

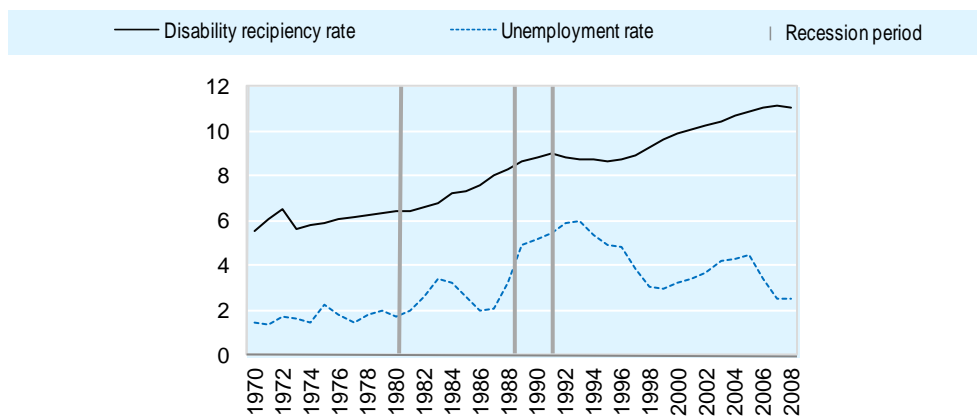
OECD (2010) – SICKNESS, DISABILITY AND WORK: BREAKING THE BARRIERS

NORWAY

KEY FINDINGS

- In Norway in the 1970s and 1980s, the number of people receiving disability benefit was 2-3 times that on unemployment benefit. After the crisis in the early 1990s, first, unemployment started to fall and, with some delay, disability beneficiary numbers increased. As a result, in 2008 the latter was around five times the number of unemployed; the largest discrepancy ever (Figure 1).

Figure 1. Long-run trends in unemployment and disability reciprocity rates in Norway, 1970-2008 (percentages)



- The number of people of working age in Norway who receive disability benefit is among the highest three in the OECD; in 2008, 10.3 % compared to an OECD average of 5.7% (Figure 2). Sickness absence rates are by far the highest in the entire OECD.
- Older people aged 50-64 are particularly likely to be on disability benefit: almost one in four of them are (23.5%), compared to an OECD average of around 12%.
- Public spending on sickness and disability makes up 4.8% of Norway's total GDP, compared to an OECD average of 1.9%.
- The employment rate for people with chronic health problems or disability at the end of 2007 was only around OECD average but, due to broad benefit coverage and generous payments, their poverty rate was comparatively low, at 11% compared to an OECD average of 22% (Figure 3).
- The unemployment rate for people with chronic health problems or disability at the end of 2007 was around half that of the OECD average, at 6.9% compared to 13.7%. But it was twice Norway's unemployment rate for people without health problems.

POLICY CHALLENGES

1. **Tackle the high level of sickness absence.** No other OECD country has such a high level of sickness absence and, at the same time, such a generous sickness benefit scheme. Introducing a range of new responsibilities for workers, employers and the benefit authority has not led to the expected decline.
 - Improve work incentives, e.g. by reducing the generosity of long-term sickness benefit as well as the *Work Assessment Allowance*, which replaced medical and vocational rehabilitation benefits.
 - Strengthen employer incentives, e.g. by increasing the period of employer-provided sick-pay or introducing co-payments to longer-term sickness benefits.

2. **Give clear directions to general practitioners in their role as gatekeepers.** Assessment of disability and sickness still rests mostly with GPs, with very little involvement by public agencies.
 - Provide clear guidelines to GPs, including on the appropriate duration of sickness absence for the main types of illnesses, as are being used with good effect in Sweden.
 - Give more power for medical assessment to the authority granting sickness and disability benefits, and control assessment decisions by GPs on a regular basis.
3. **Help people move off disability benefit.** More can be done to reduce the large number of disability beneficiaries. Current barriers include the awarding of permanent and full benefit to most applicants and the limited incentives for partial benefit recipients to increase their working hours. Following rigorous reviews of existing entitlements, more use should be made of rehabilitation and training for those currently on benefit but found to have substantial remaining work capacity.

Figure 2. **Disability benefit recipiency rates in 2008, Norway in comparison with 30 other OECD countries, plus OECD average (percentages)**

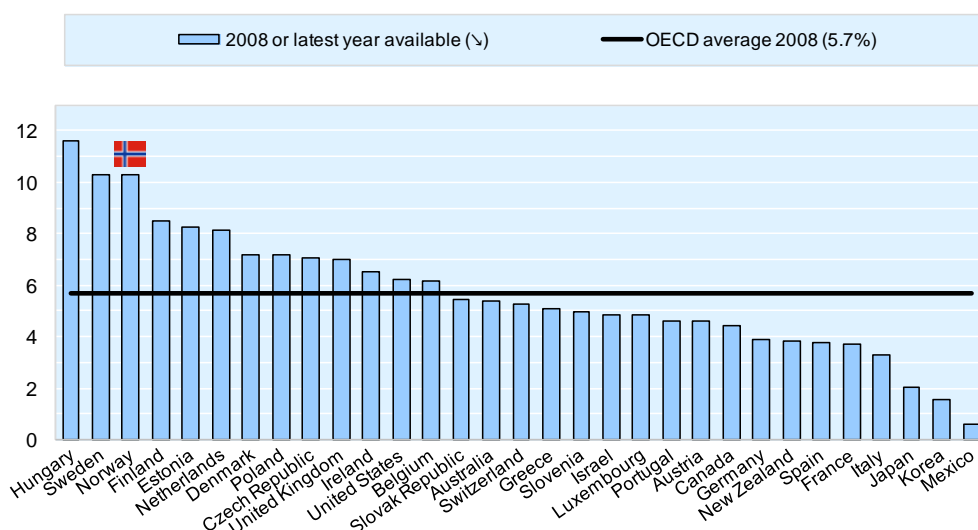


Figure 3. **Selected key labour market indicators by disability status, around 2007 i.e. before the recent economic downturn, Norway and OECD averages (percentages)**

