# Chapter 2
# Shaping an evolving framework on return to work: the role of the social partners in Belgium

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## 1. Introduction: chronic illness and employment in Belgium

Belgium faces longlasting challenges regarding the labour market activation of vulnerable groups, including sick and disabled people, notably due to persistent inactivity traps (Hufkens *et al.* 2017). Only three out of four people of working age (20-64) are active in the labour market (74.5 per cent), below the EU average of 78.7 per cent in 2019 (European Commission 2019). 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 especially in Flanders (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 per cent in 2007 to 19.1 per cent in 2019.[1] Furthermore, the share of private sector salaried employees[2] absent from work as a result of long-term illness increased significantly between 2008 and 2015, and has been continuing more recently albeit at a slower rate (Securex 2018). Population ageing and the related alignment of the statutory retirement age, as well as increased female participation in the labour market and the associated higher eligibility for benefits, seem to explain an important part of the increase in invalidity benefit claimants (Saks 2017).[3]

Associated with the extension of working lives, the incidence of chronic illness among the working population poses important challenges for the proper functioning of the labour market in Belgium. Chronic illness is associated with stigma and taboos, and often leads to social exclusion thereby producing a considerable burden on the workforce. Musculoskeletal and mental health problems are the primary causes of absenteeism, explaining about two-thirds of the significant increase in long-term sick leave and representing 67.3 per cent of sickness and disability insurance beneficiaries (Mutualités Libres 2019b). According to a study conducted between 2013 and 2017 by health insurer Mutualités Libres (2019c), over half of 'new' disability insurance beneficiaries already suffer from at least one chronic illness, depression being the most frequent. On the other hand the incidence of other types of chronic conditions, such as cardiovascular illness and cancer, has decreased (Saks 2017).

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**1.** Source: Eurostat, lfsa_igar, extracted 15 December 2020.
**2.** This figure only includes firms with less than 1 000 employees. Long-term illness refers to absences of more than one year (Securex 2018).
**3.** There is also evidence showing that women have a higher rate of reported poor health (Franklin *et al.* 2021).

This situation became more acute with the Covid-19 pandemic in early 2020 as Belgium reached its highest number of invalidity benefit recipients.[4] Covid-19 is estimated as likely to cause long-term health issues for 10 to 20 per cent of infected people (WHO 2020), leading to significant alterations in patients' ability to work and raising important issues of rehabilitation and reasonable accommodation in the workplace for those experiencing Long Covid. More broadly, the pandemic has made the return to work more difficult for people suffering from chronic illness as they face higher chances of developing severe complications from Covid-19. At the same time, however, the spread of remote working due to the pandemic might have eased the reintegration of some workers returning from sick leave.

Nevertheless, people suffering from a chronic condition in Belgium tend to face significant difficulties in terms of integration into the labour market and with their well-being. The gap for those at risk of poverty or social exclusion for people with and without disabilities amounts to 17.7 per cent, significantly higher than the EU average of 9.7 per cent (European Commission 2018). Only in February 2018 did a Belgian court apply, for the first time, the principle of non-discrimination based on disability and the associated duty on employers to make reasonable accommodation for people with chronic illness, as stated in the jurisprudence of the European Court of Justice (Eurofound 2019; CSC 2019). It should be noted here that Belgian legislation uses the concept of invalidity more than disability (CNT 2015).

Perceived as a threat to the sustainability of the social security system, 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, while the switch from welfare to workfare has also been experienced in the area of incapacity (Houwing and Vandaele 2011). The increasing incidence of long-term incapacity for work has led to mounting social security costs as spending on disability increased from 1.9 per cent of GDP in 2005 to 2.6 per cent in 2016 (Pacolet 2019). In 2018 the combined spending on disability and sickness benefits exceeded for the first time the expenditure on unemployment benefits, probably due to a 'communicating vessels' effect between the various schemes for early withdrawal from the labour market (Pacolet 2019). The government has, since 2015, been seeking to address the economic impact of sickness absence and the mismanagement of the return to work leading to unemployment, disability pensions or early retirement. Notably the *mutuelles/mutualiteits* (insurance providers) are being encouraged to increase the rate of employment of the beneficiaries of long-term sickness insurance and to provide incentives for them to return to work. New pieces of legislation on work reintegration also address the challenge of supporting the return to work, where feasible, of workers with a chronic illness (i.e. where they are 'able' and have the 'capacity' to get back to work) (Securex 2018).

This context makes Belgium a relevant case study in understanding the role that industrial relations actors can play in designing and implementing return to work

4. Source: La Libre, 18/11/2020, L. Gérard, 'Invalidité: Le Covid peut faire exploser la casserole à pression en 2021-2022' https://www.lalibre.be/belgique/societe/invalidite-le-covid-peut-faire-exploser-la-casserole-a-pression-en-2021-2022-5fb427307b50a6525b6661c6

policies, even more so given the country's industrial relations and welfare state regime. Belgium has a strong tradition of a Bismarckian continental welfare system, corporatist arrangements and social pacts as solutions in the case of social conflict (Houwing and Vandaele 2011). The Belgian industrial relations system is characterised by a strong role for the social partners, a high union density rate and significant collective bargaining coverage. Dialogue with the state also plays an important role in the social dialogue process and unions are involved in social security management and in the development of social and employment policy at federal and regional levels.

This chapter first outlines the policy framework on the return to work in Belgium. It then evaluates how the social partners shape and view policy on the return to work at national level and at company level, consolidating and analysing the data collected through interviews with relevant stakeholders, at stakeholder events and via online surveys distributed to social partners, managers in companies and workers.

## 2. Policy framework on the return to work in Belgium

According to a typology of rehabilitation and return to work systems in Europe, 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. These countries are characterised by well-developed frameworks for rehabilitation and the return to work but with limited coordination between the different stakeholders. The return to work is considered as the period of sickness absence comes to an end and with only limited possibilities for early intervention. Nevertheless recent policy developments have shifted the Belgian approach to the return to work.

### 2.1 Sickness and the invalidity benefit system

Belgium has a 'pillarised' social security system composed of separate regimes for salaried workers (sometimes differentiated by blue collar and white collar workers), self-employed and civil servants (Pacolet 2019). Trade unions, insurance providers and employer organisations co-decide various aspects of these social security regimes. Each regime has a different framework and coverage regarding sickness, disability insurance and the return to work. Different regimes also exist depending on the cause of the illness. While *Agence fédérale des risques professionnels/Federaal agentschap voor beroepsrisico's* (Federal Agency for Occupational Risks; FEDRIS) manages benefits in relation to occupational accidents and diseases, it is the federal institution *Institut national d'assurance maladie-invalidité/Rijksinstituut voor ziekte- en invaliditeitsverzekering* (National Institute for Health and Disability Insurance; INAMI/RIZIV) which is responsible for non-occupational illness. As the coordinator of the sickness and disability insurance benefit system, INAMI/RIZIV works in collaboration with the accredited insurance providers who act as intermediaries with the insured and as key gatekeepers in terms of access to sickness and disability benefits (OECD 2013). This chapter focuses on the schemes coordinated by INAMI/RIZIV for salaried workers.

Unlike in most other countries within the OECD, sickness and disability benefits in Belgium are integrated into one single system managed by INAMI/RIZIV. To be eligible for incapacity benefits, the employee must have fulfilled several contributory requirements. Work incapacity is divided into two periods: *incapacité de travail primaire/primaire ongeschiktheid* (primary work incapacity), corresponding to sickness benefits during the first year of sickness; and *invalidité/invaliditeit* (the period of invalidity), corresponding to the disability benefits which are applicable after one year of incapacity. An employee on sickness leave receives a guaranteed salary during the first month of absence (or 15 days for blue collar workers), paid by his or her employer. Following the first month, INAMI/RIZIV takes over the management of incapacity benefits, covering 60 per cent of the worker's salary up to a certain maximum annual amount. After one year of incapacity, the period of invalidity may be prolonged by a decision of the *Conseil médical de l'invalidité/Geneeskundige raad voor invaliditeit* (the Invalidity Medical Council of INAMI/RIZIV) on the basis of a medical report written by a physician from the insurance provider. The payment of invalidity benefits can continue until retirement, depending on how the employee's health condition evolves. During the period of incapacity, the beneficiary is not allowed to work unless the insurance provider's occupational physician authorises part-time work.

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 per cent per year on average (Mutualités Libres 2019b, based on INAMI/RIZIV data).

## 2.2 Provisions for rehabilitation and return to work support

The Belgian incapacity and invalidity benefit system encompasses several pathways into work based on activation and vocational rehabilitation. The federal and regional governments have focused over the last few years on increasing fitness for work among workers on long-term sickness leave and improving the incentive structure for the return to work. The policy framework on the return to work applies to several legislative areas, including legislation on social security, labour market regulations, well-being at work and disability (CNT 2015). It forms a major part of the *Code du bien-être au travail/ Codex over het welzijn op het werk* (1996 Act on Well-being at Work, as amended) which extended the concept of health and safety at work to cover all aspects of well-being in the work environment. This put a legal obligation on the employer to take all necessary measures to protect employee well-being such as risk assessments and medical check-ups conducted by external or internal prevention services. In addition the Law of 3 July 1978 on employment contracts included important provisions on the consequences for the employment contract of work incapacity, partial return to work and permanent work incapacity; while the Law of 14 July 1994 on compulsory health-care and indemnity insurance also included provisions on invalidity and incapacity benefits which can have an impact on the return to work. Furthermore the Anti-discrimination Law also encourages an employer to make reasonable accommodation for a disabled worker as advised by the occupational physician and 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 insurance provider's occupational physician must first authorise medical part-time status or adjustments to the workload (Mutualités Libres 2019a) and this is dependent on two conditions: that incapacity remains at least 50 per cent; and that the job does not jeopardise the person's health. The physician also decides on the intensity and duration of part-time work which can be gradually increased until the beneficiary is ready for regular or full-time work. Adjustments can be related to working hours (longer breaks, shorter week, fewer hours per day); work organisation (telework, slower work pace, change in tasks); workspace and equipment; the provision of specific training; and putting in place support by a coach, colleague or line manager. Benefits are adjusted according to the number of hours worked in a week. The medical part-time option was rarely used in the past but the number of authorisations of a partial return to work is now on the increase (OECD 2013; Mutualités Libres 2019b).

A new *trajet de réintégration/re-integratietraject* (formal return to work/reintegration procedure) was implemented in 2016 as a new chapter of the 1996 Act.[5] Informal dispositions regarding the return to work existed before this reform, such as the *visite de pré-reprise du travail/bezoek voorafgaand aan de werkhervatting* (voluntary medical appointment) with the occupational physician, implemented in 2004 (SPF Emploi 2018). However, the 2016 legislation added a formal procedure for the return to work, requiring physicians from insurance providers to assess the possibilities for the return to work within the first two months of sickness absence. Beyond systematising early intervention and individual case management, thereby strengthening the insurance providers' role in sickness monitoring, the reform provided a series of steps to follow for voluntary, gradual and adapted return to work.

The goal of the new procedure is to reintegrate the worker with an employment contract within the same company so that he or she can return to a familiar environment. The procedure outlines a sharing of responsibilities between the main stakeholders on a practical level and foresees a collective framework for the return to work after sick leave to be developed at company level, for example by the *Comité pour la prévention et la protection au travail/Comité voor Preventie en Bescherming op het Werk* (health and safety committee). It also clarifies the use of 'medical *force majeure*' to terminate an employment contract which can now be invoked only where the employee has gone through a formal return to work procedure. In 2016, 4 801 formal return to work procedures were initiated with 5 015 being undertaken in 2017 (Mutualités Libres 2019b, based on INAMI/RIZIV numbers).

*Réinsertion ou réhabilitation socio-professionnelle/socioprofessionele re-integratie* (occupational rehabilitation) is targeted at workers declared unfit to return to their former company as well as at unemployed or self-employed workers (Mutualités Libres 2019a). This enables the individual to attend a training or rehabilitation programme to update their skills or acquire new ones. INAMI/RIZIV 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

**5.** Royal Decree of 20 December 2016 amending the Royal Decree of 28 May 2003.

rehabilitation for disabled workers (e.g. GTB - *Gespecialiseerd Team Bemiddeling*; Service PHARE - *Personne Handicapée Autonomie Recherchée*; AViQ - *Agence pour une Vie de Qualité*) are also involved. Financial incentives are attached to this procedure: participation fees are covered by INAMI/RIZIV and participants receive a 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. Furthermore in 2018 the federal government introduced in its *Deal pour l'Emploi/Arbeidsdeal* (Job Deal) the right to an outplacement payment of up to €1 800 paid by the employer in cases where the latter has invoked medical *force majeure* to terminate the employment contract.

Some financial and technical support is available for employers at regional level in the case of an employee's recognised permanent functional limitation (e.g. the *Vlaamse ondersteuningspremie* in Flanders; SPF Emploi 2018). Regional financial support also includes adjustments to the work environment, the coverage of work and living expenses, paid interpreters in the case of hearing impairment and a premium for companies offering mentoring support to a returning disabled worker. In 2014 INAMI/RIZIV created a training course for 'disability managers', subsidised by the state but paid for by the company, to support the return to work process at company level (INAMI 2019). This is based on disability management methodology aimed at maintaining employment and facilitating a quick and adapted return to work. Additionally, INAMI/RIZIV also runs pilot programmes, such as the Individual Placement and Support programme for people suffering from mental health issues. This follows a 'place then train' model and consists of the provision of early and continuous support for the 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 existing rehabilitation schemes.

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

### 3.1 Industrial relations structures and return to work policy

This section focuses on the involvement of the social partners in the design and implementation of return to work policies at national level. The analysis relies on interviews with key stakeholders and the survey targeted at national social partners referred to in the Introduction as well as a literature and policy review.

Belgium is characterised by a strong social dialogue tradition involving established industrial relations structures and actors.[6] The country has a relatively high unionisation rate amounting to more than 50 per cent while collective bargaining covers approximately 90 per cent of employees. At national level, workers are mainly

**6.** 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 updated in 2016).

represented by three large trade union confederations: *ACV/CSC* (Confederation of Christian Trade Unions); *FGTB/ABVV* (General Federation of Belgian Labour); and *CGSLB/ACLVB* (Confederation of Liberal Trade Unions of Belgium). On the employer side, the main national association for employers is *FEB/VBO* (Federation of Belgian Enterprises). In addition, craft and trade sector employers, the 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 employer organisations in Belgium is above 80 per cent (ETUI 2016).

National social dialogue takes place within thematic advisory bodies: *Conseil National du Travail/Nationale Arbeidsraad* (National Labour Council; CNT/NA); *Conseil Central de l'Economie/Centrale Raad voor het Bedrijfsleven* (Central Council of the Economy); and *Conseil Supérieur pour la Prévention et la Protection au Travail/Hoge Raad voor Preventie en Bescherming op het Werk* (High Council for Prevention and Protection at Work), an advisory body focused on matters related to the well-being at work legislation (ETUI 2016). The CNT/NA has a cross-sectoral remit extending to the whole of Belgium and covering all companies and sectors, with a composition divided equally between representatives of the main employer 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 in policy evaluation.

Since the beginning of the 2010s, the CNT/NA has been working on the topic of the return to work. It has followed a coordination role as a 'Platform for consultation between the actors involved in the process of the voluntary return to work of people with health problems' (CNT 2015). This platform on the return to work was set up as a structural consultation framework bringing together the social partners and the other institutions (e.g. INAMI/RIZIV, Ministry of Labour, FEDRIS) involved in the process of the voluntary return to work. Its goal was to develop an integrated approach to the return to work after chronic illness, considering the social security aspects as well as employment and health and safety issues, gathering all the 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 the return to work and were jointly responsible for the Royal Decree of 2016 on the new return to work procedure. Discussion and negotiation with the social partners in preparing legislation at federal level is of key importance to the wider process.

Before the start of the CNT/NA's consultation platform, the focus of the social partners was mainly on prevention in terms of health-related issues in the workplace. Since then, the return to work has been rather high on trade union agendas. This was accentuated when the social partners noticed the adverse social consequences of the 2016 reform, notably the sharp increase in the number of contract terminations due to medical *force majeure* (CNT 2018c). However, it is still taking time for them to incorporate this issue fully into their programmes. The social partner survey noted that 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 a more active involvement.

This additionally suggests that the initiative to come up with a policy on the return to work was taken by other bodies (rather than the social partners themselves), such as the government.

A key role for the national social partners is 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). Indeed, company-level industrial relations structures matter in facilitating the implementation of national legislation at a more local level since they serve as intermediaries between the high-level decision-making bodies and the regions and companies where policies are implemented. Equally they are responsible for collating the issues observed at local levels 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 the regional social rights offices (*Office régional de droits sociaux)*, providing legal and strategic support to workers facing problems with their employers. Information and complaints can then be channelled to the sectoral and cross-sectoral levels. Regional stakeholders share information with national stakeholders, enabling them to negotiate on legitimate grounds.

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

The nature of the interaction between the key industrial relations actors is generally reported as cooperative while discussions on return to work policy tend to be constructive. All the opinions issued by the CNT/NA have been unanimous, showing the social partners' willingness to display a 'united front' to give strength to their recommendations so as to influence the government. They especially agree on the need to ensure that the return to work is a voluntary process and happens early, to change mindsets on the issue and to give a key role to the occupational physician in the process. Even so, there have been several disagreements between the social partners, one example being the financial responsibility carried by the employer: trade unions asked that they cover the salary for the first two months of sick leave but employers opposed this as it would place small and medium-sized enterprises (SMEs) in a difficult situation.

There has also been some disagreement between the social partners and the government, which intensified after the disclosure of figures on the increase in contract termination 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. Furthermore it is a matter of regret for the social partners that none of their recommendations have been implemented, a situation partly related to the political stalemate that Belgium encountered until the formation of the De Croo government in September 2020. Up to that point, the government had mainly taken responsibility only for current affairs (*Gouvernement d'affaires courantes/Regering in lopende zaken*) and had limited competence in diverse policy areas. Another bone of contention was the government's draft legislative proposal in May 2018 which

planned to impose financial sanctions where employers and employees had failed to fulfil their responsibilities regarding the new return to work procedure. The proposal was strongly rejected by the CNT/NA (CNT 2018b). The CNT/NA was also critical of the introduction, as part of the Job Deal in 2018, of a new general compensation measure for employees declared unfit to return to their former job. This measure was seen as insufficiently individualised and lacking in tailored support from the regional employment services (CNT 2018d).

Interactions on the return to work in Belgium can become complex due to Belgium's multilevel governance. Return to work issues cut across policy areas which are assigned either to the federal (social security) or the regional (active labour market policy) levels. Designing a comprehensive common policy framework can thus be a challenge. There is a major need to increase cooperation between the various stakeholders so as to facilitate the implementation of legislation on the return to work following chronic illness.

## 3.3 Outcomes of social dialogue regarding return to work policy

One of the main outcomes of social dialogue at national level on the return to work was the key role played by the CNT/NA in supporting the overhaul of legislation on the matter via the forum it established on the return to work. The overhaul of the policy framework originated around 2010 when INAMI/RIZIV put the issue of the return to work on the agenda following the sharp increase in the number of long-term sickness insurance beneficiaries. In doing so, the Institute called for a more active approach towards workers on sickness leave who are able to perform some level of occupational activity, on the grounds that this would be beneficial for their recovery prospects as well as for the sustainability of the Belgian social security system. In 2015 the CNT/NA published a report on the results of the forum's work, laying down some basic principles for legislation which embodied the need for a collective approach to the return to work, concrete incentives, a voluntary procedure, clarification on the use of medical *force majeure* and identifying the key role of the occupational physician. These discussions and agreements were later adopted as part of the Royal Decree in 2016.[7] By subsequently consulting experts and civil society stakeholders during its evaluation of the 2016 legislation, the CNT/NA also gathered relevant information on return to work policy and the potential gaps that needed to be addressed. However, it is unclear whether and how the 2016 legislation will be modified following the CNT/NA's evaluation (as well as that performed by a group of academics).[8]

Beyond influencing the legislation, it is clear that the Belgian social partners could do more on the topic of the return to work such as issuing common practical guidelines for health and safety committees, employers and union representatives on how to

7. 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
8. 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

implement a company-level return to work policy. The social partners could also work at sectoral or cross-sectoral levels on collective bargaining agreements specifically on the return to work which has not happened so far.

However, the outcomes of social dialogue at sectoral level are more difficult to determine. Sectors follow divergent approaches on the return to work as they face different prospects in finding adjustments in terms of the tasks which may be carried out by workers experiencing chronic illness. In this respect, the presence of a diversity of tasks within a sector may actually act as a facilitator in the return to work. For instance, firms in the construction sector tend to have well-established procedures on the return to work and the potential for adjustments in task allocation. Here, a progressive return to work into the workplace is possible, for example, by allocating fewer physically demanding tasks to a worker returning after sickness absence. Other sectors face more difficulties in proceeding to reasonable accommodation such as the voucher-based parts of the service sector (including cleaning and homecare services), which is characterised by a high incidence of musculoskeletal diseases. Trade union representatives here have tried to react to the negative consequences of the return to work procedure by putting the issue on the sectoral negotiation agenda.

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

Returning to work after (or indeed with) chronic illness is evidently a salient issue in Belgium. A clear formal return to work procedure is welcome on the basis that stakeholders tend to agree that action is needed in the face of the high prevalence of chronic illness and the scale of long-term sickness absence and rising expenditure linked to sickness and disability benefits. However, there is also consensus that a more 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 offer a more efficient and flexible approach to the return to work in which the occupational physician can give advice instead of making binding decisions. Moreover, 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 might then only come to be used where other informal options have been explored or if there is a conflict between the employee and the employer. Employers are also prone to criticise the return to work procedure as too cumbersome in terms of administration as well as over-formalised and slow. Together, the social partners also underline the primary importance of prioritising prevention in company-level social dialogue so as to avoid chronic diseases such as mental and musculoskeletal disorders.

Another common criticism relates to the frequency with which formal return to work procedures lead to a contract termination for medical reasons; these can result from a decision by the occupational physician that the employee is permanently unfit to return

to the former job (i.e. a category C or D decision, as designated in the legislation).[9] Such criticism is particularly offered by trade union representatives who describe the legislation as having been drafted without having considered the potential unforeseen impacts of the procedure for contract termination. Consequently trade unions sometimes advise their members not to engage in the formal procedure. This aspect was also referred to in one of the CNT/NA's unanimous opinions (2018b). Available data from 2018 (CNT 2018c) shows that the large majority of decisions taken by occupational physicians were category D decisions (68 per cent), i.e. that the worker is definitively unfit to return to work in the same company. There is no systematic support provided to this type of worker and little is known about their situation after dismissal. Support measures and procedures exist for them, such as initiatives by INAMI/RIZIV and the regional employment services, but the social partners underline the need for a coordinated and systematic approach to raise awareness on this aspect.

The lack of public, reliable data on the return to work after chronic illness has also been raised by the social partners as it renders evaluation of the new policy more difficult (CNT 2018c). This is partly a reflection of the lack of data on the situation of former employees who have been dismissed for medical reasons following a category D decision. However, the lack of consistent data also hampers an analysis of the situation of employees who have been reintegrated into their company, for example regarding adaptations in terms of workload, working time and work tasks. Better data availability would allow a measurement of the impact of the return to work on the careers of employees whether or not they return to the same company. It would also enable a better understanding of the gendered implications of the return to work, as some female-dominated sectors tend to allow for less flexibility in terms of tasks and display more atypical and precarious forms of employment, such as the cleaning sector.

It is also clear that the public debate tends to be over-focused on sanctions and the assignment of responsibilities and insufficiently on incentivising employers and employees to engage actively in the return to work. Stakeholders from both trade unions and employer organisations also regret the absence of support mechanisms to accompany stakeholders or guide them along the return to work process, including inside the firm. The cost of return to work procedures can be a burden on employers, especially on SMEs who often lack the human resources required to implement a return to work procedure and reorganise a team where the returning employee does so on a medical part-time basis. 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 the social partners is to revise the legislation to make specific provision for SMEs and to provide them with further support to implement reasonable adaptations.

**9.** As part of the work ability assessment, the occupational physician declares whether the employee is temporarily unfit or permanently unfit to perform his or her former job. If the employee is declared fit, the doctor then evaluates whether an adapted job can be performed in the meantime within the company (category A decision) or not (category B decision). If the employee is declared permanently unfit to perform his or her former job, the doctor also evaluates if an adapted job or another job can be performed in the meantime within the company (category C decision) or not (category D decision). A Category E decision means that the employee is not yet ready for a return to work and will be re-examined every two months.

The social partners in the CNT/NA are also agreed on several recommendations for modifications (CNT 2018c). They argue for more consultation with stakeholders before the occupational physician takes a category C or D decision and for the provision of support from a trade union representative or a member of the company's health and safety committee during the procedure. In addition the social partners have asked for a change in the timing of the procedure, which currently leaves either too much or too little time for dialogue and consultation, while asking that the occupational physician better underlines the remaining capabilities of the employee in the work ability assessment. The social partners also tend to agree with campaigning and patient support organisations on the lack of centralised access to information for employers and employees.

Furthermore there is evidently a need to enhance cooperation between doctors. Multiple specialists are involved in examining a worker's medical file, including occupational physicians, medical experts from the insurance providers and the general practitioner treating the worker. In most cases, decisions on the fitness of the worker to go back to work are not coordinated between these specialists as a result of confidentiality reasons, data sharing constraints and the lack of time. Therefore, the social partners have requested the creation of a digital tool that could help with data sharing and coordinated follow-up between the different health professionals and institutions involved in the return to work process. In parallel, pilot projects such as the 'Trio groups' project have been implemented by professional medical associations to address this lack of multidisciplinary collaboration between the three professions. This is a means to the organisation of common training events and dialogue (Lenoir 2017).

Finally there is a need for cultural change to avoid the stigma around the return to work. There is a growing consensus that going back to work following chronic illness can be good for the health of the worker and can prevent social exclusion. This, however, requires a shift in mindset towards focusing on and building on the remaining abilities of the worker. Therefore, the social partners – via the CNT/NA – have underlined that the 'disability case manager' training organised by INAMI/RIZIV should be more widely promoted among firms (CNT 2018c). This would help raise awareness within HR services about good practice regarding absenteeism and the return to work.

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

### 4.1 Workers' experiences of the return to work process

Analysis of the survey and interview data helps us obtain a fuller assessment of the role of the social partners in shaping the return to work in Belgium, their involvement at company level and their impact on the return to work experience of employees within the firm. However, it is important to acknowledge the limitations of the survey data given the small size of the sample.

From the perspective of workers returning to work following chronic illness, support from and the involvement of their boss, colleagues and health professionals appear to play important roles. Family seems to do likewise, but only in combination with these other actors. Workers indicated, however, that trade union or employee representatives, rehabilitation institutes and NGOs play only a minor role in facilitating the return to work after sickness leave.[10]

There is thus a mixed picture as regards the role of trade unions in facilitating the return to work at company level. Trade unions emphasise the central role of their local representatives but others, including employer organisations, state that the role of trade unions at company level is rather weak on the basis that the return to work is more of an individual than a collective issue. More than half of respondents in the worker survey were trade union members, with almost two-thirds stating that they had access to a trade union or other employee representative in their workplace. Nevertheless workers are generally not satisfied with the support offered by trade unions in their return to work and only one in five receive the expected level of advice or guidance from their trade union. Accordingly trade union representatives are generally not regarded by workers as important in the return to work process.

One explanation for this limited role is that personal health matters are seen to be too sensitive to be handled through social dialogue. Local representatives often do not have access to information on employees struggling with return to work issues unless they are directly approached, given both the confidentiality concerns and that the employer has no obligation to communicate with union representatives on this matter.

Most workers state that they did have concerns about returning to work. These include the potential lack of employer support where productivity or concentration levels did not fully meet managers' expectations, the unwillingness of the employer to adjust working conditions post-illness and an expectation that they would continue to work long hours, as they had done previously, immediately upon returning to work. Although some employees have positive experiences, the majority express feeling left alone in the return to work process with a lack of support from their employer but also from the trade union. Several employees report that, ultimately, they changed their job after resuming work. Some also express frustration with the regulations governing the return to work process.

The majority of surveyed workers benefited from few adjustments upon returning to their jobs. The most common adjustments were made in the formal work contract (e.g. from full-time to part-time work) together with the offer of flexibility to facilitate medical appointments, but only about one-third of workers received reasonable or extensive support on this. The postponement of work deadlines seemed to happen only in a few cases. The clear majority of respondents (60 per cent) receive limited or no support in adjusting their work environment, their daily working time (in terms of long or night shifts) or their tasks so as to share responsibilities with colleagues.

**10.** More detailed analysis of the survey results can be found here: http://www.celsi.sk/en/projects/detail/64/

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

Most companies indicate that employee absence does have an effect on the organisation. In particular, the worker might not be replaced in the first instance but workflow has to be rearranged and job tasks divided between other employees. Such adjustments are, as we have reported already, especially difficult for SMEs which lack the capacity to redirect workflow. During the return to work process, companies consider certain resources to be helpful, specifically legal advice during sickness leave and external counselling from doctors or therapists as well as professional associations. However, external counselling, information on workplace adjustments and guidance on financial strategies in dealing with sickness leave are sadly lacking.

The work culture in Belgium and the continuing stigma around workers with chronic illness does influence workers' ability successfully to return to work and many employers are indeed unwilling to adjust tasks for returning employees. Employers do not perceive workers to be less committed after being diagnosed with a chronic illness but they do feel that an employee returning to work on reduced duties would increase the workload of colleagues and a majority disagree that workers should have the right to a gradual return to work on full pay. However, employers also regard that workers should be entitled to adjusted working duties at the organisation's discretion (70 per cent) or as a legal entitlement (55 per cent). Moreover, most agree that staying in touch with an employee during their absence was important (89 per cent) while most also believe that returning to work during treatment should be encouraged wherever possible.

Return to work is addressed in company-level collective agreements in only a minority of companies (20 per cent), but 60 per cent confirm that they consult on their organisation's return to work issues with trade unions or employee representatives. In most cases, these interactions are of a regular nature with a trade union representative being part of a health and safety committee that discussed return to work. Praised outcomes from interactions with union representatives on the matter include training sessions for managers on interacting with chronically ill employees and informal agreements on the role of employee representatives in supporting the management of the return to work process. Specific return to work provisions in collective agreements are also seen as beneficial outcomes of interaction with union representatives.

## 4.3 Interactions between employer and employee in facilitating the return to work

From a worker's perspective, it seems that experience of the return to work process is quite individualised with little being coordinated at company level. Most employees declare that adjustments in their tasks or responsibilities are not negotiated between their trade union or employee representatives and their employer. Therefore, negotiations at company level do not seem to play an important role in the return to work process. Employees are also rather critical of the degree of coordination between

health professionals and employers as well of the preparedness of their company to make reasonable adaptations upon their return. Although half feel welcome at their workplace, only a few receive guidance or mentoring from their employer (26 per cent) or their trade union (13 per cent) during their return to work.

Reflecting on these results, while procedures do 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 the reorganisation of workflow may well increase the burden on them.

Most managers say they have regular interactions with workers on sick leave (70 per cent) and in an informal setting, i.e. via phone calls, friendly conversations or indirect information via colleagues (77 per cent). Similarly, qualitative data emphasises the importance of informally keeping in touch with workers in facilitating their return to work although employers clearly have to be careful not to give the impression of 'harassing' the employee. A majority of managers in the survey declare that, during sick leave, the company generally keeps employees informed about work-related issues but does not involve them in work-related planning and decisions.

Informal coordination between the employee and employer is the preferred way of dealing with the return to work after sick leave. This entails thorough discussion and planning of reintegration before the employee's return to work, from which to develop a joint strategy, as well as cooperation with external organisations on occupational health and safety. Managers perceive that ad hoc adjustments in working time and flexibility in workload are quite widespread and that, in general, they are understanding, declaring that they do not expect workers to come back to their pre-illness productivity levels. Measures implemented less often include common standard procedures and a defined adjustment plan for each employee discussed in the health and safety committee – even though it is now mandatory in medium and large companies to have a company-level policy on employees' return to work. Medical returns are, however, only rarely discussed by health and safety committees in practice.

Overall, the results from the company survey are somewhat at odds with those from the interviews and discussions with social partners and other key stakeholders, with the latter reporting that many companies struggle to offer substantial adjustments to employees and that employers often expect full productivity upon return especially since they lacked the incentives to offer adjustments given the current legislation. This may be due to selection bias in that those companies which are more interested in the issue of the return to work, and more committed to facilitating it for their employees, are more likely to participate in a survey and contribute to research on the topic.

### 4.4 Views on the future potential for social dialogue to support the creation and implementation of 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, agreeing that trade unions should continue to be involved in health-related issues and that the return to work should be part of the agenda for social dialogue negotiations. Employees seem, however, to prefer the negotiation of binding agreements with the employer on making reasonable accommodation during the return to work and tend to be indifferent to individual consultation with trade unions.

On the one hand, results from the social partner survey indicate that trade union representatives strive for more active involvement in the implementation of return to work policy in Belgium. On the other hand, representatives of employer associations are more split on their preferred level of involvement: a quarter are satisfied with the current situation although another quarter wish for greater involvement. Employer organisations similarly tend to see return to work as an individual rather than a collective matter, where unions only play a limited role; while trade unions emphasise the potential for social dialogue at company level to influence return to work processes.

According to managers, there are a few elements that should change in their companies regarding the return to work such as better interpersonal relations with employees to deal directly with employee reintegration, and better cooperation with health professionals and campaigning and patient support organisations to facilitate the return to work process. Managers also tend to agree that organisational policies should be improved. One avenue for improved organisational policies is the development of a return to work strategy in health and safety committees, as already mandated by national legislation since 2016, where the social partners can be involved in the process of discussion. Managers do, however, report a sceptical outlook on the current legislation which none regard as providing good guidelines for company-level action. At the same time, managers do not wish for more specific legislative provisions on company-level return to work policies; instead they prefer flexibility.

## 5. Discussion of research findings and conclusion

This chapter has analysed the role of social partners in Belgium in the design and implementation of policies on return to work for workers after, or with, chronic illness. This became an important issue on the political agenda in Belgium in the 2010s with an increasing number of cases of sick leave due to chronic illness and soaring social security expenditures. The current Covid-19 pandemic appears to have added further challenges on the return to work, causing health complications for chronically ill workers. 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 previously sick employees to come back to work. This resonates with the objectives of

the Europe 2020 strategy which is aimed at a gradual increase in the presence at work and fitness for work of previously ill employees, facilitating their longer involvement in the labour market.

The analysis in this chapter has shown that the social partners assume a significant and multi-faceted role in the development and implementation of return to work policies in Belgium. Social dialogue has helped substantially in developing a new framework for the return to work, even though this has important limitations. After INAMI/RIZIV put on the agenda the need to improve the reintegration of employees suffering from chronic illness, the social partners – via the CNT/NA – participated in the design of a new return to work procedure targeted at employees seeking to return to their former occupational activity. The social partners were able to influence the legislation by putting forward some key principles, such as the concept of a voluntary return to work process, the key role to be occupied by the occupational physician and the need for both collective return to work and concrete incentives. However, the 2016 reform's unforeseen consequences have also been criticised, especially by trade unions, mostly regarding the issue of contract termination for medical reasons.

Since EU-OSHA established its typology of systems in the return to work (2016), our findings show that the Belgian policy framework has evolved towards early intervention and a case management approach. This is exemplified by the new obligation on health insurance providers to assess, at the start of the period of invalidity, options for the return to work based on the employee's medical condition. While the financial incentives for employers to engage in early planning of the return to work have not been substantially changed, employers now have clearer responsibilities regarding the creation of an individualised return to work plan for the employee and of a company policy on return to work. Employees can benefit from transitional work options based on the work ability assessment performed by the occupational physician. However, there are still coordination problems between health professionals and the stakeholders involved at company level.

Effective social dialogue can certainly help with the return to work, but sectoral and firm characteristics play a more important role in determining the success of the return to work itself. Also, return to work following chronic illness can be difficult to tackle via social dialogue, given its sensitive and private nature, while it also involves workers shifted to the margins of traditional social dialogue as they are excluded from occupational life during the period of their illness. However, employers can play a key role at firm level, beyond human resources and occupational health services, in ensuring smooth reintegration for example by involving colleagues and line managers in the process. Some instruments and legal dispositions are in place, such as the obligation to discuss annually within the health and safety committees a company procedure on the return to work. However, these dispositions are not well implemented on the ground. Similarly, trade union or employee representatives are accorded an important role in the new legislation (CSC 2019). They can perform important functions such as offering emotional support during the return to work process and providing legal advice to the employee in the case of conflict with the employer as well as strategic guidance on the complexity of the procedure and during negotiations with the employer on the

reintegration plan. Additionally they can act as a mediator between HR and the employer as well as with colleagues. Trade union representatives can also put return to work on the agenda of health and safety committees which have the capacity to assess company return to work policies based on the quantitative and qualitative evaluations provided by the occupational physician. As part of these committees, trade union representatives can also contribute to the evaluation of the company policy and its implementation on the ground. However, there is substantial room for improvement in this area especially due to a lack of information on the part of union representatives and employees, as well as because of the sensitive nature of people returning to work with chronic 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 the return to work in which the occupational physician can give advice instead of making binding decisions. In parallel, social partners at the federal level could coordinate via the CNT/NA to issue guidelines based on best practice as a means of helping companies and local union representatives design company-level return to work procedures. Return to work after sick leave could also be tackled at sectoral or cross-sectoral level in a similar approach to that used by the social partners in addressing burnout (CNT 2018a). Ultimately, however, gathering reliable and systematic data on the outcomes of the return to work and the situation of chronically ill employees is the issue that needs to be prioritised most of all.

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