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Breaking WEIGHT BIAS

Promoting Health without harming through digital training tools

Project number:

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Desk Research Report The Netherlands

ATERMON BV

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1. Desk Review Template - Purpose of this tool

Babeș-Bolyai University has developed this tool as a guide and generic template for creating a desk research report. We have tried to makes it user-friendly by providing explanations and examples under each heading.

A desk research report is a compilation of existing secondary data in a readable and usable format. It usually includes data from before and after the crisis/emergency.

The research team from Babeș-Bolyai University is available to support any efforts to compile this desk research report and is responsible for overseeing the compilation of the final desk research report. The contact info for the coordination team for this task is provided here: alina.forray@publichealth.ro and madalina.coman@publichealth.ro.

2. Summary

In the Netherlands, the Situation of Weight Bias is rather unclear.

The obesity rate increased in the last 20 years, though the government has settled a work plan to reduce obesity and overweight. Specific health insurance programmes were created to support the people who are willing to take up such activities for their health and to balance their weight and physical activity. These activities are covered by the public insurance model the country is following.

Rules for general discrimination and stigmatisation in all the fields of everyday activity of a person have been settled, though these rules are not clear in case of weight stigmatisation.

In recent years activities by organisations and groups of people interested in this topic were organised to raise awareness on weight bias. The results of these actions are not clear and there are no available statistics on the overall impact of these activities on the whole country.

More training is required for health professionals as well as targeted research on the topic of reducing weight bias and the accessibility and equal opportunities to people who are overweight or with obesity.

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3. Country profile statistics

Country Profile Statistics				
Population (The World Bank,2019)	17,344,874	Population under 14 Population female 15-19 Population male 15-19 (The World Bank,2019)	15.883% 5.789% 6.151%	
GDP per capita (current $) (The World Bank,2019)	52,295.039	HDI Index & Ranking	0.944 8th out of 189 UN-recognized territories	
GNI per capita (current $) (The World bank, 2019)	61,480	Poverty headcount ratio at the national poverty line (% of population) (The World Bank,2019)	13.6%	
Gini Index (The World bank, 2018)	28.1	Completion rate of lower secondary education	-	
Nurses & Midwives (per 1,000 people) (The World bank, 2018)	11.2	Mental Health Professionals (per 1,000 people)	-	
Physicians (per 1,000 people) (The World bank, 2017)	4	Dietitians and Nutritionists (per 1,000 people)	-	
Physical therapists (per 1,000 people)	-	Life expectancy at birth (World Bank, 2019)	82	
			80 male	84 female
Prevalence of Type 2 diabetes	- %	Literacy rate in adults (World Data Atlas, 2014)	99%	
Prevalence of cardiovascular diseases	-%	Prevalence of overweight among adults (20 years and over) (WHO, 2013)	56,4% male	48,7% female
Saturated fat intake from total calorie intake (WHO, 2009)	13%	Prevalence of overweight among adolescents (10-19 years) (WHO, 2013)	15% boys	12% girls
Added sugars intake from total calorie intake (Nutrients-MDPI, 2016)	12%	Prevalence of overweight among children (0-9 years)	-% boys	-% girls
Fruit and vegetable supply in grams per capita per day (RIVM Report, 2016)	250gr fruit and nuts 250gr Vegetables	Prevalence of undernourished (World Bank, 2018)	2.5	
Salt intake in grams per capita per day (WHO, 2013)	8.8 gr	Prevalence of physical inactivity in adults (15 years and over) (WHO, 2013)	23,7% boys	16,4% girls

4. General information about bias in obesity management and prevention policies, strategies and services related to a health-promoting lifestyle

Up to 2014 the Dutch population self-reported as overweight was lower in comparison with other EU countries. Though, obesity is continuously rising as in the whole world. Obesity rose from under 10% in 2000 to nearly 13% in 2014 (compared to 15.9% in the EU) which has important implications for health, contributing to diabetes, CVD and selected cancers. (OECD and World Health Organization, 2017)

In 2018, 16 per cent of all children and young people in the Netherlands aged 2 to 24 years were overweight. This applied to nearly one-quarter of young adults (18 to 24 years). Overweight is most prevalent among children and young people with a non-western migration background (25.1 per cent) and 18 to 24-year-olds (24 per cent). (CBS Netherlands, 2019)

A survey conducted from 2016 to 2018 demonstrated that even the 67% of young adults - aged 18 to 24 years were satisfied with their body weight, three in ten overweight young adults are not comfortable with their body. At 29 per cent, the share of overweight young adults with a negative body image is higher than among those with healthy body weight (5 per cent). Dissatisfaction is greater among young women than among young men. (CBS Netherlands, 2019)

Main national recommendations, strategies and policies on weight bias, stigma, and discrimination

In the Netherlands, there are no specific strategies and policy for weight discrimination. Though there is generally a legal prohibition for discrimination. According to the Dutch constitution since 2018 every person is in the Netherlands should be treated equally. Discrimination on the grounds of religion, belief, political opinion, race, sex, or any other ground is not allowed. The General Equal Treatment Act (Algemene wet gelijke behandeling - AWGB) enclosed in the constitution, provides that everyone should have equal opportunities for a job and good working conditions, education and training course or a certain service or product. The Awgb focuses on employers, schools, hospitals, shopkeepers, catering, gyms, insurers and all other providers of goods or services. (De Rijksoverheid. Voor Nederland)

Partnerships and professional networks that work in nutrition, physical activity, and obesity

Through the desk research no professional work was found around weigh bias but only on the proper and healthier nutrition of the Dutch citizens and the reduction of obesity. Such programmes are as follows:

The Dutch National Institute for public health and the environment (RIVM):
One of the institute's activities is around the healthier nutrition of the Dutch citizens for better public health and to decrease the risk of premature death, cardiovascular disease, and diabetes. The institute runs guidelines on the healthier nutrition of the citizens with meals rich in vegetables, fruit, legumes, nuts, fish, wholemeal products, sufficient low-fat dairy products, and low consumption of red meat and processed meat products, alcoholic beverages and sugary drinks, salt, and saturated fats (Health Council of the Netherlands: Dutch Dietary Guidelines 2015). RIVM Centre for Healthy Living supports professionals working at companies, schools, and childcare centres in developing an integrated approach to healthy food. (National Institute for Public Health and the Environment Natherlands, 2020)

The institute participates in international research projects such as the Horizon2020 PROMISS project and SEAFOODTOMORROW. PROMISS aims to better understand and prevent malnutrition in older people, thus promoting active and healthy ageing. SEAFOODTOMORROW works on creating nutritious, safe, and sustainable seafood for the consumers of tomorrow. More international projects on food and nutrition, in which RIVM is involved, can be found in our international project database (International projects | RIVM). (National Institute for Public Health and the Environment Natherlands, 2020)

Since 2008, RIVM's Department of Nutrition and Health has been a designated WHO Collaborating Centre (CC) for Nutrition. The department supports the work of the World Health Organization (WHO) on health and sustainable diets and the prevention of chronic diseases. RIVM's activities in the field of healthy nutrition contribute to SDG2 Zero hunger and SDG3 Good health and well-being. (National Institute for Public Health and the Environment Natherlands, 2020)

The Dutch Foundation on weight (Nederlandse Stichting Over Gewicht)

The Dutch Foundation on Weight is working either with people who want to lose weight or with people who accept their body structure. They support a world in which people can feel free and comfortable with their bodies and where everyone regardless of their body size can organise their life in equal positions and opportunities. They attempt for a better quality of care, treatment, and guidance. (Nederlandse Stichting Over Gewicht, n.d.)

Amsterdam Healthy Weight Programme (AHWP) (Amsterdamse Aanpak Gezond Gewicht - AAGG)/ Health Equity Pilot Project (HEPP)

In the Amsterdam Healthy Weight Programme are participating the Amsterdam Municipality and the Public Health Service of Amsterdam. The programme initiated in 2013 by the Amsterdam Municipality to give every child 'a healthy childhood and future. The overall objective is to achieve a healthy weight for all children in Amsterdam by 2033. The project targets to create preventive measures through educating the community, children, and parents in healthy nutrition habits. The communities primarily addressed by the programme are vulnerable groups with low socio-economic and educational status. (Brookes & Korjonen, 2018)

Coordination mechanisms among healthcare professionals in treating people with overweight and obesity

There is no clear reference on this topic. In the healthcare system of the Netherlands every person is treated equally.

Social and cultural norms, awareness campaigns and media coverage related to stereotypical portrayals of people living with obesity

During the desk research some awareness campaigns that were found are as follows:

Action group Political Fatties (Actiegroep Political Fatties)

This group of women have undergone fat shaming. These women created this group to raise awareness about Weight Bias and Fat shaming. An interview in NOS magazine was settled together with a promotional video. The article is available in this link: https://nos.nl/op3/artikel/2210656-deze-vrouwen-zijn-klaar-met-fat-shaming

FAT-SHAMING PUTS EXTRA LIVES AT RISK IN CORONA TIME (FAT-SHAMING BRENGT IN CORONATIJD EXTRA LEVENS IN GEVAAR)

An article was created in One-world online magazine from the author Marjon Melissen who is a member of the organisation Women Inc. This article incorporates the weight bias and the stigmatisation the author received and analyses the phenomenon. The article is available in the following link: https://www.oneworld.nl/lezen/opinie/fat-shaming-brengt-in-coronatijd-extra-levens-in-gevaar/

5. Affected persons

Access to services and goods

In the Netherlands since 2006, the Health Insurance Act merged the public and private insurances in the healthcare sector. According to this Act, all residents (and non-residents who pay Dutch income tax) must purchase statutory health insurance from private insurers. Adults choose a policy on an individual basis (no family coverage), and children under 18 are then automatically covered. The coverage is mandatory, and every citizen has the right to change and make a contract with another private insurer. The insurers are also obligated to approve any citizen willing to acquire health insurance without any discrimination. (Wammes, Stadhouders, & Westert, 2020)

Through this act, the Dutch government wanted to tackle the phenomenon that citizens were left uninsured or paid huge amounts in private insurers while others could not afford this opportunity. The national government has overall responsibility for setting health care priorities, introducing legislative changes when necessary and monitoring access, quality, and costs in the country's market-based system. The uninsured citizens are fined. Active members of the armed forces (who are covered by the Ministry of Defence) are exempted. (Wammes, Stadhouders, & Westert, 2020)

Income taxes and government grants are collected in a central health insurance fund and redistributed among insurers following a risk-adjusted capitation formula that considers age, gender, labour force status, region, and health risk (based mostly on past drug and hospital utilisation). (Wammes, Stadhouders, & Westert, 2020)

In addition to statutory coverage, most of the population (84%) purchases supplementary insurance covering a range of services not covered by statutory insurance, such as dental care, alternative medicine, physiotherapy, eyeglasses and lenses, and contraceptives, while also reducing co-payments for non-formulary medicines. The premiums of this type of insurance are not regulated by the government and insurers can screen applicants for risk factors. This type of extra insurance does not provide higher priority and access to any type of care, nor do they have increased choice among specialists or hospitals. (Wammes, Stadhouders, & Westert, 2020)

Services covered: The government determines the statutory benefits package, and health insurers are legally required to provide the standard benefits. The mandatory benefit package includes:

- care provided by general practitioners (GPs)
- speciality care
- hospital care
- maternal care
- dental care up to age 18
- prescription drugs
- physiotherapy up to age 18
- home nursing care
- a limited number of health promotion programs, including those for smoking cessation and some weight management advice
- basic ambulatory mental health care for mild-to-moderate mental disorders
- specialized outpatient and inpatient mental care for complicated and severe mental disorders.

Long-term care is financed separately from statutory health insurance. (Wammes, Stadhouders, & Westert, 2020)

Prevention and social supports are not covered by statutory health insurance but are financed through general taxation. The Public Health Act describes municipal responsibilities for national prevention programs, vaccinations, and infectious disease management. Municipalities can install additional prevention programs, such as healthy living and obesity reduction programs, but the provision of such services can vary widely from one municipality to another. (Wammes, Stadhouders, & Westert, 2020)

In 2013, the government decided to cover weight loss advice and smoking cessation programs in the statutory benefit package. Regarding the overweight people or those with obesity a combined lifestyle intervention (Gecombineerde Leefstijlinterventie - GLI) is created for their care. The GLI is aimed at a behavioural change to achieve and maintain a healthy lifestyle. Within a GLI, advice and guidance are given aimed at:

- healthy food,
- healthy eating habits,
- healthy exercise.

This intervention lasts 2 years and consists of group meetings and individual contacts. The number of group meetings can vary per program but is on average 12 times. In addition, there are 1 or 2 individual contacts with the care provider who provides the GLI. (Zorginstituut Nederland, n.d.)

Not everyone who is overweight is eligible for a GLI. The following insured persons can receive a GLI:

- Insured persons with a BMI over 25 and an increased risk of cardiovascular disease or an increased risk of type 2 diabetes.
- Insured persons with a BMI over 30. (Zorginstituut Nederland, n.d.)

The diagnoses whether a person is eligible for GLI comes from a General Physicians. A GLI can be given by lifestyle coaches, by dieticians and by physiotherapists and/or remedial therapists. They can deliver the GLI alone, but they can also collaborate and deliver the GLI with each other. The GLI motivates the insured to exercise regularly outside the GLI. For the actual exercise, the insured person must take the initiative and match the possibilities in their own environment as much as possible. The care provider of the GLI can help the insured find the way to these options. A fitness subscription, the sports club or sports clothing are not part of the reimbursement for the GLI from the basic package. (Zorginstituut Nederland, n.d.)

If someone receives care under the Long-Term Care Act (Wet langdurige zorg - Wlz) because of their obesity or overweight the GLI can be part of this treatment. (Zorginstituut Nederland, n.d.)

Excluded groups

Every four years, variations in health accessibility are measured and published in the Dutch Health Care Performance Reports by the National Institute for Public Health and the Environment, focusing on socioeconomic differences such as ethnicity and education. Geographic or regional variation is not measured consistently.

Immigrants who are undocumented do not have the permission to a health insurance. They must pay by themselves for most treatments excluding acute care, obstetric services, and long-term care. However, some mechanisms are in place to reimburse costs that undocumented immigrants are unable to pay. Political asylum–seekers fall under a separate, limited insurance plan. Permanent residents living in the Netherlands for more than three months are obliged to purchase private insurance. Short-term visitors are required to purchase insurance for the duration of their visit if they are not covered through their home country. (Wammes, Stadhouders, & Westert, 2020)

Some treatments, such as general physiotherapy, are only partially covered for some people with specific chronic conditions. Some elective procedures are excluded, such as cosmetic plastic surgery without a medical indication, dental care after age 18, and vision care without medical indication. A range of medical devices are covered, including hearing aids and orthopaedic shoes, but wheelchairs and other walking aids are excluded. (Wammes, Stadhouders, & Westert, 2020)

6. Educational and training for health professionals working with individuals living with obesity and those that want to improve their current lifestyle

Unfortunately, during the desk research limited information on such training opportunities was found.

An educational platform target to healthcare professionals and relevant to overweight is created by the Dutch Centre for Youth Health (NCJ). The educational modules for healthcare professionals are available in the following link: https://www.ncj.nl/richtlijnen/alle-richtlijnen/richtlijn/overgewicht

7. Appendices

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