been able to create a unique working environment. The company won the Oslo Working Environment Prize for 2003 and then became an IW-firm in 2004. By the last quarter of 2004, sickness absence had fallen to 3%, a drop of some 80% within just one year. This has been achieved through the contact with the county Workplace Centre and a joint effort to intervene early – with the involvement of a physiotherapist and the use of the active sick leave system – with the objective to make sure that workers continue to be part of the action. Overall, the branch has saved over two person-years during the time it has been an IW-enterprise and is now serving as a best-practice model.

Source: Summarised from a newspaper article “Buses are running well in Bjørkelangen”

23. Cultural change brought about through this development, however, may well be two-sided: While sickness no longer seems to be a private matter, there are first indications – anecdotal evidence based on the findings of an in-depth qualitative study on 16 IW-enterprises – that recruitment of people with health problems has fallen in some of them. Hence, while recent changes might have raised the awareness about health issues and thus helped to introduce sickness management at the company level, this might be happening at the

expense of stronger health screening in the recruitment process. This problem will also have to be monitored very closely, and steps taken in response. So far, an eventual new hiring policy concerning disabled persons has not translated into higher employment figures (see Figure 1).

24. Finally, while the value of these cooperation agreements between the NIA and individual employers is undisputed, the same can hardly be stated to the same degree about the tripartite agreement between the government and the social partners itself. The impact and importance of the latter seems to be somewhat overrated in the Norwegian debate. The tripartite agreement is essentially based on a standstill agreement between the government and the social partners: The government accepts the social partners' veto against changes in the current sickness benefit system and refrains from introducing co-payments for either the employer or the employee on the promise of improved outcomes brought about through changes in workplace practices. Clearly, the social partners should have made similar efforts earlier and without any such agreement – even though the IW-agreement has created a consensus climate that has helped in implementing other policy measures more effectively.

Future directions for a possible new tripartite agreement

25. An important question is whether the tripartite agreement should be prolonged and, if so, what form this (new) agreement should take. Following from what is said above, it is not clear whether the IW-agreement should be extended. There is no doubt, however, that the cooperation agreements between the NIA's Workplace Centres and individual enterprises should be promoted and continued to be subsidised – and the same kind of service offered to companies that hesitate to sign a more binding cooperation agreement.

26. If a new tripartite agreement is to be signed, the following principles could be followed:

- In practice, the current agreement has primarily focused on the first policy objective. A new agreement should not only focus on people in employment, but also on people currently *outside* the labour market with health problems or other disadvantages, thus increasing the focus on the second objective.
- Any new agreement should include measurable quantitative and qualitative targets for *each* of its objectives, directions for how to follow-up these targets, and a set of measures to be promoted to reach them. While the agreement is predominantly directed at the company level, some objectives will need targets at a national (or maybe also local) level. Targets could, for instance, refer to the accessibility and fluidity of the labour market for different groups of the population and to the inflow into and outflow from (temporary) disability benefits.

- A stronger focus should be put on the consequences of *not* achieving the targets. In other words, a new agreement should introduce the principle of binding targets and stricter obligations. The latter implies that obligations for the different actors – employers, employees, doctors, state administration, policy makers – need to be specified in more detail (the current agreement only contains clear obligations for the government). One such consequence could be to make sickness benefits less generous (e.g. by introducing a waiting period or higher co-payments for employers or employees), as was done elsewhere. A generous benefit system puts a lot of pressure, maybe too much of it, on the system of checks and controls.
- The government should make sure that the agreement is a *driver of change* not an obstacle to reform. Therefore, it should not accept any veto against government measures. Instead, constant re-evaluation of existing tools and regulations in the light of actions taken (or not taken, as the case may be) at the workplace is needed. A veto against government intervention could be particularly counterproductive in relation to the mandate of the Disability Pension Reform Commission, which is supposed to propose changes to the disability pension scheme needed to complement the ongoing old-age pension reform.¹³ A veto would also limit the scope for the two Government White Papers (one on ageing workers and one on better labour market inclusion) that are currently being prepared and to be presented to parliament in 2006.

Conclusion

27. Shortly speaking, it is a political question whether the current tripartite IW-agreement should be extended, not one of substance. Several elements of the agreement have shown to be very useful, although at the same time bearing various new risks, such as increased health screening in the recruitment process. Signing a standstill agreement is not a prerequisite for a proactive approach. This does not mean that one should underestimate what has been achieved so far in terms of changes in attitudes and practices of workers and managers.

28. However, the promising outcomes in the last year or so became possible exactly *because* the actions of the social partners at the company level had been complemented by additional changes in regulations. Without these changes in sick pay regulations, the encouraging outcome could not have been achieved. In other words, for further improvements, adjustments of regulations so as to promote other measures and initiatives will be required. For such

13. To this end, it is not clear yet, how the current early retirement scheme (AFP) will be included in the current reform of pension parameters. Any possible substitution effects with disability pensions need to be thoroughly examined.

regulations to be effective, close cooperation with the social partners will be useful and in fact needed, but this does not require a standstill agreement.

29. Finally, so far only the trend in sickness absence has been reversed, even though it remains to be seen whether this change will be sustainable and sufficiently large. The next step will be to reduce the outflow into longer-term health-related benefits, i.e. especially the outflow from work into disability benefit, and to raise the employment rate of people with health problems. For this to be achieved, a series of government initiatives and measures will be needed. While this goes beyond the scope of this interim assessment of the IW-agreement, the following are areas where other countries have taken action that might be relevant for Norway, too. These issues will be discussed in detail in the comprehensive OECD assessment of Norway's (as well as Poland's and Switzerland's) entire sickness and disability policy system, which is currently being prepared and are, thus, only given as catchphrases here:

- Reinforce *incentives for employers* to complement ongoing change;
- Re-evaluate *financial incentives for employees*;
- Reconsider the *dual role of general practitioners* as assessors of health problems and gatekeepers for the benefit scheme;
- Strengthen and develop better *integration and coordination* of medical and vocational rehabilitation;
- Strengthen the follow-up of recent changes, such as the introduction of *temporary disability benefits*, to raise their effectiveness;
- Implement fully the current philosophy of policy change, to *shorten benefit duration and to enforce follow-up through mutual obligations*;
- Make more efforts to assess the impact of *active labour market policy*.