The Netherlands

Population
17,408,000

Area
34,188 km^2

Capital
Amsterdam

3 largest cities
Amsterdam (873,000)
Rotterdam (651,000)
The Hague (546,000)

Neighboring countries
Belgium, Germany

1. Migration history

Dutch migration history is characterised by large immigration and emigration flows. During the First World War thousands of Belgian refugees immigrated and between 1920 and 1940 many Jews and other Nazi persecuted groups fled to the Netherlands. After the German invasion of 1940, a large group of the autochthonous population emigrated to United Kingdom[1]. Between 1946 and 1969, almost half a million people left the country (mostly to Canada, Australia, the US, South Africa, and New Zealand) [2, 3]. At the same time, many people immigrated from former colonies and guest worker countries. As a result of Indonesia's independence in 1945, about 300,000 Dutch-Indonesian repatriates and 12,500 Malukans came to the country. After Suriname's independence in 1975, almost half of its population emigrated to the Netherlands. In the 1960s and 1970s, guest workers were recruited mainly from Turkey, Morocco, and Spain. After the recruitment stop in 1975, family reunification was the main source of immigration. Since 2007, labour migration has shaped the migration patterns in the Netherlands [2]. A central characteristic of recent migration history is the continuous influx of immigrants from other EU states, especially from Germany [3]. In 2019, people from Turkey represented the largest migrant group (194,300), followed by Suriname (178,300), Morocco (170,500), Poland (145,200), Germany (120,600), and Indonesia (115,100) [4]. The migrant population (born abroad) almost doubled between 1990 and 2019 (1.2 to 2.3 million). At the same time, the proportion of migrants in the total population has also increased significantly (7.9 to 13.4%) [5]. As of 2020, the net migration rate is 0.9 [6]. While the Netherlands was an emigration country after the Second World War, it evolved into an immigration country between the 1960s and the millennium. For some years now, immigration and emigration figures have been converging.

2. Estimated number of people with a migration background with dementia

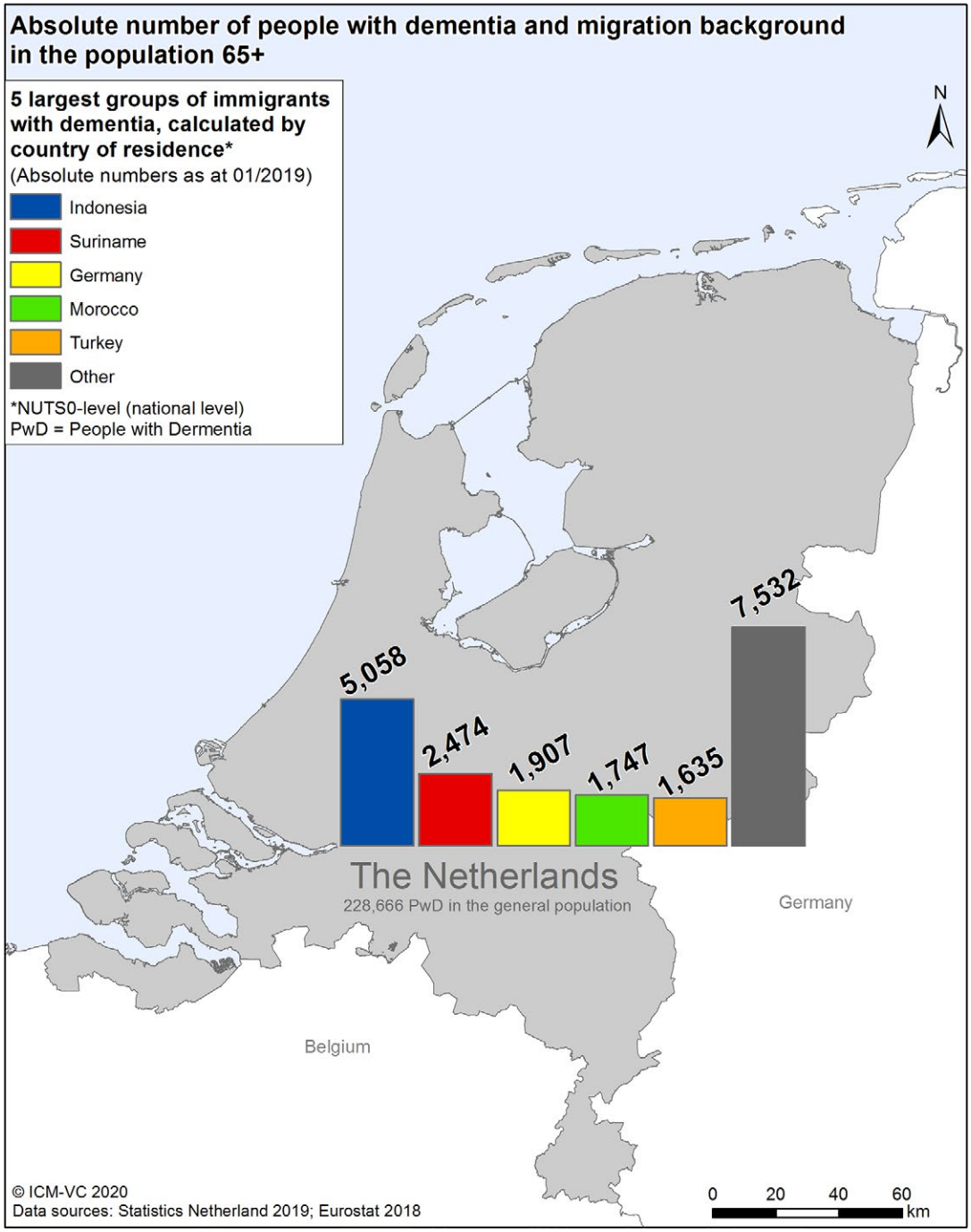

Fig. 3.7.22.1: Absolute number of PwM with dementia aged 65+ (The Netherlands – Nation)

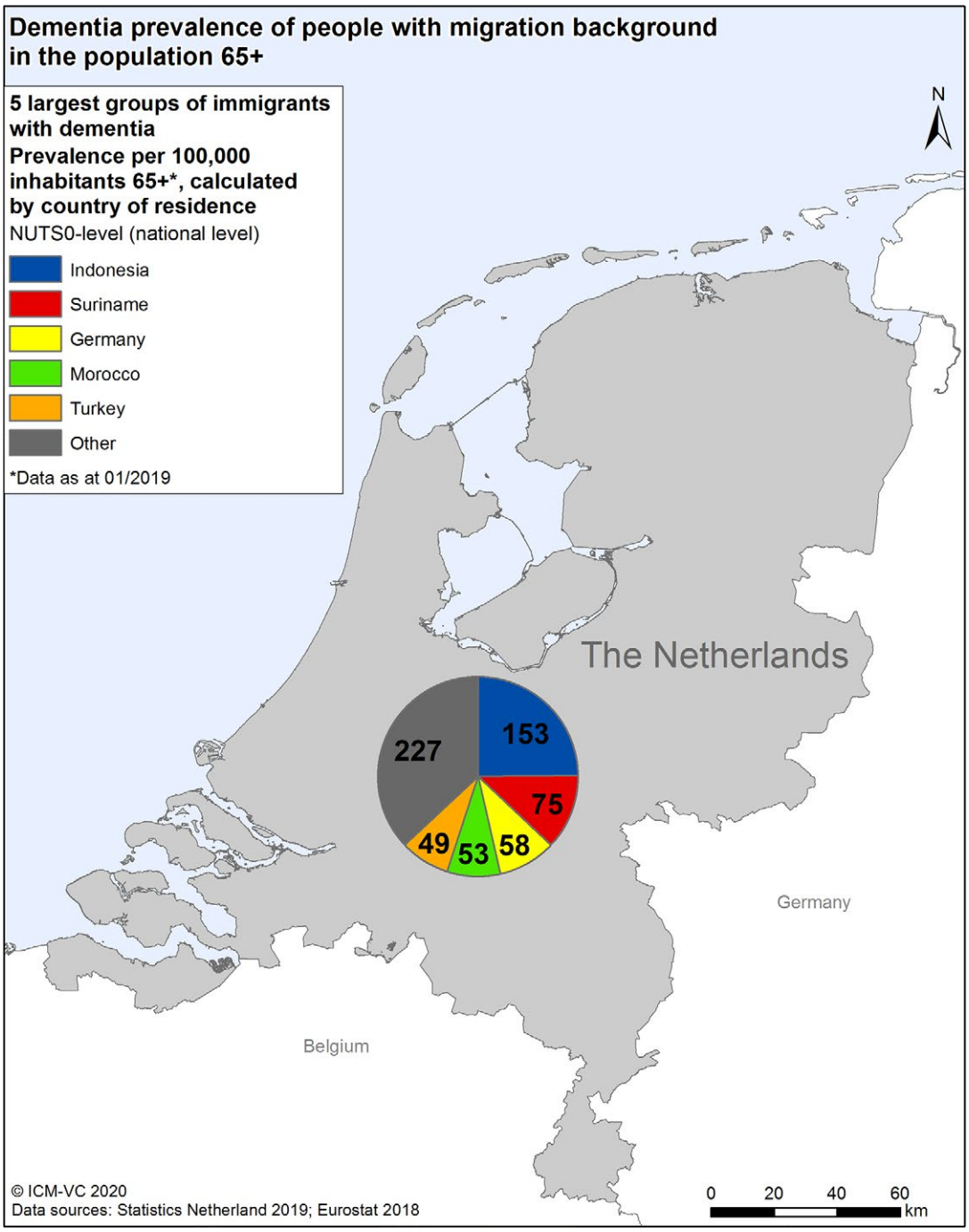

Fig. 3.7.22.2: Prevalence of PwM with dementia among the population aged 65+ (The Netherlands – Nation)

Tab. 36: PwM with dementia: Absolute numbers, prevalence among PwM aged 65+, and prevalence among overall population aged 65+ (The Netherlands – Nation)

NUTS	Total	NL	1. largest group	2. largest group	3. largest group	4. largest group	5. largest group	Other
Absolute Numbers								
The Netherlands	228,666	208,313	ID 5,058	SR 2,474	DE 1,907	MA 1,747	TR 1,635	7,532
Prevalence/10,000 inhabitants with migration background 65+								
The Netherlands	7,752	-	ID 171	SR 84	DE 65	MA 59	TR 55	255
Prevalence/100,000 inhabitants 65+								
The Netherlands	6,900	6,286	ID 153	SR 75	DE 58	MA 53	TR 49	227

Data source: Statistics Netherland (2019)

There are 295,000 PwM aged 65 or older. Of those, approx. 20,400 are estimated to exhibit some form of dementia. Figure 3.7.22.1 shows the most affected migrant groups presumably originate from Indonesia (approx. 5,100), Suriname (approx. 2,500), Germany (approx. 1,900), Morocco (approx. 1,800), and Turkey (approx. 1,600). The second graph highlights the number of PwM with dementia in the Netherlands per 100,000 inhabitants aged 65 or older (figure 3.7.22.2). Table 36 displays the values depicted in the maps on the national level. The following maps show the distribution of non-migrants with dementia and PwM with dementia from Indonesia, Suriname, Germany, Morocco, and Turkey throughout the country in the NUTS2 regions (figures 3.7.22.3 – 3.7.22.8).

Fig. 3.7.22.3: Absolute number of PwM with dementia aged 65+.
Country of origin: Indonesia (The Netherlands – NUTS2)

Fig. 3.7.22.4: Absolute number of PwM with dementia aged 65+.
Country of origin: Suriname (The Netherlands – NUTS2)

Fig. 3.7.22.5: Absolute number of PwM with dementia aged 65+.
Country of origin: Germany (The Netherlands – NUTS2)

Fig. 3.7.22.6: Absolute number of PwM with dementia aged 65+.
Country of origin: Morocco (The Netherlands – NUTS2)

Fig. 3.7.22.7: Absolute number of PwM with dementia aged 65+.
Country of origin: Turkey (The Netherlands – NUTS2)

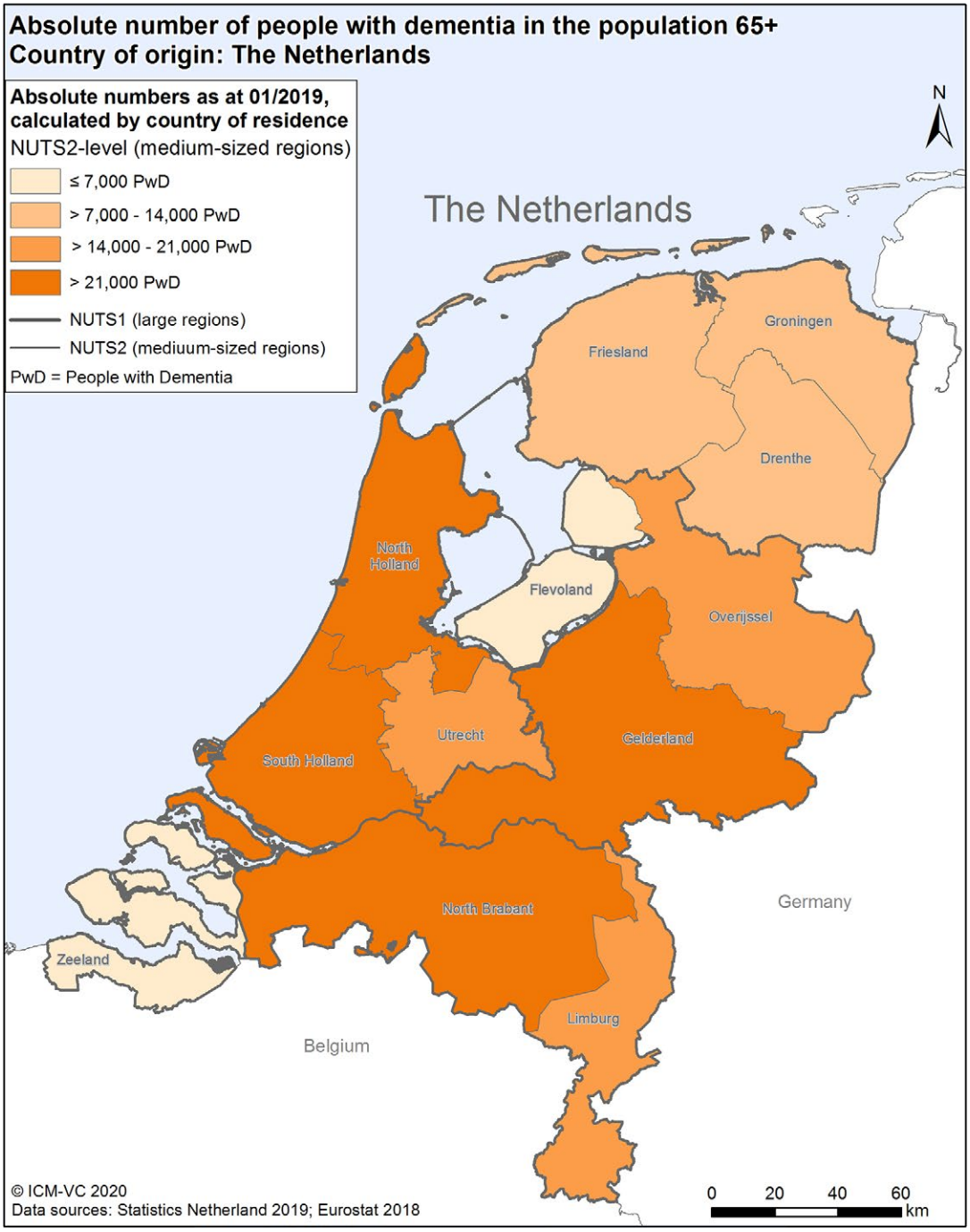

Fig. 3.7.22.8: Absolute number of people with dementia aged 65+.
Country of origin: The Netherlands (The Netherlands – NUTS2)

The graphics below highlight which immigrant groups are estimated to be the most affected at the NUTS2 level. The first map illustrates the absolute numbers of PwM with dementia in the NUTS2 regions (figure 3.7.22.9). The second graph shows the number of PwM with dementia per 100,000 inhabitants aged 65 or older in the NUTS2 regions (Fig. 3.7.22.10). The values from the NUTS2 level can be found in table 37 [7-9].

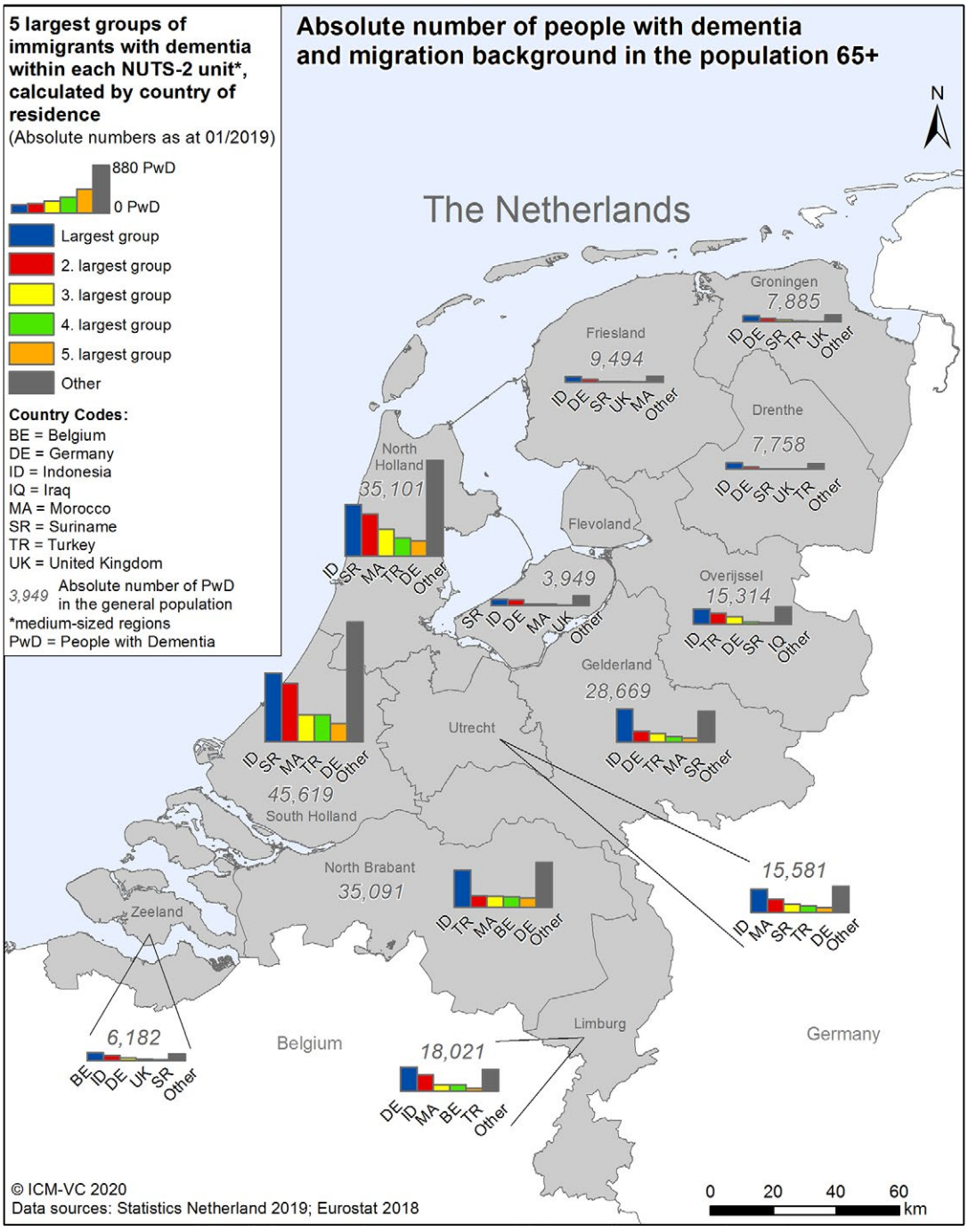

Fig. 3.7.22.9: Absolute number of PwM with dementia aged 65+ (The Netherlands – NUTS2)

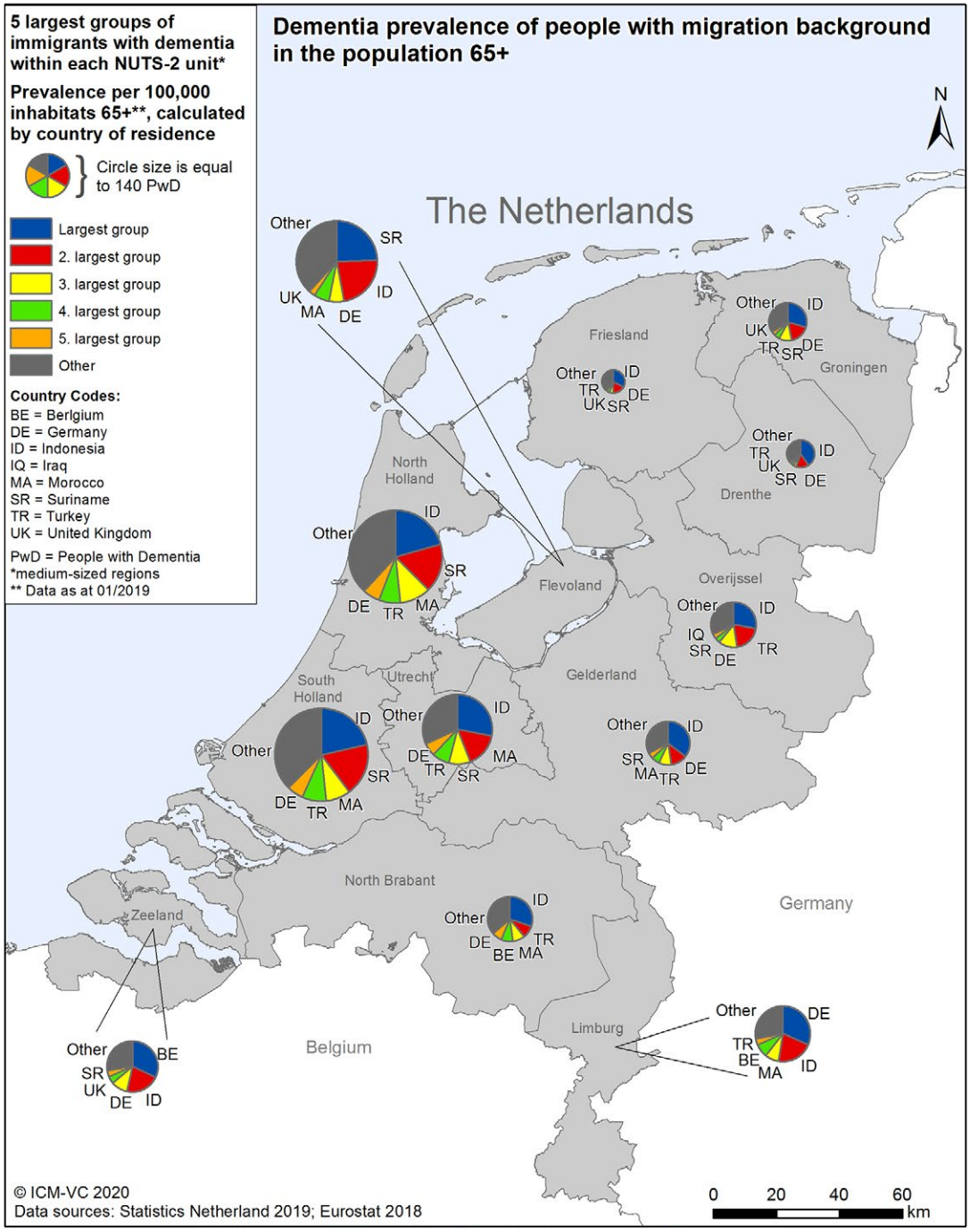

Fig. 3.7.22.10: Prevalence of PwM with dementia among the population aged 65+ (The Netherlands – NUTS2)

Tab. 37: PwM with dementia: Absolute numbers, prevalence among PwM aged 65+, and prevalence among overall population aged 65+ (The Netherlands – NUTS 2)

NUTS	Total	NL	1. largest group	2. largest group	3. largest group	4. largest group	5. largest group	Other
Absolute numbers								
Groningen	7,885	7,473	ID 122	DE 72	SR 45	TR 20	UK 13	140
Friesland	9,494	9,187	ID 101	DE 53	SR 17	UK 14	MA 8	114
Drenthe	7,758	7,462	ID 120	DE 46	SR 10	UK 10	TR 8	103
Overijssel	15,314	14,335	ID 272	TR 195	DE 132	SR 35	IQ 34	310
Gelderland	28,660	26,893	ID 629	DE 214	TR 167	MA 104	SR 83	579
Flevoland	3,949	3,498	SR 111	ID 101	DE 27	MA 27	UK 12	172
Utrecht	15,581	14,064	ID 424	MA 243	SR 152	TR 123	DE 89	485
Noord-Holland	35,101	30,501	ID 948	SR 777	MA 500	TR 341	DE 279	1,755
Zuid-Holland	45,619	39,707	ID 1,270	SR 1,086	MA 502	TR 500	DE 339	2,216
Zeeland	6,182	5,743	BE 140	ID 95	DE 47	UK 19	SR 17	122
Noord-Brabant	35,091	32,841	ID 677	TR 202	MA 201	BE 190	DE 165	814
Limburg	18,021	16,609	DE 444	ID 298	MA 114	BE 112	TR 51	393
Prevalence/10,000 inhabitants with migration background 65+								
Groningen	13,195	-	ID 204	DE 120	SR 76	TR 33	UK 22	235
Friesland	21,316	-	ID 226	DE 119	SR 39	UK 31	MA 19	257
Drenthe	18,042	-	ID 279	DE 106	SR 24	UK 23	TR 18	239
Overijssel	10,796	-	ID 192	TR 138	DE 93	SR 25	IQ 24	218
Gelderland	11,136	-	ID 244	DE 83	TR 65	MA 49	SR 32	225
Flevoland	6,044	-	SR 169	ID 155	DE 42	MA 42	UK 18	264
Utrecht	7,087	-	ID 193	MA 111	SR 69	TR 56	DE 41	220

Noord-Holland	5,265	-	ID 142	SR 117	MA 75	TR 51	DE 42	263
Zuid-Holland	5,324	-	ID 148	SR 127	MA 59	TR 58	DE 40	259
Zeeland	9,705	-	BE 220	ID 149	DE 73	UK 30	SR 27	192
Noord-Brabant	10,763	-	ID 208	TR 62	MA 62	BE 58	DE 51	250
Limburg	8,803	-	DE 217	ID 146	MA 56	BE 55	TR 25	192
Prevalence/100,000 inhabitants 65+								
Groningen	6,900	6,539	ID 107	DE 63	SR 40	TR 17	UK 12	123
Friesland	6,900	6,677	ID 73	DE 38	SR 13	UK 10	MA 6	83
Drenthe	6,900	6,636	ID 107	DE 41	SR 9	UK 9	TR 7	92
Overijssel	6,900	6,459	ID 123	TR 88	DE 60	SR 16	IQ 15	140
Gelderland	6,900	6,472	ID 151	DE 52	TR 40	MA 25	SR 20	139
Flevoland	6,900	6,112	SR 193	ID 177	DE 48	MA 47	UK 21	301
Utrecht	6,900	6,228	ID 188	MA 108	SR 67	TR 54	DE 39	215
Noord-Holland	6,900	5,996	ID 186	SR 153	MA 98	TR 67	DE 55	345
Zuid-Holland	6,900	6,006	ID 192	SR 164	MA 76	TR 76	DE 51	335
Zeeland	6,900	6,409	BE 156	ID 106	DE 52	UK 21	SR 19	136
Noord-Brabant	6,900	6,458	ID 133	TR 40	MA 39	BE 37	DE 33	160
Limburg	6,900	6,359	DE 170	ID 114	MA 44	BE 43	TR 19	151

Data source: Statistics Netherland (2019)

3. National dementia plan

Four NDPs, strategies, or standards were identified for the Netherlands. While the four-page 'Netherlands Deltaplan for Dementia' from 2017 and the 26-page 'Public Version Care Standard Dementia' from 2016 do not address migration [10, 11] the 'Care Standard Dementia' for professional service providers from 2013 (82 pages) and the 'National Dementia Strategy 2021 – 2030' from 2020 (24 pages) refer to this topic [12, 13].

The 'Care Standard Dementia' for professional service providers does not have a separate

chapter on migration, but several passages of this document briefly address the topics of dementia prevalence, specific needs, dementia diagnosis, and care in relation to PwM with dementia. Thereby, it refers to the fact that dementia is increasingly common among people of non-Dutch origin (due to the aging population and a high prevalence of cardiovascular diseases and diabetes) and that this group has special needs in dementia diagnosis and care. It is argued that patients and their families with migrant backgrounds have different preferences in communication and decision-making regarding illness and treatment. The Netherlands pays particular attention to migrants in early detection and prevention. People affected by dementia and their relatives are offered activities (mental, physical, and learning activities) oriented to their cultural background. In the future, special attention will be given to migrants with dementia in the provision of housing. In addition, information on dementia will be adapted to the linguistic and cultural background of people of foreign origin. Thus, the version of 'Care Standard Dementia' from 2013 which is targeted at professional service providers points out that in the Netherlands specifialised services are currently available for PwM with dementia and that further actions will be taken to improve the care situation of this population group [12].

The 'National Dementia Strategy 2021 – 2030' briefly refers to migration in three sub-chapters. In the section 'Facts and Figures', a short paragraph (5 lines) highlights that of the 178,000 people who have a formal dementia diagnosis and are on the radar of healthcare providers, 14% have a migration background. Furthermore, it is outlined that dementia figures among people with a non-Western migration background are rising faster than among people with a Dutch background and that dementia is three to four times more common in this population. In two subsequent sub-chapters, this document emphasizes that future care, and specifically the dementia care, networks must focus on cultural diversity among people in need of care. However, no strategy or specific measures are mentioned to achieve this. Overall, the topic of migration plays a subordinate role in the 'National Dementia Strategy 2021-2030' [13].

4. National dementia care and treatment guidelines

In the Netherlands, two documents with guidelines on dementia were identified: 1. 'The Guideline for Integrated Dementia Care' from 2009 and 2. the 'Dementia Treatment Policy' from 2012. The first document comprises 62 pages and deals with the topics such as: 1. diagnoses (sub-topics: criteria and recommendations for the diagnosis of different types of dementia, cognitive screening tools, neuropsychological tests); 2. treatment (drug treatment for dementia symptoms and neuropsychiatric symptoms, psychosocial and other non-drug interventions such as cognitive training and, physiotherapy); 3. support groups for caregivers of people with dementia; and 4. training of caregivers [14]. The second document is 38 pages long and includes the topics: 1. people with dementia and their families (sub-topics: what is dementia and what does it do, People with dementia, their families and numbers [i.e. 'Number of people with dementia in the Netherlands]; people with dementia, their families, and their questions [identification of different problem areas]); 2. integrated dementia care and its important aspects (sub-topics: what is important for good dementia care in the region [i.e. what is good dementia care]; 3. what is important in terms of good quality integrated care (i.e. criteria for good management of integrated care), and 4. case managers as a

crucial link in the care chain (i.e. good examples of case management) [15]. Neither the first nor the second document refers to migration in any of the topics mentioned [14, 15].
The following parts on services and information for PwM with dementia, professional care and support for family caregivers are based on a conducted interview and reflect the experience and opinion of the experts. A selection bias in information and a discrepancy to results from the previous sections might ensue.

5. Services and information for people with a migration background with dementia

According to the two experts, the healthcare system identifies older PwM as a vulnerable group. For example, the Centre of Expertise on Differences in Health Access Pharos, which provides health education for patients and professionals, has a special focus on migrant groups. But overall, there are large regional differences in the relevance of the topic of dementia and migration in the Netherlands. For these experts, who work in a hospital in Amsterdam, and care providers from other larger cities in the west of the Netherlands, such as Rotterdam or The Hague, where many migrants live, the topic is very important. One expert stated that in a few years, a third of people living in Amsterdam who are 60 years or older will be non-western migrants. In provinces like Groningen or Drenthe, where only a few migrants live, the topic of dementia and migration is not seen as important. Older PwM are considered vulnerable in the areas of development and prevalence of dementia (which is higher in migrant groups), lack of care, underdiagnosis, and utilisation of healthcare services. Especially older migrants from Turkey and Morocco of the first generation are identified as vulnerable (due to language, cultural, and educational barriers).
According to one expert, a hybrid healthcare strategy with integrative and segregative elements is used in both outpatient and inpatient care for PwM with dementia. In inpatient care, however, the segregative model is somewhat more widespread. This expert noted that there are slightly fewer migrant-specific care services in inpatient care than in outpatient care. The two experts still reported that there are adequately effective services for outpatient care of older migrants in several regions that meet their needs. For example, the intercultural dementia screening tool RUDAS is used in many memory clinics to assess dementia among migrants. In addition, some memory clinics offer a specialist day-care program with interpreters as well as training related to the topic of dementia and migration. As a basic model of good practice, one expert highlighted the combination of clinical practice and scientific research in the context of diagnostics in some centres and universities, such as the Amsterdam Department of Psychiatry and Medical Psychology and the Erasmus University Rotterdam. There are also many other centres that are learning from the two organisations, for example by using interpreting services, increasing their knowledge of educational and literacy barriers, and organizing symposia bringing together hospitals where diagnoses are made with general practitioners and care institutions which have many migrant patients. In follow-up care, the model of good practice is to have a strong care chain in which the actors know each other well and have knowledge about the relevant stakeholders. Although a growing number of cities such as Amsterdam, Rotterdam, or The

Hague are offering specialised services such as allocation of apartments in nursing homes for elderly migrants from Turkey and Morocco (with halal food, native-speaking staff, and religion-specific services), there are currently still many regions without such options.

One expert pointed out that the measures for intercultural care and support for dementia are spread nationwide. Most services are accessible via the Internet. For example, there are tools and videos that help people to recognize symptoms of dementia and talk about dementia. Furthermore, in many regions, there are training courses for key community members on how to recognize dementia symptoms and set up care chains. The information is available online, allowing to provide such training in all regions.

According to the experts, the existing care services are adequate for people with dementia with and without a migration background. However, as they are usually designed by non-migrants, they are more suitable for non-migrants. PwM with dementia or their relatives are also less frequently involved in the development of such services, even though such participatory projects do exist in the Netherlands.

6. Professional qualification and people with a migration background in healthcare

In the education of healthcare professionals in universities and medical faculties, a special focus is set on the topic of culturally sensitive care as stated by the experts. In addition, the institution Pharos provides special courses on culturally sensitive care and other topics relevant to older migrants, such as dementia and palliative care. Pharos has also developed a special course on end-of-life care for first-generation migrants, an initiative in which the two experts were involved. While culturally sensitive care is mostly part of curricula for the education of professionals, there seem to be no official training opportunities for doctors or caregivers in intercultural care. However, the hospital in Amsterdam, where the two experts are employed, offers courses or lectures in which health professionals or students from other regions also participate.

The proportion of professional caregivers with a migration background is increasing relatively strongly in both outpatient and inpatient care. According to the experts, it is currently still at a moderate level. The three main countries of origin of the caregivers with a migration background are Suriname, Turkey, and Morocco. An increasing proportion of professional caregivers from these countries has a very positive influence on patients who have also immigrated from these countries. However, some patients fear that they cannot trust a caregiver who has the same cultural background because they are afraid that they are gossiping about what they tell. This problem is also evident with official interpreters.

7. Support for family caregivers

According to the experts, the family is very important in supporting family caregivers of PwM with dementia. Religious communities, migrant organisations, and care providers are also relevant in this context. One expert argued that it is important for professional care providers to establish contact with religious communities and migrant organisations to provide PwM information on dementia.

Family caregivers of PwM with dementia often lack information about formal services and have a very high need for specialised services providing support and information. According to one expert, such specialised services currently only exist in a few regions (in larger cities with a higher number of elderly migrants, such as Rotterdam, Amsterdam, and The Hague). The other expert noted that in the Netherlands there is generally a lot of information on dementia, but it is primarily available online. Especially for older migrants, different paths of access to information and support are needed. There is also a high need for awareness-raising and education about dementia, as dementia is often not seen as a disease in some migrant groups (e.g. by many people from Morocco and Turkey), which is an obstacle to the active utilisation of services.

8. References

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