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Case description

Thomas is 46 years old and working as a machine operator for a big steel company. Two years ago, after some periods of pain, he was diagnosed by his general practitioner with rheumatoid arthritis (RA). About the same time Thomas started having problems in doing his work as an operator and he was forced to call himself sick. After 2 years, a time during which Thomas tried to return to his work several times despite his bad physical condition, he still did not have the ability to perform his job as he was used to, and he had to stay at home sick-listed. His boss and occupational physician advised him to apply for a disability benefit. In the Netherlands this is the so-called ‘Work and Income Act’ (WIA). In this procedure, that is what people told him, the Dutch Workers Insurance Authority UWV will look at his situation and will determine if he qualifies for a benefit.

Thomas applies for the WIA. Although he heard some stories about how UWV processes WIA applications, he is not sure what to expect. What will they ask him? Is he certain of receiving a disability benefit? And what are the financial consequences if he will receive a benefit? Furthermore, he is uncertain about how he has to prepare himself for the assessment and feels helpless in the period before the assessment. What is expected from him? What can he do to make sure that his recent medical situation is taken into account properly by UWV? When he thinks of the assessment Thomas starts to worry. Especially when he reads some negative stories about UWV physicians on the Internet. What does he need to do if the physician working for UWV does not treat him fair? All these questions are making Thomas nervous. In the days before his appointment with an insurance physician from UWV he does not sleep well…

This thesis is based on a project in which a tool was developed and evaluated, specifically for people like Thomas. This tool, the interactive website www.wagesprek.nl, was designed to be used by disability benefit claimants in the Netherlands, of whom there are about 38,000 annually.

Insurance medicine (in the Netherlands)

Through social insurance, workers with long-term medical impairments can claim a disability benefit in the case they are losing part of their income. In the Netherlands, the so-called Gatekeeper Law (‘Wet Verbetering Poortwachter’) arranges that an employer has to pay wages for 2 years if his or her employee is unable to perform his or her job due to disability. After these 2 years the patient can apply for a disability benefit. This benefit is defined in the Dutch Work and Income Act (WIA). In order to receive a benefit, a worker has to actively apply for it. This can be done through the Dutch Workers Insurance Authority, UWV. Procedures performed by professionals within UWV determine if a worker is entitled to receive a benefit and, if so, what kind of benefit he or she receives. This disability benefit procedure begins with an assessment of the claimants’ work limitations by an insurance physician, who interviews the claimant and performs a physical examination. In addition, information provided by the occupational physician, who treated the claimant during the first 2 years of disability, and information from the curative physician(s), is often available to the insurance physician. After the assessment by the insurance physician, a labour expert from UWV examines which jobs the claimant is (theoretically) still able to perform, despite the work limitations assessed by the insurance physician. The so-called loss of wage-earning capacity then determines the disability pension a claimant receives. To give an indication on the acceptance rate of disability claims in the Netherlands: in 2008 about 38,000 workers claimed a disability benefit in the Netherlands, of which 17,120 (45%) were rejected by UWV, 15,720 (41%) received partial benefits, and 4,180 (11%) got full benefits 1. Although the situation in the Netherlands is unique, in most Western countries physicians and patients are involved in similar assessments, even though national practices may vary considerably under social insurance or disability legislation 2.
The insurance physician-claimant relationship and the need for improvement

One of the key steps in the evaluation of a disability claim is the assessment interview by an insurance physician. Throughout the years, the way of assessing claimants’ disability by insurance physicians has been subject to discussion. One of the problems in adequately evaluating disability claims lies in the insurance physician-claimant relationship. Compared to the ‘normal’ physician–patient interaction, this specific physician-claimant relationship differs in several ways. Most importantly, the disability assessment interview is different from interviews held by other physicians in that they are not primarily aimed at cure or care for patients, but at assessing the work capacities and limitations of patients. Moreover, the time that is available to gather all the necessary information for this assessment is generally short, and the assessment itself is based on a one-time contact. If the sick-listed worker claims a disability benefit, then he or she is more or less obliged to attend the assessment, and there is a lot at stake for the claimant in terms of financial security and disease recognition. Because of these specific aspects of the disability assessment interview, the insurance physician-claimant relationship is more complicated than ‘normal’ physician-patient contacts.

On the physician side, it is known that many physicians report feeling uncomfortable with performing disability assessments. Various factors contribute to difficult situations during the medical encounter. Inadequate preparation for the assessment interview, the lack of knowledge about the social security procedures, the work capacity claims of patients, but at assessing the work capacities and limitations of patients. Moreover, the time that is available to gather all the necessary information for this assessment is generally short, and the assessment itself is based on a one-time contact. If the sick-listed worker claims a disability benefit, then he or she is more or less obliged to attend the assessment, and there is a lot at stake for the claimant in terms of financial security and disease recognition. Because of these specific aspects of the disability assessment interview, the insurance physician-claimant relationship is more complicated than ‘normal’ physician-patient contacts.

On the physician side, it is known that many physicians report feeling uncomfortable with performing disability assessments. Where normally a physician has a caring and therapeutic role, in disability assessments, he or she has to engage in different kinds of roles (sometimes roles they are not used to), such as being a source of information, advocate and counsellor, and adjudicator and certifier. Additionally, physicians can struggle with the political context and disability legislation in which they have to operate. In terms of the attitude of physicians towards claimants, it was found that, partly as a consequence of the one-time nature of the disability assessment, stereotyping by physicians is a common feature of the assessment, which can negatively influence the physician-claimant interaction. If the physician bases his assessment on a prejudice of the claimant from the beforehand available claimant’s medical file or on initial contact, in stead of using individual information from the claimant during the assessment, stereotyping can lead to difficulties between the physician and the claimant.

Patient empowerment

The concept of empowerment originates from the work of educators and community psychologists, who have worked primarily with socially disadvantaged populations. In this early views, empowerment was defined as a process, a mechanism by which people, organizations and communities gain mastery over their affairs. In health care, since its introduction in the 1970s, the popularity of the idea of patient empowerment has emerged in the context of several significant societal trends, such as an increased individualisation and a shift of care responsibility to individual citizens. In this context, patient empowerment describes a situation that citizens are encouraged to take an active part in their own health management. Besides the idea that empowered patients attempt to take charge of their own health, patient empowerment also contains the element of activating patients into their interactions with health care professionals and health care organizations.

As an indication of the growing amount of attention that the term patient empowerment is currently receiving, the World Health Organization (WHO) describes patient empowerment as a ‘prerequisite for health’. However, despite the importance that has been attributed to patient empowerment, it is hard to distinguish a universally agreed upon definition of the term. Therefore, in this thesis, we chose a definition of empowerment that was described earlier by van de Ven and is relevant to the context of this thesis, i.e. that focuses on people with a work disability (see Box 1).

On the claimants side, several factors can contribute to strain in the relationship with their insurance physician:

1) The combination of the assessment having a major (legal, financial and social) impact on a claimant’s life and social security arrangements, often stimulate defensive and passive behaviour among claimants.

2) The fact that claimants have to prove that they are ill in order to receive a disability pension can therefore contribute to difficult situations during the medical encounter.

3) Complicated and not fully transparent disability assessment procedures and social security arrangements cause a lack of claimants’ knowledge and understanding about this topic and results in claimants frequently having wrong expectations of disability assessment outcomes.

4) Claimants often perceive their work capacity to be limited and their odds of returning to work low. This behavioural characteristic frequently has a greater influence on the duration of recovery than factors such as the severity of the disability. In the disability assessment, these perceptions often lead to discrepancies in views on the claimants’ functional capacity between the physician and the claimant.

As a consequence of the complicated relationship between insurance physicians and claimants, many claimants experience disability assessment as unjust and reports indicate that satisfaction with insurance physicians is lower than, for example, satisfaction with occupational physicians.

To improve the insurance physician-claimant relationship, two distinct tactics are possible. One is to train physicians in order to communicate better with their claimants. Another option is to focus on the claimant. An approach that fits the idea of supporting, helping or influencing claimants in order to facilitate the physician-claimants relationship, is the idea of patient empowerment.

**Box 1: For this thesis, we focus on empowerment in the context of individuals with a long-term work disability. For this specific context, a six-dimensional empowerment model was previously described by Van Lierop and Van de Ven. We used this model as a framework. According to the model of Van Lierop et al., empowerment is defined as: “A process in which an individual raises faith in his/her capacity and skills to achieve certain goals, in doing this, the individual gets a feeling of having control and impact on his/her situation, where the choices and decisions he or she makes applies to his/her own values, standards and behaviour. In achieving these goals the individual makes optimal use of the environment whilst integrating his/her disability in life.” The model described by Van Lierop and Van de Ven defines empowerment as a multi-dimensional construct consisting of the following six dimensions:**

- Competence, the confidence or trust that one possesses the skills and abilities necessary to complete certain tasks.
- Self-determination, the feeling of having the ability to make proper choices or decisions, independently of others.
- Meaning, the feeling and experience that work is significant, meaningful and compatible with one’s values, opinions and behaviour.
- Impact, the belief that one has a significant influence and control over one’s own life and processes.
- Positive identity, the extent to which one feels positive about oneself and has accepted the limitations or boundaries of one’s possibilities or disabilities.
- Group orientation, the awareness and under standing that one is part of a social system in which one may rely on others and where cooperation often is necessary to achieve certain goals.
With regard to the specific context of the disability assessment, with the intervention described in this thesis, we specifically focus on the dimensions Competence [increasing skills that claimants can use during their assessment], and Impact [enhancing feelings of control during the assessment]. For example, in the case of Thomas (see Case Description) this would mean that through the process of empowerment, Thomas would have the skills to adequately describe his work limitations that are a consequence of his disease, as such providing the physician with direct and relevant information [Competence]. Or that Thomas would be skilled to ask questions to the physician in the case that he is unclear about the conclusions of the assessment [Competence]. Claimant empowerment also would include that, if Thomas finds that during the assessment some aspects of his disease are ignored by the physician, he would try to actively take over the interview and point out some, not yet discussed, important aspects of his disease [Impact]. Or, for example, he would bring extra medical information with him to the assessment, in order to make sure that all relevant medical information would be taken into account by the physician [Impact].

**Patient empowerment to improve the patient-physician interaction**

Patient empowerment has shown to be a valuable method in enhancing the physician-patient relationship in fields of care, other than insurance medicine. The rationale behind the idea of using patient empowerment as a tool to facilitate the physician-patient relationship is based on the idea that a pro-active and informed (or ‘expert’) patient will experience greater control over his or her disease, and will improve the relationship with his or her physician. In contrast to the classical, paternalistic tradition of a physician-patient relation, in which the patients assumes ‘the doctor knows best’, empowered patients are thought to elevate this with his or her physician. In contrast to the classical, paternalistic tradition of a physician-patient relation, in which the patients assumes ‘the doctor knows best’, empowered patients are thought to elevate this relationship by a shift of power to a so-called physician-patient ‘partnership’ 30. The suggested results are that through this partnership, patients and physicians are able to communicate more effectively with each other, and, at its turn, this will result in higher patient satisfaction with consultations, better compliance and adherence with prescribed medication or treatment, and, eventually, more positive health outcomes 31-33.

Although the theory about patient empowerment and the physician-patient relationship is still developing, evidence on the association between activated or empowered patients on the one hand, and satisfaction, adherence, and positive health outcomes on the other, has been already found to support this theory 32-36. The possible benefits of patient empowerment to insurance medicine was, however, never studied before. As a consequence of the aforementioned contextual differences between the ‘normal’ physician-patient contact and the insurance physician-claimant interaction, it is not self-evident that these beneficial effects would apply to insurance medicine.

**Methods to increase patient empowerment**

The question that remains is: how can we effectively empower patients? For health care in general, numerous empowerment interventions have been developed and evaluated. The methods used in these interventions showed many similarities. For example, in diabetes care, by far the field of care in which empowerment is most adapted, one-to-one meetings in which an extensive self-management plan (goal-setting, identifying behavioural steps to achieve these goals, information provision, overcoming barriers) was discussed with a case manager, showed to improve empowerment among these patients 37. Although many similar empowerment enhancement methods (goal-setting, motivational interviewing, self-management plans, cognitive behavioural treatment, problem solving treatment) were applied in diabetes care 38-42, these methods were also applied in other diseases, such as cancer 11, end-stage renal disease 43 or, for example, arthritis, 44-46. In an occupational setting, employees with a chronic physical condition seemed to benefit from an empowerment-based job retention programme, consisting of trainer-led group and individual sessions in which role playing exercises were practiced to improve communication and assertiveness, and assignments were made focusing on increasing self-awareness and identifying problems at work, goal setting, and problem solving 47.

Interventions aimed at patients prior to a physician-patient encounter differed in some sense. These interventions tend to be shorter and rely on different kinds of tools, such as enhancing patient question-asking by, for example, using prompt sheets, promoting active participation during the medical encounter, and/or educational tools to increase knowledge 48,49,50,51. As for the methods described, in general, empowerment enhancing interventions are mostly delivered face-to-face or in facilitator led groups sessions. However, with the rise of eHealth and Internet applications, many people believe that the real opportunities for delivering patient empowerment initiatives have just started 52.

**eHealth**

eHealth refers to “an emerging field in the intersection of medical informatics, public health and business, referring to health services and information delivered or enhanced through the Internet and related technologies” 53. In recent years, the number of Internet users has increased considerably and the Internet is more frequently being employed to locate information on health and health care delivery 54-56. The latest studies have shown that, among all Internet users, an estimated 8% consult the Web for health purposes 57.

Among the advantages of delivering eHealth interventions over the Internet are 55:

1) Internet applications reduce health care costs;
2) Internet has the potential to easily reach large patient groups and the ability to reach isolated subgroups;
3) The flexibility and timeliness of access to the Internet (interventions can be used at any time at any place);
4) The unique technological advantages and possibilities, such as tele-monitoring or video transmission.

Given these potential advantages, it was chosen to deliver the intervention, that is described in this thesis, online. Together with the problems that are encountered in the insurance physician-claimant interaction, and combining these with the developments in the field of eHealth and patient empowerment, resulted in the idea for the project described in this thesis. This project, in which the interactive web-based intervention www.wiagesprek.nl was developed and evaluated, started May 2007 and was finished January 2011. The general question that we asked ourselves in this period was: do people like Thomas (see Case Description) benefit from the intervention www.wiagesprek.nl? And what are the consequences of claimants using the intervention for insurance physicians and UWV? This thesis will try to give an answer to these questions.
Aims of this thesis

Paving the way for the main objective, the initial objectives of this thesis are:
1. To summarize the evidence on the effectiveness of web-based interventions on patient empowerment.
2. To describe the development of a new tool to measure empowerment among people with a long-term work disability.

The main objective of this thesis is:
3. To evaluate the effectiveness of a web-based intervention aimed at empowerment of disability benefit claimants.

Hypotheses

With regard to the hypotheses of the conducted project and the outcomes that were assessed, the model displayed in Figure 1 gives an idea of the proposed working mechanisms of the intervention www.wiagesprek.nl.

Figure 1. Model describing the hypothesized working mechanisms of the intervention www.wiagesprek.nl

It is hypothesized that, through the intervention www.wiagesprek.nl, disability benefit claimants will gain knowledge about social security arrangements and disability assessment procedures. This insight will lead to more realistic expectations on the way the assessment will be performed by UWV and on the outcomes of the assessment. Apart from aiming at knowledge, the intervention will focus on learning skills (e.g., questions asking), increasing claimants’ self-efficacy to use these skills, and increasing claimants’ self-awareness on their medical situation and working future. These factors will cause claimants to be empowered towards their disability assessment. At its turn, a higher level of empowerment will come hand-in-hand with a more active coping style of claimants towards the assessment and less stress and anxiety before the assessment.
Hypothetically, this will lead to claimants who are more actively participating during the assessment. An actively participating claimant who is up-to-date on the disability assessment procedures, is able to give more directed and relevant information on his or her disability, and is able to ask questions if something is unclear. This will most likely result in a more efficient assessment and an improved physician-claimant interaction. Once this interaction is enhanced, claimants will be more satisfied with the assessment, and experience the actual outcome of the assessment as more just. When perceived justice is higher, this could lead to less claimant objections or appeals on the outcome of the assessment.

Insurance physicians will experience claimants who know more about procedures and legislation as more positive because they will not have to spend much time on explaining laws and procedures. Hence, claimants who are more aware of their realistic chances in receiving a disability pension and the working mechanisms of social security arrangements, and claimants who give more directed information on their work disability, will lead to more satisfaction among physicians and to more efficient assessments.

As an organisation, UWV will be interested in the satisfaction of their ‘customers’ and also of the professionals who work for their organisation. A hypothesized benefit of the intervention is that claimants (as ‘customer’) satisfaction increases and disability assessment will be more efficient in terms of time and the quality of the assessment. Once this will be the case, the number of objections and appeals UWV has to process possibly decreases.

**Thesis outline**

In Chapter 2, a systematic review is described, in which the effectiveness of web-based interventions on patient empowerment was evaluated. Chapter 3 presents the development of a new tool that measures empowerment among people with a long-term work disability. Chapter 4 describes the development of the central intervention of this thesis, the interactive website www.wiagesprek.nl. Also, in this chapter, the research protocol by which this website was evaluated is presented.

In Chapters 5, 6 and 7 the evaluation of the interactive web-based intervention www.wiagesprek.nl is described. First, in Chapter 5 a detailed process evaluation is discussed, in which the focus is put on the reach, user satisfaction, and program use of the intervention. Then, most importantly, the effectiveness of the intervention is described in Chapter 6. Finally, in Chapter 7 emphasis is put on compliance with the intervention and its effect on the study results.

**References**

[14] Hadler NM. If you have to prove you are ill, you can’t get well. The object lesson of fibromyalgia. Spine 1996; 21(20):2397-2400.
education and coaching intervention to enhance care of cancer-related pain. Empowerment for Living without Pain (Ca-HELP): study design and rationale for a tailored intervention.


