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Shaping return to work policy: the role of industrial relations at national and company level

Country report for Belgium

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Nina Lopez-Uroz, Leonie Westhoff and Mehtap Akgüç

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Table of contents

List of Figures and Tables

1. Introduction

Belgium faces long-lasting challenges regarding the labour market activation of vulnerable groups, including sick and disabled people, notably due to persisting inactivity traps and disincentives to work (Hufkens et al., 2016). Only three out of four people of working age (20-64) are active in the labour market (74.5%), which is below the EU average of 78.7% in 2019 (European Commission, 2019). Sickness and disability have become significant reasons for inactivity: the share of inactive people not seeking employment due to their own illness or disability increased from 10.7% in 2007 to 19.1% in 2019[1]. Furthermore, the share of private sector salaried employees who were absent from work as a result of long-term illness increased exponentially from 2010, and now continues to do so at a slower rate (Securex, 2018). Only part of this increase can be explained by an ageing population and increased eligibility for social assistance due to higher female labour market participation (Saks, 2017).

Meanwhile, before the Covid-19 pandemic, labour market shortages had become more acute, creating skills shortages and impeding the smooth functioning of the labour market. This is especially the case in Flanders, where in 2018 there was a one-to-one ratio of jobseekers to vacancies (European Commission, 2019). Indeed, as reported recently by Statistics Belgium, the unemployment patterns show differences across the three regions in Belgium, with Flanders having the lowest unemployment rate (3%) compared to Wallonia (7%) and Brussels-Capital (12%) in 2019.[2]

More specifically, chronic diseases pose important challenges for the proper functioning of labour markets in Belgium. They are associated with stigma and taboos, and often lead to social exclusion. We understand chronic diseases as diseases of long duration and generally slow progression, which can be divided into several types: cardiovascular diseases (CVD), cancers, diabetes, chronic respiratory diseases, musculoskeletal diseases (MSD) and mental diseases (Akgüç et al., 2020). These categories are selected because they produce a considerable burden on the workforce and are the main cause of morbidity and mortality in the European Union (Guazzi et al., 2014). According to the jurisprudence of the European Court of Justice,[3] principles of non-discrimination based on disability and the associated duty to proceed to reasonable accommodations apply to people suffering from a long-term illness (Eurofound, 2019). A Belgian court applied the same principle to employees with a long-term illness for the first time in February 2018 (CSC, 2019). It should be noted here that Belgian legislation uses the concept of invalidity more than disability (CNT, 2015).

The issue of chronic diseases is particularly acute in Belgium, where musculoskeletal and mental health problems are the first causes of absenteeism. These categories explain about two thirds of the significant increase in long-term sick leave and represent 67.31% of sickness and disability insurance beneficiaries (Mutualités Libres, 2019b). According to a study conducted by Mutualités Libres (2019c) between 2013 and 2017, more than half of "new" disability insurance beneficiaries

[1] Source: Eurostat, lfsa_igar, extracted 15th December 2020.

[2] For more details of the latest Belgian Labour Force Survey results reported by StatBel, see https://statbel.fgov.be/en/themes/work-training/labour-market/employment-and-unemployment.

[3] European Court of Justice - Joined Cases C-335/11 and C-337/11.

were already suffering from at least one chronic disease, depression being the most frequent one. On the other hand, the incidence of other types of chronic conditions such as cardiovascular disease and cancer has decreased (Saks, 2017).

Moreover, people suffering from a chronic condition in Belgium tend to face significant difficulties in terms of integration into the labour market and wellbeing. The gap in the at-risk-of-poverty-or-social-exclusion rate between people with and without disabilities amounts to 17.7 percentage points, which is significantly higher than the EU average of 9.7 percentage points (European Commission, 2018). In 2018, the employment rate of people with disabilities (aged 20-64) was 31.6%, ranging between 31.1% in Brussels and 46% in Flanders.

The increasing incidence of long-term incapacity for work has led to mounting social security costs, which is perceived as a threat to the sustainability of the social security system. Indeed, spending on disability increased from 1.9% of GDP in 2005 to 2.6% in 2016 (Pacolet, 2019). In 2018, combined spending on disability and sickness benefits exceeded spending on unemployment benefits for the first time. This may be due to a "communicating vessels" effect between the various schemes for early withdrawal from the labour market, as early retirement schemes and the exemption of "older unemployed persons" from seeking work have gradually been phased out (Pacolet, 2019).

This evolution is reflected in the Belgian government's increasing concern over the risk of incapacity for work. Increased awareness of this issue has been noticed over the past decade, with a switch from welfare to workfare also in the area of incapacity (Houwing and Vandaele, 2011). Since 2015, the government has sought to address the economic impact of sickness absence and mismanagement of return to work leading to unemployment, disability pensions or early retirement. Notably, mutualities or mutual insurance providers (*mutuelles/mutualiteits*) are pushed to increase the employment rate among long-term sickness insurance beneficiaries and incentivise return to work. New pieces of legislation on work reintegration also address the challenge of supporting workers with chronic disease(s) in their return to work, when this is feasible (i.e. they are "able" and have the "capacity" to get back to work) (Securex, 2018).

This context makes Belgium a relevant case study to understand the evolution in return to work policy and practices, even more so given its industrial relations and welfare state regimes. Indeed, Belgium has a strong tradition of a Bismarckian continental welfare system, corporatist arrangements and social pacts as solutions in case of social conflict (Houwing and Vandaele, 2011). The Belgian industrial relations system is characterised by a strong role of social partners, a high but declining union density rate and large collective bargaining coverage. Unions are involved in social security management in what is called the "Ghent system". Dialogue with the state also plays an important role in the social dialogue process.

As part of the REWIR research project, the present report will seek to determine the role that industrial relations play in Belgium at national and company level in designing and implementing return to work policies. The report relies on a multiplicity of data sources and methodologies. As the analytical framework of the REWIR project is based on the concept of actor-centred institutionalism (Scharpf, 1997), the report focuses on the role that stakeholders play in shaping policies. Stakeholders and their perceptions and experiences are at the core of the analysis.

Therefore, this report mostly relies on qualitative data collected via six interviews, two focus groups with federal-level representatives of employers and trade unions (Annex, Table 7) and one roundtable discussion conducted with relevant national stakeholders (Annex, Tables 5 and 6). The report is also based on three small sample size surveys respectively targeted at workers, companies and national social partners (Annex, Tables 1-4). Given the limited representativeness of the survey samples, we triangulated our findings with the above-mentioned qualitative data collected and additional desk research using policy documents, opinions from the National Labour Council and academic literature on the topic.

This report is structured as follows: section 2 outlines the policy framework on return to work in Belgium, including a description of the sickness and invalidity benefit system, and of the provisions supporting rehabilitation for employment. Section 3 evaluates how social partners shape and view policy on return to work at national level, based on the interviews, stakeholder discussion groups and social partner survey performed in the realm of this study. Focusing on return to work at company level and the involvement of social partners, section 4 analyses the results of the worker survey and manager survey implemented for this study. A final section concludes and draws some recommendations regarding return to work in Belgium and the role of social partners.

2. The policy framework on return to work in Belgium

This section analyses the policy framework on rehabilitation and return to work in Belgium. Belgium is classified by EU-OSHA (2016) as part of the group of European countries together with France, Iceland, Italy, Luxembourg, Switzerland and the United Kingdom. They are characterised by well-developed frameworks for rehabilitation and return to work, but with limited coordination between the different stakeholders. Return to work is considered at the end of the sickness absence and with limited possibility of early intervention. Nevertheless, recent policy developments have shifted the Belgian approach towards return to work.

2.1 Sickness and invalidity benefit system

Belgium can be categorised as a mix between a Bismarckian and a Beveridgian welfare regime (SPF Sécurité Sociale, 2018). It has a "pillarised" social security system with separate regimes for salaried workers (sometimes differentiated by blue-collar and white-collar workers), self-employed and civil servants (Pacolet, 2019). Trade unions, mutual insurance providers and employers' organisations co-decide about various aspects of these social security regimes. Each regime has a different framework and coverage regarding sickness, disability insurance and return to work. Different regimes also exist depending on the cause of the illness: if the sick leave is due to an occupational accident or occupational disease, the Federal Agency for Occupational Risks (*FEDRIS*) is responsible. The National Institute for Health and Disability Insurance (*RIVIZ - INAMI - NIHDI*) is the federal institution responsible for non-occupational illness. This report will focus on the schemes coordinated by the NIHDI for salaried workers.

The National Institute for Health and Disability Insurance (NIHDI) is responsible for the coordination of sickness and disability insurance benefits. It also takes decisions on individual cases, such as access to a vocational rehabilitation programme. It works in collaboration with

accredited mutual insurance providers, who act as intermediaries between the NIHDI and the insured. They serve as paying agents on behalf of the NIHDI and as key gatekeepers in the access to sickness and disability benefits (OECD, 2013). Furthermore, social security remains a core federal competence, while sub-federal levels are responsible for employment matters, including activation policies and training. This means that coordination between different policy levels on return to work policies is needed. The federal legislation is implemented in coordination with the Brussels, Flanders and Wallonia regions.

Unlike in most other countries in the Organisation for Economic Co-operation and Development (OECD), sickness and disability benefits in Belgium are integrated into one single system managed by the NIHDI. Work incapacity is divided into two periods: the primary work incapacity (*incapacité de travail primaire/ primaire ongeschiktheid*), corresponding to sickness benefits during the first year of sickness; and the period of invalidity (*invalidité/ invaliditeit*), which corresponds to disability benefits and starts after one year of incapacity.

First, the employee on sick leave receives a guaranteed salary during the first month of sickness absence (or 15 days for blue-collar workers) paid by his or her employer. After the first month and the declaration of incapacity via a medical certificate, the NIHDI takes over the management of the benefits. At the start of the incapacity period, the mutuality doctor proceeds to the determination of the degree of incapacity and the duration. The incapacity benefit covers 60% of the worker's salary, with a maximum annual amount determined according to the starting year of the incapacity. After the seventh month of incapacity, a medical officer carries out a medical evaluation of the beneficiary to check if he or she still fulfils the medical criteria.

After one year of incapacity, the invalidity period is established and prolonged by the Invalidity Medical Council of the NIHDI (*Conseil médical de l'invalidité / Geneeskundige raad voor invaliditeit*) on the basis of a medical report written by the mutuality doctor. The payment of invalidity benefits can continue until retirement age depending on the evolution of the employee's health condition. The amount of the invalidity benefits depends on the family situation and the starting date of the incapacity.

Table 1 below sums up the eligibility and characteristics of the incapacity and invalidity insurance schemes. During the period of incapacity for work, the beneficiary is not allowed to work, unless permission to work part time is granted by the mutuality doctor. Sometimes, a benefit may be refused or reduced if the person receives a supplementary disability allowance. The invalidity period is not interrupted by a return to work of less than three months, in case of relapse. In 2018, incapacity benefits amounted to €1.8 billion and invalidity benefits to €5.8 billion. Between 2013 and 2018, invalidity benefits increased by 7.8% yearly on average (Mutualités Libres based on data from the NIHDI, 2019).

Disabled people with a reduced earning capacity can be eligible for two non-contributory and means-tested disability allowances from the Federal Public Service for Social Security (*SPF Affaires Sociales*), namely income replacement allowance and integration allowance. Unemployment benefits can also be an important source of income for people suffering from chronic diseases and incapacity. The payment of unemployment benefits is organised at federal level by the National Employment Office (*RVA/ONEM*), while regional employment services (*VDAB* in

Flanders, *Actiris* in Brussels and *Forem* in Wallonia) are responsible for job placement and active labour market policies.

Table 1. Eligibility conditions and benefit rates for Belgian sickness and disability insurance scheme for salaried workers on sick leave

Eligibility	**Incapacity benefits**: 180 days of work (paid vacation and sick leave included) during a period of six months prior to obtaining benefits; minimum contributory requirements (obligation to prove a sufficient amount of social contributions); loss of earnings capacity of 66% or more as a result of injuries or functional difficulties. **Invalidity benefit**: depending on a medical examination by the NIHDI medical officer, after one year of receiving incapacity benefits.
Duration	**Incapacity benefits**: first year of absence **Invalidity benefits**: after one year of absence. Depends on the evaluation of the invalidity by the Medical Invalidity Council of the NIHDI on the basis of the advice of the mutuality doctor, as well as on the evolution of the illness.
Source of payment	Contribution-based, paid by the NIHDI.
Level of benefits	**Incapacity benefit:** 60% of previous earnings. **Invalidity benefit:** either 65% (person with dependants), 55% (single person) or 40% (cohabitant) of previous earnings.
Timing of return to work considerations	A formal reintegration procedure can be initiated after one month of absence. The mutuality doctor needs to assess the return to work prospects of the employee within two months of the start of the incapacity.
Procedures to return to work	▪ Informal reintegration (visit to the occupational physician) ▪ Formal reintegration procedure (since 2016) ▪ Vocational rehabilitation ▪ Medical part time ▪ Voluntary work
Type of source of these provisions (e.g. law (dedicated or general), collective agreement, other)	▪ Act of 4 August 1996 on Wellbeing at Work ▪ Law of 3 July 1978 on employment contracts ▪ Anti-discrimination legislation ▪ AMI legislation of 14 July 1994 on obligatory healthcare insurance

Source: own elaboration.

2.2 Provisions for rehabilitation and return to work support

The Belgian incapacity and invalidity benefit system includes several activation and vocational rehabilitation pathways into work. Belgian federal and regional governments have focused over the last years on increasing fitness for work among long-term ill workers and improving the incentive structure to return to work.

The policy framework on return to work applies to several legislative areas, including legislation on social security, labour market regulations, wellbeing at work and disability (CNT, 2015). It is mainly part of the wellbeing at work legislation (*Code du bien-être au travail du 4 Août 1996*). The Act on Wellbeing at Work replaced the concept of health and safety at work with the broader concept of wellbeing at work, with the intent to cover all aspects of the work environment and promote a multidisciplinary approach to prevention. It puts the legal obligation on the employer to take all necessary measures to protect the wellbeing of their employees, such as risk assessments and medical check-ups conducted by external or internal prevention services (or *Preventiedienst*). The act has been successively reformed over the past 20 years. In addition, the Law of 3 July 1978 on employment contracts includes important provisions on the consequences of work incapacity, partial return to work and permanent work incapacity on the employment contract. The Law on compulsory healthcare and indemnity insurance of 14 July 1994 also includes provisions on invalidity and incapacity benefits, which can impact return to work. Finally, the Anti-discrimination Law encourages the employer to proceed to reasonable accommodations for a disabled worker as advised by the occupational doctor. It also forbids any employment-related discrimination due to health or disability status.

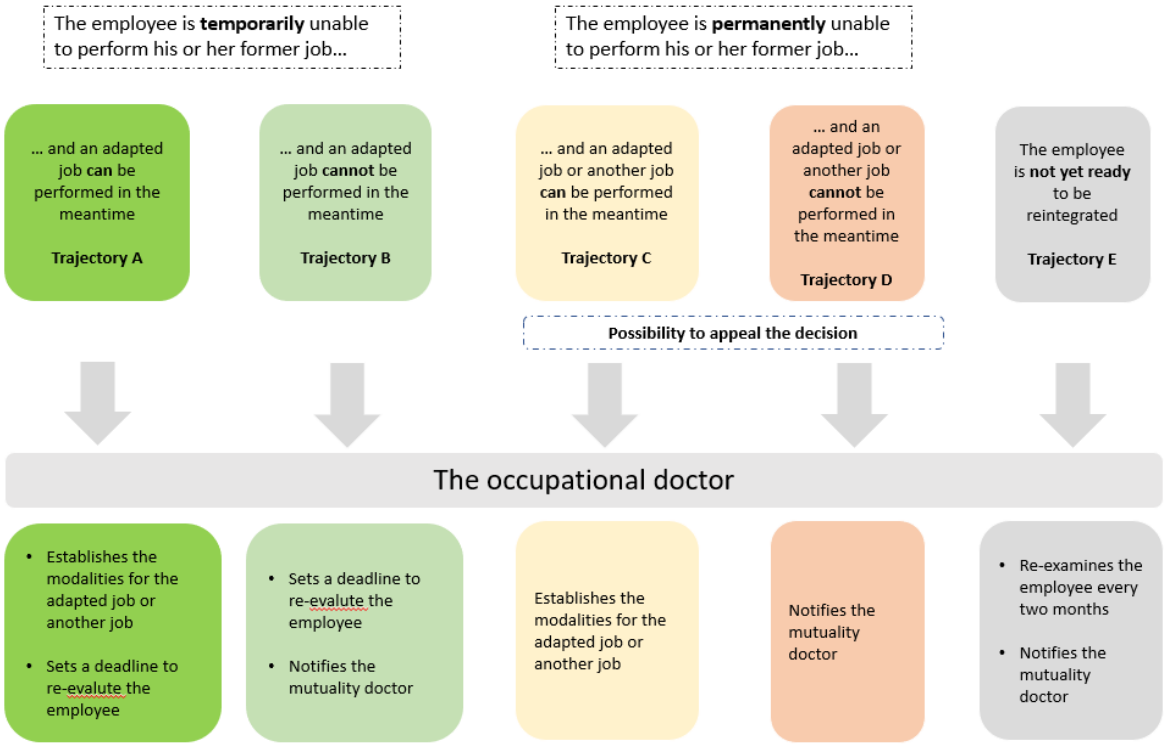
Returning to work gradually while keeping partial invalidity or incapacity benefits has been possible since 1996. The mutuality doctor must first authorise a medical part-time status or adjustments to the workload (Mutualités Libres, 2019a). This depends on two conditions: that the incapacity remains at least 50% and that the job does not jeopardise the person's health. The mutuality doctor also decides about the intensity and duration of part-time work. Part-time work can be less or more than 50%, as long as the incapacity remains at least 50% in medical terms. If an improvement in the health situation is envisaged, the hours and days worked may be gradually increased over time until the beneficiary is ready for regular or full working time. Adjustments can be related to working hours (longer breaks, shorter week, fewer hours per day), work organisation (telework, slower workpace, change in tasks), workspace and equipment, and specific training, as well as support by a coach, colleague or line manager. The medical part-time option was rarely used in the past (OECD, 2013): in 2014, 35,989 authorisations for partial return to work were granted. This number rose to 54,526 in 2017 (Mutualités Libres based on NIHDI numbers, 2019b). Benefits are adjusted according to the number of hours worked in a week, and decrease if the person works more than 20% of the normal weekly working time. Before the reform of the calculation method in 2018, benefits used to be calculated according to the amount of the part-time income. Trade unions criticised this reform as it was estimated to negatively impact low-paid workers. To accommodate for this effect of the reform, a gradual compensation measure was implemented for people negatively impacted by the reform.

A new formal reintegration procedure (*trajet de reintegration /re-integratietraject*) was implemented in 2016 as a new chapter to the 1996 Act on Wellbeing at Work.[4] Informal dispositions for return to work existed before this reform, such as the voluntary medical visit (*visite de pré-reprise du travail / bezoek voorafgaand aan de werkhervatting*) with the occupational doctor implemented in 2004, or the mandatory return to work examination for workers under mandatory medical surveillance (SPF Emploi, 2018). The 2016 legislation added a formal procedure for reintegration, requiring mutuality doctors to assess the reintegration possibilities within the first two months of sickness absence. Beyond systematising early intervention and individual case management, its aim is also to provide a series of steps to follow for voluntary, gradual and adapted return to work. Its goal is to increase the chances of successful reintegration by reintegrating workers with an employment contract within the same company, so that he or she can come back to a familiar environment. It outlines the sharing of responsibilities between the main stakeholders on a practical level, and foresees a collective framework for reintegration to be developed at company level, for example by health and safety committees (*Comité pour la prévention et la protection au travail / Comité voor Preventie en Bescherming op het Werk*). It also seeks to turn mutualities into more active gatekeepers regarding the control of access to incapacity and invalidity benefits. Since 2006, the professional integration of sick workers had been the legal responsibility of the mutuality doctors, but the approach remained very medically oriented with little attention to the employment aspect. Mutualities used to have a passive role without a strong focus on sickness management or return to work (OECD, 2013). The reform was thus aimed at ensuring a better use of activation measures, strengthening sickness monitoring and the mutualities' management obligations. It also strengthened the dialogue and cooperation between the mutuality doctor and the company's occupational doctor. Plus, it clarified the cases in which an employment contract could be terminated due to "medical force majeure", which can now be invoked only if the employee has gone through a formal reintegration procedure. Figure 1 below gives an overview of options included in the reintegration procedure and their consequences (SPF Emploi, 2018). The procedure is described in more detail in Annex 2. In 2016, 4,801 formal reintegration procedures were initiated, and 5,015 in 2017 (Mutualités Libres based on NIHDI numbers, 2019b).

Vocational rehabilitation (*réinsertion ou réhabilitation socio-professionnelle / socioprofessionele re-integratie*) also exists in the Belgian system for workers declared unfit to return to their former company, as well as for unemployed or self-employed workers (Mutualités Libres, 2019a). It enables the individual to attend a training or rehabilitation programme to update or acquire new skills, and is part of the sickness-invalidity insurance legislation. Financial incentives are attached to this procedure: since July 2009, the costs associated with the training (registration, materials, public transport, etc.) have been covered by the NIHDI. Participants continue to receive their benefits and are paid €1 for each hour of training plus a lump-sum payment of €500 at the end of the training (this amount has been recently been doubled to increase incentives).

[4] Royal Decree of 20 December 2016 amending the Royal Decree of 28 May 2003.

Figure 1. Formal reintegration procedures and their consequences



Source: SPF Emploi, 2018

However, participants can lose their entitlement to disability benefits within six months of the training, which can act as a disincentive. Plus, in 2018 the federal government introduced in its Job Deal (*Deal pour l'Emploi*) the right to an outplacement (training) of up to €1,800 paid by the employer, in cases where the latter invokes the medical *force majeure* to end the employment contract.

Vocational rehabilitation (*réinsertion ou réhabilitation socio-professionnelle / socioprofessionele re-integratie*) is targeted at workers declared unfit to return to their former company, as well as at unemployed or self-employed workers (Mutualités Libres, 2019a). It enables the individual to attend a training or rehabilitation programme to update or acquire new skills. The NIHDI cooperates with several regional public employment services on this matter, as they are responsible for labour market activation policies and training. Regional agencies specialised in vocational rehabilitation for disabled workers (GTB, PHARE, AViQ) are also involved. Financial incentives are attached to this procedure: participation fees are covered by the NIHDI and participants receive lump-sum payment of €500 at the end of the training. However, participants can lose their entitlement to disability benefits within six months of the training, which can act as a disincentive. Plus, in 2018 the federal government introduced in its Job Deal (*Deal pour l'Emploi / Arbeidsdeal*) the right to an outplacement (training) of up to €1,800 paid by the employer, in cases where the latter invokes the medical *force majeure* to end the employment contract.

Financial and technical support is available for employers at regional level if the employee's permanent functional limitations are recognised (e.g. *Vlaamse ondersteuningspremie* in Flanders ; SPF Emploi, 2018). Regional financial support also includes adjustments to the work environment, coverage of work and living expenses, paid interpreters in the case of hearing impairment and a mentoring premium for companies offering mentoring support to a returning disabled worker. Finally, in 2014 the NIHDI created a training course for "disability managers", subsidised by the state and paid by the company, to support the return to work process at company level (NIHDI, 2019). It is based on the disability management methodology aimed at maintaining employment and quick and adapted return to work. Additionally, the NIHDI also runs pilot programmes, such as the Individual Placement and Support (IPS) programme for people suffering from mental health issues. It follows the "place-then-train" model and consists of providing early and continuous support to return to work, including after the start of the job. Depending on the results of the pilot programme, this model could be implemented as an alternative to the existing rehabilitation schemes.

3. Involvement of social partners in shaping return to work policy at national level

3.1 Industrial relations structures and return to work policy

Belgium is characterised by a strong social dialogue tradition involving established industrial relations structures and actors.[5] The country has a relatively high unionisation rate amounting to more than 50%, and collective bargaining covers approximately 90% of employees. At the national level, workers are mainly represented by three large trade union confederations: Confederation of Christian Trade Unions (*ACV/CSC*), General Federation of Belgian Labour (*FGTB/ABVV*) and Confederation of Liberal Trade Unions Belgium (*CGSLB/ACLVB*). On the employer side, the main national employers' association is the Federation of Belgian Enterprises (FEB/VBO). In addition to this, craft and trade sector employers, self-employed and small and medium enterprises are represented by *UNIZO* in the Flemish-speaking region and *UCM* in the French-speaking region. The membership rate of employers' organisations in Belgium is above 80% (ETUI, 2016).

National social dialogue takes places within thematic advisory bodies: the National Labour Council (*Conseil National du Travail / Nationale Arbeidsraad*), the Central Council of the Economy (*Conseil Central de l'Economie / Centrale Raad voor het Bedrijfsleven*), and the High Council for Prevention and Protection at Work (*Conseil Supérieur pour la Prévention et la Protection au Travail / Hoge Raad voor Preventie en Bescherming op het Werk*), which is an advisory body focused on matters related to wellbeing at work legislation (ETUI, 2016). The National Labour Council (NLC) has a cross-sectoral remit extending to the whole of Belgium, covering all companies and sectors. Its

[5] For a brief overview of the industrial relations system in Belgium, see www.worker-participation.eu/National-Industrial-Relations/Countries/Belgium/Trade-Unions provided by the European Trade Union Institute (ETUI) (last update in 2016).

composition is divided equally between representatives of the main employers' associations and trade unions. Its principal functions are to provide advice and deliver opinions to a minister or the two chambers of the legislature (upon request or on its own initiative) on general issues of a social nature. It also provides a platform for collective bargaining agreements and performs an important role of policy evaluation.

Since the beginning of the 2010s, the NLC has been working on the topic of return to work. It holds the coordination role of the "Platform for consultation between actors involved in the process of voluntary return to work of people with health problems" (CNT, 2015). This platform on return to work was set up as a structural consultation framework bringing together the social partners (NLC) and the other institutions (NIHDI, Ministry of Labour, Federal Agency for Occupational Risks - Fedris) involved in the process of voluntary return to work. Its goal was to develop an integrated approach to return to work after an illness, taking into account social security aspects as well as employment and health and safety issues, gathering all institutions involved in the issue. As regards the government, the Ministry of Labour and the Ministry of Social Affairs have been involved in the issue of return to work and prepared jointly the Royal Decree of 2016 on the new reintegration procedure. Government representatives stressed the key importance of discussion and negotiation with social partners in preparing the legislation at federal level.

As mentioned in the introduction, part of the data collection of REWIR involves national social partners across the EU gathering information on their involvement in return to work policies in their respective countries. The main characteristics of the respondents to the REWIR social partner survey in Belgium are summarised in Annex 1, Table 4. In the following text, some key findings from this survey are reported alongside the information gathered during stakeholder discussion groups and semi-structured interviews.[6]

The information gathered from these various sources provides a variety of views and involvement of different industrial relation actors on return to work policy in Belgium. The majority of the social partner survey respondents also stated that they were aware of national policies and measures that facilitate return to work after sickness absence. It was also highlighted that the main regulatory framework in return to work in Belgium does not specifically focus on workers experiencing a chronic disease, but more generally on those workers who have been long-term absent from work for medical reasons generally, which might be due to a chronic disease, but can also include other factors.

One result that emerged from various discussion groups with stakeholders was that the focus of social partners was mainly on prevention when it came to health-related issues in the workplace. Since the start of the consultation platform organised by the NLC, the topic of return to work has been rather high on the trade unions' agendas. This was accentuated when social partners

[6] We acknowledge the limitation of drawing general conclusions about the perspectives of social partners in Belgium based on the online social partner survey due to its relatively small sample size. To compensate for this, additional information has been gathered through literature review, a roundtable event and stakeholder discussion groups involving key stakeholders on return to work in Belgium.

noticed the adverse social consequences of the 2016 reform, notably the sharp increase in contract terminations due to medical *force majeure* (CNT, 2018c). However, it is still taking time for social partners to fully incorporate this topic into their programmes. According to results from the social partner survey for Belgium, nearly two thirds of social partners had only marginal and *ad hoc* involvement in return to work policy making or policy implementation, but would like to have more active involvement. The results from the survey additionally suggest that the initiative to come up with a return to work policy was taken by other bodies (rather than social partners themselves) such as the government.

Against this short background, and as previously mentioned in section 2 of this report, it is important to note that other actors at national level play a key role in shaping return to work policy, such as the National Institute for Health and Disability Insurance (NIHDI), the National Employment Office (RVA/ONEM), mutual insurance providers, regional employment agencies, and occupational physicians and academics, who are currently finishing an evaluation of the return to work legislation.[7] Patient organisations are also important stakeholders in return to work, as they advocate for patient rights and inform patients about the various options and legal tools at the workplace after their disease. These organisations try to engage with social partners and the government to raise awareness, as well as talking to employers to inform them about the possibilities for reasonable adjustment at the workplace. They are also occasionally consulted by the government.

Company-level industrial relations structures also matter substantially in facilitating the implementation of national legislation at the more disaggregate level via their members, as discussed in detail in section 4 of this report. They serve as the intermediaries between high-level decision-making bodies and the regions and companies where the policies are implemented. A key role for national social partners is therefore to inform and support their local members in understanding how the new procedure works, for example via study days and training courses or booklets (CSC, 2019; FGTB, 2019). Equally, they are responsible for collecting the issues observed at the local level and raising them for discussion and negotiation at national level. This important bottom-up function follows the pyramidal structure of trade unions: local branches are in contact with company-level union members and run regional offices of social rights (*Office régionale de droits sociaux)* to provide legal and strategic support to workers facing problems with their employers. Information and complaints can be then channelled to the sectoral level and at cross-industry level. Regional stakeholders share information with national stakeholders, which enables them to negotiate on legitimate grounds.

[7] For more information on the evaluation conducted by researchers from KU-Leuven and ULB: https://emploi.belgique.be/fr/projets-de-recherche/2018-evaluation-de-limpact-de-la-nouvelle-reglementation-sur-la-reintegration.

3.2 Interactions between industrial relations actors and other stakeholders in return to work policy

The nature of interactions between key industrial relations actors is generally reported as cooperative, and discussions tend to be constructive on return to work policy. All of the opinions issued by the NLC have been unanimous, which shows the social partners' willingness to display a "united front" and give strength to their recommendations to influence the government. They especially agree on the need to ensure that reintegration is a voluntary process and happens early, to change mindsets on reintegration and to give a key role to the occupational physician in the reintegration process. However, there have been several instances of disagreement between social partners. One example involved the financial responsibility that the employer should carry, as trade unions asked for the latter to cover the salary for the two first months of sick leave. Employers opposed this proposition as this measure would place small and medium-sized enterprises (SMEs) in a difficult situation.

There has also been some disagreement between social partners and the government. Dissensions intensified after the disclosure of figures on the increase in contract terminations due to medical *force majeure*. Trade unions condemned these adverse social consequences in the media and the issue became increasingly debated in the public sphere. Social partners also regret that none of their recommendations have been implemented, which is partly related to the political stalemate that Belgium encountered until the formation of the De Croo government in September 2020. Before then, the government was mainly in charge of current affairs (*Gouvermenent d'affaires courantes / Regering in lopende zaken*) with limited competences in diverse policy areas. Another bone of contention was the government's draft legislative proposal in May 2018, which planned to add financial sanctions in case employers and employees failed to fulfil their responsibilities regarding the new reintegration procedure. The proposal was strongly rejected by the NLC (CNT, 2018b). The NLC also criticised the introduction of a new general compensation measure for employees declared unfit to get back to their former job as part of the Job Deal in 2018. This measure was seen as not individualised enough and lacking tailored support from regional employment services (CNT, 2018d).

Interactions on return to work in Belgium can become complex due to Belgium's multilevel governance. Return to work policy cuts across policy areas assigned either to the federal level (social security) or the regional level (active labour market policy), which can make the design of comprehensive policy common framework challenging. One of the key results emerging from data collection was to the need to increase cooperation among various stakeholders to facilitate the implementation of the legislation on return to work after an illness.

3.3 Outcomes of social dialogue regarding return to work policy

One of the main outcomes of social dialogue on return to work at national level was the key role played by the NLC in supporting the overhaul of the legislation on the matter via the Platform on return to work. The overhaul of the policy framework originated around 2010, when the NIHDI put the issue of return to work on the agenda following the sharp increase in long-term sickness

insurance beneficiaries. It called for a more active approach towards workers on sick leave who are able to perform some professional activity, as it would be beneficial for their recovery prospects and for the sustainability of the Belgian social security system. In 2015 the NLC published a report on the results of this consultation, laying some basic principles for the legislation: the need for collective reintegration, concrete incentives, voluntary procedure, clarification on the use of medical *force majeure*, and the key role of the occupational doctor. These discussions and agreements were later adopted as part of the Royal Decree in 2016.[8] By consulting experts and civil society stakeholders during its evaluation of the legislation, the NLC also gathered relevant information on return to work policy and potential gaps that needed to be addressed. However, it is unclear whether and how the legislation will be modified following the 2018 evaluation from the NLC and the evaluation performed by a group of academics[9].

Some stakeholders interviewed for this project highlighted that beyond influencing legislation, Belgian social partners could do more on the topic of return to work, such as issuing common practical guidelines for health and safety committees, employers and union delegates on how to implement a company-level reintegration policy. Social partners could also work at cross-sectoral or sectoral levels on collective bargaining agreements specifically on return to work, which has not been the case so far. Outcomes of social dialogue at sectoral level are more difficult to determine. Sectors follow diverging approaches on return to work as they face different prospects in finding adjustments in terms of tasks for workers suffering from chronic conditions. In this respect, the availability of diverse tasks within a sector seems to be a facilitator for return to work. For instance, firms in the construction sector tend to have well-established procedures for return to work and potential for adjustment in task allocation. In this sector, progressive reintegration into the workplace is possible, for example by allocating fewer physically demanding tasks to the worker returning to work after a sickness absence. Other sectors face difficulties in proceeding to reasonable accommodations, such as the Belgian service voucher sector (including cleaning and homecare services) which is characterised by a high incidence of musculoskeletal diseases. Trade union representatives in this sector have tried to react to the negative consequences of the reintegration procedure by putting the issue on the sectoral negotiation agenda.

3.4 Views of industrial relations actors on the policy framework on return to work

As mentioned previously, it was confirmed by a number of stakeholders that return to work after a chronic disease is a salient issue in Belgium. Most stakeholders interviewed welcomed the creation of a clear formal reintegration procedure and tended to agree that action was needed in the face of high prevalence of chronic diseases, long-term sickness absence and rising expenditures linked to sickness and disability benefits. However, there is a consensus that a more

[8] For more details on the Royal Decree, see the legal documentation (in French): www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=2016102808&table_name=loi

[9] For more information on the evaluation conducted by researchers from KU-Leuven and ULB: https://emploi.belgique.be/fr/projets-de-recherche/2018-evaluation-de-limpact-de-la-nouvelle-reglementation-sur-la-reintegration.

thorough *ex-ante* impact assessment should have been conducted and that the procedure should be revised.

Trade unions and employers share the view that informal procedures are a more efficient and flexible approach to reintegration, where the occupational doctor can give advice instead of making binding decisions. Informal procedures allow for a case-by-case approach, taking into account sectoral and company-level considerations, as well as those specific to the worker's health and preferences. Formal procedures tend to be depicted as instruments of last resort if all other informal options have been explored, or if there is a conflict between the employee and the employer. Indeed, employers criticise the reintegration procedure for being too cumbersome in terms of administration, as well as too formalistic and slow. Social partners also underline the primary importance of prevention, which should be prioritised in company-level social dialogue to prevent mental and musculoskeletal illnesses.

Another common criticism relates to the fact that formal reintegration procedures lead too often to a contract termination due to medical reasons, which can result from the occupational physician's decision C or D as designed in the legislation. This criticism is particularly shared by trade union representatives, who describe the legislation as having been drafted too hastily and without reflection on the potential unforeseen impacts of the procedure on contract termination. Group discussions conducted in the realm of this project showed that trade unions are now advising their members against engaging in the formal procedure, as the risk of dismissal is very high. This aspect was also mentioned in a unanimous opinion issued by the NLC (2018b), which underlined the regrettable human and social consequences of the use of medical *force majeure* to end a contract following the decision of the occupational physician. In general, social partners underline that the procedure suffers from a bad reputation among labour market stakeholders, and that the latter need to focus more on making the most of the remaining capabilities of returning employees when implementing the procedure. The data available in 2018 (CNT, 2018c) showed that the large majority of decisions taken by occupational doctors were decisions D (68%), i.e. the worker is definitively unfit to work in the same company. There is no systematic support provided to this type of worker, and little is known on their situation after the dismissal. Support measures and procedures exist for them, such as initiatives by the NIHDI and regional employment services, but social partners underline the need for a coordinated and systematic approach to raise public awareness on this aspect.

The lack of public and reliable data on return to work after an illness is also criticised by social partners, as it renders the evaluation of the new policy more difficult (CNT, 2018c). No federal institution is responsible for gathering the results of the reintegration procedure. More importantly, there is no data on the situation of former employees who have been dismissed for medical reasons following a decision D. The lack of consistent data also hampers the analysis of the situation of employees who were reintegrated into their company, for example regarding adaptations in terms of workload, working time and tasks.

Various stakeholders emphasise that the public debate tends to be too focused on the idea of sanctions and assigning responsibilities, and not enough on incentivising employers and

employees to actively engage in reintegration. Stakeholders also regret the absence of support mechanisms to accompany the stakeholders or guide them along the return to work process, including inside the firm. This is one of the common points raised by representatives of both the trade unions and employers' organisations. The cost of reintegration procedures can be a burden on firms and employers, especially SMEs, which are often not aware of the financial support available to them or of the specificities of the regulation. As a result, budgets dedicated to reintegration often draw on the budget allocated to prevention. Plus, SMEs often do not have the human resources to implement a reintegration procedure and reorganise the team if the returning employee is on medical part time. Another issue highlighted by trade unions is that employers are not strongly incentivised to invest in prevention or create opportunities for adapted work in the company, given the short duration of the guaranteed salary period. One avenue suggested by social partners is to revise the legislation with provisions specific to SMEs and to provide them with further support to implement reasonable accommodations.

Social partners in the NLC agree on several recommendations for modification (CNT, 2018c). They argue for more consultation with stakeholders before the occupational physician takes a decision C or D (i.e. permanent unfitness) and for support from a trade union delegate or representative of the company's health and safety committee during the procedure. Social partners also ask to change the timing of the procedure, as it currently leaves either too much or too little time for dialogue and consultation. The occupational physician should also underline more the remaining capabilities of the employee in the work ability assessment. The period allocated to appeal against the decision of the physician is considered too short, and the time that the employer has to prepare the reintegration is seen as too long (it now amounts to 12 months). Social partners and patient organisations also stress the lack of centralised access to information for employers and employees, arguing that a central website with all the information on how to get back to work and the type of allowances available would be helpful.

The need to enhance cooperation between doctors was strongly pointed out. Multiple doctors are involved in treating the medical file of a worker, including the occupational physician, the medical officer of the mutual insurance provider and the general practitioner (GP) following the worker privately. In most cases, decisions on the fitness of the worker to go back to work are not coordinated among these doctors due to confidentiality reasons and data sharing constraints. The GPs are not involved in the procedure and tend not to refer patients to occupational health physicians if they think that their job or workplace has contributed to their health disorder or sickness absence. Plus, despite their crucial role, occupational doctors are depicted as overburdened and disapproving of the very limited and binding range of options they have to choose from. Therefore, social partners asked for the creation of a digital tool that could help data sharing and coordinated follow-up between the different health professionals and institutions involved in the reintegration process. In parallel, pilot projects, such as the TRIO project, have been implemented by professional medical associations to address this lack of multidisciplinary collaboration between the three professions, by organising common training events and dialogue (Lenoir, 2017).

Finally, the industrial relations stakeholders interviewed stressed the need for a cultural change to avoid the stigma around return to work. There is a growing consensus that working after a disease can be good for the health of the worker and can prevent social exclusion. This requires a shift in mindset regarding the remaining abilities of a chronically ill employee, and how to build on those abilities. However, the lack of willingness or possibility to adapt a job/occupation, and the feeling of being demoted can hamper a smooth return to work. Therefore, social partners – via the NLC – underlined that the "Disability Case Manager" training organised by the NIHDI should be more widely promoted among firms (CNT, 2018c). This would help raise awareness among HR services and staff about good practices regarding absenteeism and return to work.

4. The return to work process at company level and the involvement of social partners

4.1 Workers' experiences of the return to work process at company level

Having described the policy context on the topic of return to work after chronic illness in Belgium, as well as the involvement of social partners in shaping policy at national level, we now complement this information with an analysis of return to work processes in Belgium at company level. As detailed previously, part of the data collection for the REWIR project consisted of national company and worker surveys, in order to gather qualitative information on return to work at company level in Belgium and the involvement of industrial relations actors. In the following section, information from the two surveys is gathered and analysed.[10] In addition, the data is complemented by information from the national interviews and stakeholder discussion groups where relevant. Summary tables on the sample composition of the two surveys can be found in the Annex, Tables 2 and 3.

We first turn to the perspective of workers on returning to work after a chronic disease. The majority of workers in the sample had already returned to work at the time of data collection, though a minority were due to undergo their treatment after a recent diagnosis.[11] Of the workers that had already returned to work, 59% stated that this was upon their own initiative. The vast majority of workers also stated that they had concerns about returning to work. These included potential lack of employer support if productivity or concentration did not fully meet manager expectations, unwillingness of the employer to adjust the working conditions post-illness, and an expectation to work long hours and continue as they had done previously immediately upon returning to work.

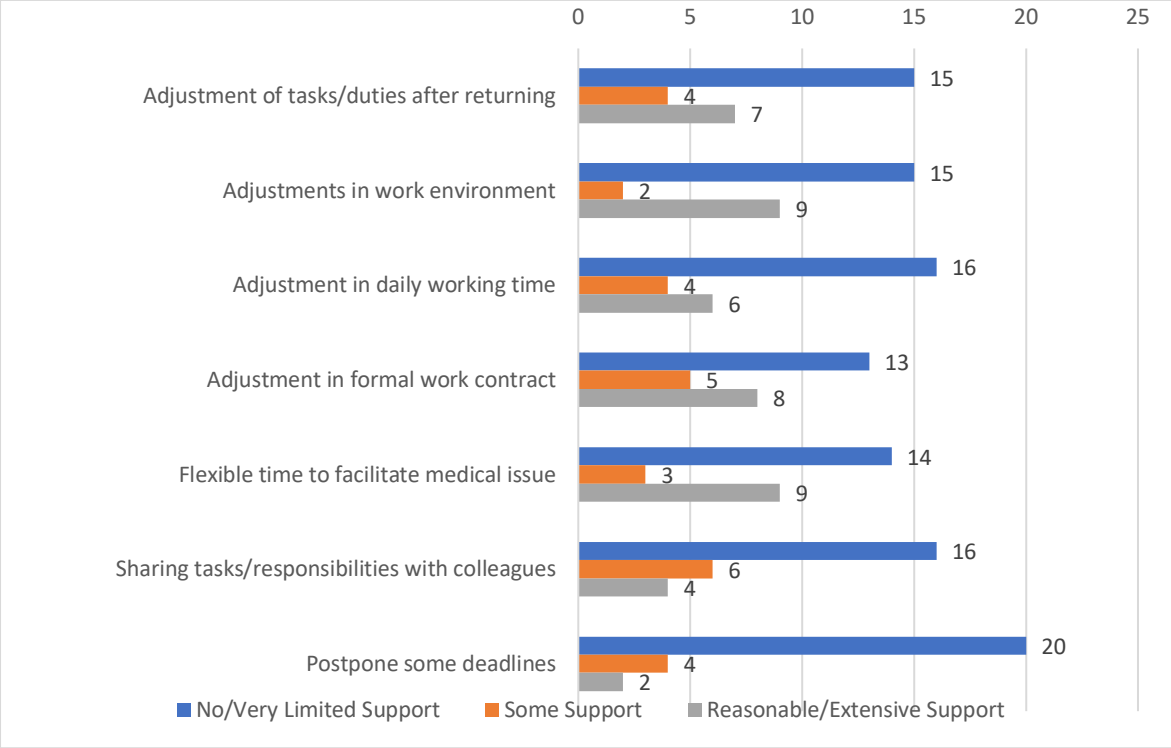
Two thirds of the workers surveyed stated that, at least initially, they returned to the same job. As Figure 2 demonstrates, the majority of workers received little adjustment upon returning to

[10] As with the social partner survey, it is important to highlight that the results of the worker and company survey cannot be regarded as representative, given the small sample size and non-random sampling techniques. Rather, the aim is to supplement the previous results with additional qualitative information.

[11] Questions addressed only to workers yet to undergo treatment are not addressed here due to a very small sample size of 10 responses.

their jobs. Most common were adjustments in daily working time and flexible time to facilitate medical issues, but only about a third of workers received reasonable or extensive support in this. Adjustments in tasks, the work environment or the formal work contract were also rare, and the sharing of tasks with colleagues or the postponement of deadlines even more so.

Figure 2. Adjustments offered to workers when returning to work after a long-term illness



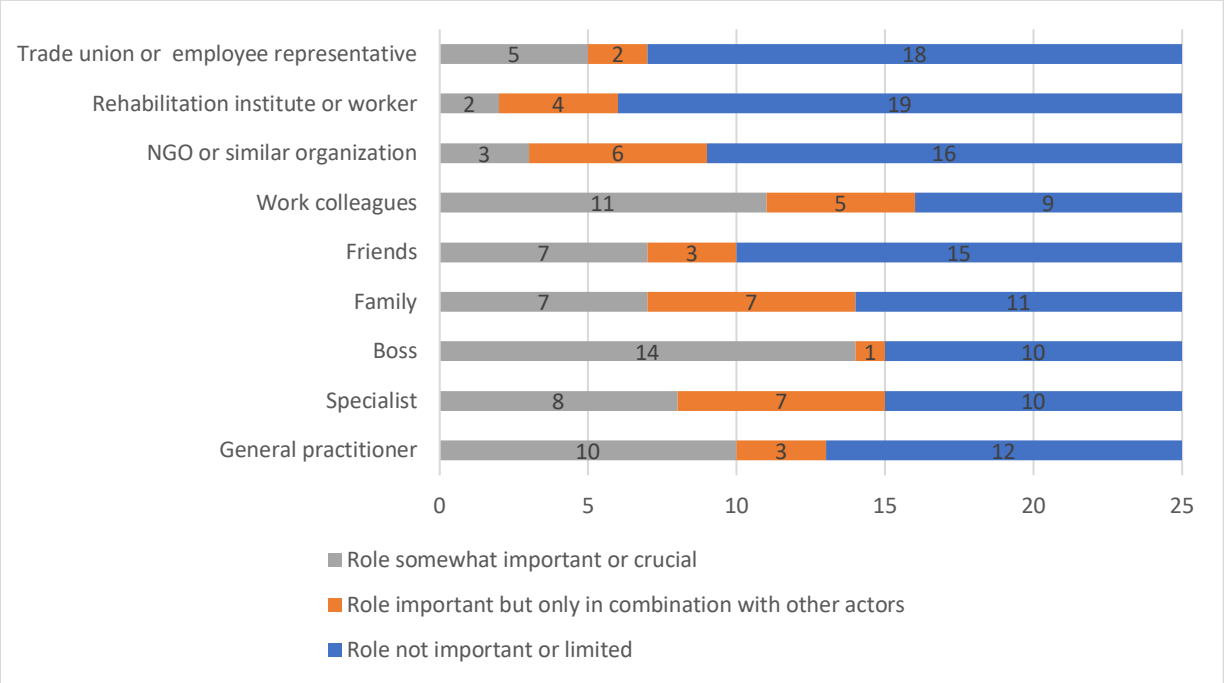
Source: REWIR worker survey, own calculations. Number of respondents: 26.

The results from interviews and stakeholder discussions present a mixed picture as regards the role of trade unions in facilitating return to work at company level. While trade union representatives emphasised the central role of local trade union representatives, respondents from other organisations, including employer organisations, stated that the role of trade unions at company level was rather weak, and that return to work was more of an individual rather than collective issue. Indeed, the survey results indicate that trade union delegates play a limited role in facilitating return to work at company level. More than half of the survey respondents were trade union members, and almost two thirds stated that they had access to a trade union or other employee representative at their workplace. Nevertheless, workers were generally not satisfied with the support offered by trade unions in their return to work process. Only one in five respondents received the expected advice or better from their trade union.

Accordingly, as Figure 3 shows, trade union representatives were generally not regarded as important in the return to work process. The vast majority of respondents evaluated the role of trade union representatives as not important or very limited. One explanation for the limited role of unions, emerging from the group discussions, is that personal health matters are seen as too

sensitive to be handled through social dialogue, and local delegates often do not have access to information on employees struggling with return to work issues unless directly approached, given both confidentiality and the fact that the employer has no obligation to communicate with union delegates. The actors that were generally regarded by workers as being the most significant were their boss and work colleagues, as well as, to some extent, their GP and family.

Figure 3. Workers' evaluation of the role of different actors in facilitating return to work after sick leave



Source: REWIR worker survey, own calculations. Number of respondents: 25.

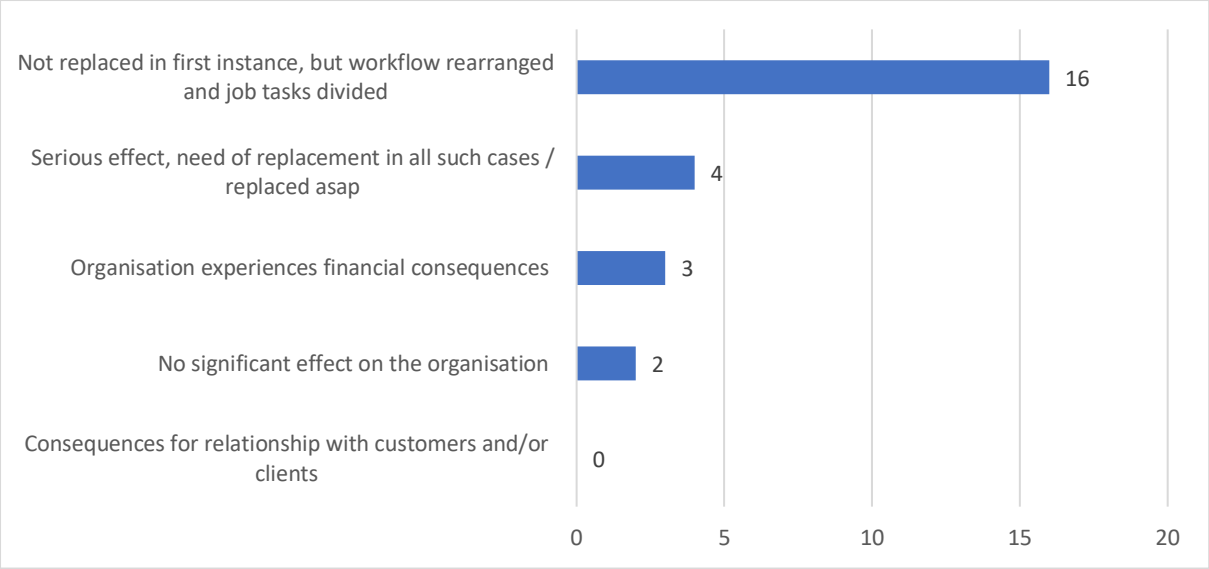
The survey respondents were also asked to share additional information on their return to work process. Their comments reflect the results presented above. Although some employees had positive experiences, the majority expressed that they felt left alone in the return to work process, with a lack of support from their employer, but also from the trade union. Some also expressed frustration with the regulation that governs the return to work process. Ultimately, several employees reported leaving or changing their job after their return to work.

4.2 Perspectives of company actors on the return to work process at company level

Looking at the perspective of companies on the return to work process, in most cases companies did indicate that an employee absence has an effect on their organisation (Figure 4). In particular, the worker is not replaced in the first instance, but workflow has to be rearranged and job tasks divided between other employees. As underlined during interviews, such adjustments are especially difficult for SMEs, which lack capacity to redirect workflow. During the return to work process, companies consider certain resources as helpful, specifically legal advice during sick leave and external counselling from doctors or therapists, as well as professional associations. It

was stated that such external counselling, information on workplace adjustments and guidance on financial strategies in dealing with sick leave absences are lacking.

Figure 4. Perceived effect of an employee absence on the organisation



Note: Multiple answers possible.
Source: REWIR manager survey, own calculations. Number of respondents: 20.

Respondents to interviews and participants in group discussions strongly emphasised that Belgian work culture and continuing stigma around workers with chronic disease influenced their ability to return to work successfully, and that many employers were unwilling to adjust tasks for employees returning to work. However, this is not reflected in the results from the company survey. In general, survey respondents did not perceive workers to be less committed after being diagnosed with a chronic disease. Nevertheless, a colleague returning to work on reduced duties will increase the workload of colleagues. The majority of respondents disagreed that workers should have a phased return to work on full pay (60%) or that they should have more time off than the legislation currently stipulates (45%). However, it was also stated that workers should be entitled to adjusted working duties at the organisation's discretion (70%) or even as a legal entitlement (55%). Finally, the vast majority of respondents agreed that staying in touch with an employee during their absence was important, and most also thought that returning to work during treatment should be encouraged if possible.

Turning to the perception of trade unions, in 90% of organisations there was some form of employee representation. While return to work was addressed in company level collective agreements only in a minority of companies (20%), 60% of respondents confirmed that they consulted on their organisation's return to work issues with trade unions or employee representatives. In the majority of cases, these interactions were of a regular nature, and a trade union representative was part of a health and safety committee that discussed return to work. While 60% of companies see no challenges in interacting with trade unions, there was little support for the suggestion that they would rather interact with trade union representatives than

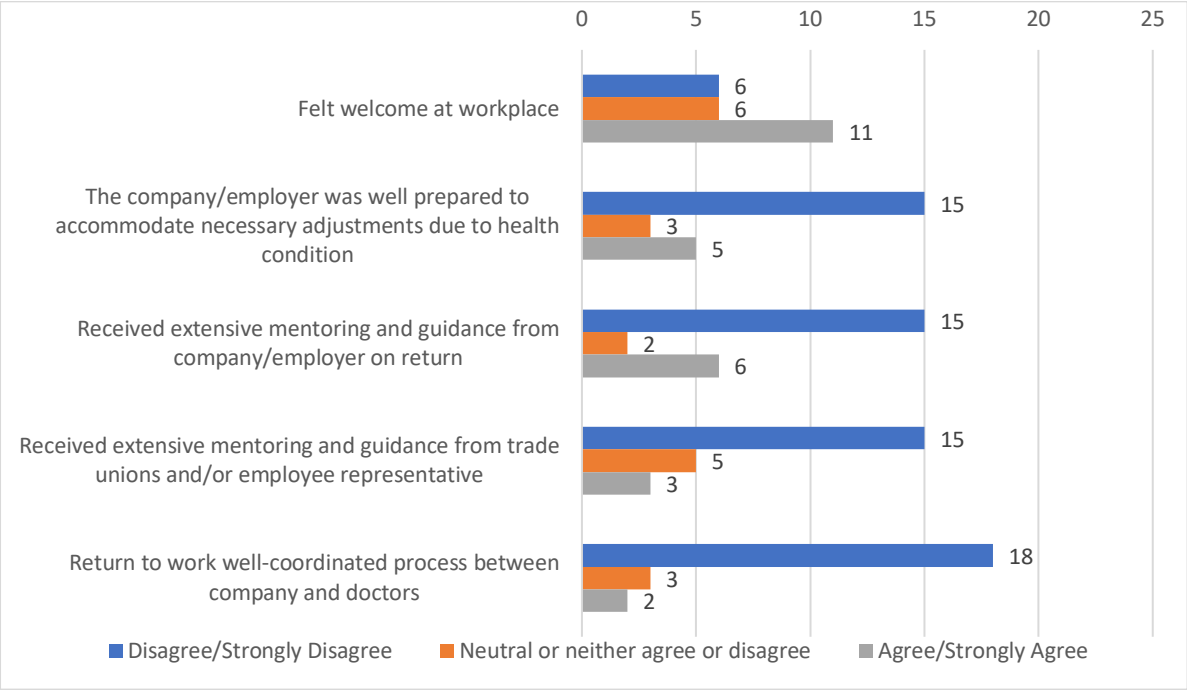
with other employee representatives. Beneficial outcomes from interaction with trade unions that were highlighted included agreements on specific return to work provisions in binding collective agreements, informal agreements and training sessions for managers or team leaders on dealing with employees returning to work.

4.3 Interactions between employer and employee in facilitating return to work

From a worker's perspective, it seems that the experience of the return to work process is quite individualised and not much is coordinated at company level. Most employees declared that adjustments in their tasks or responsibilities were not negotiated between their trade union or employee representatives and their employer. Therefore, negotiations did not seem to play an important role in the return to work process. Employees still under treatment were finding support from either their boss, their team leader or line manager, or a patient organisation.

Regarding interaction with between employers and employees, the return to work process did not seem very coordinated. Employees were rather critical of the coordination between health professionals and employers, as well of the preparedness of their company regarding reasonable accommodations upon their return. Half of the employees surveyed felt welcomed at their workplace, and only a few respondents declared having received guidance and mentoring from their employer or their trade union during their return to work. As found in the interviews and stakeholder group discussions, while procedures exist at company level they are often not well implemented and can be difficult to understand for the worker. In addition, the creation of a welcoming social environment in the company, while crucial, can be challenging, particularly as colleagues might be sceptical of reintegration given that it will increase the burden on them.

Figure 5. Workers' experience with the return to work process



Source: REWIR worker survey, own calculations. Number of respondents: 23.

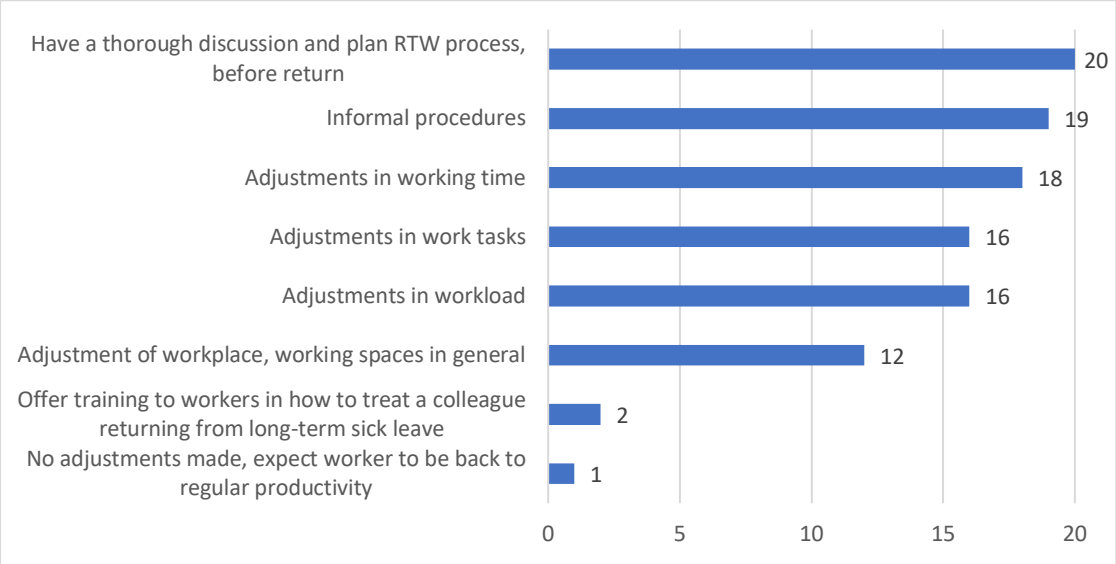
On the other side, most managers declared that they had regular interactions with workers on sick leave (70%) and in an informal setting, i.e. via phone calls, friendly conversations or indirect information via colleagues (77%). Similarly, the qualitative data strongly emphasises the importance of informally keeping in touch in facilitating return to work, though employers had to be careful not to give the impression of "harassing" their employee. Reflecting this, the majority declared that they did not involve their workers in work-related issues, and only half of respondents kept the worker informed about issues such as work decisions and planning. Most returns to work were initiated by the employees themselves: only 14% of respondents declared that they initiated the return.

Regarding measures to support and foster return to work, the most implemented measures included cooperation with external organisations on occupational health and safety, the possibility for a phased return to work, and *ad hoc* and flexible adjustment plans for each employee. Informal coordination between the employee and employer was the preferred way of dealing with reintegration. This entailed thorough discussion and planning of the reintegration before the employee returned to work to develop a joint strategy. Adjustments in working time, workload and tasks were also widespread among the companies that took part in the survey. In general, respondents were understanding and declared not to expect the workers to come back to their pre-illness productivity level. Again, these results are somewhat at odds with those from the interviews and stakeholder discussions, where it was reported that many companies struggled to offer substantial adjustments to employees and often expected full productivity upon return, especially since they lacked incentives to offer adjustments given the current legislation. Integration becomes more difficult the longer the worker is away. Of course, there may be selection bias in the company survey sample, in that companies that are more interested in the topic of return to work and are more committed to facilitating it for their employees are more likely to participate in research on the topic. This may explain why companies in the sample appear generally more supportive of return to work and more willing to offer adjustments.

Praised outcomes from interactions with union representatives on the matter included training sessions for managers on interacting with chronically ill employees, and informal agreements on the role of employee representatives in supporting management of return to work. Specific return to work provisions in collective agreements are also seen as beneficial outcomes of the interaction with union representatives.

Less implemented measures included common standard procedures and a defined adjustment plan for each employee – even though it is now mandatory to have a company-level policy on employee reintegration for medium and large companies, to be discussed in the health and safety committee. The fact that medical reintegration is only rarely discussed in the health and safety committees in practice was also raised in interviews. Trainings for co-workers on how to interact with the employee returning from a long-term illness happen very rarely.

Figure 6. Support offered by the company to the employee returning to work (number that agree/strongly agree)

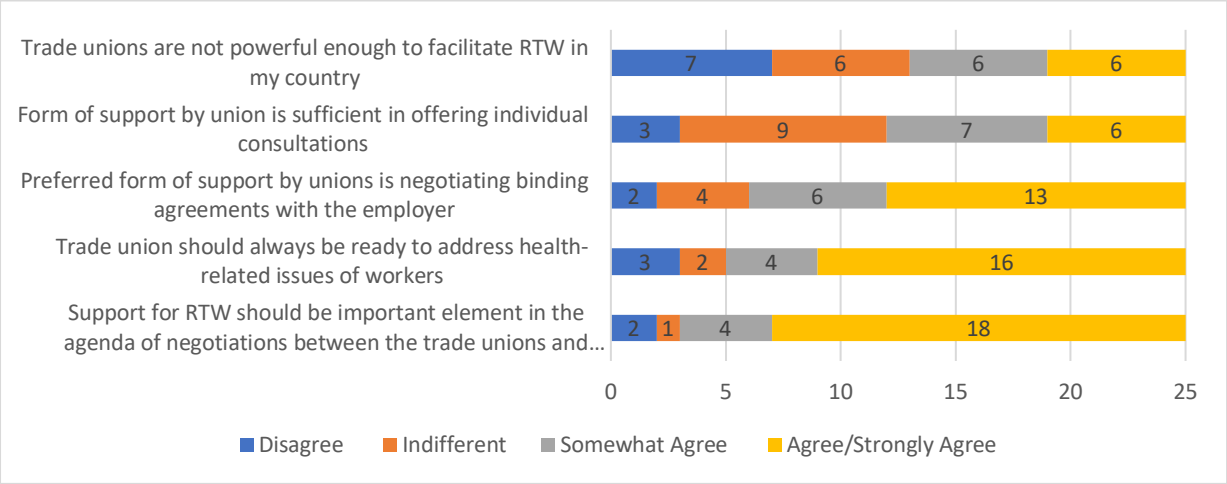


Source: REWIR manager survey, own calculations. Number of respondents: 19.

4.4 Views on future potential for social dialogue to support return to work policies at company level

As regards the future role of social dialogue to support return to work policy at company level, employees favour a stronger role for trade unions (Figure 7). They agree that trade unions should continue to be involved in health-related issues, and that return to work should be part of the social dialogue negotiation agenda. Regarding the favoured form of support that should be provided by unions, employees seem to prefer the negotiation of binding agreements with the employer on reasonable accommodations during reintegration, while they tend to be more indifferent about individual consultations with trade unions. Respondents are rather split on the capacity for unions to be able to facilitate return to work in Belgium.

Figure 7. Workers' opinions on the role of unions and their dialogue with employers for facilitating return to work



Source: REWIR worker survey, own calculations. Number of respondents: 25.

Results from the social partner survey indicate that trade union representatives strive unanimously for more active involvement in the implementation of return to work policy in Belgium. On the other hand, representatives of employers' associations are more split on their preferred involvement in return to work policy: a quarter of them are satisfied with their current involvement and another quarter wish for more involvement. Similarly, in the interviews and stakeholder discussions, employer organisations tended to see return to work as an individual rather than collective matter, where unions only play a limited role, while trade unions emphasised the potential for social dialogue at company level to influence return to work processes.

According to managers' opinion, a few elements should change regarding return to work in their companies, such as better interpersonal relations with employees to deal directly with employee reintegration, or better cooperation with health professionals and patient organisations to facilitate the return process. They also tend to agree that organisational policies should be improved. One avenue for improved organisational policies that was raised in the interviews was the development of a return to work strategy in the health and safety committee, mandated by national legislation. Social partners can be involved in this process of discussion within the committee.

On the other hand, they do not see more legislative and institutional support as a promising perspective. Respondents had a sceptical outlook on the current legislation: no respondent declared that it provided good guidelines for company-level actions, which resonates with some interviews performed during the REWIR project in Belgium. They agree that legislation serves as a general framework and suffers from being too broad or unclear and confusing. However, they do not wish for more specific legislative provisions on company-level return to work policy, with most respondents welcoming flexibility.

5. Discussion of research findings and conclusion

This report has analysed the role of social partners in the design and implementation of policies on return to work after a long-term illness in Belgium. This topic became an important issue on the political agenda in Belgium in the 2010s, as the increasing number of incidences of sick leave due to chronic disease came hand in hand with soaring social security expenditures. Faced with increasing concern over incapacity for work, absenteeism (mainly due to mental health and musculoskeletal illnesses) and the financial sustainability of the Belgian welfare state, governments have sought to address the economic impact of sickness absence by means of activation policies, i.e. by offering more opportunities to formerly sick employees. This resonates with the objectives of the Europe 2020 strategy, as it gradually increases formerly ill employees' presence at work and fitness for work, and enables longer labour market involvement.

Our analysis of the role of social partners in facilitating reintegration into the workplace relied on various sources and data collection methods, including interviews with key informants and three

surveys targeted at social partners, workers and employers, as well as two focus groups and a roundtable discussion, complemented by a literature and policy review. What shows from our analysis is the significant and multi-faceted role that social partners assume in the development and implementation of return to work policies in Belgium. To a higher extent than in other countries studied in the realm of the REWIR project, social dialogue has helped in developing a new framework on return to work, despite important limitations.

After the National Institute for Health and Disability Insurance put the need to improve the reintegration of employees suffering from a long-term disease on the agenda, social partners – via the National Labour Council – participated in the design of a new reintegration procedure targeted at employees seeking to return to their former professional activity. They influenced the legislation by putting forward some key principles, such as the concept of a voluntary reintegration process, the key role of the occupational physician, the need for collective reintegration and concrete incentives. However, the unforeseen consequences of the 2016 reform have been criticised, especially by trade unions, mostly regarding the issue of contract termination due to medical reasons.

Regarding the evolution of the policy framework on return to work as a result of the reform, one of our key findings is that since EU-OSHA established its typology of systems of return to work (2016), the Belgian policy framework has evolved towards early intervention and a case management approach. This is exemplified by the new obligation for the health insurance provider to assess reintegration options based on the employee's medical condition at the start of the invalidity period. The scope of the system remains fragmented, with separate schemes for employees with occupational or "private" illnesses, but the reintegration scheme now entitles all employees on sick leave (due to a non-occupational disease) to start a reintegration procedure and get support from the occupational doctor.

The financial incentives for employers to engage in early planning of return to work have not been substantially changed. This contrasts with the Dutch example, where the guaranteed salary period has been extended to two years, compared to one month in Belgium (Pacolet, 2019). On the other hand, the employer now has clearer responsibilities regarding the creation of an individualised reintegration plan for the employee, and of a company policy on return to work, as well as the duty to fund training in the case of termination of the contract for medical reasons. The employee has several incentives to return to work thanks to transitional work options. The occupational physician still holds a key intermediary role between the employer and the employee (EU-OSHA, 2016), as the new reintegration procedure is structured around the work ability assessment. However, occupational physicians tend to have little time for personalised case management and there are still coordination problems between health professionals involved in return to work.

It emerged from data collection that effective social dialogue can help reintegration, but that sectoral and firm characteristics play a more important role in determining the success of

reintegration. Also, return to work after a long-term illness can be difficult to tackle via social dialogue, given its sensitive and private nature. It involves workers at the margin of traditional social dialogue, as they are excluded from professional life during the period of their illness. However, employers can play a key role at firm level in ensuring smooth reintegration, for example by involving colleagues and line managers in the process, beyond HR and occupational health services. Some instruments and legal dispositions are in place, such as the obligation to discuss a company procedure on return to work every year within health and safety committees. However, these dispositions are not well implemented on the ground. Similarly, trade union delegates or employee representatives are given an important role in the new legislation developments (CSC, 2019). They can perform important functions: offering emotional support during the reintegration process, providing legal advice to the employee in case of conflict with the employer, guiding him or her strategically through the complexity of the procedure and during the negotiations with the employer, and being a mediator with the HR services and employer, as well as with colleagues. Delegates can also put reintegration on the agenda of health and safety committees, which can assess the company reintegration policy based on the quantitative and qualitative evaluation provided by the occupational physician. However, there is substantial room for improvement in this area, especially due to a lack of information on the sides of union delegates and employees, as well as to the private and sensitive nature of reintegration after a long-term illness.

Our findings highlight that a tailored company-level approach tends to be more efficient when combined with a broad national framework enforcing basic rights and requirements regarding return to work procedures. Informal procedures are often praised as a more efficient and flexible approach to reintegration, in which the occupational doctor can give advice instead of making binding decisions. In parallel, social partners at federal level should coordinate via the NLC to issue practical guidelines based on best practices to help companies and local union delegates to design company-level return to work procedures. They could also start cross-sectoral or sectoral negotiations on collective agreements on return to work. Social partners had already applied such a proactive approach on other topics related to wellbeing, for example to tackle burnout (CNT, 2018a).

Finally, the reintegration procedure instituted by the 2016 reform has some substantial “starting flaws”, which should be addressed by the next federal government, as highlighted in section 3 of this report. Ultimately, gathering reliable and systematic data on the outcomes of reintegration procedures and the situation of former employees who have been dismissed for medical reasons should be prioritised. It would allow the impact of reintegration on the career of employees to be measured, whether they return to the same company or not. It would also enable a better understanding of the gendered implications of return to work, as female-dominated sectors tend to allow for less flexibility in terms of tasks and display more atypical and precarious forms of employment.

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Annexes

Annex 1: Summary of the data collection

Table 1: Overview of sample and respondent identification – Belgium

Survey and target group	Total number of responses	Number of relevant responses
Workers' survey	115	48
Social partners' survey	10	8
Managers' survey	37	22

Notes: Total number of responses refers to overall data intake for Belgium, within the period of data collection. Number of relevant responses refers to the number of completed surveys for the social partners and the company survey. For the workers' survey, the number of relevant cases refers to responses where the respondent selected "Yes" in Question 6 – *Have you experienced a chronic disease in your working life?*

Table 2: Overview of sample and respondent identification – REWIR workers' survey for Belgium

Workers' survey – structure of responses	Responses
Gender	
Male	12
Female	35
Mean age in years	48
Mean length of working life in years	26
Level of education	
Low qualified (up to lower secondary)	2
Middle qualified (up to post-secondary vocational)	14
Highly qualified (up to university education)	26
Other	5
Type of organisation where the respondent worked prior to diagnosis/treatment	
Domestic	32
Foreign owned	11
Don't know	4
Private sector	34
Public sector	11
Trade union membership	
Yes	25
No	20
Trade union presence at the workplace	
Yes	26
No	21
Type of job	
Intellectual	24

Manual	5
Indoor	28
Outdoor	0
Intensive physical activity	6
Intensive emotional stress	22
Company size	
Below 20	11
20 - 50	5
50 - 500	12
500 – 1,000	1
Above 1,000	18
Currently on sick leave	
Yes	5
No	5
Three most frequently reported diseases	
1.	Other (21)
2.	Mental disease (8)
3.	Cancer (8)

Table 3: Company survey data structure for Belgium collected within the REWIR project

Structure of responses	Responses
Ownership type	
Domestic	19
Foreign	14
Company size	
0-9	2
10-49	2
50-249	12
Above 250	17
Predominant type of workers	
1.	Administrative workers / office clerical (19)
2.	Highly skilled specialists (5)
3.	Low-skilled manual workers (3)
Three most commonly reported economic sectors represented	
1.	Financial services (21)
2.	Other (4)
3.	Manufacturing (3)

Presence of trade union or other form of workers' representation	
Yes	17
No	1

Table 4: Social partners survey data structure for Belgium collected within the REWIR project

Structure of responses	Responses
Type of organisation	
Employers' associations	4
Trade unions	4
Other	0
Level of social dialogue engagement	
National	5
Sub-national (territorial)	2
Sectoral	3
Three most commonly reported sectors represented	
1.	Financial intermediation (2)
2.	Agriculture and manufacturing (1)

Notes: The social partner survey was run from October 2019 until August 2020. For more details on the questionnaires, see the analytical framework report by Akgüç et al. (2020).

Table 5: Summary of types of stakeholders involved in national interviews

Stakeholder	Number
Academic expert	1
Government representative	1
Patient organisation representative	1
Civil servant	1
Disability insurance representative	1
Sectoral employers' organisation representative	1

Table 6: Summary of participants in focus group

Stakeholder	Number
EU sectoral employer organisation	1
National employer organisation representative	2
Disability insurance representative	1
Civil servant	2

Table 7: Summary of participants in stakeholder group discussions

Stakeholder	Number
Trade union group discussion	
National trade union representative	4
Employer group discussion	
National employer organisation representative	2
Sectoral employer organisation representative	1
HR consultant	1
Company HR manager	1

Annex 2: Description of the formal reintegration procedure

The reintegration procedure is divided into several predefined steps (SPF Emploi, 2018). The first one is the **start of the procedure, which can be triggered by the occupational physician only**. Three stakeholders can ask the occupational physician to start a formal procedure: the employee (any time during the sick leave), the employer (four months after the start of the incapacity) and the employee's mutuality doctor. During the medical examination (quick scan) in the first two months of incapacity, the mutuality doctor classifies the worker into one of the four categories, which can lead to a start of a procedure: return to work after six months (if the worker does not return, the officer can ask to start a procedure), no reintegration possible, re-examination every two months (the officer can ask to start a procedure when he/she assesses that the person is ready to return to work), possible return to work to an adapted job (*travail adapté*) or to a different job. The occupational doctor needs to notify the other parties when one party asks for the procedure to be started.

The second step is the **medical examination of the employee by the occupational doctor**. This focuses on two aspects: whether the employee can perform his or her previous job (*travail convenu*) with some possible adjustments, and what the reintegration possibilities are based on the employee's capability. These assessments do not consider the practical possibilities inside the company. Regarding reintegration possibilities, the legislation distinguishes between permanent and temporary inability to perform the former job, and the possibility to return to an adapted job (*travail adapté*) or a different job (*autre travail*). Adapted job means that the content remains the same, but the working time and number of hours worked are modified. A different job means that the content of the job changes, as well as the working time and number of hours worked. With the agreement of the employee, the occupational physician can consult the employee's general practitioner or specialist doctor, the mutuality doctor, another prevention counsellor specialised in psychosocial risks or ergonomics, for example, or the disability case manager. The occupational physician also evaluates the workstation and work environment. Finally, he or she decides which procedure fits the employee better (A, B, C, D or E). In total, the occupational physician has 40 days to go through the procedure. The employee can appeal the doctor's

decision within seven days in the case of decision C or D. If the decision D is confirmed during the appeal within 31 days, it marks the end of the procedure.

The third step is the **design of the reintegration plan by the employer** (within 55 days for decision A and a year for decision C). The employer can consult the employee, the occupational doctor and other relevant stakeholders (disability case manager, employee representatives, prevention counsellors). If a partial return to work is chosen, the occupational physician needs to contact the mutuality doctor, who will check if the job is adapted and if the employee can continue to receive incapacity or invalidity benefits. The plan contains detailed and concrete adjustments of the workstation, the number of hours worked, the work schedule, possible progression, and the duration of the plan. It also includes training that could be useful for the employee. The latter must agree with the plan within five days. If he or she does not agree, the reasons must be stated. A copy of the reintegration plan is sent to the occupational and mutuality doctors. If the employer declares that no reintegration plan is possible, he or she must justify this decision in a report. The fourth step is the **implementation of the reintegration plan**, if both parties have agreed to it. The occupational doctor follows up on the implementation and can propose adjustments to the plan if needed in the case of deterioration or improvement in the employee's health condition.

A reintegration procedure may end by a **termination of the employment contract due to "medical *force majeure*"**. This justification can be used in three configurations: if the employee is permanently unable to perform the job and no reintegration possibilities exist (decision D, or permanent work incapacity), if the employer cannot offer an adapted or a different job, or if the employee disagrees with the reintegration plan. A medical *force majeure* can now only be invoked if the employee has gone through a reintegration procedure, which was not the case before 2016.