6.6 Netherlands

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6.6.1 Short history of migration and trends

Migration to and from the Netherlands is by no means a new phenomenon. The country has had a long tradition of migrant settlement and emigration (Nicolaas & Sprangers, 2007). Dutch citizens emigrated to Australia, Canada and the United States of America after World War II which was followed by immigration to the Netherlands in the second half of the 20th and into the 21st century. Net migration to the Netherlands has been positive since the mid-1990s with a few exceptions; i.e. between 2003 and 2007 more people left the country than arrived. However, since then net migration has been positive again with a surplus of 79.000 persons in 2016 (Statistics Netherlands, Statline 31 July 2017). Over the past decade the largest single country of origin that has contributed to this positive net migration is the inflow of Polish migrants (with a net migration of around 10.000 persons per year). Only in 2015 and 2016 they were outnumbered by Syrian migrants (with a net migration of around 20 and 27.000 persons respectively) (Statistics Netherlands, Statline 31 July 2017). Since World War II the composition of these flows to the Netherlands has, however, changed. In line with and building on the work by Van Mol and de Valk (2016) it is crucial to distinguish four different migration flows that may also be related to different periods in time.

First, immigrants from the former Dutch colonies of the Netherlands arrived to the country. These included Indonesia, Suriname and the Netherlands Antilles. Migrants from Indonesia had to a large extent Dutch citizenship as some of them were part of the administration in the former colony whereas immigrants from the former Dutch Antilles and Suriname initially came for educational purposes to the Netherlands (Nicolaas & Sprangers, 2007). Furthermore, substantial numbers of Surinamese came to the Netherlands around the independence of Suriname in 1975. Since Surinamese kept Dutch citizenship until 1980 they could rather easily settle in the Netherlands without residence permits. Before this transition period ended many Surinamese decided to move to the Netherlands to not lose their rights (Nicolaas & Sprangers, 2007; de Valk, Huisman, Noam-Zuidervaart, 2011). Since the Netherlands Antilles are still part of the Kingdom of the Netherlands, immigration from there is relatively easy. In recent years, limited job opportunities in the Antilles and Aruba have motivated young inhabitants to migrate. Nevertheless, although migration from these countries was rather numerous in the 1960s/70s and into the 90s it has been rather limited in the past decade.

Second, the Netherlands recruited (mainly male) migrants in the Mediterranean area during the economic boom of the 1960s and early 1970s. Due to the prosperous economic developments in this period many workers were needed in the industries located in the Western, Eastern and Southern part of the country (Van der Erf, Heering & Spaan, 2006). These labour migrants were recruited, especially in Morocco and Turkey, as well as Italy and Spain. Most of them came from poor agricultural regions. This labour recruitment ended abruptly, when the oil crisis started, and all contracts with the sending countries were ended in 1974. From that moment onwards, basically, the only way for legal entry into the Netherlands was family reunification and formation (Van Mol & de Valk 2016). And although, originally, the labour migrants, who came, were expected to return, this happened only to a limited extent. Many settled permanently in the Netherlands and had their families joining them. Up into the

early 2000s young adults of Moroccan and Turkish descent also still often found their partners in the countries of origin of their parents, resulting in an ongoing migration in the form of marriage migration to the Netherlands (de Valk et al., 2011). At the same time other groups like Spanish immigrants started to return to Spain when the political and economic situation in the country stabilised and improved.

The third main type of migration to the Netherlands has been refugee immigration, which started to increase in the early 1990s. Although there had been refugees arriving to the country before, mainly from former Communist countries, Vietnam, and Chile, the number of asylum seekers rose significantly in the 1990s and peaked in the mid-1990s. The substantial increase in asylum applications from within Europe in the early 1990s, for example, was linked to the disintegration of the Soviet Union and the Yugoslavian wars (Hatton 2004) and has been dropping ever since. Not all of these migrants acquired permanent residence permits for the Netherlands, which resulted in large-scale return migration, e.g. to the countries of former Yugoslavia. Refugees, however, also in the 1990s, came from countries of conflict in Africa (e.g. Somalia), and the Middle East or Asia (e.g. Iraq, Iran and Afghanistan) (Website "vijf eeuwen migratie"; De Valk et al., 2011).

Since 2014, the Netherlands, like many European countries, has again received a relatively large number of asylum applications. Between 2014 and 2016, about 20.000 applications were issued per year, with a peak of 43.000 applications in 2015 (Statistics Netherlands, Statline, 18 July 2017). In 2017, asylum applications have dropped substantially, and in the first two quarters of the year, a total of 8.000 applications were made. Most applicants in the 2014-2016 period came from Syria, Eritrea, Iraq and Afghanistan. Not all these applicants did or will get a permanent residence permit for the Netherlands (de Valk et al., 2011; Van Mol & de Valk 2016). Over the past five years around 55.000 regular residence permits were granted to migrants in the Netherlands of which half for family reunification and the other half split between study and work motives of stay. During the same time the number of residence permits to those seeking asylum was around 9.000 between 2010 and 2013 and increased to slightly over 30.000 in 2015 and 2016. This implies that even with the peak in asylum in recent years still more people came to the Netherlands for other reasons and as such the relative influence of the refugee population in the total migrant population remains limited (Statistics Netherlands, Statline, 25 July 2017). As such the elderly population now and in the past is not very much determined by this specific group.

Finally, immigration from within Europe was always and remained important also in recent decades (EMN 2006a,b; Van Wissen & Heering 2014). European migrants in the Netherlands mainly come from the neighbouring countries Belgium and Germany, as well as the United Kingdom. The respective figures have been rather stable over time, but in recent years, other European groups have also settled in the country. While immigration from the four main countries of non-Western origin in the Netherlands (the Antilles and Aruba, Morocco, Suriname and Turkey) decreased, immigration from new members of the European Union (EU) – the EU-10 – increased. The accession of Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia to the EU in May 2014 resulted in more migrants from these countries of destination, particularly Poland. However, Polish migration to the Netherlands is not a recent phenomenon, but the numbers have increased substantially after joining the EU (Dagevos 2011). At the beginning of 2017, the size of the Polish population in the Netherlands was the second largest European origin group in the Netherlands after Germans (with 162.000 and 357.000 residents respectively including both 1st and 2nd generation). This is the result of the fact that, over the past decade, the Polish group was the largest single origin group

in the immigration flows to the Netherlands (Statistics Netherlands, Statline 2014), with the exception of 2015-2016, when they were outnumbered by Syrian asylum seekers. At the same time, a large share also returns to Poland: About 60 % of those, who arrived in the past decade, have left the Netherlands within seven years, and the large majority returned to Poland (Dagevos, 2011; Nicolaas 2017). Despite the relative high levels of return migration, the net migration rate has been strongly positive since 2004 and has varied between 5.000 and 11.000 persons per year (Statistics Netherlands 2014). These recent inflows have resulted in a larger number of Polish residents in the Netherlands, who are currently mainly in their young working ages. For the future, this may however become an important group of elderly migrants in the Netherlands.

Migrants of these four distinct migration flows are the current and future population of elderly migrants. Many of the current older population migrated as young adults in the 1960s and 1970s and are now between 60 and 70 years of age. In the future, the population of older migrants will be composed mainly by those, who migrated in more recent times, as well as those who were born as offspring of the earlier settlers (the 2nd generation). In the future the group of migrant elderly is thus expected to have much more diverse origins and include for example those who arrived as refugees as well as European migrants who settled in the country in the past decade.

6.6.2 A brief demography of older persons of diverse origin in the Netherlands

The number of older persons of migrant origin in the Netherlands is defined by the country of birth of the person and its parents. First-generation migrants are those, who were born abroad themselves, whereas the group of second-generation migrants comprises all those, who were born in the Netherlands but have, at least, one foreign-born parent. This definition is rather inclusive. As a consequence, of the total Dutch population of 17 million people, 12 % have a first-generation and 11 % have a second-generation migrant background (Statistics Netherlands Statline 2017). Hence, around 77 % of the population was born in the Netherlands with two native-born parents. About 56 % of the migrant population has a non-Western origin in 2017. Comparing these figures with those of 10 or 20 years ago, it becomes evident that the share of migrants in the population has substantially risen: In 1997, 16 % and in 2007, 20 % had a migrant origin of the respective total population sizes of 15.6 and 16.4 million. The increase in the share of migrants is mainly due to an increase of first-generation migrants from Asia and Europe, and the growing second-generation population of African origin. Also noteworthy, in earlier years about equal shares of the migrant population were of Western versus non-Western origin: 48 % and 55 % migrants were of non-Western origin in 1997 and 2007 respectively (Statistics Netherlands Statline 2017).

Within the resident migrant population in the Netherlands, there is an increasing share of those, who are 50 years and older. In 1997, 21 % of the total migrant population was 50 years and older, while, in 2017, this share was already at 28 %. Although incoming migrant groups are still predominantly young, due to ageing of this population in the Netherlands an increase in older persons among this group is observed and also expected for the future according to the predictions of Statistics Netherlands. If the overall population in the Netherlands of 50 years and older is concerned, migrants are still mainly in the “younger old-age groups”. Currently, 19 % of people at 50-60 years, 15 % of all 60-70 year-olds and 14 % of the 70-80 year-olds have a migrant background (Statistics Netherlands Statline 2017).

For the future, it is expected that the share of the 65+ year-olds in the total population will increase further (Garssen & van Duin 2009). This is true, particularly, in more rural areas, as cities tend to attract

a younger population, that, after starting a family, often leave the city and does not return. However, also in the largest cities of the Netherlands, the elderly population will grow and more importantly, it will be increasingly composed of older persons of migrant origin. Expectations are, that the share of older persons of non-Western origin in the four largest cities (Amsterdam, Rotterdam, the Hague and Utrecht) will be three times as large in 2040 as it is currently. At the moment, the figures show that most elderly of 65 years and older with a migrant origin (irrespective of their region of origin) live in the Western part of the country (i.e. the provinces North and South Holland), followed by the Southern province of Brabant (bordering with Belgium) and the Eastern province Gelderland (partially bordering with Germany) (Statistics Netherlands Statline 2017; Kooiman et al., 2016).

In terms of the main countries of origin of migrants, who are currently 65 years and older, the top ten clearly reflects the Dutch immigration history, and its diversity described above. Around 180 different countries of origin are represented by the 65+ population in the Netherlands. In numerical order (from largest to smallest) the top ten countries of origin are: Germany (138.000), Indonesia (83.000), Suriname (32.000), Belgium (28.000), Morocco (23.000), Turkey (23.000), United Kingdom (9.500), Antilles and Aruba (9.000), former Yugoslavia (7.000) and Italy (5.000). Although these origin groups will remain important for the future composition of the elderly population, it seems likely that a significant share of the migrants that arrived more recently will also become older in the Netherlands. Therefore, while countries like Iraq, and Afghanistan are currently ranked 21 and 22 in terms of countries of origin among the 65+ migrant population, this can be expected to change in the future. Meanwhile, the older population of Polish origin currently counts for around 5.000 people of 65 years or older. Given the recent migration to the Netherlands, this group can also be expected to become more important among the elderly population in the future (Statistics Netherlands, Statline, 2017). The described context poses new and relevant questions on how migrants from different origins and reasons of settlement may age in the Netherlands.

6.6.3 Data

Although in the early 2000s, ample attention was given to the ageing of non-Western migrants in the Netherlands, the issue has gradually disappeared from the public and policy discourse. This observations is backed by a report by the Dutch social and cultural planning agency (SCP) published in 2011, and since then no radical changes can be observed (Den Draak & de Klerk, 2011). The few survey data sources on older persons of migrant origin in the Netherlands mainly capture the period of the early 2000s, with a specific focus on the four largest immigrant groups in the Netherlands. Although the Netherlands has a range of data sets (both population registers and survey data) that can be used for the study of migrant elderly, little large-scale research specifically focusing on migrant elderly has been carried out to-date. An exception was a study conducted by the SCP on the health and well-being of migrant elderly from the early 2000s (Schellingerhout 2004a & 2004b).

There are different data sources available in the Netherlands: On the one hand, the population registers capture all legal residents in the country. These registers, therefore, also include those of migrant origins of whatever age. Thanks to these register data we can get a quite detailed insight into the general characteristics (like gender, age, place of residence in the Netherlands) of the migrant population who are currently above 55. In addition, the registers may also provide insight into the future number of older people – with and without migrant origin – based on the current resident population and the expected demographic behaviour. In the past, it was often assumed that migrants

would return to their home countries. However, it has become clear that is only the case for a limited group of people. In this regard, Statistics Netherlands calculates scenarios for the future population of the Netherlands based on assumptions on partial return, and the acknowledgement that a large share of migrants will stay in the Netherlands and will thus age in the country (van Duijn & Stoeldraijer, 2014; Van Duin, Stoeldraijer & Ooijevaar, 2015).).

Recently various attempts have been made to link the population register data with other registers. The system of social statistical datasets (SSD) was constructed by Statistics Netherlands in the late 1990s, by linking several registers to the Municipal Personal Records Database (*Gemeentelijke Basisadministratie,* GBA) (Bakker et al. 2014). Linkage is based on an individual identification number that all residents are required to have. In this way demographic information from the population register can be related to individual socio-cultural and socio-economic data. In the population registers all immigrants who intend to stay in the Netherlands for more than 90 days are legally obliged to register themselves within five days after arrival. A proof of registration is often a prerequisite for getting access to (welfare state) facilities making that most (but certainly not all) migrants will register themselves. Immigrants who stay for a short period (< 3 months) in the Netherlands are less well represented in these data. In addition to the date of entry to the country, the data provide information on the individuals' marital status and household composition on a daily basis. Through record linkage of parents and children one can distinguish married or cohabiting persons, with and without children living in the household, as well as, those who are married and living at the same address as their partner, and those who are married but living without their partner. Within this whole development of linking of different sources, the population registers are also more and more used to be linked to surveys like for example the labour force survey (Bakker et al., 2014). Despite the different options for data linkage and data analysis, there has been little empirical exploration of the elderly migrant population in the Netherlands.

The majority of small-scale studies and qualitative work on the older migrant population largely focused on interventions carried out in a specific city or neighbourhood. For the most part, the effects of these interventions for targeted groups of migrant elderly are evaluated in these studies (Distelbrink et al., 2007; Engelhard et al., 2006; Booij 2006). Some of these studies have focused not only on physical health, but also on mental well-being, loneliness and dementia (Bekker & Mens-Verhulst 2008; Hagen, 2010). Intervention studies typically have a targeted aim and focus, which distinguishes them other studies that aim to get insight into the situation of migrant elderly at large, their living conditions, health issues, care needs, care use and the role of informal care givers. The reason why limited survey studies explicitly target the migrant elderly is, at least, partially related to the fact that research among this group of (often first-generation) migrants is costly and labour-intensive. They are known to be not easy to reach populations that may also have language barriers. Large data collection investments are needed for this. However in the past decade the resources for researchers to invest in this type of data collection is only limited reducing the options for collecting detailed large scale survey data among older migrants of diverse origin in the Netherlands.

There are a range of data sets that are collected among the general population that also include migrants that can and partially are used for the study of migrant elderly. The health survey (Gezondheidsenquete) is a annual survey on the health of the Dutch population and is carried out by Statistics Netherlands. It collects data among a random sample of 10.000 persons in non-institutional households in the Netherlands and covers all ages (Statistics Netherlands, gezondheidsenquete). As

such it does give a general overview of the health situation among the population but is not particular suitable for specific analyses of migrant elderly given the limited sample and coverage of different groups. Another example is the Public health future exploration (Volksgezondheid Toekomst Verkenning; VTV carried out by the RIVM), which provides insight into the future challenges of public health in terms of determinants, prevention and care. The study is carried out every four years but does not explicitly address migrant health. Another example of a general survey with a focus on family ties, intergenerational relations, and health is the "NKPS" (Netherlands Kinship Panel Study). In wave 1, the "NKPS" oversampled the four largest migrant groups in the Netherlands (Dykstra et al., 2005; project website www.nkps.nl). However, these data refer to the full adult population and do not specifically focus on migrant elderly. Hence, this leads to rather small-scale sample sizes with a limited amount of origins that make analyses and generalizable conclusions difficult. Also the "LISS" (Longitudinal Internet Studies for the Social sciences) included an immigrant panel between 2010 and 2014, in addition to the general panel. Again also this study does not specifically aim at older migrants, neither explicitly on health or care .

Health has been addressed in a study in Amsterdam (HELIUS) in which participants of diverse origins took part and in which they were both medically examined as well as interviewed. The latter focuses on cardiovascular and infectious diseases as well as mental health. The study is a collaboration between the Academic Medical Center (AMC) and the Public Health Service of Amsterdam (GGD Amsterdam) (Helius project website http://www.heliusstudy.nl/). This study does not particularly aim at the elderly population but may generate important insights into health inequality in Amsterdam and necessary interventions for the future. A study that does focus on the older population is the well-established "LASA" study (LASA project website http://www.lasa-vu.nl/index.htm). This study has been running since 1991 to study determinants and consequences of ageing. The study covers different dimensions of health from physical, emotional to cognitive and social aspects. However, again, few migrant elderly are included, which makes it difficult to analyse, for example, migrant health. The study that focused explicitly on Health and wellbeing among migrant elderly (Onderzoek Gezondheid en Welzijn van Allochtone Ouderen GWAO) was carried out by the social and cultural planning agency (SCP) almost 15 years ago, which is why the data are outdated. Yet, no new data collection has been done since then. The study aimed at the age group of 55 years and older and different countries of origin (Turkey, Morocco, Suriname and Antilles) along with the native Dutch population. A broad range of topics was studied, including not only physical and mental health, but also housing, social networks and return intentions (Schellingerhout 2004a, 2004b).

Beyond the efforts to collect and analyse information about the health status of migrants, migrant caregivers, as well as their role and problems have also attracted some attention. Yet, again most of these studies focused on a particular city and a limited group of migrant origins (de Graaff et al., 2005; de Gruijter et al., 2008; Kloosterboer, 2004; Meulenkamp et al., 2010).

6.6.4 Ageing migrants: socio-economic position and health

The existing studies on elderly migrants show that non-Western migrants at older ages tend to have a worse socio-economic and health background than the majority of non-migrant population in the Netherlands. The existing studies predominantly focus on Turkish and Moroccan elderly, who have a had a rather low socio-economic position in the Netherlands starting at the moment of their arrival:

Many of these male migrants were mainly low-educated and recruited as labour migrants for low-skilled positions in the Dutch industry. The heavy work they had to do, along with the economic recession and mass firings in the 1980s made many of them dependent on welfare benefits already a long time ago. Due to the accumulation of adverse health events over the life course, older migrants of Turkish and Moroccan origin are reported to have more physical health issues and are more often depressive (Forum 2004; Schellingerhout, 2004a/b; Bekker & Van Mens-Verhulst, 2008). The fact that these groups also face difficulties with the Dutch language is also mentioned as a major issue for their health and care use Çelik & Groenestein, 2010).

Overall, self-rated health is lower, while different chronic diseases and limitations in daily activities are reported to be higher among the Turkish and Moroccan population in the larger cities in particular. These differences persist even after controlling for socio-economic position and age. Lifestyle differences have been cited as an explanation for the health differences between migrants and natives. For example, migrant elderly are more likely to be obese and have less physical activity, while native Dutch elderly are more likely to drink alcohol more but have a healthier weight and are more active (Public health services Amsterdam, 2015). Overall, migrant elderly of the largest migrant groups in the four largest cities of the Netherlands also report worse mental health and a higher degree of loneliness than the Dutch (de Graaf et al., 2010; Public health services Amsterdam, 2015).

In terms of healthcare use, it has been reported that migrant elderly use these formal ways of care less often than non-migrant elderly (e.g. de Graaf et al 2005). One explanation may be that they receive more informal care (Schellingerhout, 2004b; Merz et al., 2009). Again, however, these findings are mainly based on studies that cover the four largest migrant groups in the Netherlands. Recent qualitative work indicated that this informal care might be less often available for the new generations of elderly. Although they might prefer that children and family take care of them, there may be practical obstacles since more women of migrant origin are active on the labour market and have to balance informal care demands with other obligations (Rooyackers, Merz, & de Valk, 2017; Arts et al., 2009; Çelik & Groenestein, 2010; de Valk & Schans, 2008). It has also been found that many of the current elderly migrant generation do not know about the different care arrangements they may apply for and, if so, how to arrange it, get information about the costs etc. This is related to a combination of reasons, in which limited Dutch language abilities may not help either (Pharos 2015). Given the limited research since the early 2000s and the fact that the care and welfare state arrangements in the Netherlands have changed quite dramatically, it is largely unknown how this may have already affected the migrant elderly. In the past decade, the Dutch health system and policies have increasingly emphasised informal care arrangements and living independently at the own home as long as possible. Furthermore, health insurance costs have increased substantially. Whether, how and which migrant elderly groups have been mainly affected by this is yet unknown given the lack of suitable data and analyses.

Furthermore, studies did show that migrant elderly have different wishes in terms of housing when they are ageing (de Graaf et al., 2010a/b & Meulenkamp et al., 2010; Bui et al., 2011). In some of the large cities in the Netherlands, nursing homes that target specific migrant populations (either of a specific origin or religious background) have developed in the past. The extent to which these are successful in achieving a higher degree of healthy and fulfilled ageing among their residents is so far

not studied.

6.6.5 Conclusion and research opportunities

Overall, the current and future population of the Netherlands will include an ever increasing number and share of older persons with a migrant background. In research, there is still limited knowledge on this group. First of all, many data sources are fairly outdated as they were typically collected in the early 2000s. Second, most of the research to-date focused on non-Western migrants, in particular, on the four largest immigrant groups in the Netherlands, which are of Turkish, Moroccan, Surinamese and Antillean origin. This does not reflect the large group of Western migrants and the wide range of origins, also including those of European origin. For many of these migrants, ageing in the Netherlands may also include challenges of loneliness. As a recent study showed, the emotional well-being of European migrants is also affected by their change of residence (Koelet & de Valk, 2016; Arpino & de Valk 2017). Similar findings were found when it comes to physical well-being, where migrants of Western origin take an intermediate place between the non-migrant majority group and non-Western migrants (Reus Pons, Vandenheede & de Valk, 2017). In addition, the diversity in the group of non-Western elderly migrants in the Netherlands will most likely increase in the future. Even though the four largest migrant groups will remain the most important groups in the foreseeable future, there are relevant other groups with very different migration histories and origins (like those with a refugee background from Africa or the Middle East) that may face very different situations again later in life.

Thus far, the larger cities have been most active in addressing issues of migrant sensitive care and cultural preferences for care at older age. A range of more small-scale qualitative studies has been carried out by the public health services (GGD) in the four largest cities. However, these issues have not been addressed sufficiently at the national level or for migrant elderly, who do not live in the larger cities of the Netherlands, and for whom old-age care may take a very different form and who face different challenges. Again also here the cultural diversity that was addressed for the group of migrant elderly has mainly included those of the largest immigrant groups, implying that not much is known for migrant elderly of different origins.

Data collections on migrant health typically either focus on physical or mental health or on formal or informal care. A more integrated view on health is needed, in which the different dimensions of health are addressed simultaneously, and in which the different forms of care (needs) are explored together. Only in this way, it is possible to develop an understanding of possible health outcomes and the necessary mix of care arrangements for the diverse recipient groups now and in the future.

The policy directions in the health domain have more and more emphasised individual independency and informal care as important ways to maintain health care in an ageing population in the Netherlands. The potential effects that different newly introduced policies in health and care have for migrant elderly has so far not been addressed in detail. More insights are needed to address issues of inequality that may develop and pertain over the life course. This is not only of major importance for the lives of the migrant elderly but also for society at large. In order to facilitate more research into these societal relevant issues, new data collection efforts, or at least, additional migrant samples to the existing efforts would be an important investment that is needed. Currently, the sample sizes of surveys are often too small to carry out meaningful analyses among migrant elderly.

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