

# From Economic Incentives to Dialogic Nudging – The Politics of Change and Inertia in Norwegian Sickness Insurance

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## **Abstract**

In 1978, Norway established a sickness insurance with no waiting days and full wage compensation. For the past thirty years, Norwegian authorities have repeatedly attempted to change this incentive structure in order to reduce comparatively high sickness-absence levels, but with little success. Thus, Norway seems to exemplify the retrenchment literature's diagnosis of fiscally unsustainable welfare states whose attempts to reduce costs are blocked by strong interest groups and institutional inertia. However, while changes in the incentive structure have been blocked, policy development has taken other paths.

New structures for monitoring sickness absence and for activating employers and employees have been established. The course of a sickness-absence spell has been regulated, with 'stop points' and procedures which must be adhered to. Rather than increasing employers' and employees' economic responsibility, these actors have been made responsible for the establishment of individual plans, they are to enter into dialogue at compulsory meetings and aim towards the use of active measures. While this often has been perceived as a sign of inability to reform, it may alternatively be viewed as the silent establishment of new relations of governance.

By analysing this specific case, the paper addresses the wider issue of welfare state change. Through the analysis of incremental, qualitative reforms such as these – often overlooked in comparative social policy research – it throws light upon how social policies may work through restructuring citizen–employer–social partner–state relationships.

## **Introduction**

Questions about change – the need for change, preconditions for change, barriers to change, types of change – permeate the social policy literature. In this paper, I analyse a case which in many ways looks like non-change, and which thus seems to exemplify the retrenchment literature's diagnosis of fiscally unsustainable welfare states where attempts to reduce costs are blocked by strong interest groups and institutional inertia. Looking more closely however, it can also be read as an example of how incremental change is still taking place, but without cutbacks. Should we care about such apparently undramatic and non-retrenchment changes? While their fiscal effects are uncertain, I will argue that

they do *something* – both to labour market relations and to politics – and that this something is worth exploring.

At first glance, the system of Norwegian sickness insurance seems remarkably stable. Since its establishment in 1978, all its basic features seem to be intact: employees' degree of self-risk is very low with no waiting days and full wage compensation. The distribution of costs between employers and state is nearly unchanged: employers pay the first two weeks (fourteen days until 1998, sixteen days thereafter), then national insurance takes over. Several attempts have been made, both from the left and the right, to change the system in order to increase primarily employers', but also employees', economic incentives to reduce sickness absence. But despite the considerable costs of Norway's comparatively high level of sickness absence (OECD, 2010) and the many claims made to increase self-risk and reduce government expenditure, hardly any such attempts have been successful (Hagelund and Bryngelsson, forthcoming). This resilience to change has, for good reasons, often been explained by the strong position of the social partners in the policy process. Both employers' and employees' confederations have at times campaigned hard – and successfully – to avoid being made responsible for a larger share of the cost. In sum, as nearly all attempts at changing the risk distribution of sickness insurance since 1978 have failed, we seem to be faced with the type of situation portrayed by Pierson (1996), where necessary cutbacks do not take place due to the political risks entailed by promoting cutbacks and resistance from organised interest groups.

Against this picture of resilience, it is also possible to paint a different image of Norwegian sickness insurance. In this version of the story, change has actually taken place. While the cost structure and economic incentives remain fairly stable, much has happened with the *process* of being on sick leave and receiving these benefits. Sickness absence is being regulated and monitored in a more active and extensive way today than in the 1980s and 1990s. Activity requirements have been introduced. Longer sickness spells are being structured by the drawing up of individual follow-up plans and dialogue meetings. Emphasis is being placed on making the main parties – employers, employees and physicians – accountable for the sickness-absence spells they are involved in. Employers are to adapt work conditions; physicians must assess work capacities; and employees are required to actively participate in efforts to enable them to return to work.

The effect of such measures is debatable. Media commentators have at times used expressions such as 'Much ado about little' (*Dagbladet*, 7.11.2006), suggesting that the new measures are introduced more to calm down a heated debate on how to reduce sickness absence than to have a real effect on absence rates. When the rates actually do drop, politicians are quick to claim it as an effect of efficient policies, but they can also be rather quick in discounting the very same measures when the figures point upwards. Research is limited. There is documentation however that the policy changes have led to changed patterns of behaviour at

the workplace with respect to adaptation of work tasks and active follow-up of sick-listed employees (Ose *et al.*, 2009). Whether this in turn has actually led to lower absence rates is more uncertain. It falls outside the scope of this article to fully assess the effects of the new measures on sickness-absence rates or in the workplace. The argument is rather that this set of policies (at least) has an impact on *politics* in the sense that they work to establish consensus in, but also to depoliticise, an otherwise conflict ridden area of politics. In short, the questions raised are: How can we understand welfare reforms that do not take the shape of cutbacks, but rather constitute change of a more qualitative or technical nature? How have the Norwegian policy changes worked to restructure citizen–employer–social partner–state relationships? These more subtle alterations of power relations are often overlooked in analyses of large-scale expenditures and replacement rate data, and it is to these we now turn.

### The welfare state and change

Influential parts of the welfare state literature in the 1990s promoted an image of the welfare state being trapped in a Catch-22 situation: the welfare state under pressure from ageing populations, globalisation and rising costs. At the same time, strong interest group formations and the general popularity of welfare programmes make it both risky and difficult for politicians to press forward with welfare cuts and retrenchment (Pierson, 1996). Cross-national comparisons of social expenditure to the GDP gave empirical support to this image of resilience. Based on various social expenditure measures, Francis Castles, for example, concluded (before the current crisis) that ‘there has been no “race to the bottom” . . . while there are real signs of a slowdown in expenditure growth compared with a previous era of welfare state expansion, there are equally no signs of a consistent trend to welfare retrenchment or diminishing welfare standards’ (Castles, 2004: 15).

Other and more recent bodies of literature are yet concerned with welfare state change and maintain that retrenchment is indeed taking place. While most authors acknowledge the thesis of welfare state resilience, analytical interest has moved to the question of how retrenchment can still take place *despite* the hindrances identified by Pierson (Starke, 2006). Criticising the crudeness of the social expenditure variable, Korpi and Palme (2003), for example, maintain that retrenchment is the general trend. They use cross-national data on citizenship rights, as measured by the wage replacement rates in important social security measures (including sick pay), and find indications that the long gradual increase in average benefit levels that characterised the pre-1975 era has indeed reversed.

Nevertheless, the generosity of Norwegian sickness insurance has remained remarkably intact even by Korpi and Palme’s standards. As indicated by Figure 1,<sup>1</sup> it seems to represent an exception to a wider trend of cutbacks and retrenchment.

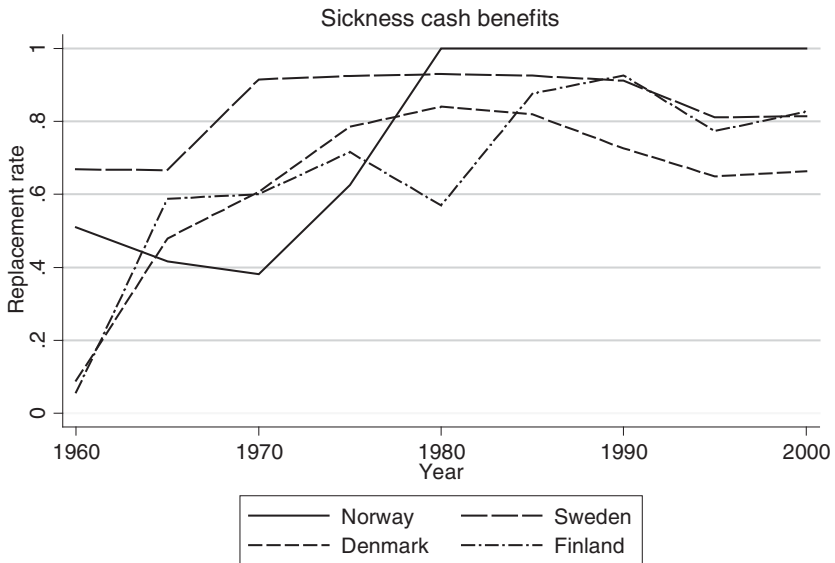


Figure 1. Evolution of replacement rates for sickness benefits in Norway, Sweden, Denmark and Finland

Source: Social Citizenship Indicator(SCIP).

The figure shows the evolution of the net replacement rate compared to other Nordic countries using data from the same SCIP-database as applied by Korpi and Palme. The flatness of the Norwegian curve is indeed conspicuous, and it would have remained equally stable if the timeline had been continued till today (SCIP-data are not publicly available for the period after 2000). If change is taking place, it must be along other variables than this one.

The search for retrenchment-after-all has also directed attention to other types of change than radical cuts in rights or expenditure. This was in a sense also Pierson's point; that change would be channelled in the direction of incremental modifications of existing policies (Pierson, 1996: 174).

Institutionalist literature has taken issue with its own traditional tendency to overemphasise stability and path dependency. Some authors have developed typologies of institutional change, distinguishing, for example, between displacement, layering, drift and conversion (Streeck and Thelen, 2005; Mahoney and Thelen, 2010). In displacement, existing rules are removed and new ones introduced. Layering involves the introduction of new rules on top of or alongside existing ones. Drift is the changed impact of existing rules due to shifts in their environment. Conversion means that rules remain formally the same, but are interpreted and enacted in new ways. By addressing how change can happen in incremental ways, these authors indicate how welfare reform can take place without showing up on the radar of political opponents, but also without necessarily making a big impact on social policy analysts' grand depictions of policy trends.

Another approach to change is taken by authors interested in the role of ideas, discourses and frames. Here the argument tends to be that ideas and discursive change is crucial in enabling welfare reform. In some versions, actors use frames (how an issue is presented, for example by emphasising certain aspects and omitting others, use of wording, etc.) very strategically in order to persuade (Chong and Druckman, 2007). Some approaches give less attention to strategic actors, but nevertheless tell stories about how compelling ideas can work to advance reform plans. It is the reformers who command the ideas who succeed, while those who fail in establishing a convincing discourse also fail in reforming the welfare state (Schmidt, 2002; Cox, 2009). Authors who arrive at the notion of discourse through a more Foucauldian trajectory, on the other hand, tend to be more interested in how the ideas and the knowledge are working through the political actors, thus performing a kind of depersonalised power (Dean, 1999; Rose, 1999; Bacchi, 2009).

In the context of this article, one of the interesting aspects of the ideas-literature is the way in which it directs attention onto a multitude of types of change. Robert Henry Cox suggests that such discursively enabled reform typically does not take the shape of budget cutting, but rather tends to be qualitative in nature, aimed at eliminating opportunities for moral hazard by targeting specific groups and improving the efficiency of welfare delivery (Cox, 2001). Gatekeeping and activation can be performed in a multitude of ways, but all, in one way or other, involve technologies of power and steering. Ideas then are not only to be used to convince and compel an audience, but may also constitute the knowledges by which steering is performed. A movement from the use of diagnostic categories to functional assessments, for example, may constitute a significant change in how sickness absence is understood and managed. Finally, new ideas may also call for new types of governance. Damgaard and Torfing (2010), for example, describe how ideas of activation have not only hegemonised social policy development in Denmark, but also led to the emergence of new governance networks involving local stakeholders.

Governance is an interesting concept in this context. It often refers to the role of networks in the pursuit of common goals (Kjær, 2004: 3) and to 'practices of steering through public-private-civil society co-operation' (Larsson *et al.*, 2012: ch. 1.5). As such, the term points to how other types of relations than hierarchical relations of control are being activated in the pursuit of political goals. The active involvement of social partners in drawing up policies for reducing sickness absence in Norway illustrates this well, but also indicates that governance is not a novel invention but can draw on longstanding corporatist traditions (*ibid.*). But governance may also refer to the governance of citizens and subjects of policy, in which the population is being moulded through specific policy devices which, in particular, aim at enhancing citizens' capacity of self-governing (Daly, 2003).

It is clear that Norwegian sickness insurance has not changed in ways that have reduced social spending or cut wage replacement levels in any significant way. But the claim of this paper is that, by looking at changes in the governance of sickness absence, we get an insight into other types of social policy change which are worthy of our attention. One point is that grasping these changes is instrumental for analysing the delivery of social policy (van Berkel and Borghi, 2008). Another point, which so far has received less attention in the literature, is the part these types of incremental changes play in the practice of politics. While cuts in welfare entitlements are often highly politicised, these more subtle changes in the governance of welfare are adopted without the same ado – as if they are above politics (Clarke, 2010). As such, these devices may work as depoliticising instruments in politically stormy terrains.

### **Data and analysis**

This article is written in the context of a research project about the evolution of the Norwegian political debate on sickness absence from the late 1970s till today. As a part of this project, I have collected and read an extensive selection of policy documents (public reports, white papers, parliamentary bills and debates) related to sickness insurance (covering the period 1977 till today), as well as several hundred newspaper articles, sampled from the periods when debates over sickness absence have been most intense, for the period since 2000. The policy texts have been read and notes taken with several purposes in mind. First, to establish an overview of how the wide set of policies and regulations that address sickness absence have evolved. What measures have been proposed, adopted and rejected? Second, to identify the ideas that inform policy making, and analyse the changing discourses of sickness absence that the policy texts are part of. Put simply, how is the problem of sickness absence formulated (Bacchi, 2009)? I have not done a systematic content analysis of the media texts, but used them as information about the political process and context. The focus of this article is on the period between 2000 and 2012, but the broader time frame of the wider project has provided an important background to the analysis.

### **The evolution of sickness-absence policies in Norway, 2000–2012**

#### **The Sandmann-commission and the first IA-agreement**

In the latter half of the 1990s, both sickness absence and the number of new entries into disability pension were reported to be on the rise. This was the explicit pretext for the public commission, headed by the former Labour Party minister Matz Sandman, that was appointed to discuss possible explanations for this trend, assess existing measures as well as make recommendations for future policy change. The commission was broadly composed with representation from the social partners, ministries, the medical profession and academia.

This was not the first time rising sickness-absence figures caused concern with the authorities. The sickness insurance that was adopted in 1978 gave limited incentives to employers and employees to reduce sickness absence. Sick-listed employees were given 100 per cent wage compensation (up to a fairly high maximum roof, which has since been reduced) from the first day of absence, and sickness spells could last for a year before other and less generous schemes started to apply. Sickness absence could be self-certified for the first three days, after that a doctor's report was required. Employers were responsible for sickness payments for the first fourteen (since 1998, sixteen) days of absence, after which the National Social Security Fund would bear the costs. Thus, the result was a system where employees carried little of the risk, employers paid for short-term absence and the state for the longer sickness spells.

It was precisely the longer sickness spells that caused most concern among policy makers. Over time, sickness-absence levels fluctuated, but in times of growth the longer sickness spells constituted most of the increase. Nearly every government since the late 1980s has contemplated increasing the self-risk of employers in order to reduce sickness-absence levels (and costs). Eight proposals to extend the employer period were formally presented to the parliament between 1986 and 2000. Only one partially succeeded, by extending the period of employer payment from fourteen to sixteen days. Only one bill was presented proposing to increase the self-risk of employees, but was also turned down. However, both types of claims were made repeatedly both by political parties and other actors in the policy debate.

Prior to the launch of the Sandman commission's report, sickness absence was already a contested issue in the public sphere. The media reported on 'record levels' of sickness absence and concomitant concerns over rising social security costs 'eating the oil fortune'. Leaks suggested that the commission struggled to find solutions on which the social partners could agree. Employers were willing to pay more, but only on condition that employees carried a greater part of the risk. The employees' associations, headed by the powerful national confederation of trade unions (*Landsorganisasjonen*, LO), did not accept a weakening of employees' rights to sick pay. Thus, the main protagonists of the ensuing drama had already been lined up: on the one hand LO, on the other its counterpart, NHO (*Næringslivets hovedorganisasjon*, the national confederation of employers). The political parties were divided. The Centre Party and the Socialist Left Party had signalled resistance to any kind of cuts in sickness benefits. The parties on the right were positive. The Labour Party's position was unclear. Rumour had it that influential parts of the party were positive to cuts, but feared challenging its allies in LO.

The Sandman commission recommended a considerable restructuring of the distribution of costs and risks of the sickness insurance. The recommendation was to make employers pay 20 per cent of the cost for sickness absence from

day seventeen, in order to improve their incentives to prevent sickness absence and stimulate employees on sick leave to return to work. The majority also argued that employees should accept a lower wage replacement level for the first sixteen days of absence (80 per cent as opposed to the current 100 per cent). The minority (mainly representatives from the employees' associations, disabled persons' association as well as medical professionals) rejected this part of the proposal.

The majority's recommendation immediately became the subject of a very heated debate, which would last, on and off, for a full year. It was a public debate, being played out in the mass media and even becoming a main issue in the election campaign the following year. But in parallel with the public spectacle, the government and the social partners also engaged in extensive negotiations behind closed doors.

The public debate focussed primarily on the commission's proposal to change the economic incentives in sickness insurance, in particular the proposed changes to sick pay. But this was only one aspect of the commission's report. The other part of the extensive package of new measures was less about money and more about practices. More specifically, it was about *workplace-orientated measures*. Early intervention, monitoring, dialogue between employers and employees and functional assessments were key concepts. The premise was that 'measures to reduce sickness absence can only succeed if these are implemented in collaboration between employer and employee' (NOU, 2000: 250). Employers and employees had to be made accountable for sickness absence; they were to become responsible agents in the efforts to reduce sickness absence. Measures had to be constructed in a way which worked to sustain employees' relation to working life, also when in ill health. The use of economic incentives was one part of this package of measures, but a range of other elements was also crucial. Dialogue between employers and employees was one such element. One means to achieve this was the use of self-certificated sickness, whereby sick employees had to report their inability to work in a more detailed manner than hitherto as a means to facilitate dialogue about steps to be taken at the workplace to enable return. The significance of a medical diagnosis was to be played down in favour of so-called functional assessment (*funksjonsvurdering*) and functional ability (*funksjonsevne*) – focussing on a person's ability to work rather than on their illness. Likewise, the National Insurance Service's role as service providers for the workplace was to be upgraded through providing guidance and supervision, both to sick-listed employees and to employers.

The media discussed prospective cuts in sickness benefits, but in the on-going negotiations between the government and the social partners such proposals were eventually put to rest, reportedly due to very strong resistance, particularly from the LO (Tranøy, 2007). In October 2001, the parties signed the first Intentional Agreement on a More Inclusive Working Life (the IA-agreement).



The agreement contained an overall goal of reducing sickness absence by 20 per cent within four years, a set of means to reach the goal and, crucially, a guarantee that there would be no further proposals to change either employers' or employees' self-risk in the sickness insurance in the four-year period. The specific measures were to a high degree directly inspired by the Sandman report. Early intervention, workplace orientation, emphasis on functional ability, active dialogue between employer and employees, self-certified sickness – these were all elements where the IA-agreement echoed the report. While the revised incentive structure proposed by the Sandman commission had been shelved, the other half of the package had indeed been adopted. In the years to come, this was to be continued both through the continuation of specific measures for the businesses which had joined the IA-agreement and through the adoption of general measures which shared the ethos of the IA-measures but were applied to all workplaces. It is on the latter that I will concentrate here.

The ideas about using economic incentives to change behaviour had been at the foreground of the debate, but failed to make an impact on policy. Other ideas about the workplace as the arena of intervention however did have an impact, but entered policy, so to say, through the back door. The ideas remained in the background of the debate, 'largely accepted and unquestioned, almost as principles of faith' (Campbell, 1998: 384). We could speak of an IA-paradigm. Or phrased differently, while the attempts at retrenchment had failed, the commission's proposals to restructure the *governance* of sickness insurance had been adopted – without public debate.

### **Continuation of the IA-paradigm**

Halfway through the four year-period, reaching the target of a 20 per cent reduction in sickness absence seemed unrealistic. Yet, all parties agreed that rather than discontinuing the agreement it had to be strengthened. A new regulation was introduced which required that all sick-listed employees should engage in work-related activities after eight weeks at the latest. Doctors who were granting sick leave to their patients had to fill in a revised form which explicitly required a medical assessment of the patient's ability to work while sick. New sanctions were introduced. Also, the requirements made on employers and employees to engage in dialogue and activity were sharpened.

Gradually, a new consensus seemed to emerge that the IA-agreement was indeed a useful strategy. There was a significant dip in the sickness-absence level in 2004, probably due to the new regulations which were put in place at that time (Bleksaune and Dale-Olsen, 2010). This was interpreted by politicians, the social partners and the media-as a sign that the agreement was indeed working. A new agreement covering the period 2006–09 was signed in December 2005.

However, the downward trend was short-lived (Bleksaune and Dale-Olsen, 2010). Confronted by rising welfare insurance budgets, in 2006 a new centre-left

government took the social partners by surprise by proposing that employers pay a share of the sick pay for longer absences as well (20 per cent for the first six months, 10 per cent thereafter). ‘The economic incentives to prevent sickness absence at the workplaces are not good enough’ (St prp nr 1 (2006–07): 26) was the argument. But the preservation of existing funding structures in the sickness insurance was a precondition for the entire IA-collaboration. The social partners were furious at the perceived breach of agreement, and a strong LO-leader fronted a massive resistance. In the end, the government withdrew the proposal. A fast-working commission chaired by the prime minister himself, with representation from the social partners, was established. The result was another set of measures to counter the growing sickness-absence level within the framework of the IA-agreement.

The new measures implied a further structuring of the course of a sickness absence through the establishment of ‘stop points’. The compulsory drawing up of individual plans for follow-up (*oppfølgingsplaner*) was pushed forward from eight to six weeks. Compulsory dialogue meetings were introduced. Dialogue meeting 1 would take place within twelve weeks. In these meetings, the sick-listed employee, the employer and the person who had authorised the sick leave (normally a physician) would meet to revise the follow-up plan and discuss the scope for measures at the workplace and for partial sick leave. Dialogue meeting 2 would take place within six months and also involve NAV (the Norwegian Labour and Welfare Service). Potential assistance from NAV, such as rehabilitation measures, would be on the agenda. The purposes of these meetings was to improve the interaction between the involved parties and to make them responsible for finding alternatives to full-time sick leave. Diagnosis would not be an issue; the focus was to be directed at what tasks the employee was actually able to perform and on enabling such activities. Moving from full-time to part-time sick leave was an explicit target.

The authorities had already invested considerably in building up an institutionalised collaboration with the social partners based on a discourse of dialogue and collaboration. When the government’s one-sided attack on this collaboration failed, it returned to this very same alliance, instituting new measures which further strengthened the ideas about dialogue and workplace-based measures. If anything, the IA-paradigm came out of the commotion in stronger shape.

### **The third IA-agreement**

In the winter of 2010, the government once again invited the social partners to the negotiation table to draw up a new IA-agreement. Sickness-absence rates were on the rise. This had been the focus of months of intense public debate, where issues such as failing work ethics and the potential abuse of social insurance had been at the heart of the debate. The government, fronted by the prime minister,

proposed to increase employers' economic responsibility for longer absences. But, wiser from the 2006 experience, the idea was framed differently. The main purpose was not to save money, but to reduce the human costs of sickness absence. Sickness absence is a 'lose-lose situation', prime minister Stoltenberg told *Dagsavisen*, 'it hits primarily those who are sick-listed and who are barred from the labour market, but also the community which misses out on the added value it could have been part of' (19.11.2009). Furthermore, this was only one of a range of measures which was offered for discussion. In the public debate, more attention was given to thoughts about establishing stricter guidelines for the length of sickness-absence periods by diagnosis than to adjustments in the funding of sickness insurance.

An expert commission was appointed to assess possible measures to reduce sickness absence. Its main perspective was that 'there is no clear distinction between healthy and sick' (Mykletunutvalget, 2010: 7), and that activity and being present in the workplace would benefit the health of major groups of the sick-listed (muscle and skeletal pains and mild psychiatric diagnoses) more than being absent from work. The commission named its proposal an *activation and presence reform*. A core idea was to promote the use of part-time sick leave as an alternative to full-time absence, especially for sickness spells lasting more than eight weeks. As had happened previously, a package of proposals was launched with two main components: one set of measures to restructure the economic incentives in the insurance and one set of workplace-based measures involving dialogue and monitoring of sickness spells. The former involved increased employer responsibility for longer spells of full-time sickness absence. The idea was to make it more profitable for employers to have employees on part-time sick leave, and to move their risk from short-term to long-term sickness absence, thus 'giving employer(s) incentives to make use of employees' potential work ability throughout a sickness spell' (Mykletunutvalget, 2010: 37).

Despite the apparently favourable reception of the report, when the third IA-agreement was signed some weeks later, the new incentive structure had been relegated to an issue the parties 'would return to'. It was later shelved by the Ministry of Labour, citing the lack of IT-capacity. But, while the economic incentives that had been suggested to support the commission's vision of activation and presence were shelved, the vision was upheld. New regulations were introduced based on the premise that dialogue between the involved parts would enable adaptations in the workplace, which in the next step would enable the sick-listed person to return to work – full-time or part-time. The stop points were moved forwards in time. The follow-up plan had to be ready by four weeks of absence, dialogue meeting 1 was to take place by week seven and an optional dialogue meeting 3 was introduced. Regulations were rephrased in ways that underlined physicians' obligation to take part in dialogue meetings, employers' obligation to make adequate adaptations in the workplace and sick-listed persons'

TABLE 1. Intensification of dialogue and activity regime over time

Measures	2001–03	2004–05	2006–09	2010–12
Follow-up plans	8 weeks		6 weeks	4 weeks
Dialogue meeting 1	–	–	12 weeks	7 weeks
Dialogue meeting 2	–	–	6 months	6 months
Dialogue meeting 3	–	–	–	Optional
Partial sick leave		Preferred alternative		Increasingly emphasised
Access criteria	Functional assessment	Activity obligation (after 8 weeks)		

obligations to cooperate. These obligations were also emphasised further by revised, stricter sanctions, introducing fines both for employers and physicians who failed to observe the requirements of the follow-up process. A new concept was introduced: follow-up culture (*oppfølgingskultur*). An improved ‘follow-up culture’ was the aim of the new measures. The concept quickly entered also the vocabulary of the opposition despite their fears of bureaucratisation, and they underlined that ‘we believe these requirements are important in an important transitional phase in order to create a new culture or elaborate a new culture both in the workplaces, among physicians and in the NAV-system’ (MP Torbjørn Røe Isaksen, Conservative, Stortinget 6.6.11.). At this point, none of the parties represented in the *Storting* argued for changes in the economic incentive structure. Opposition and the ruling parties were united in their endorsement of the IA-paradigm.

### Discussion and conclusion: the changing governance of sickness absence

The economic incentive structure of the Norwegian sickness insurance has remained largely unchanged since 1978. But this historical account of political struggle and policy development in the past twelve to thirteen years reveals that other types of changes have taken place. In Streeck and Thelen’s (2005) terms, it seems that a type of *layering* has taken place. The economic incentive structures remain intact, but new sets of rules that make claims on employers, employees and physicians to write up plans and assessments, and participate in meetings and follow-up activities are layered on top (see Table 1). Thus, new types of governance are growing in importance where responsibility is transferred to wider networks of organisations and actors – in this case, the social partners as well as the physicians, individual businesses and their employees. Let us take a closer look at these changes and at how they could be conceptualised.

First, the IA-agreement represents a corporatist mode of governance. Policies are negotiated between the government and the social partners, and the social

partners take on responsibility for making their members do their part in producing the desired outcomes. Corporatism has a long history in Norway, also with respect to sickness insurance. In the 1990s, hikes in the sickness-absence figures were met by collaborative efforts between the state and the social partners to reduce sickness absence without touching the economic incentives. These agreements have given the social partners strong veto-like powers, at least within the time frame of the agreements. In return, the authorities can enjoy a relative lack of public conflict over sickness insurance. It remains to be seen if future, right-wing, governments will continue to endorse this kind of collaborative structure, but it is worth noting that currently the parties on the right in general (despite some dissenting voices) endorse the IA-agreement and have mostly toned down their earlier claims for waiting days. So far, the IA-framework has been surprisingly robust to attacks, especially in light of the agreements' questionable merits in terms of actually reducing public expenditure.

The very idea that sickness absence is best addressed in the workplace (and not through the incentives parcelled into sickness insurance itself) has achieved a paradigmatic character in the debate – it constitutes 'cognitive background assumption[s] that constrain action by limiting the range of alternatives that policy-making elites are likely to perceive as useful and worth considering' (Campbell, 1998: 385). And if the workplace is the central arena for action, it follows that the government must collaborate with the representatives of the workplace (the employers' and employees' associations) in order to achieve its targets of reduced sickness absence.

Second, the relation between work and health has been reformulated. The principle of functional assessment meant that medical diagnoses were to be relegated to the background in the assessment of a person's right to sick pay. The point was to direct attention at 'what the individual can do, despite ill health and sickness' (Ot prp nr 29 (2001–02): 11). Latterly, the concept of work ability assessment has become crucial, further stressing the ability to *work* despite health problems. Distinctions between ill (absent) and healthy (working) are being rejected. Instead the talk is about the wide grey areas where people may suffer from various ailments but are still able to work, and would even benefit from working given the right kind of support and adaptations. Activity requirements have been strengthened. The sick-listed person must provide information about his functional abilities and work capacities and contribute to the adaptation of work tasks and to further assessments. Work-related activity is to be the default option for the long-term absent as well, preferably in the shape of part-time sick leave.

Third, there has been an emphasis on fostering dialogue – between employers and employees, and also with physicians and the National Insurance Service. Employers have been made responsible for developing individual follow-up plans for sick-listed employees, thus further strengthening the dialogue about measures

to enable return to work. Compulsory *dialogue meetings* were introduced in 2006. Over time, this regime of set ‘stop points’ has been intensified in the sense that plans and meetings are to take place earlier in an absence spell (thus affecting more cases). In this way, employers, employees and physicians are gently nudged (economic sanctions exist, but are rarely applied) into meeting and talking, for example about possible adaptations of work tasks and the possibility of returning to work part time.

Fourth, the National Insurance Service has been recast as *service providers* for (as opposed to controllers of) the main protagonists (employers and employees). Its compulsory twelve-week assessment of continued right-to-sickness benefits was abolished in 2004, precisely in order to stress the authorities’ role as supporters of the workplace actors’ own efforts. This is in line with the ambitious 2006 merger of the National Insurance Services, the National Employment Services and the municipal social assistance services into the Norwegian Welfare and Labour Service (NAV). A core idea in this reform was to leave behind the social insurance worker’s role as case officer assessing claims for funding. Instead, the ideal is for the role to be supervisory, guiding users through individualised trajectories on the way back to work (Helgøy *et al.*, 2011). The management of rules was toned down, to the benefit of facilitation, follow-up and guidance.

A key idea in all this is to make employers and employees (and physicians) accountable for the management of sickness absence (*ansvarliggjøring*). While corporatist modes of negotiation have been crucial in the making of such policies, it is not the social partners who are construed as the main actors in the desired efforts to reduce sickness absence. The main protagonists are to be the actors on the ground: the employers, the employees and the physicians who authorise the sick leave. They – the ordinary people (Clarke, 2010) – are the ones who are made responsible for the management of sickness-absence levels. While the state may have conceded power to the social partners, this does not mean that the state has relinquished power to the actors on the ground. Rather, the role of the state has been redefined in a way that authorises employers to govern (Dean and Taylor-Gooby, 1990).

These changes include the most local of stakeholders in a type of steering *network*, but they are also worth noting for their emphasis on *self-government*. The governance literature has drawn attention to the complexity of contemporary forms of steering, where different types of coordination mechanisms – hierarchy, network, market – operate in different institutional mixes. The so-called governmentality literature (Dean, 1999, Rose, 1999) also looks beyond the state to understand how governing takes place, but instead of looking at the actors and relations they are interested in ‘the knowledges through which rule takes place’ (Bacchi, 2009: 26) and in the technologies of government (Dean, 1999). The dialogue-focussed policies are technologies which produce knowledge: dialogue meetings are held in order for physicians to acquire knowledge about workplaces

that enable them to assess patients' functional potential, so that employers can report on work requirements and possibilities for adaptation, and where employees can inform their superiors about their own health and abilities. Such techniques engage citizens, employers and professional groups in managing their own risks of contributing to sickness absence. Taking their inspiration from Foucault, governmentality writers have been especially fascinated by how state power operates through an illusion of individual freedom and autonomy. From this perspective, the insistence on dialogue can be read as a case of how power operates through convincing people that they need to partake in producing knowledge about their own health and work abilities.

The critical question is of course: Does all of this matter? Or is it just talk (about dialogue)?

Most of the debate over the IA-agreements and related policies has focussed on their ability to deliver lower sickness-absence rates. In this respect, the effect of the IA-agreements and related policies is at best uncertain. What they certainly have done is to impose a range of new requirements on employers, employees and physicians. Nobody has tried to measure the amount of working days that goes into the production of plans and dialogue meetings, but NAV figures from 2012 state that each month more than 13,000 plans and 9,000 dialogue meetings are reported. Evaluation of workplace practices suggests that these measures have indeed affected how people act in the workplace *and* how they speak about how to act (Ose *et al.*, 2009). Case studies indicate that IA has led to the emergence of new workplace 'cultures', norms and values, where one informant states that IA is a 'culture for mutual trust, to be able to speak to each other about personal issues' (*ibid.* 269). Closer attention to such changes and to what this means in terms of power and governing should be a task for future research.

Finally, and this is perhaps the most important point, the IA-agreements and related policies have, in a paradoxical way, brought about a depoliticisation of this most contested of all Norwegian social security insurances. While public and political controversies have been intense, these have mostly focussed on compensation levels and employer contributions. The IA-style measures of adaptation and dialogue have remained in the background of the political debate, while being at the forefront with respect to actual policy making and implementation. The technologies of dialogue and individual follow-up plans are hardly contested in the political debate. There is broad political endorsement of the IA-agreement, and this seems to have grown stronger and more unanimous over time. Who can be opposed to dialogue and collaboration? Cutbacks tend to activate classical lines of political conflict, between labour and capital, left and right, rich and poor. Dialogue policies on the contrary seem to soften these tensions. They largely take the shape of administrative procedures, and may thus appear to be of a more technical and less political nature. There is very little discussion and analysis of whether these types of measures also have conflicts of

interest attached (Ose *et al.* 2013 is one exception). Are the administrative demands made on employers and physicians reasonable? And what do the intensified follow-up regimes imply for employees in terms of paternalism and increased employer control?

It is precisely at times when conflicts over sickness insurance have been rekindled that these *soft* kinds of measures have been intensified in order to reunite the antagonists. It may seem mysterious that the IA-agreements have been renewed thrice despite their shortcomings in reaching the target of 20 per cent sickness-absence reduction. Perhaps the key lies here in their achievements at delivering peaceful collaboration across the labour market.

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### Note

1 Thanks to Niklas Jakobsson for making this figure.

### References

- Bacchi, C. (2009), *Analysing Policy: What's the Problem Represented To Be?* Frenchs Forest: Pearson Australia.
- Bleksaune, M. and Dale-Olsen, H. (2010), 'Sykdom og sykefravær', in A.-H. Bay, A. Hatland, T. Hellevik and C. Koren (eds.), *De norske trygdene. Framvekst, forvaltning og fordeling*, 2nd edn, Oslo: Gyldendal Akademisk.
- Campbell, J. L. (1998), 'Institutional analysis and the role of ideas in political economy', *Theory and Society*, 27: 3, 377–409.
- Castles, F. G. (2004), *The Future of the Welfare State: Crisis Myths and Crisis Realities*, Oxford: Oxford University Press.
- Chong, D. and Druckman, J. N. (2007), 'Framing theory', *Annual Review of Political Science*, 10: 103–26.
- Clarke, J. (2010), 'Enrolling ordinary people: governmental strategies and the avoidance of politics?', *Citizenship Studies*, 14: 6, 637–50.
- Cox, R. H. (2001), 'The social construction of an imperative: why welfare reform happened in Denmark and the Netherlands but not in Germany', *World Politics*, 53: 3, 463–98.
- Cox, R. H. (2009), 'Ideas and the politics of labour market reform', in I. Dingeldey and H. Rothgang (eds.), *Governance of Welfare State Reform: A Cross National and Cross Sectional Comparison of Policy and Politics*, Cheltenham: Edward Elgar.
- Damgaard, B. and Torfing, J. (2010), 'Network governance of active employment policy: the Danish experience', *Journal of European Social Policy*, 20: 3, 248–62.
- Daly, M. (2003), 'Governance and social policy', *Journal of Social Policy*, 32: 1, 113–28.
- Dean, H. and Taylor-Gooby, P. (1990), 'Statutory sick pay and the control of sickness absence', *Journal of Social Policy*, 19: 1, 47–67.
- Dean, M. (1999), *Governmentality: Power and Rule in Modern Society*, London: Sage Publications.



- Hagelund, A. and Bryngelsson, A. (forthcoming) 'Change and resilience in welfare state policy: the politics of sickness insurance in Norway and Sweden', *Social Policy and Administration*, DOI: 10.1111/spol.12009.
- Helgøy, I., Kildal, N. and Nilssen, E. (2011), 'Ny yrkesrolle i en organisasjon i endring', *Nordiske Organisasjonsstudier*, 13: 3, 34–54.
- Kjær, A.-M. (2004), *Governance*, Cambridge: Polity Press.
- Korpi, W. and Palme, J. (2003), 'New politics and class politics in the context of austerity and globalization: welfare state regress in 18 countries, 1975–95', *The American Political Science Review*, 97: 3, 425–46.
- Larsson, B., Letell, M. and Thörn, H. (2012), 'Transformations of the Swedish welfare state: social engineering, governance and governmentality – an introduction', in B. Larsson, M. Letell and H. Thörn (eds.), *Transformations of the Swedish Welfare State: From Social Engineering to Governance?*, Basingstoke & New York: Palgrave Macmillan.
- Mahoney, J. and Thelen, K. (2010), 'A theory of gradual institutional change', in J. Mahoney and K. Thelen (eds.), *Explaining Institutional Change: Ambiguity, Agency and Power*, Cambridge: Cambridge University Press.
- Mykletunutvalget (2010), *Tiltak for reduksjon i sykefravær: Aktiviserings-og nærværreform*, Expert commission report to the Ministry of Labour, 1 February 2010.
- NOU (2000), *Sykefravær og uførepensjonering: Et inkluderende arbeidsliv*, Norges Offentlige utredninger 2000:27, Oslo: Statens forvaltningstjeneste.
- OECD (2010), *Sickness, Disability and Work: Breaking the Barriers – A Synthesis of Findings Across OECD Countries*, Paris: OECD.
- Ose, S., Bjerkan, A. M., Pettersen, I., Hem, K.-G., Johnsen, A., Lippestad, J., Paulsen, B., Mo, T. O. and Saksvik, P. Ø. (2009), *Evaluering av IA-avtalen (2001–2009)*, Trondheim: SINTEF.
- Ose, S., Dyrstad, K. and Brattlid, I. (2013) 'Byråkratisk og uten effekt?', *Dagens Næringsliv*, 29 April 2013.
- Ot prp nr 29 (2001–02), *Om lov om endringer i folketrygdloven (tiltak for å redusere sykefravær mv.)*, Oslo: Ministry of Social Affairs and Health.
- Pierson, P. (1996), 'The new politics of the welfare state', *World Politics*, 48: 2, 143–79.
- Rose, N. (1999), *Powers of Freedom: Reframing Political Thought*, Cambridge: Cambridge University Press.
- Schmidt, V. (2002), *The Futures of European Capitalism*, Oxford: Oxford University Press.
- Starke, P. (2006), 'The politics of welfare state retrenchment: a literature review', *Social Policy and Administration*, 40: 1, 104–20.
- Streeck, W. and Thelen, K. (2005), 'Introduction: institutional change in advanced political economies', in W. Streeck and K. Thelen (eds.), *Beyond Continuity: Institutional Change in Advanced Political Economies*, Oxford: Oxford University Press.
- Tranøy, T. (2007), *Vallas fall*, Oslo: Forlaget Manifest.
- Van Berkel, R. and Borghi, V. (2008), 'Introduction: the governance of activation', *Social Policy and Society*, 7: 3, 331–40.