Should We Let Employers Decide Who Can Return to Work After Being Sick? Lessons From Belgium's Reintegration Trajectories

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Abstract

This paper evaluates the impact of employer discretion in selecting participants for Reintegration Trajectories (RTs) among Disability Insurance (DI) recipients. These programs aim at promoting work-resumption through workplace adaptations and active employer involvement. Exploiting a 2018 policy change in Belgium that allowed employers to freely select participants, we use a Regression Discontinuity Design (RDD) to estimate the causal effects of this discretion on employment outcomes. Employer-selected participants are 13.1 percentage points less likely to resume work and 19.7 percentage points more likely to remain in DI. We find that employers tend to select participants who are older and have longer durations of disability, resulting in reintegration trajectories that are often not initiated due to the inability of these individuals to start work adaptations. In contrast, an event study reveals that reintegration trajectories initiated by doctors significantly accelerate the work resumption process among disability insurance (DI) recipients.

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Introduction

Workers exiting the labor market due to health-related issues represent a growing challenge in many industrialized countries. This trend burdens public finances, while reduing overall welfare and individual well-being. Since the early 2000s, the OECD advocated for a policy shift toward increasing the employability and labor market retention of individuals with disabilities (OECD, 2010). Despite the efforts, the proportion of working-age individuals reliant on disability benefits has remained constant over the last decade. In Belgium, this issue is particularly severe, with 10% of the working population in disability, well above the OECD average of 5.9% and twice the rate observed in 2007 (OECD, 2022).

Reintegration Trajectories (RT) aim to support Disability Insurance (DI) recipients in resuming work through tailored workplace accommodations and active employer involvement. The employer's role in these programs, and in the broader design of social insurance systems, is pivotal due to their direct influence on workers' labor market attachment. Previous evidence highlights the benefits of workplace accommodations in fostering job retention for workers with disabilities (Høgelund & Holm, 2014; Jansen, Van Ooijen, Koning, Boot, & Brouwer, 2021; Hill, Maestas, & Mullen, 2016). However, many workers who could benefit from such accommodations fail to receive adequate support (Maestas, Mullen, & Rennane, 2019; Hill et al., 2016). This raises key questions about the design of Reintegration Programs and the appropriate role of employers. While collaboration between workers and employers is acknowledged as a critical success factor (Jansen, Boot, Alma, & Brouwer, 2022; Hill et al., 2016; Aizawa, Mommaerts, & Rennane, 2022), little is known about the optimal timing and extent of employer involvement, or whether adequate incentives are in place to ensure their effective participation (Aizawa, Mommaerts, & Rennane, 2023).

This paper wants to understand the effects of employer discretion in selecting DI recipients for RT programs, using evidence from the Belgian Reintegration Trajectory policy. The policy aims to reintegrate DI recipients with their current employers by fostering

collaboration between workers, employers, and occupational doctors in designing work adaptations. Leveraging a policy change in Belgium that lifted employers' restrictions on selecting candidates for reintegration trajectories, our study employs a Regression Discontinuity Design (RDD) to assess its impact on DI recipients' work resumption.

Our findings suggest that employer-initiated trajectories fail to reintegrate participants into active work and instead increase reliance on disability benefits. We argue that employers may target participants less effectively, resulting in trajectories that end before the accommodation process starts. We find that employers select participants who are older and have longer disability durations, reducing their likelihood of successful reintegration. In contrast, when initiated by doctors, reintegration trajectories successfully decrease reliance on DI benefits. Using an event study design, we find that one year after the start of the RT, DI recipients selected by their doctor are 12 percentage points less likely to be on DI rolls, either because they resumed work at their employer or because they are looking for a new job.

This paper contributes to two areas of literature. First, it advances the understanding of the employer's role in designing effective social insurance programs. While much of the existing research focuses on worker-side incentives, such as the effects of benefit generosity on labor supply and return-to-work delays (Maestas et al., 2019; Kostøl & Mogstad, 2014; Rehwald, Rosholm, & Rouland, 2018), fewer studies address the role of employer-side factors in these programs. Hawkins & Simola (2020) show how employer co-insurance rates can reduce DI inflow rates but may also lead to unintended consequences, such as higher sustained unemployment. More closely related is the recent work of Aizwa er al. (2022, 2023), who highlight the pivotal role of firm-specific factors in shaping workplace accommodations. Their findings suggest that 29% of the variation in accommodations is attributable to firm-level characteristics and show that subsidies for accommodations not only improve long-term labor market outcomes for workers with disabilities but also generate welfare gains for most employees. Similarly, Van Ooijen et al. (2021) demonstrate that about 10% of the variability in continued employment among workers with residual

work capacity can be explained by employer characteristics, using multilevel regression analysis in the Netherlands. This paper aims at advancing this body of literature by investigating whether the employer's role should extend beyond simple provision and collaboration, to also include the capacity to accurately identify which employees are most likely to benefit from these accomodations.

On a second stance, this paper contributes to the broader literature on the effectiveness of Return to Work strategies for workers in disability, a topic with mixed evidence on policy outcomes. The OECD (2022) report highlights the inconclusive nature of these strategies, which vary widely in their implementation and effectiveness. For instance, Engström et al. (2015) found that early RT in Sweden led to an increase in DI recipient rates and long-term sickness absence, particularly among unemployed workers. In contrast, Everhardt & De Jong (2011) observed that vocational interventions in the Netherlands improved work return rates for long-term sick workers. It is important here, to understand that in the Dutch institutional context, firms operate under strong financial and administrative incentives to employ effective Reintegration activities. Similarly, Kools & Koning (2019) identified that these interventions are especially beneficial when initiated early in the sickness absence period. In Belgium, Fonteney and Tojerow ((2022)) found that a work-first approach was particularly effective in reintegrating individuals with mental health problems, significantly increasing the probability of working while on claim. Graded return-to-work strategies, such as partial sick leave, have emerged as among the most effective interventions, as demonstrated by Hern (2017) in Norway, where a program requiring part-time work for long-term sick leave recipients resulted in faster and more sustainable reintegration outcomes. Similar findings were reported by Viikari-Ventura er al. (2012) and Høgelund et al. (2010), who showed that part-time sick leave facilitated quicker and more enduring reintegration for patients with musculoskeletal disorders. It seem clear the importance of participants targeting in the success of RTs. Therefore, this study also aims to provide valuable insights into the optimal design of these programs while offering a context-specific evaluation within Belgium.

The remainder of the paper is organized as follows: Section 1 discusses the institutional context and the Reintegration Trajectory program. Section 2 describes the data, while Section 3 outlines the identification strategy. Section 4 presents the main results on employment outcomes, and Section 5 investigates the mechanisms driving these results. Section 6 validates the findings using an event study, while Section 7 examines additional robustness checks within the RDD framework. Section 8 concludes.

1 Institutional Context

In Belgium, the National Institute for Health and Disability Insurance (NIHDI) offers public insurance coverage to both employed and unemployed individuals, protecting them against health-related shocks that impair their ability to work. Eligibility for compensation requires workers to have paid sufficient social security contributions, which include a minimum of 180 working days (or active days of job search for the unemployed) in the last 12 months for full-time and unemployed workers, and 800 hours for part-time workers. Compensation is provided when workers experience a health issue that results in at least 66% loss of earning capacity, as recognized by a health insurance advisor.

Belgium's compensation scheme aligns with those in other OECD countries, such as Norway (OECD, 2020) and Denmark (OECD, 2020). When a worker's health impairment lasts less than a month, they are considered on sick leave, during which the employer pays a guaranteed salary based on the worker's employment status. For incapacity lasting longer than one month but less than a year, workers enter short-term disability (or "incapacité primaire"), receiving compensation of 60% of their gross salary from the mutual insurance company. As of 2021, the maximum gross compensation for short-term disability is €2,292.94 per month. When incapacity extends beyond one year, workers are classified as having long-term disability, with compensation ranging from 45% to 65% of their gross salary, depending on household status. The maximum gross compensation for long-term disability is €2,486.12 per month, effective from 2021.

In 2017, the Belgian government launched the Reintegration Trajectory (or SPF) Program to assist salaried workers receiving disability compensation to return to work with their original employer. The program consists in consultations between the worker, employer, and an occupational doctor to assess the worker's capacity to resume their original job and determine appropriate work adaptations. These adaptations can include physical changes, such as modified office furniture, or adjustments to the work schedule, workload, or task assignments. The process can be initiated by the worker, employer, or a medical advisor. During the first year of implementation, employers were restricted to initiating the program only for workers with short-term disabilities. After January 2018, employers have been able to access the full pool of disability recipients. This policy change creates a clear cutoff point, enabling the estimation of the effect of employer initiation using a Regression Discontinuity Design (RDD) to analyze the discontinuity in outcomes at the January 2018 threshold.

Figure 1 illustrates the full process. Regardless of whether the program is initiated by the worker, the employer, or the medical advisor, the occupational doctor conducts an initial assessment to evaluate the worker's health status and the employer's work environment. Based on two key dimensions—(1) whether the worker can perform their original job and (2) whether an adaptation plan can be implemented—the doctor makes one of five decisions (see Panel B). If the worker is deemed able to carry out adapted work (Decisions A and C), the doctor defines the terms of the adaptations and the employer drafts a reintegration plan accordingly.

The adaptations comprehend adjustments to the workstation (i.e. provision of laptops for remote working, different types of office, chairs or tables), variations to the workload, schedule and tasks, and the possibility of following a training or guidance course to help the worker cope with their illness in the workplace, as well as the possibility to perform graded work (working part-time and having the benefits cover the missing part of the full-time salary). If both the worker and the employer accept this plan, the worker will return to work.

In cases where the worker is temporarily unable to return to work (Decisions B and E), the occupational doctor schedules follow-up evaluations, after which the process is restarted. If a worker is definitively unable to perform their job (decisions C and D), the employment contract may be terminated on grounds of "force majeure médicale," relieving the employer from severance obligations. While this process can benefit workers by entitling them to unemployment benefits, it may also create moral hazards for employers, particularly if the worker has long tenure and severance costs are high.

It is important to note that the reintegration process is voluntary. Workers and employers can decide not to participate at various stages. The worker is not obligated to attend the initial meeting with the occupational doctor, nor is there any requirement to accept the proposed adaptations. If the doctor deems adaptations feasible, the employer must draw up a reintegration plan, though they can refuse to carry out adaptations if justified.

The regulation excludes self-employed workers and those with occupational diseases or work-related accidents. It also does not apply to statutory employees, who face different rules for sickness and disability compensation and are not entitled to dismissal for medical force majeure. Therefore, this analysis focuses solely on salaried workers with "ordinary" disability, as defined by the reintegration program.

2 Data

For this study, the Co-Prev Organization[1] provided access to data on all Reintegration Trajectories initiated from January 2017 to December 2020. These data allow us to identify program participants, their start dates, and the decisions made by the occupational doctor during the process. Additionally, the Crossroad Bank for Social Security (CBSS) and the Institut National d'Assurance Maladie-Invalidité (INAMI) granted access

[1]The Sectoral Organization of all Belgian External Services recognized for Prevention and Protection at Work

to individual-level administrative records. These include data from the National Institute for Health and Disability Insurance (NIHDI), which captures long-term disability spells, and the National Intermutualist Board, which records short-term spells.

The identification strategy focuses on evaluating the discontinuities for Trajectories initiated in January 2018. Before this date, employers were restricted to accessing only short-term disability recipients. Using the starting date of the disability spell, individuals who became eligible due to the policy change were identified - specifically, those whose disability spell began before January 2016. This group accounts for 20% of all Co-Prev Trajectories.

The primary outcomes of interest are the probability of being in DI and the probability of working 12 months after the start of the Trajectory. Both variables are coded as a binary outcomes, where 1 indicates the individual has received disability benefits, or a salary from employment during the quarter in question. This codification allows us to understand the degree of self-reliance that the trajectory manages to achieve. Due to the fact that it is possible to receive DI benefits and labor market earnings, these categories are not mutually exclusive. We successfully merged the Reintegration Trajectories dataset with outcome data for participants up until December 2019, representing 80% of the sample. This resulted in a final sample of 5,906 Trajectories, initiated between January 2017 and December 2019, for individuals who had been sick for at least one year.

As shown in Table 1, this sample consists primarily of women (65%), with a median age of 49 years, and a majority having blue-collar occupations (66%). Participants had, on average, spent 5.5 years on sickness leave, with the most common causes being musculoskeletal disorders (40%, mainly back pain) and mental health conditions (30%).

3 Identification Strategy

To identify the effect of the employer selection of the participants to the Reintegration Trajectory on the outcomes of interest, this study exploits the fact that from January 2018 a change of policy occurred that gave employers more freedom, allowing them to start the program for DI beneficiaries who had been sick since before January 2016. This allows the implementation of a Regression Discontinuity (RD) design in which we estimate the discontinuity of Trajectories started in January 2018 of several outcomes up to one year after treatment, for DI beneficiaries whose sickness duration is at least 12 months, corresponding to 24 months at the discontinuity. The running variable is thus the start date of the Trajectory. The design is modeled as follows:

$$Y_{ik} = \alpha + \tau \cdot T_i + \beta_1 \cdot (X_i - c) \cdot (1 - D_i) + \beta_2 \cdot (X_i - c) \cdot D_i + \epsilon_{2i} \tag{1}$$

Equation 1 computes the intention-to-treat (ITT) effect, where Y_{ik} represents outcomes such as employment status, benefit receipt, or salary levels for Trajectory i, k quarters after the program starts. T_i indicates whether the employer initiated the Trajectory i, α_1 is a constant, and D_i is an indicator for the Trajectory starting on or after January 2018. The coefficient τ estimates the effect of treatment at the cutoff $c =$ January 2018.

We explore a set of different windows around the threshold (from 3 to 12 months), as well as report results of the optimal bandwidth selector proposed by Calonico, Cattaneo, and Titiunik (forthcoming). Additional robustness checks include estimating effects at a placebo cutoff to rule out seasonality and falsification tests with placebo outcomes. These robustness checks are detailed in Section 7.

In this analysis, we do not expect perfectly balanced predetermined characteristics among individuals participating in RTs around the threshold. Instead, we acknowledge that the selection process drives the outcomes and that this selection is the focus of our evaluation. To support this approach, we assume and test for parallel pre-trends

in outcomes using an event study. Specifically, if we observe that participants' outcomes moved in parallel prior to the employer's initiation of the program, but diverged thereafter with significant effects only for employer-initiated RTs, we can attribute these effects to the employer's selection process rather than pre-existing differences. A more detailed explanation is provided in Sections 5 and 6.

4 Main Findings

Table 2 presents the main results of the analysis. Figure 2 shows that more than 60% of Trajectories on the right of the cutoff are initiated by the employer. The estimated discontinuity in January 2018 is 44.8 percentage points, suggesting that the Local Average Treatment Effect (LATE) is approximately twice as large as the ITT estimates computed in the second stage.

Figure 3 illustrates the effects on the two key outcomes measured four quarters (12 months) after the start of the trajectory. Column (1) of Table 2 reports ITT estimates for trajectories initiated 12 months before and after the policy change, while Columns (2) to (4) present robustness checks using 6-month, 4-month, and optimal bandwidths, respectively. Panels (b) to (d) of Figure 3 provide a visual representation of the effects on participants' statuses.

Results reported in 3 indicate that Reintegration Trajectories initiated from January 2018, when employers are more involved in choosing participants, are less successful. In particular, we estimate a 13-percentage-point drop in the probability to be working after 12 months. Given a baseline employment rate of 15.6%, this represents an 84% relative decline. These findings are corroborated by a 19.4 percentage point (24%) increase in reliance on disability benefits.

Together, these results suggest that employer-initiated trajectories fail to reintegrate participants into active work and instead increase reliance on disability benefits. However,

these trajectories are also less likely to lead to unemployment. A plausible explanation is that employers may target participants less effectively, resulting in trajectories that fail to activate the reintegration process. When appropriately initiated, trajectories may lead to exits from disability insurance, either through reemployment or transitions to unemployment. This may be because employers have less knowledge about participants' medical conditions or because their incentives are misaligned with effective reintegration strategies. A detailed investigation of this mechanism is presented in the next Section.

5 Mechanism

To better understand the under-performance of employer-initiated trajectories, this section examines two potential mechanisms: (1) differences in the development of the trajectory itself and (2) selection bias in participant characteristics.

We first examine how the trajectory evolves after initiation. As outlined in Figure **??**, the occupational doctor evaluates the participant's condition and work capacity to determine suitability for adapted work. Only participants receiving Decisions A or C proceed to the adaptation plan. In contrast, Decisions B, D, or E place participants in the "No Adapted Work" (NAW) category, as they are deemed unfit for adapted work, either temporarily or permanently. Additionally, Decisions D and C allow employers to terminate contracts under Medical Force Majeure (FMM), although participants in Decision C are still eligible for adapted work.

Table 3 shows the estimated discontinuities in doctor's decisions. We find a significant 10.2 percentage point (13%) increase in trajectories classified as NAW for paths started after January 2018. This increase appears to be driven by a higher prevalence of workers deemed unable to start adapted work, reflected in an increase in Decision E and a decrease in Decision C. Importantly, this reframes the issue: it is not the adaptations themselves that fail but the selection of participants who are unsuitable for the program.

Next, we examine participant characteristics at the time of evaluation. Figure 5 and Table 4 reveal that increasingly selected by employers (after January 2018) are older by nearly five years and have been on disability for an additional 15 months compared to other trajectories. Both factors likely contribute to their reduced capacity for reintegration into the workforce (OECD, 2022; OECD, 2010; Kools & Koning, 2019).

These findings indicate that employers select participants who are older and have longer disability durations, reducing their likelihood of benefiting from the program. Consequently, reintegration trajectories fail to progress, and participants remain on disability. In contrast, when participants are selected by doctors or themselves, the program is more likely to follow through, with individuals either starting the adaptations and resuming work.

6 Event study

The presence of discontinuities in predetermined variables raises concerns about the validity of the RDD design as a sole identification strategy. It can be argued that these discontinuities suggest the design fails the falsification test, undermining its ability to isolate the effect of employer-initiated trajectories. To address this, we perform a complementary event study comparing trajectories initiated by employers with those initiated by doctors. By excluding trajectories initiated by workers, we aim to reduce potential self-selection bias. The goal is to assess whether predetermined differences influence the outcomes of interest differently for employer-initiated and doctor-initiated trajectories, particularly before participants are selected into the program.

This event study includes all trajectories initiated between 2017 and 2019 for individuals who had been on DI prior to 2016. In Figure 6, we plot average outcomes for each group in each quarter. The red dotted line represents trajectories initiated by employers, while the blue line corresponds to doctor-initiated trajectories.

A key finding is that, prior to trajectory initiation (Quarter = [-4, -1]), trends for all four outcomes move in parallel for the two groups. After trajectory initiation, differences begin to emerge and grow over time. Consistent with RDD findings, employer-initiated trajectories are associated with a lower likelihood of working and a higher likelihood of remaining on disability, compared to doctor's. Notably, these differences do not appear to stem from shifts in the success rates of employer-initiated trajectories, which remain stable, but rather from changes in doctor-initiated trajectories. This descriptive evidence suggests that individuals chosen by employers undergo little to no meaningful reintegration effort.

To formally test whether post-treatment trends differ significantly between the two groups, we conduct an event study analysis using employer-initiated trajectories as the treatment group, with Quarter = -1 as the reference period. The estimated coefficients, plotted in Figure 7, indicate that pre-treatment differences are statistically indistinguishable from zero for all outcomes. Post-treatment, significant effects emerge in line with the RDD results: employer-initiated participants are 9.8 percentage points less likely to work and 13.6 percentage points more likely to remain on disability.

These findings corroborate the results of the RDD analysis, demonstrating that employer selection has measurable consequences on participant outcomes. The absence of pre-treatment differences further supports the validity of this strategy, reinforcing the argument that observed effects arise from the trajectory initiation process rather than pre-existing trends.

7 Robustness checks

This section presents the results of standard validation tests for the Regression Discontinuity Design (RDD).To assess the internal validity of the RDD design, we begin with a falsification test. This test examines whether we can find discontinuities in "placebo outcomes," which are outcomes that should not be affected by the policy change. Specif-

ically, we analyze outcomes measured one year (or four quarters) prior to the start of the program. Since this period falls before any participation in the program, we expect no significant discontinuities in these placebo outcomes. This approach is standard in RDD applications to ensure that pre-treatment trends are parallel and that the identified discontinuity can be attributed to the policy intervention rather than other factors. Table 5 displays the results from this falsification test. As expected, we find no significant discontinuities in any of the placebo outcomes.

To rule out the possibility that seasonality or other temporal factors are influencing the results, we perform an additional analysis using a different cut-off point. Specifically, we examine the impact of a cut-off in January 2019, which allows us to compare outcomes one year after this alternative threshold. By checking the presence of discontinuities around this new cut-off, we can confirm that the results are not driven by seasonal patterns. Table 6 presents the estimates from this analysis, where Column 2 reports the discontinuities in outcomes one year after the new cut-off. We find no significant changes, supporting the robustness of the initial results.

8 Conclusion

This study examines the role of employer-driven selection in work reintegration trajectories (RTs) for disability insurance (DI) beneficiaries, focusing on a program introduced in Belgium in 2017. Contrary to its objective of enhancing work participation, our findings indicate that employer-led selection often results in confirming participants' disability status rather than fostering their reintegration into the labor market.

Using a Regression Discontinuity (RD) design, we exploit a policy shift in 2018 that granted employers autonomy to initiate RTs for their employees. This approach is complemented by an event study framework comparing the trajectories of employer-initiated and doctor-initiated RTs, leveraging comprehensive administrative data to track participants' employment and social safety net statuses up to one year post-program initiation.

Our key findings can be summarized as follows. First, we find a negative and statistically significant effect of Employer's RT on work resumption, driven by a higher probability of staying in DI. Second, we find evidence that employer's participants do not actually follow the program, and do not engage in work adaptations, they are declared too sick to start the Reitegration Trajectory. This result is driven by the fact that these employers participants have been in sickness for longer and are older, leading to a confirmation of their disability status rather than an activation towards the job market. The event study corroborates these findings, showing that employer-led participants exhibit limited changes in employment or DI status over time. In contrast, doctor-initiated RTs demonstrate a higher likelihood of reintegration into work. These results underscore the differing objectives and outcomes of the two RT types.

One limitation of our study is the absence of a comparison with individuals who did not participate in any RTs. Future research could address this gap to provide a more comprehensive evaluation of the program's overall efficacy. Nonetheless, our findings emphasize the importance of aligning reintegration programs with participants' medical conditions and realistic labor market goals, ensuring that employer involvement enhances, rather than hinders, effective reintegration.

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Table 1: Descriptive Statistics

N=5,906	**Mean**	**(SD)**	**[min, max]**
Worker Characteristics:			
Age	48.953	(9.149)	[23, 68]
Female	0.653	(0.476)	[0, 1]
Prior Quarterly Salary (100 €)	3.221	(13.158)	[0, 1]
Full-Time Contract	0.473	(0.499)	[0, 1]
Blue Collar	0.662	(0.473)	[0, 1]
Flanders	0.565	(0.496)	[0, 1]
Employer Characteristics:			
$>$ 100 Employees	0.532	(0.499)	[0, 1]
Flanders	0.552	(0.497)	[0, 1]
DI Characteristics:			
Sickness Duration (months)	67.304	(44.073)	[12, 446]
Long Disability	0.959	(0.197)	[0, 1]
Illness Type:			
Musculoskeletal	0.409	(0.492)	[0, 1]
Environment (i.e. burn out)	0.079	(0.270)	[0, 1]
Mental	0.306	(0.461)	[0, 1]
Other	0.164	(0.370)	[0, 1]

Notes: Table 1 presents descriptive statistics for all trajectories in the sample. All variables refer to the status of individual characteristics one quarter before the start of the trajectory. "Age" denotes the individual's age during the year of the reference quarter. Prior quarterly salary is calculated by aggregating all salaries received by the individual within the quarter. Information on the type of illness is available only for individuals in Long DI. The sample includes all trajectories initiated between January 2017 and January 2019.

Table 2: Outcomes 12 months after the start of the RT

Window	**12 Months**	**6 Months**	**4 Months**	**CCT**
	(1)	**(2)**	**(3)**	**(4)**
Panel A – First Stage				
Started by Employer	0.448***	0.420***	0.406***	0.409***
	[0.0352]	[0.0427]	[0.0507]	[0.0537]
Panel B – Second Stage				
Working (0/1)	-0.131***	-0.131***	-0.126***	-0.114**
Mean	0.156	0.150	0.150	
	[0.0344]	[0.0411]	[0.0478]	[0.0524]
Disability Benefits (0/1)	0.194***	0.197***	0.201***	0.195***
Mean	0.797	0.802	0.811	
	[0.0379]	[0.0456]	[0.0533]	[0.0589]
Observations	4,133	2,565	1,942	1,942

*This table displays the estimated discontinuities at the January 2018 cutoff. Panel A presents the coefficients for the probability of being selected by the employer. Panel B reports the coefficients for the two outcomes of interest one year after the start of the trajectory, alongside the sample mean and standard errors (in parentheses). Column 1 shows coefficients estimated on a sample of trajectories spanning 12 months before and after the cutoff. Column 2 uses a 6-month window, and Column 3 uses a 4-month window. Column 4 estimates the coefficients using the optimal bandwidth selection method developed by Cattaneo et al. The sample includes all trajectories initiated between 2017 and 2019 for individuals who entered Disability Insurance (DI) before January 2016. ***p<0.01,**p<0.05,*p<0.1.*

Table 3: Doctor's Decisions after the Evaluation of the Individual

	Decision A	**Decision B**	**Decision C**	**Decision D**	**Decision E**	**FMM**	**NAW**
	(1)	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
Probability Change	-0.00414	0.00638	-0.0685**	0.00186	0.0935***	-0.0666*	0.102***
Mean	0.036	0.056	0.097	0.550	0.123	0.648	0.730
	[0.0139]	[0.0188]	[0.0285]	[0.0412]	[0.0201]	[0.0385]	[0.0391]
Observations	4,133	4,133	4,133	4,133	4,133	4,133	4,133

*Notes: This table presents the estimated discontinuities at the January 2018 cutoff. Columns 1 to 5 report the coefficients for the probability of receiving decisions A through E. Column 6 provides the coefficient for Force Majeure Medical decisions (the cumulative probability of decisions C and D), while Column 7 reports the coefficients for No Adaptation Plan decisions (the cumulative probability of decisions B, D, and E). All columns include the sample mean and standard errors (in parentheses). All estimates are based on a first-order polynomial and a 12-month bandwidth. The sample consists of all trajectories initiated between 2017 and 2019 for individuals who entered Disability Insurance (DI) before January 2016. ***p<0.01,**p<0.05,*p<0.1.*

Table 4: Discontinuities in Predetermines at the cut-off

N=4,133	**Changes at Cut-Off**
Worker Characteristics:	
Age	4.492***
	[0.755]
Female	-0.0294
	[0.0394]
Prior Quarterly Salary (100 €)	-0.337
	[0.818]
Full-Time Contract	0.0615
	[0.0410]
Blue Collar	0.0484
	[0.0398]
Flanders	0.0140
	[0.0408]
Employer Characteristics:	
$>$ 100 Employees	-0.0415
	[0.0413]
Flanders	0.00917
	[0.0409]
DI Characteristics:	
Sickness Duration (months)	15.44***
	[2.775]
Long Disability	-0.0143
	[0.0160]
Illness Type:	
Musculoskeletal	-0.00320
	[0.0410]
Mental	-0.00109
	[0.0359]
Other	-0.00109
	[0.0299]

*Notes: This table presents the estimated discontinuities for predetermined characteristics at the January 2018 cutoff. The reference period is Q-1, the quarter preceding the start of the trajectory. The computation of variables follows the same methodology as in Table 1. Standard errors are reported in parentheses. All estimates are based on a first-order polynomial and a 12-month bandwidth. The sample includes all trajectories initiated between 2017 and 2019 for individuals who entered Disability Insurance (DI) before January 2016. ***p<0.01,**p<0.05,*p<0.1.*

Table 5: Flasification Test - Placebo Outcomes

	Working - Placebo	**In Disability - Placebo**
	(1)	**(2)**
Probability Change	-0.0452	0.0243
Mean	0.101	0.928
	[0.0276]	[0.0230]
Observations	4,133	4,133

*Notes: This table presents the estimated discontinuities for placebo outcomes at the January 2018 cutoff. The outcome variables are calculated as in Table 2, but with the reference period set to Q-4, one year prior to the start of the trajectory. All estimates are based on a first-order polynomial and a 12-month bandwidth. The sample includes all trajectories initiated between 2017 and 2019 for individuals who entered Disability Insurance (DI) before January 2016. ***p<0.01,**p<0.05,*p<0.1.*

Table 6: Artificial cut-off at January 2019

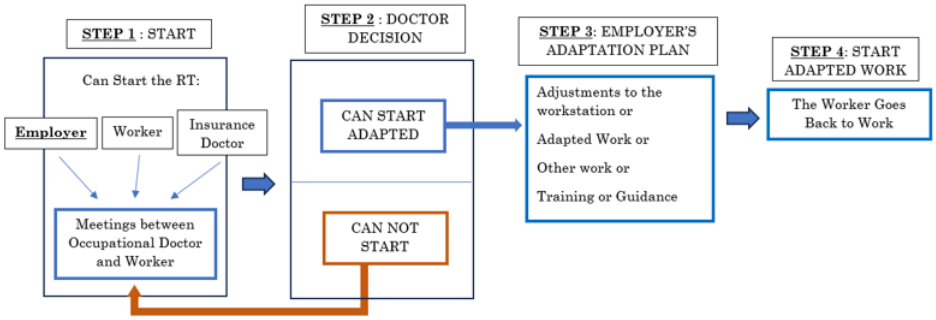
	Employer RT	**Working**	**In Disability**
	(1)	**(2)**	**(3)**
Probability Change	-0.00970	-0.0347*	-0.00673
Mean	0.621	0.117	0.847
	[0.0304]	[0.0209]	[0.0223]
Observations	5,066	5,066	5,066

*Notes: This table presents the estimated discontinuities for the main outcomes of interest at the January 2019 cutoff. All estimates are based on a first-order polynomial and a 12-month bandwidth. The sample includes all trajectories initiated between 2018 and 2020 for individuals who entered Disability Insurance (DI) before January 2016. ***p<0.01,**p<0.05,*p<0.1.*

Figure 1

The Belgian Reintegration Trajectory Program

Panel A: Reintegration Path



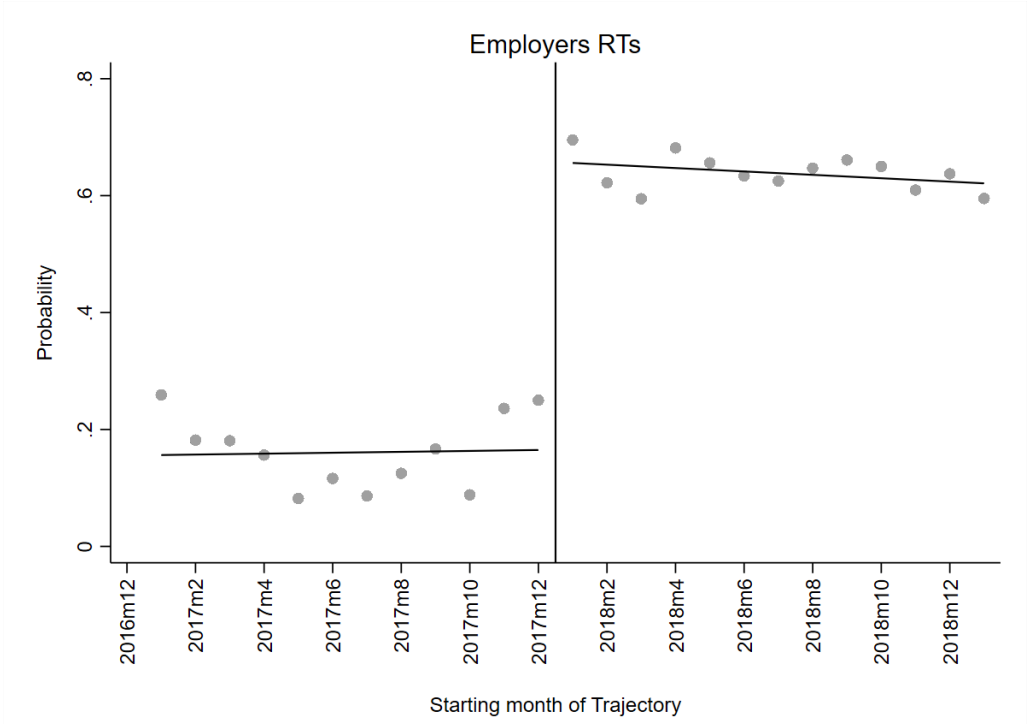
Panel B: Step 2 Doctor Decisions

		Perform Adapted Work	
		Able	Unable
Perform the agreed work	Eventually Able	*Decision A*	*Decision B*
	Definitively Unfit	*Decision C*	*Decision D*
Decision E: It is not appropriate to start adapted work at the moment for medical reasons			

Notes: This figure illustrates the process of the Reintegration Trajectories. Panel A depicts the different steps, while Panel B describes the decisions that the doctor can make in step 2. The trajectory can be initiated by the employer, a medical advisor, or the worker themselves. The first step of the program involves a series of meetings about the worker's health status and their workplace. Following these meetings, the doctor evaluates whether the worker can proceed with adapted work. If the assessment is positive, it becomes the employer's responsibility to draw up an adaptation plan. This plan may include modifications to the workplace, workload, or tasks, aiming to facilitate the worker's return. If all parties accept the plan, the worker can resume work with the agreed adaptations. Panel B provides a more detailed description of the decisions that follow the doctor's evaluation.

Figure 2

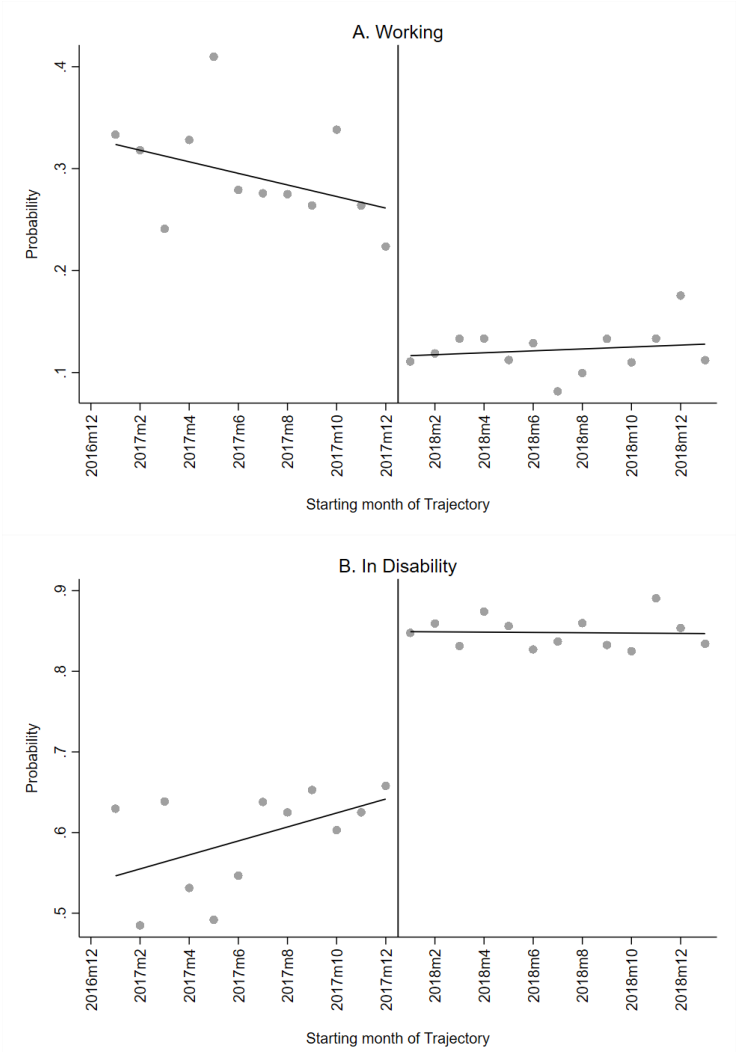
Share of Employer-Initiated Trajectories



Notes: This figure provides a visual representation of the discontinuity in the share of employer-initiated RTs for Trajectories started in 2018. The bandwidth is of 12 months. The dots are averages within each monthly bin and the black lines are linear fits.

Figure 3

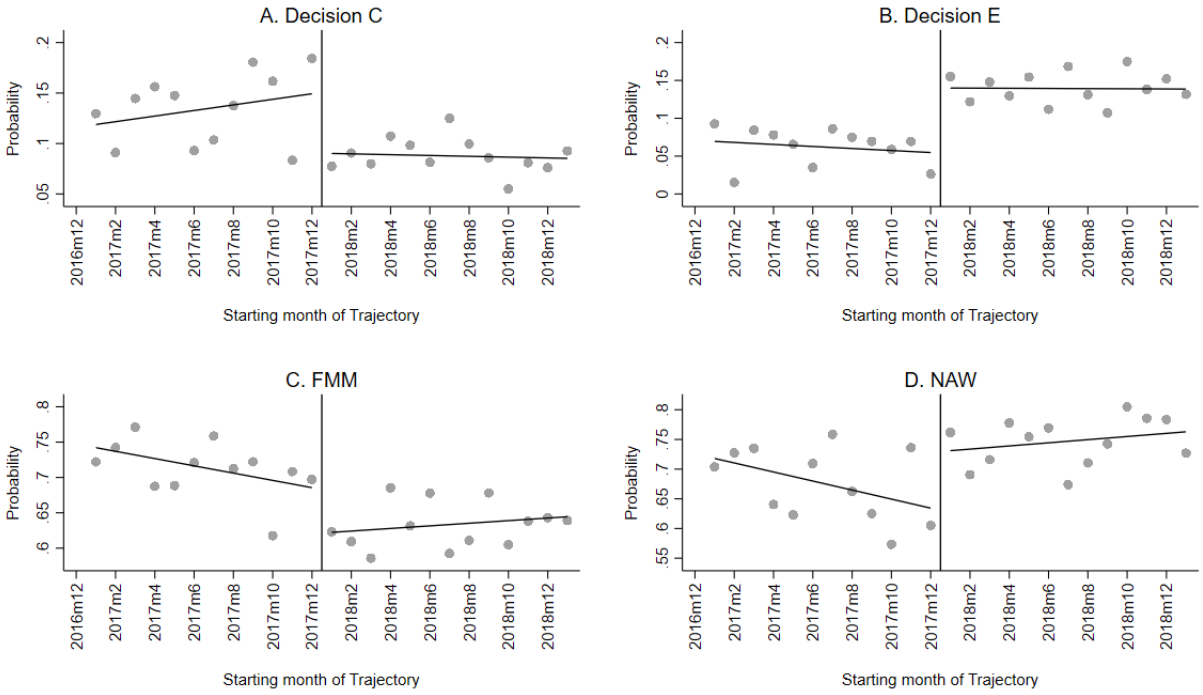
Main Results - Effects on Working and Disability



Notes: This figure provides a visual representation of the discontinuity in the main outcomes of interest for Trajectories started in 2018. Panel A plots the proportion of individuals who are working and earnings a positive salary one year, or four quarters after the start of the Trajectory. Panel B plots the proportion of individuals receiving Disability Benefits one year, or four quarters after the start of the Trajectory.The bandwidth is of 12 months. The dots are averages within each monthly bin and the black lines are linear fits.

Figure 4

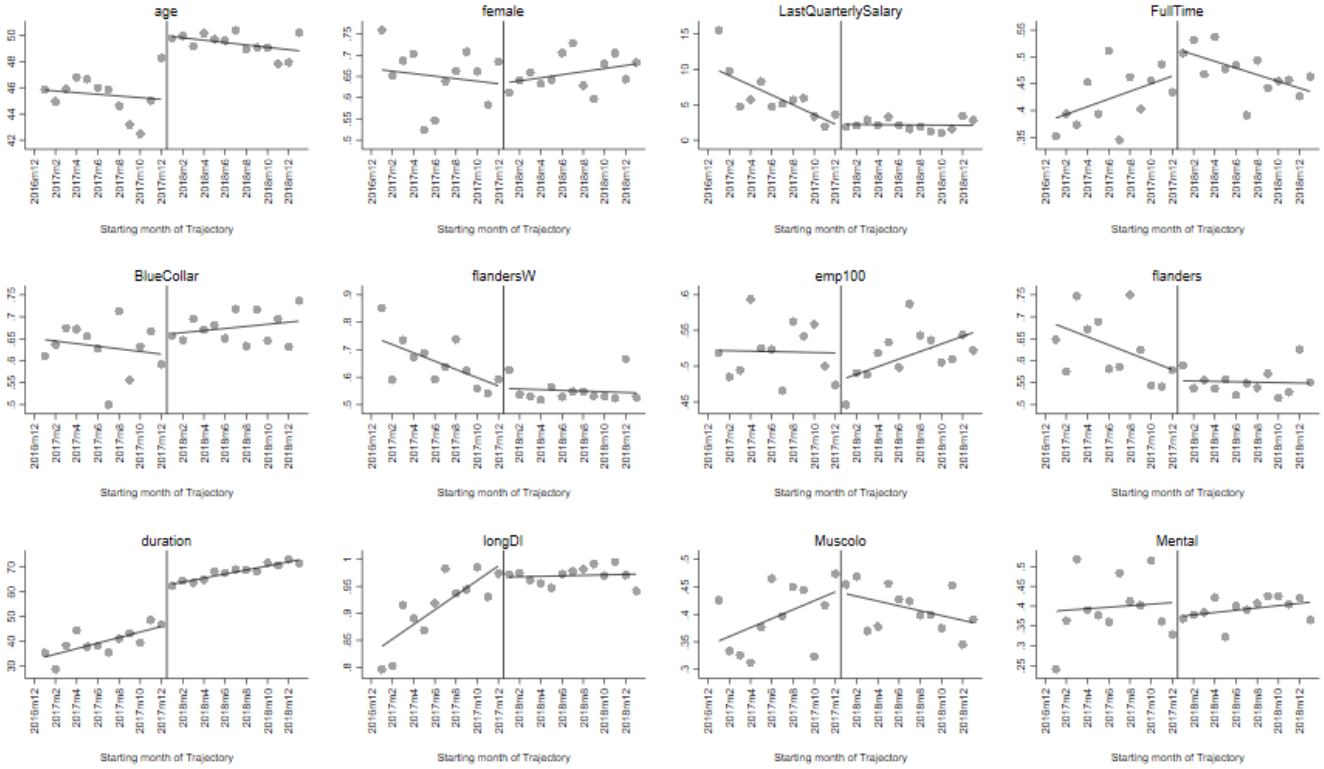
Effects on Doctor's Decisions



Notes: This figure provides a visual representation of the discontinuity in the Doctor's Decisions for Trajectories started in 2018. Panel A plots the proportion of decisions C. Panel B plots the proportion of decisions E. Panel B plots the proportion of "Force Majure Medical Decisions", combining decisions C and D. Panel D plots the proportion of No Adapted Work decisions, combining decisions B D an E. The bandwidth is of 12 months. The dots are averages within each monthly bin and the black lines are linear fits.

Figure 5

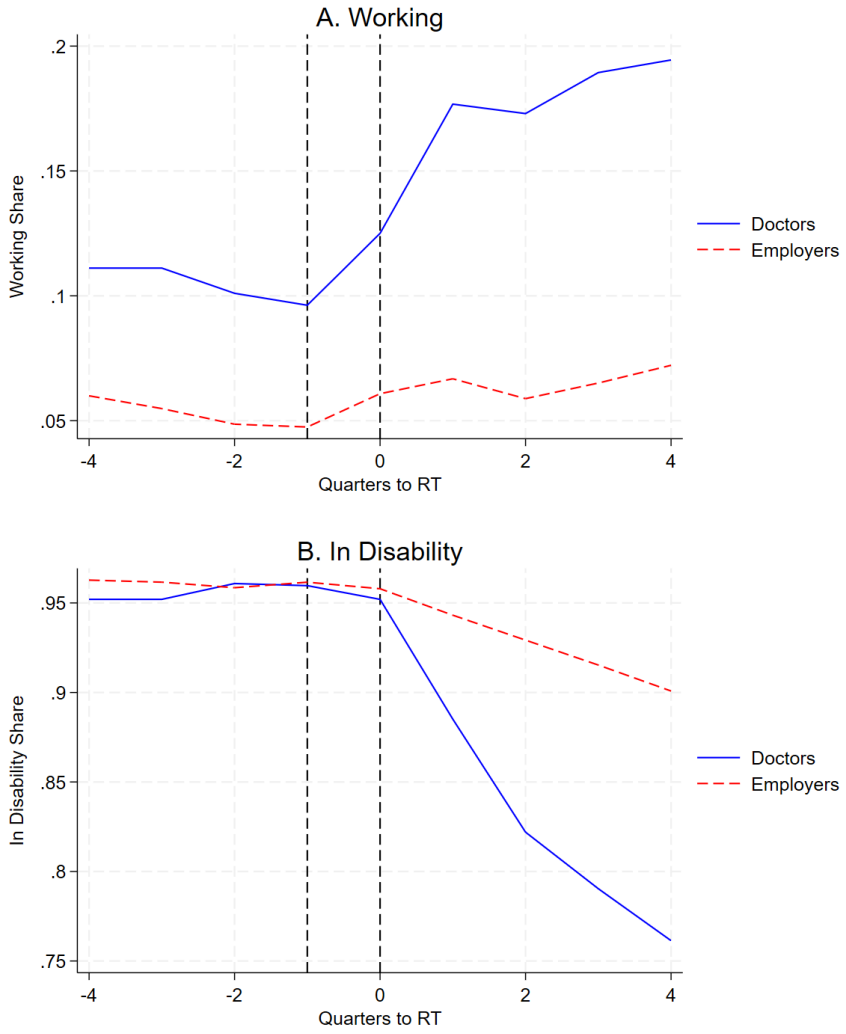
Discontinuities on Predetermined Charactheristics



Notes: This figure provides a visual representation of the discontinuity in participants' predetermined characteristics for trajectories initiated in 2018. Each predetermined characteristic is measured relative to the same reference period: the quarter before entering the trajectory. The bandwidth is 12 months. The dots represent averages within each monthly bin, while the black lines indicate linear fits.

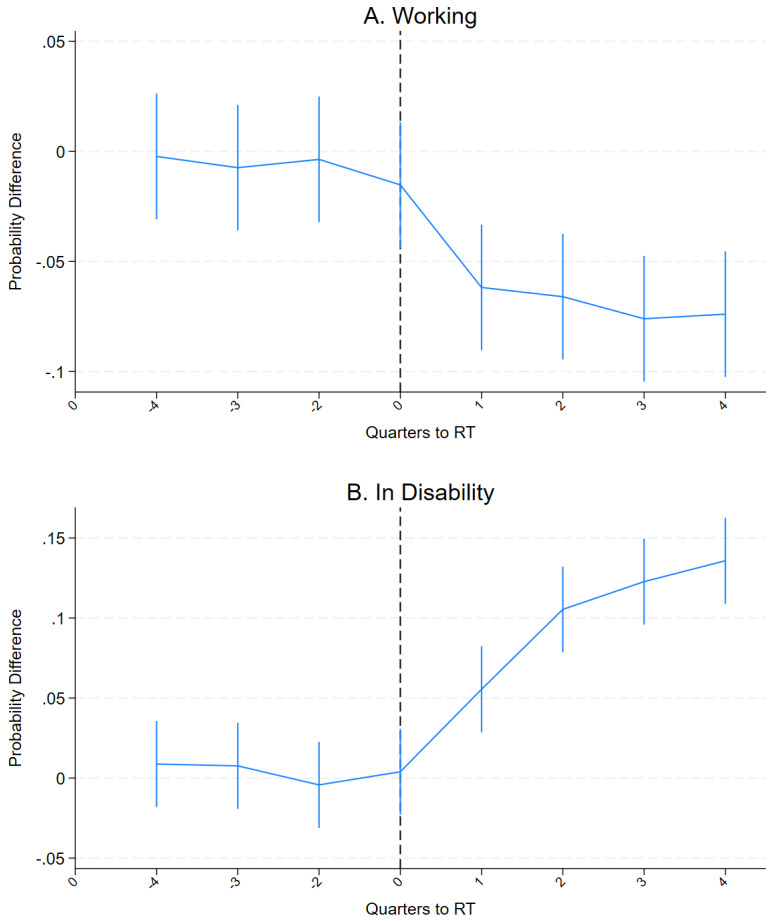
Figure 6

Outcomes for employer-initiated vs doctor-initiated Trajectories



Notes: This figure illustrates the status of individuals in trajectories initiated by the employer and by the doctor, for each quarter, spanning one year before and one year after the start of the trajectory. The red dotted line represents trajectories initiated by the employer, while the continuous line represents those initiated by the doctor. The two vertical dotted lines indicate the quarter in which the trajectory began. Panel A shows the number of working individuals as a fraction of the total group in the trajectory. Panel B displays the number of individuals in Disability Insurance (DI) as a fraction of the trajectory group.

Figure 7 Outcomes for employer-initiated vs doctor-initiated Trajectories



Notes: This figure presents the coefficients from the event study on employer-initiated trajectories, using Q = -1 as the reference period, over a window of one year before and after the start of the trajectory. Panel A shows the coefficients for changes in the probability of working among employer-selected participants, while Panel B displays the coefficients for changes in the probability of being in Disability Insurance (DI).