De toekomst van de arbeidsgerelateerde zorg in Nederland – korte notitie van het NIP
Utrecht, 04 oktober 2013

Notitie in reactie op verzoek van de SER aan het NIP (Nederlands Instituut van Psychologen) om de visie van het NIP op de toekomst van de arbeidsgerelateerde zorg in Nederland. Dit ter voorbereiding van een advies van de SER over dit onderwerp op verzoek van minister Asscher van Sociale Zaken en Werkgelegenheid.

I Arbeidsgerelateerde zorg

Beredeneerd vanuit het werkveld van de arbeid- en organisatiepsycholoog (en de Psycholoog Arbeid & Gezondheid) is sprake van arbeidsgerelateerde zorg voor zover het behandeling van *psychische klachten gerelateerd aan werk* betreft.
Deze klachten worden in hoofdzaak veroorzaakt door de aard van het werk of de omstandigheden waaronder het werk wordt verricht. Anders gezegd, er is gezondheidsschade ontstaan die er niet zou zijn geweest als de werkzaamheden niet zouden zijn uitgevoerd.

Bij werkgerelateerde psychische klachten dient men te denken aan stress, burnout/overspannenheid, depressie, anxiety en posttraumatische stress-stoornis (PTSS).

II Oorzaak arbeidsgerelateerde psychische klachten: werk of arbeidsomstandigheden

Reden van het ontstaan van arbeidsgerelateerde psychische aandoeningen is te zoeken in een verkeerde person-environment-fit: de capaciteiten van de werknemer vormen geen goede match met de eisen die het (de) werk(omstandigheden) stelt. Dit kan meerdere oorzaken hebben die zowel in de persoon (o.a. copinggedrag, stressbestendigheid als in het werk (o.a. te hoge eisen, te moeilijke omstandigheden, gebrek aan (mede)zeggenschap of sociale ondersteuning) kunnen liggen.

III Rol werkgevers

Los van de behandeling van werkgebonden psychische aandoeningen is het tevens van belang werkgevers bewust te maken van hun rol bij het realiseren van de juiste match tussen persoon en omgeving. In dit licht is het van belang dat werkgevers worden geïnformeerd over zowel de zorg als over preventief beleid rondom gezondheid, ziekte, vitaliteit, werkmotivatie en productiviteit van de werkende.

IV Behandeling van arbeidsgerelateerde psychische aandoeningen

Behandeling van arbeidsgerelateerde psychische aandoeningen vindt plaats middels twee typen interventies. Het eerste type interventie is gericht op de persoon: diagnose en behandeling van de werknemer. Hierbij valt naast training en scholing te denken aan psychologische zorg voor welbevinden op het werk: motivatie, vitaliteit, effectiviteit, productiviteit en werkplezier, alsmede het verminderen van gezondheidsklachten.
Het tweede type interventie richt zich op de arbeidssituatie (de taken en de omstandigheden waaronder gewerkt moet worden): dit vraagt onder meer een analyse van het werk en de werkomstandigheden om te bekijken waarom er geen goede match is tussen persoon en omgeving met als doel het aandragen van met name werkgerichte oplossingen (zoals taak- of functieherontwerp).

V Knelpunten

Een knelpunt bij de oplossing van arbeidsgerelateerde psychische klachten is de *communicatie tussen* en *rol* van de betrokken professionals. Alleen met gespecialiseerde kennis kan de juiste diagnose worden gesteld en vervolgens de juiste begeleiding ingezet. Een verkeerde diagnose en daarmee begeleiding kan erin resulteren dat bij terugkeer van de werkende op de werkvloer deze binnen afzienbare tijd nogmaals uitvalt. Dit met alle schade van dien voor de werkende zelf, diens werkgever en de maatschappij. Het is dan ook noodzakelijk dat arbeidsgerelateerde psychische klachten direct worden gesignaleerd door onder andere huisarts, bedrijfsarts en psychologen. Daarvoor moeten met name de genoemde professionals beter onderling samenwerken en communiceren. Zij dienen goed opgeleid te zijn om de problematiek te kunnen signaleren en te weten naar wie moet worden doorverwezen voor de juiste diagnostiek en begeleiding.

Medisch model versus psychologisch model

Het medisch model is nog steeds de meest ingezette behandelmethode bij arbeidsgerelateerde psychische klachten. Echter, dit model is gericht op 'beter maken', al dan niet met behulp van medicatie. Bij veel psychische problematiek ten aanzien van arbeid werkt dit 'medische model' niet goed en is het *psychologische model* de aangewezen aanpak. Dit tweede model is gericht op 'omgaan - coping - met de problematiek' en daarmee gericht op functioneren, dus arbeidsparticipatie.

Psychologen zijn bij uitstek opgeleid in het diagnosticeren van psychische problemen, evenals voor de begeleiding (behandeling) ervan. Artsen zijn dat niet. Naast specifieke kennis van diagnostiek en begeleiding heeft de psycholoog ook kennis van *preventie van arbeidsgerelateerde psychische problemen*.

VI Oplossingen

a. De juiste professional: psycholoog met specifieke kennis van werk en psychisch en klachten

Het is van belang dat bij psychische arbeidsgerelateerde problematiek van de werkende direct de juiste onderzoeksvraag wordt geformuleerd om vervolgens (eventueel) aanvullend onderzoek te (laten) verrichten; dit vereist een academisch denk- en werkniveau. De professional dient over de benodigde kennis (psychologische opleiding, gedragstherapeutische kennis en vaardigheden) te beschikken om de juiste begeleiding in te kunnen zetten, met als doel de werkende op de werkvloer te houden dan wel weer te krijgen. Bij uitstek is hiervoor de psycholoog met gespecialiseerde kennis van werk en psychische klachten opgeleid en dus aangewezen betrokken te zijn in dit traject. Juist deze psycholoog heeft de benodigde (arbeids)psychologische kennis en kennis van functies, organisaties en arbeidsmarkt.

Kwaliteitseisen aan de professional

Het NIP is beheerder van het register Arbeid- en Organisatiepsycholoog en het register Psycholoog Arbeid & Gezondheid. Voor inschrijving in deze registers worden strenge eisen gesteld aan opleiding, werkervaring en nascholing middels het volgen van geaccrediteerde cursussen. Hiermee wordt de kwaliteit van het professionele handelen van deze psychologen gegarandeerd. Door het verplicht stellen van herregistratie dient de geregistreerde permanent te werken aan diens werkervaring en nascholing, en daarmee aan de kwaliteit van diens professionele functioneren.

b. Samenwerken tussen professionals

Zoals reeds boven vermeld is het van het grootste belang dat betrokken professionals (huisarts, bedrijfsarts en psycholoog) bij de problematiek van arbeidsgerelateerde psychische problemen optimaal samenwerken. De juiste onderlinge communicatie in combinatie met kennis van elkaars expertise en vaardigheden zijn daarbij van het grootste belang.

VII Aanvullende literatuur

Graag wijzen wij in dit kader op de volgende documenten:

1) studie Stress impact project (link)
2) bijlage I bij deze notitie: hoofdstuk (onlangs afgerond: september 2013) getiteld 'Return to work for long-term absentees: An undervalued topic in (psychological) research', auteurs Prof. Dr. F.R.H. Zijlstra en Prof. Dr. F.J.N. Nijhuis. Dit hoofdstuk wordt onderdeel van een nog te verschijnen boek dat over gerelateerde problematiek gaat.

Tot slot

Het NIP is gaarne bereid op 28 oktober a.s. met de commissie nader van gedachten te wisselen over dit onderwerp.

Bijlage I

Hoofdstuk (*zie § VII Aanvullende literatuur*):

Return to work for long-term absentees: An undervalued topic in (psychological) research

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Introduction

Most EU countries, and the European Commission itself, would like to increase labour participation of their population. Thus they have put this high on their political agenda. Partly, because demographic developments indicate that there will be shortages on the labour market in the next decades. In addition most governments believe that participation in society is best guaranteed through (paid) work, and thus having a job. Nevertheless, we see that there are large groups of people that have difficulties in participating in the labour market. This applies to people with health issues and that have had (long term) sickness absence, and those who have particular limitations that prevent them from obtaining a job. Incapacity to work is a serious problem in our Western society, in many respects. There are societal, financial and psychological consequences involved. Non-participation means that people are dependent on social security, and with high numbers of incapacity recipients the system may become unsustainable. Also it means that people feel as if they are not participating in society, which may result in reduced levels of self-esteem, depressive feelings and ultimately in feeling alienated from society (cf. Black, 2008). These psychological aspects itself are serious hindrances in participating in society and the labour market.

In the Netherlands the number of incapacity claims have steadily increased up till 2005, when a change of Law caused a reduction of the numbers , but has increased slightly again since that point (UWV, 2012). Statistics of the Dutch Social Security system (UWV, 2013) indicate that of the total number of the new Incapacity Benefit Recipients approximately 33 % are 'partly disabled' and of the ones that receive 'full benefits', approximately 40 % of the Incapacity Benefit Recipients are incapacitated for 'mental health reasons' (like depressive feelings, stress, burnout, etc.)The WHO suggests that mental illness is currently the 2nd cause for work-disability.

In this chapter we will discuss system's, organizational and psychological factors that affect the issue of labour market participation for people with functional limitations, either caused by health (mental and or physical) issues or by structural limitations. And we make some recommendations that could help to increase labour participation of people that have been absent from the labour market for a long time, and those who have problems entering the labour market because of health problems or functional limitations.

We will start with outlining some background factors.

Changes in the domain of work

Over the past decades the demands of work have changed considerably. An employee of 40 years ago would be practically unfit to work nowadays. Not only because of lack of adequate education and training, but also because of functional capacities. In particular for the lower educated group of people their work has changed considerably, and this change is expected to be on-going (Josten, 2010). This is largely caused by the fact that manufacturing and production type of work have been outsourced to countries with lower costs of labour. And to some extent people working in production and manufacturing have been replaced by technology and the remaining jobs are upgraded to a higher professional level (e.g. process operators). At the same time employment in the service industry has increased, currently approximately 75 % of all employment can be found in the service sector of the economy. But the demands and requirement for people working in the service sector are very different from those working in manufacturing (cf. Zijlstra, Mulders, & Nijhuis, 2012).
Service oriented work implies that employees are often in contact with clients, customers or patients. This means that concepts like 'client oriented', 'customer satisfaction' have become important and relevant to assess employees´ skills and performances. And these concepts represent completely different requirements for employees than working in the classical production (usually in a factory). For a service job 'social skills' are very

important, which are part of the behaviour that people actually display. So, in fact peoples' behaviour at the work place is part of their work performance.

Furthermore, over the last decades the role of technology has become very important. There are very few jobs in which employees do not have to work with computer technology. These technological developments have also changed the demands imposed on people: cognitive capacities have become quite important since working with this technology requires a particular level of abstract thinking to understand the functionality of the system. People need to have a mental model of the functionalities of the system in order to be able to work properly with the system, and in addition is operating the system a matter of information exchange. In general the implications are that a certain level of abstract thinking is an essential requirement for employees. And it is generally believed that the introduction of Information and Communication technology (ICT) has led to an increase of complexity and intensity of work (Eurofound, 2011). It is generally acknowledged that these factors have translated into an increase of work demands imposed on people.

From an organizational perspective there have also been numerous changes, particularly in the way processes are organized. In the 1990's the *sociotechnical systems approach* became a leading principle for organizing production processes. This sociotechnical systems approach advocates joint optimization of both, the technological systems (machines) and the social systems (people) (Emery, 1959), and the modern version of this approach led to the introduction of (semi) autonomous teams in order to support the development of 'lean' production system' (cf. Dankbaar, 1997). The consequences for employees of working in teams are manifold: first of all, employees need social skills in order to maintain themselves in a group, and to negotiate or discuss their work with colleagues. These social skills require planning skills in order to plan one's work, and in addition it requires adequate psychological awareness of one's capacities, strengths and weaknesses.

So, whereas in 'traditional' manufacturing the technical skills (crafts) were sufficient, we can now conclude that in order to be able to find work and maintain one's job, employees need additional skills (Zijlstra, et al, 2012). Furthermore, the concept of 'performance' has changed (cf. Roe, 1998), in the past performance referred to the output of the employee (the number of goods that was produced); nowadays, in a service oriented industry, the concept of 'performance' also includes the *behaviour* of the employee while interacting with clients or customers (think of a salesperson or shop assistant).

All in all, this makes clear that the work demands imposed upon employees have increased substantially over the past decades. And this information is important in order to understand the rise in numbers of people who are incapable of working, or finding work, while the necessity to *have* work has only increased in our society. The cultural and economic development of western societies now advocates that both men and women actively pursue a professional career. As a consequence couples have to negotiate their domestic responsibilities (i.e. responsibility for children, household affairs, etc), which has put the topic of 'work-family balance' on the agenda as an additional challenge for employees (Eurofound, 2011).

Due to high competitiveness organizations are always looking for the 'most suitable' candidates, and nowadays this translates into employees that are 'flexible', 'stress resistant' and 'team players'. These high level of demands form the background of what is in Human Resources Management circles called 'the war on talent' (Michaels, Handfield-Jones, & Axelrod, 2001).

Population changes

As mentioned in the introduction the population of people who are assessed to be (temporarily) incapable of work has also changed over the past decades. The Dutch agency for Social Security (UWV, 2012, UWV 2013) publishes statistics about the number of Incapacity Benefit Recipients. The general trends in those statistics match quite well with statistics in other countries, like the UK (HSE, UK, 2012; OECD, 2010). An important trend that is underlying these statistics is that there is a shift from people being incapacitated because of physical health complaints towards people with mental health complaints and cognitive and behavioural disorders. According the World Health Organization (WHO) is 'mental illness' currently the 2nd cause for work-disability (WHO, key facts, 2013), and in particular 'anxiety' and 'depressive disorders' are currently highly prevalent in the working population. These are the symptoms that are closely associated with 'stress syndrome'

and ‘burnout’, both generally recognized as work-related health problems originating from being exposed to work demands that exceed one’s capacity to work (Lazarus & Folkman, 1984; Schaufeli & Enzmann, 1998). Furthermore the WHO expects ‘depressive feelings’ to be among the top 3 causes for long-term absence from work in 2030.

Although it is difficult to demonstrate that there is a direct relationship between these tendencies and the earlier described increase of work demands, many authors suggest that there is a relationship between increased complexity of our society (including work) and the fact that an increasing number of people seem to be unable to cope with this increased complexity (Eurofound, 2009).

From absence to ‘return to work’

Implicit in the reasoning presented above is that people can be temporarily absent, and/or have more structural limitations that determine their capacity to work. Sickness absence generally has a temporarily character, and people generally return to work again. Short term absence is generally not seen as a major problem: most people catch a cold or flew from time to time. However, when the period of absence is longer the statistics indicate that return to work becomes more problematic. For instance in those cases were people have been absent for more than 5 or 6 weeks approximately 60 % of sickness absentees do not return to work on short notice and might be absent for months. Furthermore, statistics indicate that approx. 80 % of long term absentees that move on to Incapacity Benefit do not return to work within 5 years.

These findings justify more attention to the processes underlying sickness absence and return to work. Allegro & Veerman (1998) have presented a psychological model concerning sickness absence that describes sickness absence as a ‘decision making process’ in which several thresholds are built in. The model is presented in Figure 1.

According to the model the decision to be absent from work for health reasons is dependent on at least two factors: 1) the necessity to stay at home; and 2) the opportunity to stay at home.

The decision to stay at home because of health reasons is influenced by various factors from the non-work (private) domain, from the work context, Personal reasons, or other Contextual factors. These various factors can act like ‘push’ or ‘pull’ factors influencing the decision to stay at home or go to work. A personal ‘pull’ factor to stay at home can be the health situation; while when private conditions at home do not allow much rest (because of children, or a reconstruction going on) this could be a factor that ‘pushes’ one to work. On the other hand a ‘pull’ factor from the work setting that makes one go to work can be the feeling to be irreplaceable at work (an important meeting, or the responsibility for a project), while a ‘push’ factor that pushes the person away from work could be a conflict with a colleague or supervisor, or high levels of stress at work. For example: if the health situation does not allow to travel the outcome of the decision is evident; but sometimes people manage to go to work even when they are seriously ill, because they feel they cannot miss a particular meeting. Another example is the situation when one of the parents doesn’t feel well, and one of the children is not well either. In this case, two ‘push’ factors act together to keep the employee at home.

The person’s individual health situation is always an important factor, but certainly not the only factor that is included in the decision making process. Generally, in cases of more severe health problems there is no decision latitude at the start of the sickness absence period: people cannot, or are not allowed to travel. In general, there will be more freedom to stay absent or to return to work at the end of the recovery process. And it also makes a difference whether the health problems concern physical health (which may immobilize a person) or mental health. In case of mental health problems the decision processes may be different, or at least give leeway for other factors to be included in the decision making process.

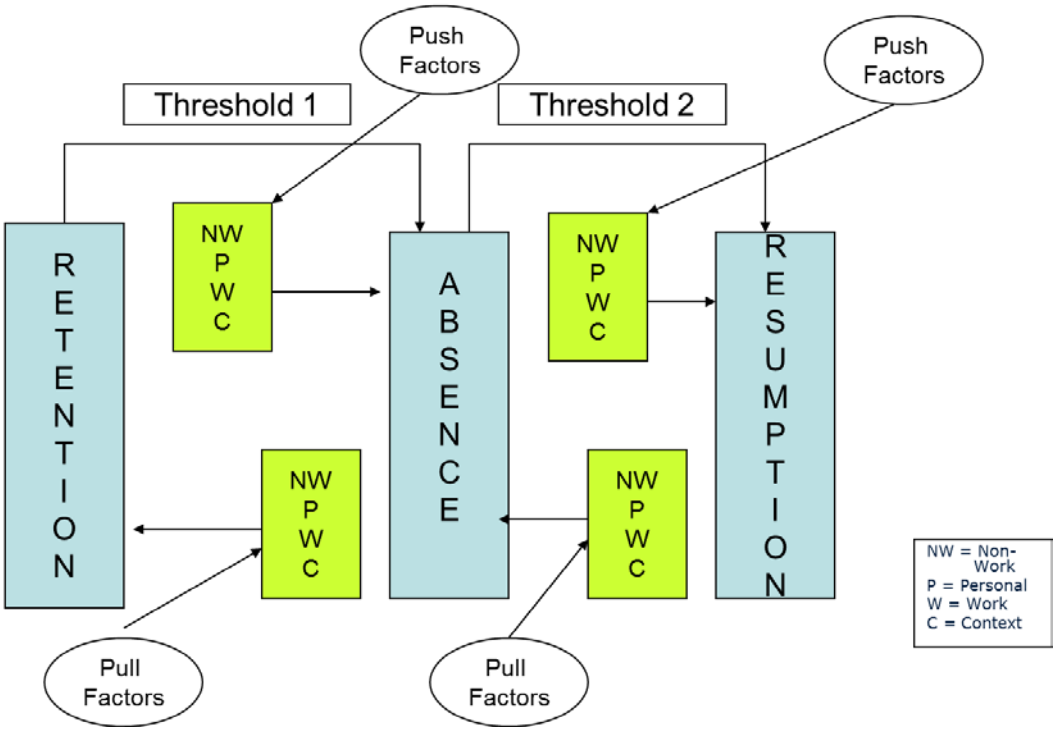

***Figure 1**: Sickness absence model, after Allegro & Veerman (1998).*

Similarly one can also describe the process of return to work as a decision making process with thresholds that more or less mirror the absence threshold: there are 'pull' and 'push' factors that either facilitate or hinder going back to work and/or stay at home. Evidently the perceived health situation is influencing the decision to stay at home, but there may also be other factors from the non-work, personal, or work situations that influence that decision. Examples of factors that may act as either 'push' or 'pull' factor are: financial situation; attitudes of spouse or family members toward being absent from work; the situation at work, such as relationship with supervisor and colleagues, and so on. And, of course, contextual factors are generally related to laws or systems aspects that pertain to one's situation (i.e. are there: medical check-ups; frequent contacts with professionals that monitor the process).

In a study that looked into the 'return to work threshold', or rather factors that hinder or facilitate return to work findings on the personal level, organizational level and systems level have been identified (Stress Impact, 2006). This study collected longitudinal data from a sample of 1460 people in 5 European Countries that were Long-term Absent from work for health reasons (primarily mental health). Furthermore in each country in-depth interviews were held with a sub-sample and their family-members; and professionals working in this domain were interviewed.

The results of this study provide a good overview of the relevant factors in the return to work process. On the individual or psychological level there a few rather obvious factors affecting peoples' decisions, but also some factors that are less obvious. For instance, people who find their work important and relevant and rewarding are much more likely to return to work than those people for whom work is less central in their life's. And those stressors that were responsible for absence also inhibit return to work. In practical terms this means that if there were problems (conflicts) at work, these problems need to be solved before considering return to work. Furthermore, it appeared that level of income is an issue that people take into consideration regarding their decision to return to work or not; but money is not a good incentive to return to work. People (families) receiving Incapacity Benefit often experience financial difficulties because of the lower level of income, but the health situation is more important for the return to work decision.

On the organizational level the study indicates that many organizations do have policies in place regarding return to work, but often these policies are not recognized by employees (have no knowledge of those policies), or the policies are not effective. Example: organizational policy is that when an employee is on sick leave the

organizations should remain in contact with this person. And, although this is generally recognized as important, this is also a very delicate aspect, in particular with respect to 'who' initiates the contact, and when. In many cases it appears that a (perceived) conflict (with supervisor or manager) lies at the basis of the absence, in these cases it is obvious that the manager or supervisor should not be the person to initiate the contact as this might aggravate the situation. But also when there is not a conflict underlying the absenteeism, employees might feel that the supervisor enquiring about their health situation is in fact 'checking' whether their health situation is serious enough and/or putting pressure on to return soon. And in both cases initiating contact, although with good intentions, may backfire. Study results indicate that organizations that have designated a specific person in the organizations (a 'case manager') are more successful in terms of likelihood that people return to work (Hoefsmit, De Rijk, & Houkes, 2013, Hoefsmit, Houkes, & Nijhuis, 2013; Stress Impact, 2006).

Furthermore it appeared that organizations respond more effectively towards stressful *incidents* than towards *chronic* work stressors; while the chronic stressors (like poor job characteristics, managerial issues) are generally responsible for long term absence than critical incidents. And as outlined above, the role of the supervisor is very important and often underestimated. Supervisors' poor relationships with employees are often part of the causes for long-term absence. On the other hand a supportive attitude of supervisor in the return to work process is also crucial for a successful return to work process. In the return to work process employees need from time to time some extra help, or some extra leeway, and supervisors need to be willing to be considerate in these situations. This implies that a particular level of awareness of stress and stress-related problems in the organization is beneficial for the return to work process (D'Amato & Zijlstra, 2010).

Interviews with professionals working in the occupational health domain and involved in return to work processes pointed out that the communication and collaboration between various professional groups can be improved (see Hoefsmit, Houkes & Nijhuis, 2013).
In particular the attitudes of Medical General Practitioners, and Occupational Health Physicians towards return to work are very important, these groups see most of the absentees in a rather early stage of their absenteeism. If from start on the focus of these professionals is on return to work and they communicate this with their patients this has a beneficial influence on the process. However, these professionals seem to have little consensus about concepts and definitions concerning 'stress' and 'burnout' which makes diagnosis and hence treatment difficult (see Stress Impact study, 2006). In particular when such mental health issues are the reason for being absent medical professionals should adopt a different treatment strategy. Whereas medical professionals are trained in the medical approach of 'making the patient better' (i.e. treatment) which works fine with physical health problems, with mental health issues a different approach is needed that can be best characterized as 'coping with the situation' (i.e. therapy). Psychologists are better trained to deal with patients that require 'therapy' rather than 'treatment', and this suggests that psychologists should have a more prominent role in the return to work process.

The 'Stress Impact' study also compared the systems in the six participating European countries (Ireland, United Kingdom, Netherlands, Finland, Italy, and Austria), on several system characteristics (Stress Impact, 2006). First of all, an attempt was made to classify the systems, resulting in identifying three different types: 'welfare based', 'decentralized social insurance', or 'integrated centralized'. 'Welfare based' implies that the society finds that people should be supported to make a living and thus they receive some money. 'Decentralized social insurance' can be understood as that individuals pay into a social security fund that is not controlled by the government. Whereas 'integrated centralized' refers to systems where the government has set up a legal system that indicates what kind of income the absentee receives, but also what further steps (and obligations) are expected of the absentee. In particular the latter type of system (integrated) has also instruments that have a focus on return to work. This type of system was found in Finland and The Netherlands. (The Netherlands indeed has measures and regulations, such as *Wet Verbetering Poortwachter*, introduced in 2002, that aim at return to work). Other systems are less explicit in their focus on return to work, or sometimes it is even absent and is the only focus 'income replacement' during absence.

The countries with an 'Integrated System' (Fi & NL) were also the countries with the highest levels of income for absentees AND the most successful in terms of percentage of people returning to work. This seems to be counterintuitive as most economists and policymakers see reducing the level of income during absence as a major instrument to stimulate return to work. However, based on this finding, and the finding that individuals see finances not as an incentive to return to work, the conclusion should be that reducing income levels may be an 'easy' measure, but not an effective measure in terms of stimulating return to work.

New Perspectives for the Labour Market

In order to accommodate the future demand for labour and to make the social security system sustainable return to work should indeed be high on the political agenda. The findings above suggest that there is still a lot to gain as far as return to work is concerned. However, this does not mean that we should stop thinking about new strategies to help people entering the labour market.
From that perspective it is worthwhile to examine the recently introduced concept of 'Inclusive Organizations' (cf. Zijlstra, Mulders, & Nijhuis, 2012). Inclusive organizations aim to enhance diversity in the organizations, in particular diversity in terms of capacities of employees. This means that these organizations aim not to exclude those people that cannot meet the current demands of work, but rather try to rearrange work in such a way that there are jobs in the organization for people with a large range of capacities, including people with (cognitive or mental) limitations. The underlying principle here is 'task differentiation', i.e. designing tasks for people with different levels of capacities (cf. Zijlstra, Mulders, & Nijhuis, 2009, Nijhuis, Mulders, & Zijlstra, 2011).

The idea behind this concept is that work has become very complex and demanding over the past decades as argued above, with the implication that an increasing group of people fail to meet the current requirements for the labour market. Or in other words: there are no 'simple jobs' anymore, as a result of moving production to low wage countries, and introducing technology. And to help the group of people with a 'distance to the labour market' to find a job, we have to create 'simple jobs' again. 'Simple jobs' are jobs for which not a high level of training and or skills are required and for which the demands are not as high as for 'regular' jobs. This would help people with low levels (or no) education, people with limited capacities (including those with psychological or social disorders, but still have a capacity to work), and to some extend also people that try to return to work from long term absence. The underlying idea is that, although people may have limitations, they often have some capacity to work. And this work capacity should be used, both for personal (psychological) reasons as well as for societal reasons. However, their working capacity cannot be used in the current arrangement of work (work is too complex or too demanding). Therefore we should adjust this arrangement by using the principle of task (or job) differentiation. A job consists of a set of several tasks. The larger the variety, or complexity of tasks, the more complex the job is. Task design is one of the traditional topics in the discipline of work and organizational psychology, and is mostly used to design jobs that enhance effectiveness and efficiency of employees (without harming their well-being). However, task design (or job design) can also be used to facilitate optimal performance and well-being of workers with different levels of capacities. The reference point has always been: healthy, able and fit people. The approach is seldom used to design jobs that match the capacities of people that might have limited capacities.

The dominant principle for organizing work nowadays is making teams responsible for the results. This is a consequence of the socio-technical systems approach that became very popular in the last decade of the previous century. Teams are very flexible elements in a production process, in particular when the teams function well. But one of the prerequisite of making teams flexible is that team members should be able to replace each other, and therefore need to be multi skilled. As a consequence we notice that individual team members do all kind of tasks, and some tentative estimates suggest that team members sometimes spend 30 or 40 % of their time on tasks that do not match their level of training or skills, and for which they are thus actually overqualified.

This means that we may wonder whether this principle is nowadays still the most preferred way of organizing work processes. We argue that it is time to reconsider this approach and focus on the concept of 'task differentiation' (or job differentiation) in order to accommodate the needs various groups in order to allow them to participate on the labour market. This principle may, for instance, also apply to elderly workers; currently all members of a team (no matter whether they are 35 or 55 years old) face the same demands, while they have different skills, experience, needs, motivation, and so on.

Evidently when differentiations are made according to level of jobs we also need to reconsider the level of pay. In the Netherlands a minimum level of pay is required for employees; evidently the level of this 'minimum wage' is frequently debated between employers and trade unions. However, for certain groups, in particular people 'with a distance to the labour market', it is impossible to be as productive as regular employees, and in order to give these people chances at the labour market there are ways to compensate employers for the gap between the level of productivity for these people and the minimum wage (a system of 'wage supplementation' or wage subsidies). Evidently the problem here is to assess the level of productivity of people or to make an adequate assessment of work capacity of people with limitations. Thus far several 'systems' or 'approaches' have been developed for assessing work capacity. The systems that have been developed so far are roughly based on physical or energetic limitations of people to be productive. And although the various systems claim to be different from each other, the underlying principle of all these system is largely based on time restrictions: the amount of time people can be active during a day, and or the physical limitation that rules our particular work. For most type of work nowadays this is not always adequate, as, is argued earlier, for most types of work the social, and cognitive skills are more relevant than the physical skills. None of the systems assessing work capacity are designed to take this into account. Therefore it is evident that this aspect of assessing the (remaining) work capacity needs further attention, which will require more research on this topic.

Conclusion

In this chapter we have argued that numerous people are being left out of the labour market because their level of qualifications does not match the demands of the current labour market. The labour market has become too selective, in the sense that organizations prefer young, healthy, strong and highly educated people. However, the population that is trying to get access to the labour market is highly diverse in terms of their qualifications and capacities, and this population does not always meet the criteria of organizations. Where economists try to influence the labour market with financial measures, we have argued that financial measures may not be the most effective when particular groups should be facilitated to (re)enter the labour market. We also may have to examine different strategies to stimulate participation on the labour market and thus facilitate participation in society. Facilitating organizations to take up a larger diversity of people in terms of their capacities may be one of those alternatives.

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