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Article

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Rising number of sick pay recipients in Belgium : causes and results of reintegration policies

by W. Gelade and Y. Saks

National Bank OF BELGIUM
Eurosystem

Rising number of sick pay recipients in Belgium: causes and results of reintegration policies

W. Gelade
Y. Saks

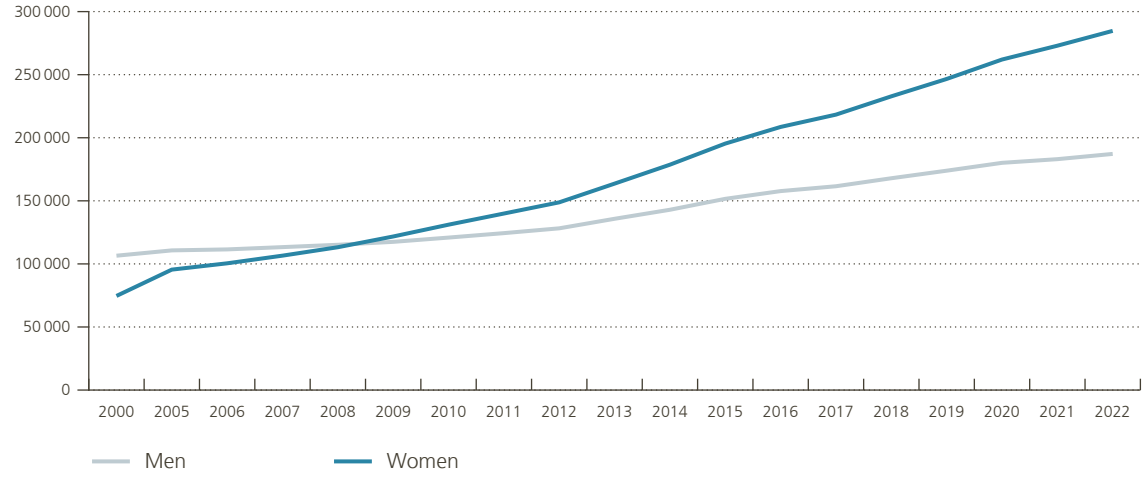
1. Sick pay insurance in Belgium: the institutional context

In Belgium, almost half a million people receive sickness allowances due to long-term illness (lasting more than twelve months). This number has been growing rapidly since the early 2000s for both men and women. On 31 December 2022, more than 187 000 male workers and almost 285 000 female workers were on sick leave for at least one year. Sick pay applies as soon as a medical problem prevents a person from working, regardless of whether the problem is work-related. The person must completely cease their activities to be entitled to the allowance.

Figure 1

The number of workers[1] receiving sickness allowances for more than 12 months has risen sharply, especially among women

(number of individuals)



Source: NIHDI.
1 Wage earners in private sector employment.

Sick pay is an important tool of public policy for insurance and redistribution. Coverage of sick workers redistributes from the healthy to the vulnerable, and can prevent an individual health shock from translating into an economic shock to the household (Adams-Prassl et al., 2023). Sick pay insurance is an element of mandatory social insurance in Belgium and therefore coverage is very high; all private employees are covered, as well as jobseekers. Self-employed workers are also covered but under different conditions. Statutory civil servants are covered by a separate scheme. In the present paper, we are only considering private sector employees.

The compensation rate of sick pay insurance is about 60 % of earnings, capped at a maximum daily ceiling. This rate can increase to up to 65 % should the period of sick leave exceed twelve months; a worker's family situation (i.e. whether they have a dependent family, are unmarried and live alone or in cohabitation, for example) is also a determinant factor in the calculation of the size of allowance to which an individual is entitled. The compensation rate of this social insurance is therefore in line with the replacement rate of the Belgian unemployment insurance scheme as well as with the net replacement rate of the Belgian pension system (at 61 % for the average earner (OECD, 2023)).

Although it is difficult to compare the social security systems of different countries, it appears that both the share of and increase in the number of people receiving sickness allowances is more pronounced in Belgium than elsewhere in Europe.

Given the challenges posed by a labour market in which labour shortages are hampering growth, and inactivity is limiting the feasibility of achieving an 80 % employment target by 2030, the High Council for Employment decided to analyse the trajectories of people affected by incapacity for work. This article is a summary of the resulting report,[1] which was compiled using a database of individual personal data that makes it possible to track private sector workers before and after a period of illness and analyse the impact on their labour market status. The data were collected and made available by the Crossroads Bank for Social Security[2] for the period 2013 to 2020.

2. Factors determining the proportion of workers entering sick leave

2.1 Socio-demographic factors influence individual health status

A private sector employee can benefit from sick pay insurance provided they fulfil the entitlement criteria, and only after a period of sick leave exceeds the statutory sick pay period during which the employer continues to pay the absent worker. The duration of the latter period depends on the status of the worker but is generally one month. This article therefore looks at those workers entering the system after a period of absence of one month, at which point sickness allowances are distributed to the worker by the sickness and invalidity insurance system, via their health insurance fund.

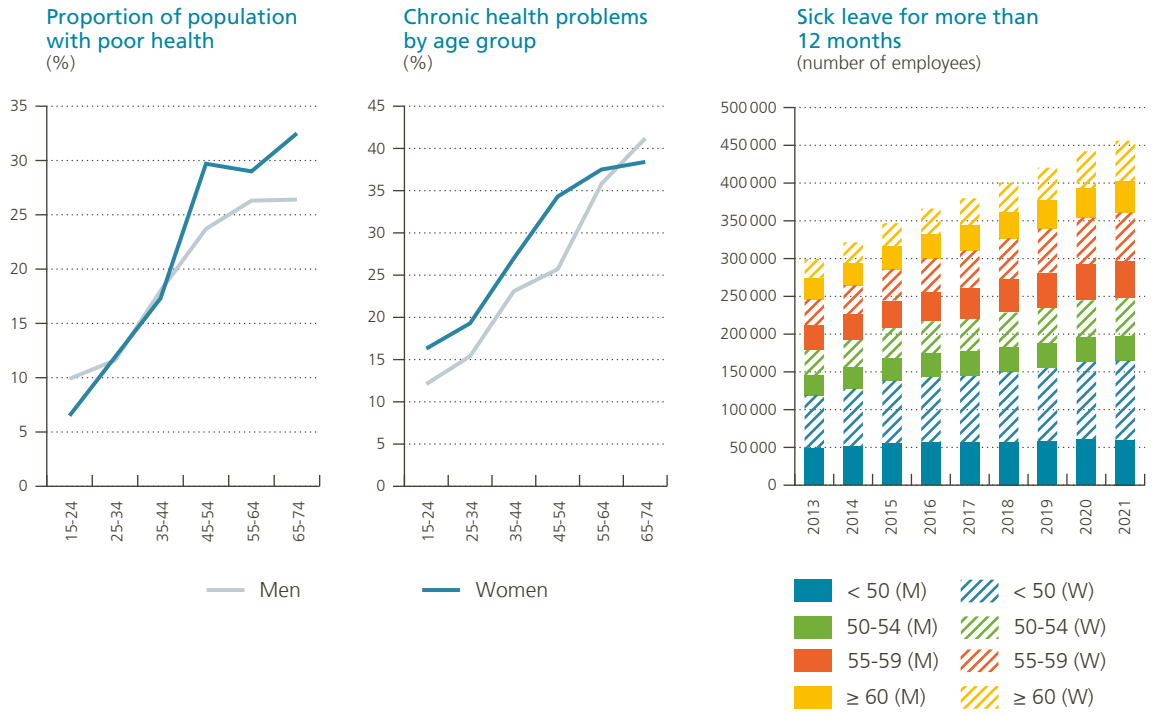
The primary condition that a worker needs to meet to benefit from sick leave is certification by a physician that they are not fit to perform their professional duties due to a medical issue or a worsening of the state of their health[3]. The characteristics of the population entitled to sickness and invalidity allowances that have an influence on their health status must therefore be examined in detail. The ageing of the working population and increased female labour force participation are major developments in this respect.

The ageing of the working population is well documented (see, for example, Minne and Saks, 2023). The proportion of over-45s employed by Belgian companies has been rising steadily. Given Belgium's

1 See the full report of the High Council for Employment (2024) *here*.
2 See the acknowledgments at the end of this article.
3 The gainful capacities of the worker should be reduced by 2/3, also taking into account the occupation and education level of the person.

Figure 2

The ageing of the working population and increased female labour force participation partly explain the increase in the number of workers on sick leave



Sources: NIHDI, Statbel, Sciensano.

demographic trends and employment policies, the population of private sector workers is getting older. While barely one in four Belgian workers was aged 45 or over in 1999, this age group is becoming increasingly significant within the workforces of Belgian companies. By 2006, more than a third of employees were within this age group, and this proportion has been rising steadily ever since. In 2019, 42 % of private sector employees were aged 45 or over.

All general health status indicators (i.e. self-perceived health, chronic morbidity and activity limitations) unanimously demonstrate that health deteriorates with age. The ageing of the population and, in particular, of private-sector employees, therefore goes hand in hand with an increase in the number of people entering the sickness and invalidity insurance system.

The other major trend is the increase in female labour force participation: the female employment rate in Belgium rose from 50 % in 1995 to 67 % in 2022. Over the same period, the employment rate for men fluctuated between 70 % and 75 %. It is from the age of 45 onwards (i.e. at the end of the distribution of working ages), above all, that the female employment rate has increased the most. This is also true for men, albeit to a lesser extent. It should be noted that between 1996 and 2009, the statutory retirement age for women was gradually raised from 60 to 65, to bring it into line with that for men.

A series of factors have prompted the increase in female labour force participation, which include changing attitudes to the roles of men and women in the household and in society, and higher levels of education among women. On the labour market, the growth of the service sector, in which the female workforce is more significant, has enabled many women to find employment. Technological advances that facilitate housework, childcare and contraception have also played a key role.

Although it is more difficult to link gender differences to the likelihood of falling ill more frequently, data from benchmark health surveys show that women's perceived health is poorer and that there is a higher frequency of chronic health problems among women. The fact that household chores are still very unevenly distributed within couples[4] could also contribute to women's poorer health during their working careers. Different empirical studies have shown a link between work-family conflict and sickness absence, in line with the 'the double-burden hypothesis'. A significant part of the gender gap in long term sickness absence remains however unexplained.

As shown below, the number of new recipients of sick pay insurance (i.e. those entering their first year of sick leave, or so-called "primary sick leave") rose steadily from 2013 to 2019, with a more marked upward trend for women. On average, more than 25 000 men and almost 30 000 women enter primary sick leave each quarter.

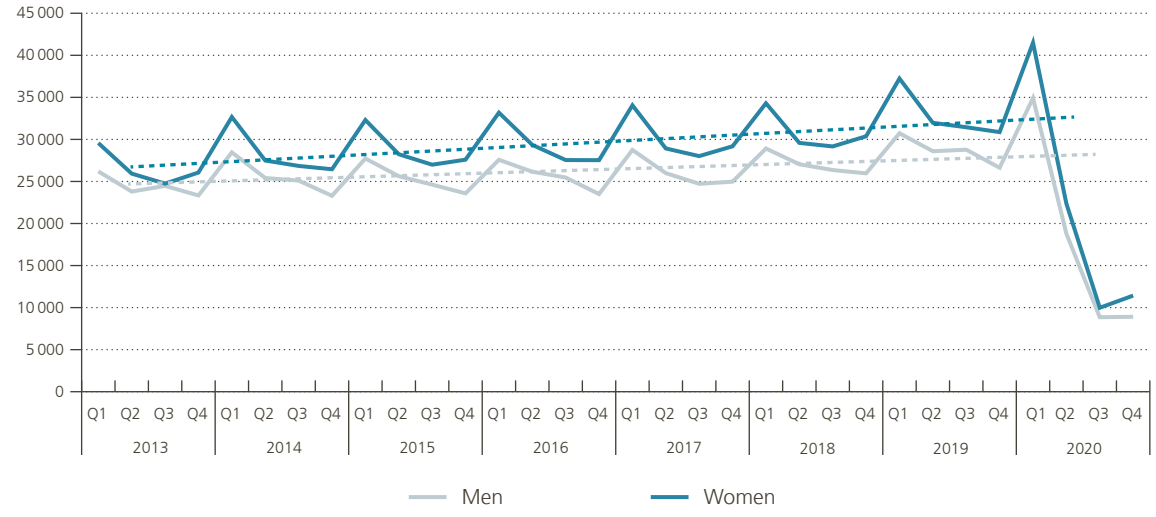
However, during the first quarters of the health crisis, the number of new recipients of sick pay insurance fell sharply. According to the NIHDI, this may have been due to a number of factors. There were fewer cases of certain illnesses, notably infectious diseases (with the obvious exception of COVID-19), thanks to the reduction in social interaction. As a reminder, new recipients of sick pay insurance are defined here as those employees on sick leave for a period of at least one month. Consequently, the increase in COVID-19 cases was not necessarily reflected in the number of new recipients, since the vast majority did not result in an absence of more than a month. During the health crisis, teleworking was used on a widespread scale and commuter-related road accidents decreased. These new working conditions resulted, at least in the short term, in a reduction in the inflow into sick leave. There is, as yet no consensus in the scientific literature on the effect of teleworking on employees' health status.

4 See Institute for the equality of women and men (2020), "Chapter 7: Use of Time" in Women and men in Belgium, Brussels.

Figure 3

New sick pay insurance recipients, by gender

(number of new recipients of sick pay insurance per quarter and who are employed in the private sector)



Source: authors' own calculations based on CBSS data.

Other forms of financial support for employees, which were stepped up during the health crisis, may also have contributed to the reduced reliance on the sickness and invalidity insurance system. Private sector employees were able to benefit from additional measures such as temporary furlough schemes, in particular.

2.2 The rate at which new recipients enter the sick pay insurance system varies by sector

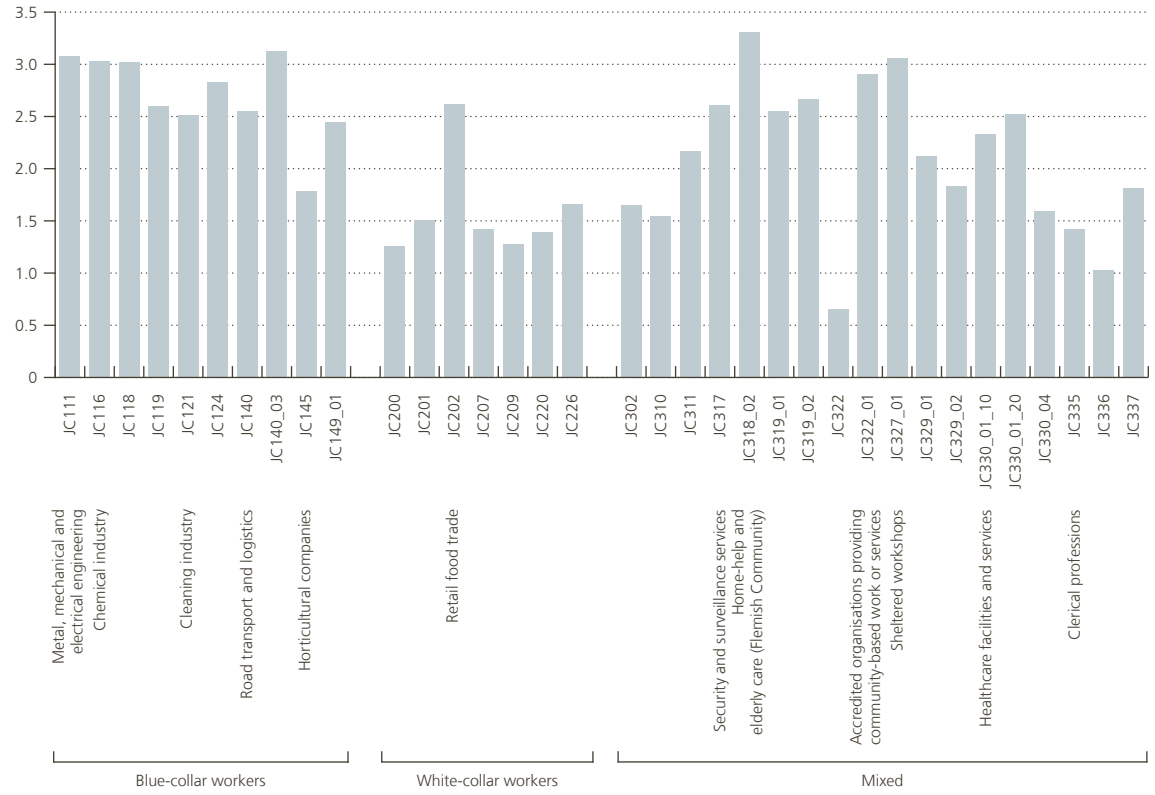
Among the differences within the population eligible for sickness allowances, the sector in which they work/joint committee can also have a particular influence on the state of their health, due to the risks to which workers are exposed as a result of their occupation, sector of activity or their responsibilities.

As a result, some workers are more exposed to risks to their physical health (e.g. working in tiring or painful positions; undertaking repetitive movements; handling heavy loads; experiencing strong vibrations; exposure to chemical products, dust, fumes, or smoke; undertaking activities requiring visual concentration, etc.). According to labour force surveys, these work-related physical health problems are more common in the following sectors in particular: water supply, sewerage, waste management and remediation activities; construction; transportation and storage; energy; and manufacturing. Other workers are more exposed to mental health risks (e.g. due to excessive time constraints or overwork; violence or the threat of violence; harassment or bullying;

Figure 4

Rates[1] at which new recipients enter the sick pay insurance system vary markedly by Joint Committee

(in %, estimated rates for 2019)



Source: authors' own calculations based on CBSS data.

1 Estimated inflow rates by Joint Committee after controlling for gender, age, region, level of education, family situation, and NACE (1-digit) sector of employer. A change in specification can influence these results.

a lack of communication or cooperation within the organisation; dealing with difficult customers, patients, or pupils, etc.). These risks are more frequent in the following sectors: human health and social work activities; transportation and storage; accommodation and food service activities; and financial and insurance activities.

This is why employers are subject to a whole range of legislation designed to reduce, as far as possible, the risks to which workers are exposed. This legislation is well-developed vis-à-vis physical health risks, which mainly concern manufacturing and sectors related to it. Psychosocial risks have only recently been taken into account. But in recent years, the social partners have been working to improve their understanding of burnout, in particular, and through the National Labour Council, have set up a series of pilot projects aimed at tackling this specific issue.

The degree to which a job is considered feasible (so-called "workable work") remains a complex dimension to grasp. In this respect, it is worth highlighting the quality of the "workability monitor" analyses carried out by the Social and Economic Council of Flanders for the region (SERV & SIA, 2023). Nevertheless, it remains difficult to say whether work has intensified over the last fifteen years. On the one hand, the scale of intensification depends on the occupation/tasks performed and the sector of activity; on the other hand, sociological, institutional, and technological environments have also changed profoundly. These various developments have not been experienced by all workers in the same way. Finally, budget constraints (particularly in the healthcare sector, etc.) and shortages in certain sectors are probably also having an impact on the existing workforce.

3. Outcomes from reintegration pathways

To counter the increasing number of people on sick leave, attention has increasingly been placed on reintegrating people into the labour market. In this section, we turn our focus towards those workers exiting the sick pay insurance system and the outcomes of the various reintegration pathways available to them.

3.1 Exiting the sick pay insurance system

The probability of exiting the sick pay insurance system decreases rapidly after six months of absence from work. In those first six months, two-thirds leave the system; thereafter, returning to work appears to become much more difficult. About two in ten people receiving sick pay insurance remain out of work for one year, of which eight out of ten are still on sick leave a year later. The probability of exiting the system continues to decrease as the duration of a worker's absence grows longer.

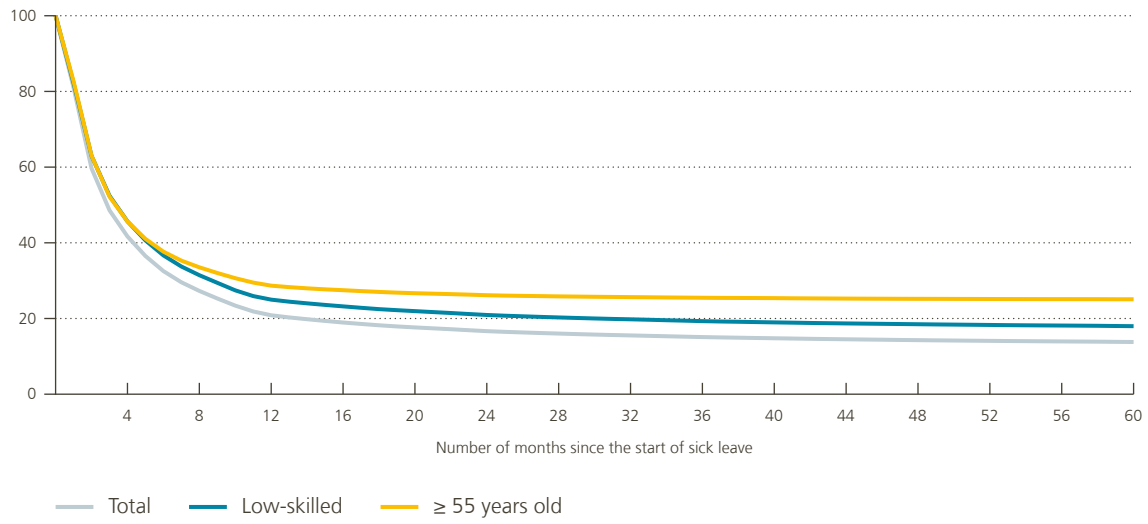
There are several reasons why returning to work becomes increasingly difficult. On the one hand, individuals with less severe health issues can be expected to return to work more quickly. On the other hand, a prolonged absence can itself hinder a return to work: this may be due to a decline over time in work-related competencies or a weakening of a worker's connection to their employer or work environment. Factors unrelated to the job market, such as a loss of confidence, fear of resuming work, and changes in family dynamics (e.g., taking on more childcare duties), can also make a later return more difficult.

On average, low-skilled and older workers remain on sick leave for longer. For the latter group, the likelihood of exiting the system already begins to be very low after a year of absence, with workers exiting the system only when they reach retirement age or pass away. Flanders has the shortest average duration of sick leave, and Brussels the longest, even after correcting for demographic differences. Overall, groups enjoying a stronger position on the labour market appear to exit the system more quickly. Although entitlement to sickness allowances is based on a medical assessment, an individual can spontaneously leave the system when they are fit to work – for their existing or a new employer. A stronger position in the job market, or a more dynamic labour market, which can contribute to increased job opportunities for people with health issues, can help expedite departure from the system.

Figure 5

The probability of exiting the sick pay insurance system decreases sharply after six months of absence

(in % still on sick leave, private sector employees, 2014-2020)



Sources: authors' own calculations based on CBSS data.

Note: Kaplan-Meier survival curves based on sick leave periods of at least one month starting between 2014 and 2020, with a follow-up period up to the end of 2020. Periods are censored at the moment of retirement or death, which are thus not considered to be an exit from the system.

After exiting the sick pay insurance system, people do not necessarily return to the labour market. About seven in ten people begin working again[5] after a period of leave of at least four months' duration. An important reason for this is that not all departures from the system are voluntary. When sick leave lasts more than one year, the physicians at the health insurance fund and the NIHDI determine whether the person still qualifies for allowances.[6] About 22 % of cases of sick leave end pursuant to this, as opposed to 28 % which are ended voluntarily (the other half end because of retirement or death). When the physician puts an end to sick leave in this way, only one in three people start working again, and this share barely increases in the year after exiting the sick pay insurance system. While sick leave is, in principle, brought to an end because a person's medical condition permits them to start working again, the prolonged period of absence or remaining health issues can make it difficult to return to the labour market.

After having been on sick leave, a significant proportion of people begin working for a different employer. Of those who return to work after at least four months of leave, most resume their existing job. However, one in five workers moves to a different employer and, in that case, usually also a different sector. This proportion is higher amongst people whose absence was due to mental health issues, and rises to half amongst those who were out of work for health reasons for more than two years. Moreover, a significant proportion of people return to their current employer but change employer in the following year. Thus, due to the state of their health or their prolonged absence, a large group wishes, or needs, to look for a new employer or even a new occupation.

5 This excludes exits because of retirement or death. It does include people who were unemployed when their sick leave began. When focusing only on people who worked in the six months prior to entering the sick pay insurance system, this share increases to 8 in 10.

6 The physicians at the health insurance fund are also responsible for determining whether a person qualifies for allowances during their first year of sick leave, but this is based upon medical certificates issued by the attending physician which include a suggested period of time during which the person should not be working.

3.2 Interest in reintegration is growing …

Several pathways exist to support reintegration into the labour market. A partial return-to-work is possible, whereby a worker partially resumes work and their salary is supplemented by sickness allowances. To facilitate the resumption of work with an existing employer, a visit prior to a return-to-work can take place or, since 2017, a reintegration trajectory can be followed. The occupational physician will then assess whether a (partial) resumption of work is possible and whether adaptations to the workplace are needed. These two pathways thus serve a similar purpose, but the reintegration trajectory formalises the different steps in the process. For people looking for a new job or who need new skills to return to work despite their health issues, the regional public employment services and their partners offer guidance and training, which is henceforth referred to as a job placement programme.

The health insurance funds have an important role to play in referring people to these pathways. The physicians at the health insurance fund, supported by a multidisciplinary team, are responsible for assessing eligibility for sickness allowances, but also for assisting people in returning to work. For this purpose a new role has recently been created within the health insurance funds: so-called "back-to-work coordinators" are now available to help with referring people to these various reintegration pathways. The diagram below gives a simplified overview of these pathways.

Some elements of each pathway are obligatory. For example, an employer must provide appropriate justification in a reintegration trajectory if they do not agree with the proposals of the occupational physician. The physician at the health insurance fund can also decide that a person is no longer eligible for sickness allowances when their health has improved sufficiently to justify this. However, for people on sick leave, any steps taken are generally voluntary. They can choose whether to embark on a pathway, and whether to accept proposals to (partially) resume working.

The number of people making use of these pathways is increasing. By far the most widely used is the option of a partial return-to-work, with the number doubling to 120 000 between 2015 and 2021. People on this pathway typically work half-time, but also have the possibility of resuming work for fewer (or more) hours per week.

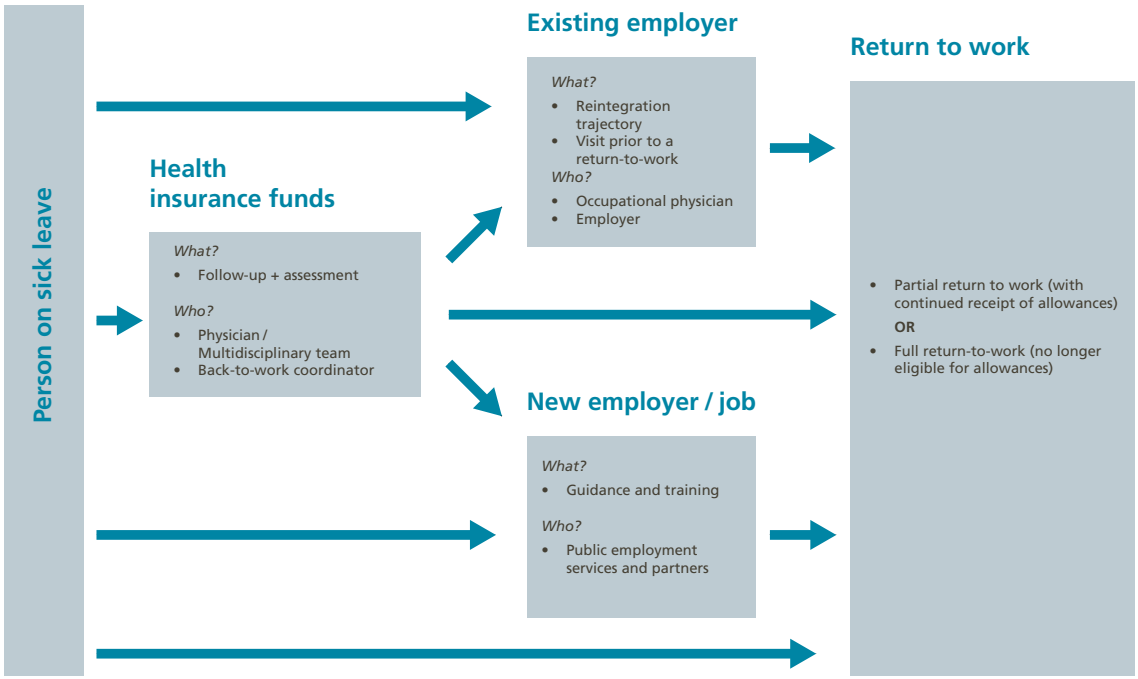
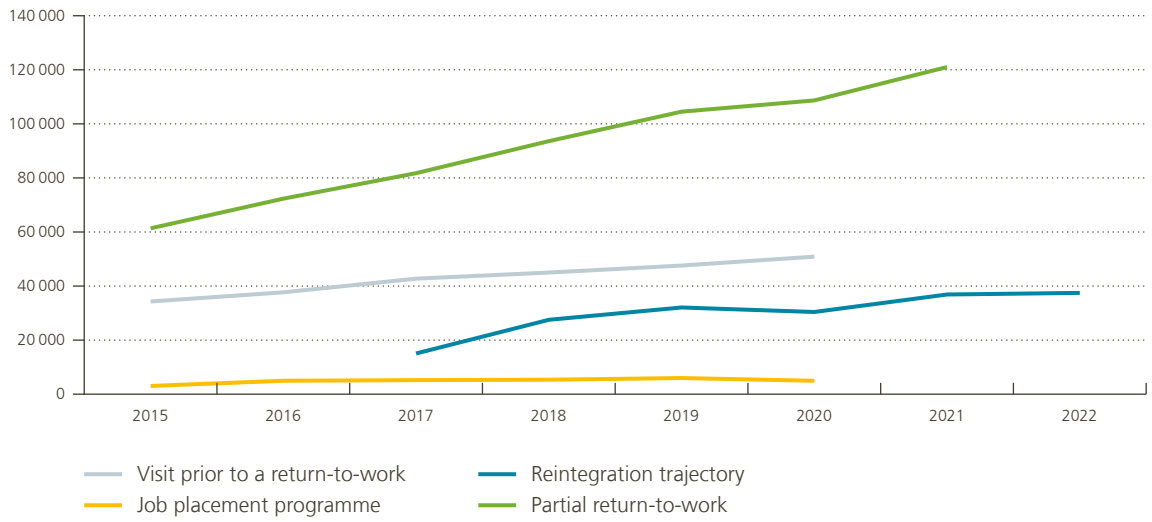


Figure 6

The number of people making use of reintegration pathways is increasing

(number of persons)



Sources: NIHDI, Co-Prev, authors' own calculations based on CBSS data.

Note: Figures on reintegration trajectories and visits prior to a return-to-work are based on data from the external prevention services (Co-Prev) and do not include pathways at companies with internal prevention services. Figures refer to the number of individuals who begin a reintegration trajectory or a job placement programme or who undertake a visit prior to a return-to-work in a given year. The number of individuals undertaking a partial return-to-work corresponds to the number of employees who have an authorisation to resume work in this way for at least one day in a given year.

On the other hand, take-up of job placement programmes remains very limited (5 000 in 2020). This is remarkable given that many people switch employers or jobs after a long absence, and this programme is intended to help with just such a transition. Some changes are, however, being made to these programmes. The agreements between the federal and regional entities to set up the programmes, which were initially signed in 2012 and 2013, were renewed in 2023. In the process, the target groups in Brussels and Wallonia were expanded to include all persons in need of guidance – previously only training was offered – as was already the case in Flanders. There is now also such an agreement for the German-speaking community. In addition, a target of 18 000 was set for the number of participants in 2024, but that remains low.

Reintegration with an existing employer almost exclusively occurs following the (more informal) pre-return-to-work visits. When the reintegration trajectory was first introduced in 2017, it was made a mandatory step in the process of ending a contract on the basis of medical force majeure, resulting in just over half of such cases leading to this outcome (Boets et al., 2020). For this reason, reintegration trajectories were made distinct from the medical force majeure process at the end of 2022, resulting in an 80 % drop in the number of such trajectories being initiated. As a result of this, visits prior to a return-to-work, which were the most popular pathway even before the reform (used by 51 000 people in 2020), are now by far the most important procedure for reintegration with an existing employer. Note that the period covered by this study (up to 2020) is prior to this reform, and all data related to reintegration trajectories thus refer to their use pre-reform.

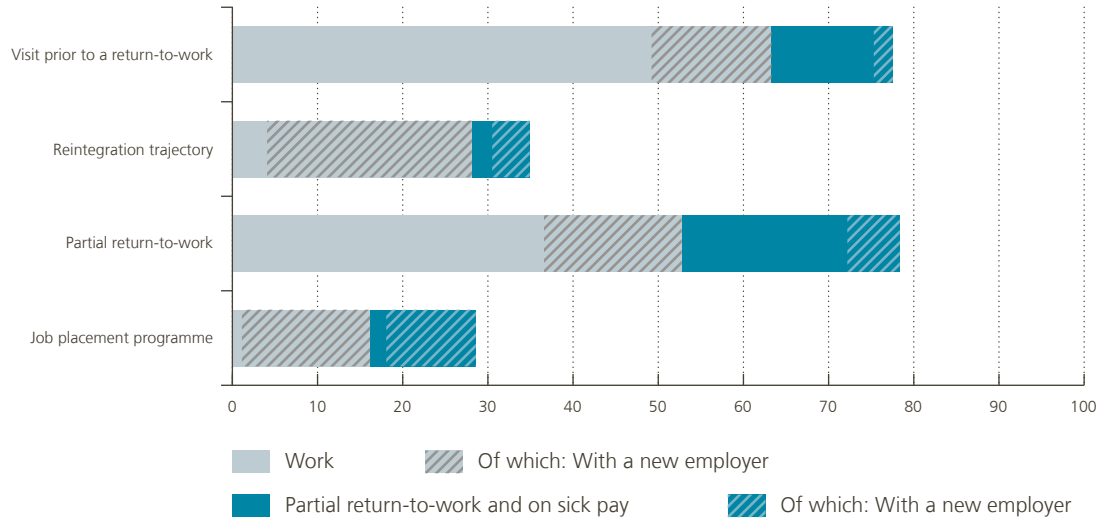
3.3 … but people are not (yet) exiting the sickness allowance system more quickly

The labour market outcomes of these reintegration pathways differ strongly. The graph below shows the share of people returning to the labour market two years after they embark on one of these pathways. We distinguish between people who work (and exited the sickness allowances system), and those who combine sickness

Figure 7

Labour market outcomes differ strongly between reintegration pathways, but the characteristics of participants are also very different

(in % of participants in work two years after taking up a pathway, private sector employees, 2017-2020)



Sources: authors' own calculations based on CBSS data.

allowances and partial employment. For all pathways, an important share resumes work through partial employment, underlining its importance for reintegration. The characteristics of participants on each pathway are very different, which can help to explain the differences in labour market outcomes from each one.

The probability of resuming work is lowest for the job placement programme pathway: about three in ten people return to the labour market, of which almost half do so via partial employment. However, this is the group for whom reintegration is likely to be most difficult. Participants need to change employer or acquire new skills, more often have a lower level of education, and, importantly, have been on sick leave for a long period.

When participants successfully complete a training course, the probability of returning to work is much higher, with more than half finding a job within six months of completing a course. However, successfully completing a training course is a challenge for this group and only about half of those who start a course manage to do so.

Of those who pursue a partial return-to-work, about eight in ten are still working two years later.[7] About half of the people who resume work on a partial basis, leave the sick pay insurance system within half a year and fully resume work. However, after this initial period, few additional people within this group exit the system.

Indeed, about a quarter continue to combine sickness allowances and partial work after two years. This can be a valuable outcome for people with chronic illnesses, for whom exiting the sick pay insurance system might not be an option. However, this also raises the question of whether there are barriers to exiting the system after a partial return-to-work. On this pathway, a person's salary can be supplemented by reduced sickness allowances[8]:

7 Note that the partial employment scheme is both considered as an outcome and a pathway for reintegration. A partial return is also a return to work, but at the same time it can be seen as a reintegration pathway that can be a first step to exiting the sick pay insurance system later on.

8 If a person works for the equivalent of 20 % or less of a full-time job, sickness allowances are not reduced. If working more than this, allowances are reduced proportionally based on the number of working hours above that 20 % threshold. For example, if working on a half-time basis (50 %), sickness allowances are reduced by 30 % (50 % – 20 %).

for people who have to resume working at a low wage (or a lower wage than before their absence), there may be a very limited or no financial incentive to exiting the system and fully resuming work (Hufkens et al., 2016).

Overall, the probability of success of the partial employment scheme is highest for people who resume work on at least a half-time basis, but even among those who resume working at most one day per week, seven out of ten were still working two years later.

Labour market outcomes differ strongly after participation on the different pathways involving an existing employer: eight in ten return to work after a visit prior to a return-to-work, against about one-third after a reintegration trajectory had been followed. However, the profiles of participants on these pathways differ greatly: a visit prior to a return-to-work is often used at an early point during a period of sick leave and by people for whom the occupational physician assesses that a return is possible. Reintegration trajectories, in the period before their reform, were often used by people who could not return to their existing jobs, and when they did resume work it was usually with a new employer.

In large companies, visits prior to a return-to-work have a substantially higher success rate. The likelihood of returning to work gradually increases with the size of the company, and in an organisation with more than 200 employees, it is ten percentage points higher than in those with fewer than ten employees. Smaller companies may indeed have fewer opportunities to propose adaptations to a job/workplace to employees.

A regression analysis[9] shows that early take-up is the most important success factor for all of these reintegration pathways: depending on the pathway, the probability to return to work is 20 to 50 percentage points higher when comparing people who embark on a pathway in the first six months of sick leave with those who start after two years or more. Undoubtedly, differences in the state of health of workers contribute to this difference. But aside from that, an early start is, in and of itself, also a factor in a successful future transition.

Groups for whom it is more difficult to exit the sick pay insurance system in general, also have a lower probability to return to work after embarking on these pathways. This is the case for the lower-skilled, single people (with or without children), and residents of Wallonia and Brussels. This suggests that these pathways are not necessarily less effective for these groups, but that other factors reduce the overall probability of people within these groups returning to the labour market. The regional differences may be explained by the fact that there are more opportunities for workers in the Flemish labour market, given that it is more dynamic. Overall, however, differences in the probabilities of returning to work are smaller when also taking into account partial employment, suggesting that this pathway is especially valuable for workers for whom a return to the labour market is more challenging.

Despite the increased take-up of these reintegration pathways, people are not exiting the sick pay insurance system more quickly. The probability of sick leave lasting at least one year remained relatively stable between 2013 and 2020, at around 20 %. For people whose sick leave began in 2019 that probability increased to 22 %, but this is presumably linked to the fact that reintegration into the labour market was more difficult during the COVID-19 pandemic. Overall, the probability of a person moving to long-term sick leave appears stable.[10] This does not imply that the different reintegration pathways have no impact. However, their overall impact does not appear large enough to reduce substantially the average duration of sick leave.

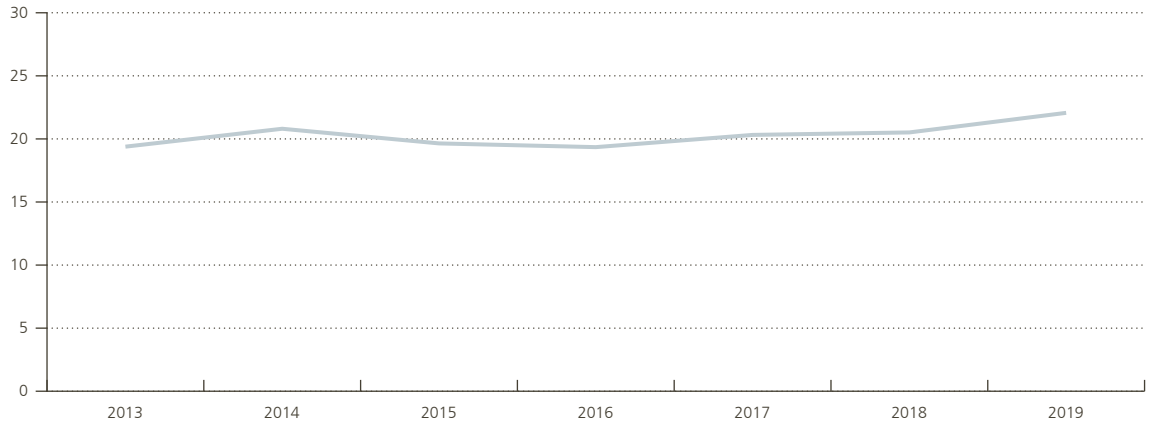
9 Regression with the outcome of a return-to-work one year after embarking on the different pathways and controlling for the duration of sick leave, gender, age, blue-collar/white-collar work, region, level of education, family situation, number of employees at the company, nature of health issue, and NACE (1-digit) sector of employer. Additionally, controls specific to the reintegration pathway are added: "Programme with/without training" for the job placement programme; "number of working hours on partial employment" for the partial employment pathway; and "assessment by occupational physician" and "person who initiated the trajectory" for the reintegration trajectory. For the job placement programme, the outcome is a return-to-work two years (instead of one year) after embarking on the programme, to take into account the longer duration of the programme.

10 Over this period, the share of people on sick leave who are over 55-years old has also increased. Since this group, on average, stays on sick leave for a longer time, this affects the evolution of the risk of long-term sickness. However, even when we adjust for demography and other factors in a regression framework, the probability of long-term sick leave appears stable.

Figure 8

The risk of long-term sick leave is stable

(in % of people for whom sick leave lasts at least one year, as compared to the total number of people who began a period of sick leave in a given year)



Sources: authors' own calculations based on CBSS data.

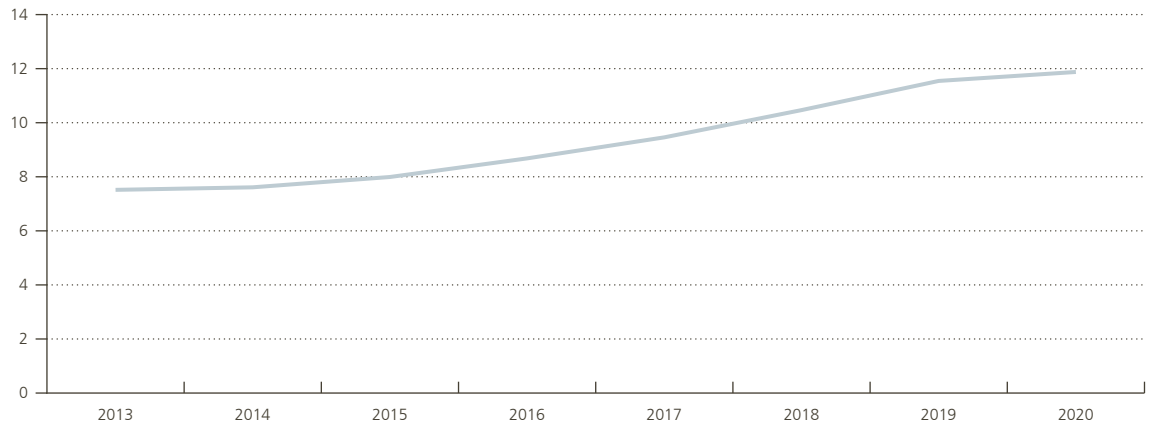
Several factors can help explain this. Firstly, as we have seen, a sizeable group of people needs to, or wants to, embark on the difficult transition to a new employer or a new job after a long period of absence, but take-up of the job placement programme intended to support such a transition is very low.

Secondly, while the duration of sick leave is not decreasing, because of the increased take-up of partial work, the share of people receiving long-term sick pay allowances and who are working has substantially increased: from 8 % in 2013 to 12 % in 2020. However, as discussed earlier, the (lack of) financial incentives do not always encourage people to exit the sick pay insurance system and transition from partial to full employment, particularly for those on low wages.

Figure 9

The number of people working while on long-term sick leave is increasing

(in % of people receiving long-term sickness allowances)



Sources: authors' own calculations based on CBSS data.
Note: Long-term sick leave refers to people on sick leave for at least one year.

Finally, and perhaps most importantly, steps towards reintegration are often taken late, which we explore in the next section.

3.4 Steps towards reintegration are often taken late

Clearly, a worker's state of health primarily determines when a return to work is possible. However, when medically possible, the probability of a successful reintegration into the labour market is much higher when initiated in the first six months of absence (OECD, 2022).

The graph below examines reintegration efforts during the initial period of sick leave. It focuses on a cohort of individuals who were on sick leave for at least four months, indicating a high risk of long-term absence.[11] After six months of sick leave, one in four of this group ended their sick leave without recourse to a reintegration pathway, presumably because they did not need it. The comparison between the two other groups during the first six months of sick leave is more instructive: two out of ten made use of these pathways, while slightly over half were still on sick leave and had not made use of a reintegration pathway.

In other words, a small majority of people at risk of long-term absence do not take steps towards reintegration in the first six months of leave. Clearly, not everyone should be expected to do so. But after one year, this share drops to three in ten, indicating that steps towards reintegration are eventually taken, but often later.

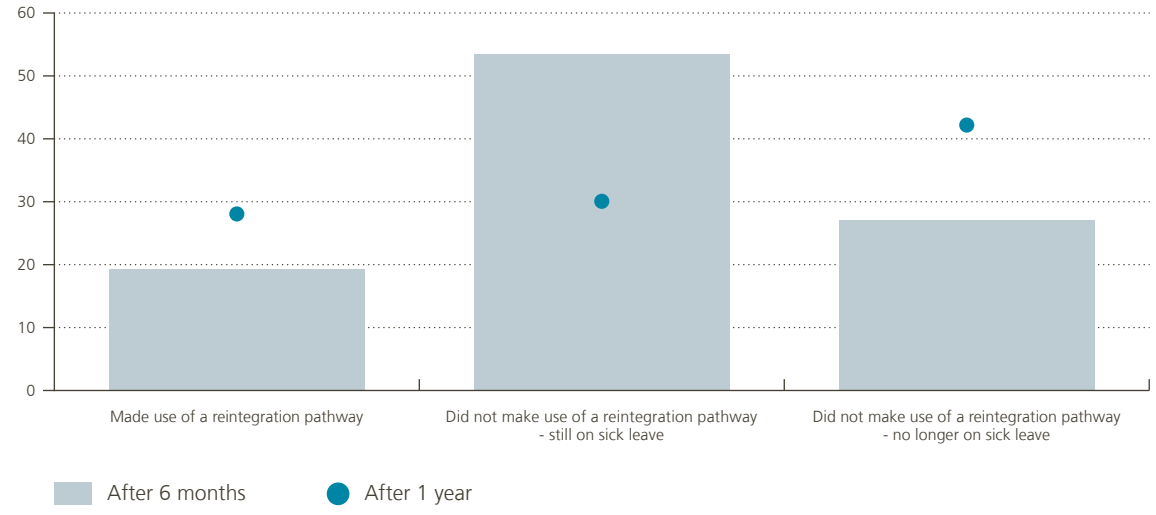
There is also a clear difference with other countries, such as the Netherlands and Germany, where it is obligatory after two months of absence to assess reintegration possibilities and set up a plan for reintegration together

11 During the fourth month of absence, the health insurance fund also assesses whether reintegration is possible and refers people to the different reintegration pathways.

Figure 10

Steps towards reintegration are often taken late

(in % of people who made use of a reintegration pathway and/or were still on sick leave six or twelve months after beginning sick leave, 2017-2020)



Sources: authors' own calculations based on CBSS data.
Note: only people who have been on sick leave for at least four months are taken into account.

with the employer. Such an approach ensures that, when possible, the first steps towards reintegration are taken much earlier than in Belgium.

The moment at which the different pathways are used also varies considerably. More than half of pre-return-to-work visits and partial resumptions of work occur within the first six months of absence, but this is true for only three in ten of the cases involving a reintegration trajectory and for less than one in ten cases involving a job placement programme. Although the latter are likely to begin later – given that they may be used only after a failed attempt at reintegration with a previous employer – half of them only start after at least two years of absence, when the chances of returning to work are very low. This suggests that the problem of beginning reintegration efforts late is most acute for people who need to change employer or job.

In recent years, reforms have, however, been implemented to address this issue. Most people are now seen three times during the first year of sick leave by the physician or a member of the multidisciplinary team at the health insurance fund, with a first visit during the fourth month of absence. The occupational physician is also responsible for informing people about possible pathways for reintegration with their employer after four weeks of absence. Such measures could increase both the take-up of these options, and the moment at which they are used.

4. Conclusion

The number of people entering the sickness and invalidity insurance system continues to rise, quarter after quarter. Over time, it was expected that this number would grow due, on the one hand, to the increase in the size of the working population, but also due to legislative changes that imply an increase in the population eligible for allowances under the sick pay insurance system. For example, raising the legal retirement age from 65 to 66 in Belgium from 1 February 2025 will lead to a further increase in the population eligible for sickness allowances and inevitably bring new upward pressure on the numbers of people entering the system.

In addition to the size of the population eligible for allowances, its composition also has a direct effect on the numbers entering the system. As is the case for the population as a whole, Belgium's working population is ageing. Given that the frequency of health problems is a function of age, part of the growth in the number of people entering the system can be explained by this phenomenon. Finally, there has been an increase in female labour force participation and given that women are more likely than men to suffer chronic health problems, this also implies a rise in long-term sickness. However, the impact of these dynamics takes time to play out; the increase observed in the number of people entering the system over the last fifteen years cannot be explained by these trends alone. All other things being equal, employees may have made greater use of sick leave. The reforms in the unemployment insurance system since 2004 and the gradual curtailing of early retirement schemes may have indirectly impacted the sick pay insurance.

According to certain indicators, stress-related problems have increased among working people, at least within certain sectors or amongst certain roles. On the other hand, the level of exposure to physical health risks has probably decreased, thanks to technological developments and the prevention-focused measures that have been put in place in the sectors most concerned.

Faced with the rising number of people on sick leave, reintegration pathways have gained prominence and the number of people making use of such measures has increased substantially. However, in the period up to 2020 this had not yet led to a rise in the numbers of peoples exiting the system, which may be explained by several factors. First, and foremost, steps towards reintegration are often taken late. To increase the chances of a successful reintegration, such steps should be taken as soon as a person's health allows it, ideally during the first six months of absence (OECD, 2022).

Secondly, after a long absence due to sickness many workers need or want to change employer or job. This can be a difficult transition, especially for people with enduring health issues. However, the guidance and training offered by the public employment services and their partners remains under-used. Finally, an increasing number of people are partially working while receiving sickness allowances, which can be an important first step towards a full resumption of work or a good solution for people with chronic health problems. However, the (lack of) financial incentives do not always encourage the transition from a partial to a full resumption of work, particularly for people who would be on low wages after ending sick leave.

In view of the growing number of people on sick leave and long-term sick leave, a change in mentality is needed. People who enter the long-term sickness insurance system (i.e. after twelve months of sick leave) should not be considered as definitively unfit for work. There are now more people entering the system, some of whom are at a young age when beginning sick leave, and the pathologies involved do not necessarily imply permanent incapacity for work. In fact, in many situations, a return to work is possible, and this step can be an integral part of the care process. While taking account of the state of an individual's health, it is therefore important to help workers (and employers) in this transition, by supporting institutional actors to put in place credible reintegration policies. The report by the High Council for Employment (2024) puts forwards a series of recommendations to reinforce the role of all actors – employee, employer, occupational physician, health insurance fund and (regional) authorities – in such policies.

Annex

List of joint committees featured in Figure 4

111	Joint Committee for metal, mechanical and electrical engineering
116	Joint Committee for the chemical industry
118	Joint Committee for the food industry
119	Joint Committee for the retail food trade
121	Joint Committee for the cleaning industry
124	Joint Committee for the construction Industry
140	Joint Committee for transport and logistics
140.03	Joint sub-committee for road transport and third-party logistics
145	Joint committee for horticultural companies
149.01	Joint sub-committee for electricians: installation and distribution
200	Joint auxiliary committee for employees
201	Joint committee for independent retailers
202	Joint committee for white-collar workers in the retail food trade
207	Joint committee for white-collar workers in the chemical industry
209	Joint Committee for white-collar workers in the metalworking industry
220	Joint Committee for white-collar workers in the food industry
226	Joint Committee for white-collar workers in the international trade, transport and logistics sector
302	Joint Committee for the hotel industry
310	Joint Committee for banking
311	Joint Committee for large retail companies
317	Joint committee for security and/or surveillance services
318.02	Joint sub-committee for the services of home-help and elderly-care workers in the Flemish Community
319.01	Joint sub-committee for educational and residential establishments and services of the Flemish Community
319.02	Joint sub-committee for education and residential establishments and services of the French Community, the Walloon Region and the German-speaking Community
322	Joint Committee for temporary work and accredited organisations providing community-based work or services
322.01	Joint sub-committee for accredited organisations providing community-based work or services
327.01	Joint sub-committee for the Flemish sheltered workshops sector
329.01	Joint sub-committee for the socio-cultural sector of the Flemish Community
329.02	Joint sub-committee for the socio-cultural sector of the French and German-speaking Community and the Walloon Region
330.01.10	Joint sub-committee for private hospitals and psychiatric care homes
330.01.20	Joint sub-committee for rest homes, nursing homes, assisted living facilities, day care centres and day centres for the elderly
330.04	Joint sub-committee for residual healthcare establishments and services
335	Joint committee for the provision of services and support to businesses and the self-employed
336	Joint committee for the clerical professions
337	Joint auxiliary committee for the non-profit sector

Bibliography

Adams-Prassl A., T. Boneva, M. Golin and Ch. Rauh (2023), "The value of sick pay", *European Economic Review*, 151.

Boets I., L. Godderis, V. De Greef en H. Deroubaix (2020), *Evaluatie van de impact van de nieuwe reglementering op de re-integratie op het werk. Kwantitatieve en kwalitatieve evaluatie,* FOD WASO.

De Brouwer O. en I. Tojerow (2023), "The consequences of job search monitoring for the long-term unemployed: Disability instead of employment?", *Journal of Public Economics*, 224.

High Council for Employment (2014), ***Deelname aan de arbeidsmarkt van personen met een arbeidsbeperking of een chronisch gezondheidsprobleem.***

High Council for Employment (2024), ***Arbeidsongeschiktheid en de re-integratie van werknemers op de arbeidsmarkt.***

Institute for the equality of women and men (2020), "Chapter 7: Use of Time" in: *Women and men in Belgium,* Brussels.

Lamberts M., K. Faes, J. Pacolet and N. Verhaeghe (2021), *Traject naar werk vanuit arbeidsongeschiktheid: Evaluatie raamovereenkomst RIZIV-VDAB-VICO-GTB,* HIVA KU Leuven.

McVicar D., R. Wilkins and N.R. Ziebarth (2022), *Five decades of disability benefit policies in five OECD countries,* Work and the Social Safety Net, Oxford University Press.

Minne G. and Y. Saks (2023), *"Older workers and retirement decisions in Belgium: mapping insights from survey data",* NBB, *Economic Review*, December.

National Labour Council (2023), Recommandation nr 30, Recommandation adressée aux entreprises et secteurs concernant la prévention du burn-out.

OECD (2022), *Disability, Work and Inclusion: Mainstreaming in All Policies and Practices*, OECD Publishing, Paris.

OECD (2023), *Pensions at a Glance 2023*, OECD Publishing, Paris.

Østby K. A., A. Mykletun and W. Nilsen (2018), "Explaining the gender gap in sickness absence", *Occupational Medicine,* 68.

Rekenhof (2021), ***Langdurig zieken: Maatregelen tot re-integratie op de arbeidsmarkt.***

Saks Y. (2017), "Een beter inzicht verwerven in het verloop van het aantal begunstigden van de invaliditeitsverzekering", NBB, *Economic Review*, 59-73, September.

SERV & Stichting Innovatie & Arbeid (2023), ***Hoe werkbaar is je job? Werkbaarheidsmeting werknemers 2023.***

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Conventional signs

%	per cent
e.g.	*exempli gratia* (for example)
et al.	*et alia* (and others)
etc.	*et cetera*
i.e.	*id est* (that is)

List of abbreviations

Countries or regions

BG	Bulgaria
CY	Cyprus
DE	Germany
DK	Denmark
EE	Estonia
ES	Spain
FR	France
HR	Croatia
HU	Hungary
LT	Lithuania
LU	Luxembourg
MT	Malta
PL	Poland
PT	Portugal
RO	Romania
SE	Sweden
SI	Slovenia
SK	Slovakia
EA	Euro area
EU	European Union
UK	United Kingdom
US	United States

Abbreviations

CBSS	Crossroads Bank for Social Security
COVID-19	Coronavirus disease 2019
NACE	Statistical classification of economic activities
NAR/CNT	National Labour Council
NIHDI	National Institute for Health and Disability Insurance
OECD	Organisation for Economic Cooperation and Development

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