MIGRANT INTEGRATION POLICY INDEX
HEALTH STRAND

Country Report Netherlands

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This report was produced within the framework of the IOM’s EQUI-HEALTH project, in collaboration with Cost Action IS1103 ADAPT and the Migrant Policy Group (MPG). Full details of the research and its methodology are contained in Sections I and II of the Summary Report, which can be downloaded from the IOM website at http://bit.ly/2gOGIRd. It is recommended to consult this report for clarification of the exact meaning of the concepts used.

Sections 5–8 are based on data from the MIPEX Health strand questionnaire, which covers 23 topics, in 10 of which multiple indicators are averaged. Each indicator is rated on a 3-point Likert scale as follows:

- 0 no policies to achieve equity
- 50 policies at a specified intermediate level of equity
- 100 equitable or near-equitable policies.

‘Equity’ between migrants and nationals means that migrants are not disadvantaged with respect to nationals. This usually requires equal treatment, but where migrants have different needs it means that special measures should be taken for them. Scores relate to policies adopted (though not necessarily implemented) by 31st December 2014. However, some later developments may be mentioned in the text.

To generate the symbols indicating a country’s ranking within the whole sample, the countries were first ranked and then divided into five roughly equal groups (low score – below average – average – above average – high). It should be remembered that these are relative, not absolute scores.

The background information in sections 1–4 was compiled with the help of the following sources. Where additional sources have been used, they are mentioned in footnotes or references. It should be noted that the information in WHO and Eurostat databases is subject to revision from time to time, and may also differ slightly from that given by national sources.

<table>
<thead>
<tr>
<th>Section</th>
<th>Key indicators</th>
<th>Text</th>
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These reports are being written for the 34 countries in the EQUI-HEALTH sample, i.e. all EU28 countries, the European Free Trade Area (EFTA) countries Iceland, Norway and Switzerland, and three ‘neighbour’ countries – Bosnia-Herzegovina, FYR Macedonia and Turkey.

All internet links were working at the time of publication.

¹ For the definition of these indicators please see p. 21 of the WHO document General statistical procedures at http://bit.ly/2lkds8J
1. COUNTRY DATA

<table>
<thead>
<tr>
<th>KEY INDICATORS</th>
<th>EU RANKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (2014)</td>
<td>16.829.289</td>
</tr>
<tr>
<td>GDP per capita (2014)</td>
<td>130</td>
</tr>
<tr>
<td>Accession to the European Union</td>
<td>1957</td>
</tr>
</tbody>
</table>

**Geography:** The Netherlands are located in Western Europe, bordering the North Sea, Belgium, and Germany. The terrain is mostly coastal lowland and polders. Almost 20% of the country’s total area is water; much of the land has been reclaimed from the North Sea. The country is one of the world’s most densely populated nations, with 90% of the population living in urban settings. The most populous city is the capital Amsterdam (850.000). Together with Rotterdam, The Hague and Utrecht, these four cities form the nuclei of the Randstad area, where an estimated 7 million inhabitants live.

**Historical background:** The country began its independent life as a republic in the 16th century. During the ‘Golden Age’ (the 17th century) it became the world’s foremost maritime and economic power and was renowned for its art and science, as well as its stability and tolerance at a time when much of Europe was in turmoil. It also exploited colonies on three continents and played a pivotal role in the international slave trade. After a 20-year French occupation, the Kingdom of the Netherlands was formed in 1815. The country remained neutral in World War I, but was invaded and occupied by Nazi Germany during World War II.

**Government:** The Netherlands are a constitutional monarchy divided in 12 provinces. The country was a founding member of the EEC (now the EU) and participated in the introduction of the euro in 1999.

**Economy:** The economy is primarily services-based, but trade also plays a major role. Rotterdam is by far the largest port in Europe and Schiphol (Amsterdam) is the third largest airport. The country is the world’s second largest agricultural exporter and has large natural gas resources. The banking sector was particularly affected by the global financial crisis and required substantial government support. Following a protracted recession from 2009 to 2013, during which unemployment doubled, austerity policies were introduced and household consumption contracted, economic growth began inching forward again in 2014 and reached 2,2% in 2016. A slight slackening is expected in 2017 and 2018.

After reaching an all-time high of 7,9% in February 2014, the unemployment rate has slowly decreased to 6,0% and is expected to continue falling, though for youth (15-25) it is higher at 9%. In 2013, the unemployment rate among people with a ‘non-western’ migration background was over three times higher than among native Dutch (16% versus 5%); for youth, the figures were 28% versus 10%.

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5 [https://tradingeconomics.com/netherlands/unemployment-rate](https://tradingeconomics.com/netherlands/unemployment-rate)
6 [http://www.scp.nl/dsresource?objectid=08fd53c2-0fed-44ae-83e0-5463557ae42d&type=org](http://www.scp.nl/dsresource?objectid=08fd53c2-0fed-44ae-83e0-5463557ae42d&type=org)
2. MIGRATION BACKGROUND

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign-born population as percentage of total population</td>
<td>11,6</td>
<td>●●●●●</td>
</tr>
<tr>
<td>Percentage non-EU migrants among foreign-born population</td>
<td>73</td>
<td>●●●●●</td>
</tr>
<tr>
<td>Foreigners as percentage of total population</td>
<td>4,4</td>
<td>●●●●●</td>
</tr>
<tr>
<td>Non-EU citizens as percentage of non-national population</td>
<td>44</td>
<td>●●●○○</td>
</tr>
<tr>
<td>Inhabitants per asylum applicant (more = lower ranking)</td>
<td>686</td>
<td>●●●○○</td>
</tr>
<tr>
<td>Percentage of positive asylum decisions (2014)</td>
<td>67</td>
<td>●●●●●</td>
</tr>
<tr>
<td>MIPEX Score for other strands</td>
<td>61</td>
<td>●●●●●</td>
</tr>
<tr>
<td>Eurobarometer 82 (2014) – Positive or negative feelings about immigration of people from outside the EU (QA11.2)</td>
<td>47</td>
<td>●●●○○</td>
</tr>
</tbody>
</table>

From the late Middle Ages onwards, the Dutch had a reputation in Europe for religious and political tolerance. During the ‘Golden Age’ immigration was at even higher levels than today, as groups fleeing persecution sought refuge in the Netherlands (Penninx 1996). However, between the early nineteenth century and World War II there was little incentive for migrants to come to the Netherlands.

After the war, Dutch authorities and opinion makers maintained that the Netherlands was overpopulated and should never become a country of immigration (Bruquetas-Callejo et al. 2011). When, at the end of the 1970’s, the government finally had to take seriously the need to enact policies for residents of foreign origin, it categorised them as ‘ethnic minorities’. However, because of the negative connotations this term rapidly acquired, a new one was introduced in the 1980’s: ‘allochtonen’. This combined two groups: those who had been born in a foreign land, and those born in the Netherlands to one or two foreign-born parents. Predictably, this term also acquired negative overtones, but from 1990 until quite recently it remained the central concept for researchers and policy-makers. In 2012 a government body recommended abandoning it, and in 2016 the Scientific Council for Government Policy (WRR) and Statistics Netherlands did so. Allochtonen, like the term proposed to replace it (‘persons with a migration background’) had the practical advantage that it included not only first-generation migrants, but also their children – though not their grandchildren.

Within the category ‘allochtonen’, policies tended to focus on those of ‘non-western’ origin, on the assumption that they face the most hardships. The Dutch government’s definition of ‘western’ included the United Nations’ 1947 category of ‘developed regions’ – Europe, North America, Oceania and Japan – and (somewhat idiosyncratically) the former Dutch East Indies, currently Indonesia. The category ‘non-western’ was used in policy discourse as a shorthand reference to the largest socially-disadvantaged ethnic minorities (Turkish, Moroccan, Surinamese and Antillean/Aruban). Unfortunately, this often led researchers and policy-makers to overlook the needs of other ‘non-western’ groups (e.g. Chinese or
Somalian), as well as recent migrants from EU Member States. It also implied, quite inaccurately, that all migrants from ‘non-western’ countries form a disadvantaged group. Along with the term *allochtonen*, the use of the ‘western/non-western’ distinction is now declining.

The first major immigrant group to arrive after the war came from the former Dutch East Indies, when the colony gained independence and became Indonesia. Many of these *postcolonial migrants* were of Dutch descent, or were at least familiar with the Dutch language and culture; their integration into Dutch society was not regarded as especially problematic. Indeed, there was so little concern about the group’s problems that it was not even recognised as an ‘ethnic minority’ in the government’s 1983 minorities’ policy. As a result, the group has become virtually invisible to demographers. By contrast, the 12,500 *Moluccans* who had arrived in 1951 were classified as an ethnic minority. In fact the Moluccans regarded themselves as political refugees – victims of a military and political miscalculation, who had never intended to come to the Netherlands but were unable to leave once they got there.

From about 1950 to 1973 the Netherlands, together with Germany, France, the UK, Belgium, Sweden, Austria and Luxembourg, enjoyed a period of rapid economic expansion, accelerated by the employment of large numbers of foreign workers to fill labour shortages. These so-called *‘guest workers’* were recruited by or for Dutch industries – first from Southern European countries such as Italy, Spain, Portugal, Yugoslavia and Greece, later from North Africa, Palestine and Turkey. However, any gratitude which may have been felt for the immense contribution of these workers to Dutch prosperity (in particular those from Turkey and Morocco) has long since evaporated; today, they and their descendants are frequently regarded as fallout from a policy blunder and a burden on the State.

While most European ‘guest workers’ did indeed return to their country of origin, many others stayed: they also acquired the right to bring family members and marriage partners to the Netherlands. Many migrants also came to the Netherlands from former Dutch colonies. The independence of Suriname in 1975 prompted a wave of migration, while most inhabitants of the Dutch Antilles and Aruba remained until 2010 Dutch citizens with the right to migrate to the Netherlands.

With the 1973 oil crisis, large-scale labour migration from third countries to Western Europe came to an end. Family reunion or formation, asylum or study became virtually the only routes into the Netherlands for third-country nationals, except for a very small number of highly-skilled workers.

In 2014, 3,1% of all residents were born in another country within the EU/EFTA and 8,5% outside. In terms of foreign citizenship, the totals were only 2,4% and 1,9% respectively, reflecting the fact that Dutch nationality is relatively easy to acquire. Using the concept of *‘allochtonen’* as defined above, altogether 21,4% of the population fell in this category, divided equally between ‘western’ and ‘non-western’ origins, with a slight preponderance of the first generation over the second (11,9% versus 9,5%). The population of the ‘non-western’ groups is growing five times faster than the native Dutch population. In Rotterdam these groups formed 37% of the population in 2014, alongside 35% in The Hague and Amsterdam. In socioeconomic terms, these groups are seriously disadvantaged compared with the rest of the population. Their socio-economic status is lower and as we saw in the previous section, unemployment is much higher (particularly among young people). Fig. 1 shows the main origins of migrants.

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7 [http://www.clo.nl/indicatoren/nl210905-allochtonen](http://www.clo.nl/indicatoren/nl210905-allochtonen)
Asylum seekers and refugees. Fig. 2 shows the annual rate of asylum applications to the Netherlands.

Figure 2. First-time asylum applicants to the Netherlands, 1985-2016 (Eurostat data)
Annual numbers of asylum claims increased dramatically from less than 6,000 in 1985 to a peak of almost 53,000 in 1994. Relative to the size of its population, the rate at which the Netherlands received asylum seekers became one of the highest in Europe. This led to the adoption of stricter rules in the Aliens Act of 2000, immediately followed by a rapid fall in numbers (though after 2002, numbers also fell in the EU as a whole). In 2015 asylum applications rose again to something like the levels experienced in the 1990s – yet still lower than in 1994, 1998 and 2000. In 2016 the numbers fell back, as they did in the EU28 as a whole, as a result of the closing of some borders and the EU-Turkey deal.

In addition to officially recorded migrants, there are an unknown number of undocumented migrants – often referred to in the Netherlands both officially and colloquially as ‘illegals’, despite efforts by international organisations to discourage this term. Many of these are rejected asylum seekers who have not returned to their country of origin; others have overstayed their visas or entered without authorisation. Kovacheva and Vogel (2009) presented overall estimates ranging from 62,000 to 131,000. However, the latest study (Van der Heijden et al. 2015) estimates the total in 2009 much lower at between 21,000 and 63,000, and in 2012-2013 at between 23,000 and 48,000.

**Dutch integration policy.** As we saw in Section 1, the Dutch have historically had a reputation for tolerance. Disapproval of racism was strengthened by the experience of Nazi occupation from 1940-1945, although the proportion of the Jewish population deported to concentration camps (63%) was higher in the Netherlands than anywhere else in Europe (Croes 2006) – something which could hardly have happened without substantial collaboration.

In 1983 the Dutch Government adopted an integration policy that was strongly influenced by Canada’s multicultural approach (Penninx 1996). This policy stressed the active inclusion of minorities in the education system and labour market, as well as ‘integration without loss of cultural identity’ and firm action against discrimination. Towards the end of the 1990s, however – as in other parts of Europe – increasing doubts began to be voiced about multiculturalism. The rapid increase in numbers of asylum seekers, as well as the presence of Muslim immigrants who seemed reluctant to abandon their religion and customs, led to growing tensions. These were greatly intensified by ‘9/11’ and the murders in 2002 of Pim Fortuyn and Theo van Gogh, both outspoken critics of Islam. Having led Europe in adopting multicultural policies, the Netherlands were soon at the forefront of reaction against them, as opposition to migration became more ‘politically correct’ than support for it.

Realities on the ground, however, were less black-and-white. Multicultural policies in the Netherlands may have been exemplary on paper, but 20 years after their introduction, ‘non-western allochtonen’ were still to a large extent a marginalised underclass (Vasta 2006). And although tough-sounding policy measures were taken by Dutch governments after 2002 to reduce immigration and put pressure on immigrants to integrate – in effect, to assimilate – the 2015 Migrant Integration Policy Index (MIPEX) still put the Netherlands in seventh place in the EU, after coming fifth in 2011 and fourth in 2007.

Vasta (2006) and Koopmans (2007) have argued that Dutch multiculturalism was in fact the old policy of ‘pillarization’ in a new guise – an illustration of ‘path dependency’, i.e. the inherent resistance of a country’s institutions and ideology to fundamental change. Ethnic differences were resolved in much the same way as religious differences had been in the past: by categorising people according to labels and keeping them safely away from each other in social ‘pillars’ (zuilen). Both the earlier multicultural policies and the new ‘no-nonsense’ policies, drawn up by centre-right governments since 2002 in the
hope of outflanking far-right populist politicians, are seen as stereotyping and racializing foreigners in ways that hark back not only to ‘pillarization’, but also to the Netherlands’ colonial past.

Since 2002 many measures that had been put in place by multicultural policies have been dismantled, as can be seen by the Netherlands’ gradual slide down the MIPEX ladder. Moreover, the new policies obliging migrants to ‘integrate’ seem – all too predictably – to have had the opposite effect: members of ethnic minorities now have fewer social contacts with the majority population, preferring not to venture out of the ‘comfort zone’ of their own communities. They feel that majority attitudes to migrants have become more hostile since 2002.8

Whereas multicultural policies had encouraged migrants to integrate by providing subsidies and targeted assistance schemes, after 2002 the responsibility for integration was placed firmly on their shoulders. (As we shall see, this approach also reversed the policies that the government had hitherto supported in the health sector.) In 2013 financial support for integration courses was drastically reduced and their organisation was outsourced to private companies. Research by the Dutch Court of Audit (Algemene Rekenkamer) revealed in 2017 that success rates have been halved since the introduction of this policy,9 which was particularly disadvantageous for the integration of refugees.

Yet despite all these negative developments, the Netherlands remain more ‘migrant-friendly’ than the majority of EU28 Member States, which never had multicultural policies and perhaps never will. During the ‘refugee crisis’ of 2015, organisations such as Vluchtelingenwerk were overwhelmed with volunteers and had to start turning down their offers of help.10 Unfortunately, these ‘grass-roots’ supporters of asylum seekers were nothing like as adept as their opponents in making their views known publicly. Action groups opposing the arrival of asylum seekers, often by violent means,11 have weakened support for a humane asylum policy; during the March 2017 parliamentary election, the largest party (the liberal VVD) campaigned on a platform of abolishing the right to asylum in Europe and supporting only initiatives in the regions that refugees come from.

The bottom line is that the argument traditionally used by parties of both right and left to support immigration now fails to cut ice: after the long period of recession and austerity in 2009-2013, the Dutch economy shows little vitality, with the result that there are few labour shortages that migrants could alleviate. Popular and political support for immigration as a way to revitalise the economy and rejuvenate the ageing population is still ‘toekomstmuziek’ – a distant prospect.

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8 http://www.scp.nl/Publicaties/Alle_publicaties/Publicaties_2012/Dichter_bij_elkaar
9 https://www.rekenkamer.nl/publicaties/rapporten/2017/01/24/inburgering
3. HEALTH SYSTEM

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total health expenditure per person (euros)</td>
<td>3,933</td>
<td>🌑🌑🌑🌑🌑</td>
</tr>
<tr>
<td>Health expenditure as percentage of GDP</td>
<td>11,0</td>
<td>🌑🌑🌑🌑🌑</td>
</tr>
<tr>
<td>Percentage of government expenditure on health / National health system (NHS) or social health insurance (SHI)</td>
<td>7</td>
<td>SHI</td>
</tr>
<tr>
<td>Percentage of health financing from out-of-pocket payments (higher percentage = lower ranking)</td>
<td>5,2</td>
<td>🌑🌑🌑🌑🌑</td>
</tr>
<tr>
<td>Score on Euro Health Consumer Index (ECHI)</td>
<td>898</td>
<td>🌑🌑🌑🌑🌑</td>
</tr>
<tr>
<td>Overall score on MIPEX Health strand</td>
<td>55</td>
<td>🌑🌑🌑🌑◯</td>
</tr>
</tbody>
</table>

The quantity and quality of health service provision in the Netherlands is high. Since 2008, the country has obtained the highest scores on the Euro Health Consumer Index (EHCi). During the same period, health care costs (both in terms of spending per capita and percentage of GDP) have also risen to the top end of the league table. Putting these two facts together indicates the high value attached to individual health in Dutch society – in contrast to public health, where powerful industrial lobbies have succeeded in weakening policies on air pollution, alcohol consumption and smoking.

Most health service providers, although centrally regulated, are private non-profit organisations. Concerning the financing of the system, before 2006 people with higher incomes (about 30% of the population) were expected to take out private health insurance, while the rest were covered by state health insurance (the Ziekenfonds). The current system obliges all Dutch residents (as well as non-residents paying income tax) to insure themselves in a single insurance market with a number of players, with government subsidies for the less well-off. A small proportion of the registered population (1-2%) remains uninsured.

The general practitioner (GP) plays a central role as ‘gatekeeper’ to the rest of the health system. Often the GP will have tests carried out before referring a patient to a specialist, while policy on antibiotic use is very conservative (the rate of prescribing antibiotics is the lowest in Europe – three times lower than in Greece). Many migrants who are accustomed to direct access to specialist care and a low threshold for prescribing drugs do not know about these policies and may experience Dutch GPs as ‘unhelpful’.

**History of policies and practices in relation to migrant health care.** Although the Netherlands played a pioneering role in the development of health services for migrants and ethnic minorities, many interventions had a fragmentary, short-term character with little structural embedding in policies. The recent ‘marketization’ of Dutch health care has, so to speak, made this lack of structure structural.

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12 The figure of 5,2% quoted above for out-of-pocket payments is misleadingly low, because it does not include the ‘mandatory deductible’ (eigen risico) which patients have to pay before receiving reimbursements (€350 in 2013).
Moreover, the weakening of the Dutch tradition of openness to diversity as a result of changes in the political climate has reduced the willingness to adapt services to the needs of migrants.

Half a century ago, however, health professionals in the Netherlands were already responding to the challenge of caring for ‘guest workers’ and ex-colonial migrants. Articles on these topics started appearing in medical journals as early as the 1960’s, usually identifying linguistic and cultural barriers as the biggest obstacles to good care. Doctors complained that they were forced to practice a kind of veterinary medicine, in which body language was the main medium of communication with the patient. In 1972 the government set up the Board for Medical Care for Migrant Workers, which a year later recommended setting up local centres for interpretation services. Six of these were established in 1975, and from 1983 interpreters were available free of charge. In 2011, as we shall see, the government decided to withdraw this financial support, on the grounds that migrants should be made responsible for learning the Dutch language.14

Another pioneering decision of the Health Ministry in 1976 was that separate, ‘categorical’ services for migrants were neither practical nor desirable: mainstream services had to be adapted to deal with patients of foreign origin. (Asylum-seekers and refugees were excluded from this policy.) In 1977, again responding to the Board’s recommendations, an agency was set up to provide newcomers with health and healthcare information in their own languages. These services, too, have recently seen their government subsidies withdrawn, under the motto that migrants are responsible for their own integration. Since 2003 the goal of adapting mainstream services to the needs of migrants and ethnic minorities has been abandoned by the Health Ministry; as a result, separate provisions for minorities are now on the increase.

From the above we can see that between 1972 and 1977, even before the government had adopted any general policies on integration, three fundamental ingredients of a forward-looking migrant health policy were introduced: interpretation services, the principle of integrated service provision, and targeted health education.

In response to the inescapable fact that the Netherlands had become a country of immigration, the government commissioned in 1977 a report to make recommendations for a policy on ‘ethnic minorities’ (WRR 1979). This report, drafted by the migration specialist Rinus Penninx, set out the blueprint for a multicultural policy aimed at the following target groups: ‘guest workers’, Moluccans, Surinamese and Antillians, refugees, gypsies and caravan dwellers. On the one hand, the report proposed measures to combat disadvantage and promote integration by facilitating access to education and the labour market, as well as by tackling discrimination; on the other, it aimed to strengthen minority communities and cultures (Bruquetas-Callejo et al. 2011). The assumption was that a strong sense of their own distinct identity would actually help ethnic minorities to integrate, rather than handicapping them. ‘Integration with maintenance of one’s own cultural identity’ thus became the new maxim.

Much of this policy was inspired by the examples of Canada, the USA and Sweden. However, the way ‘multicultural’ principles were implemented in the Netherlands bore the mark of the ‘pillarization’ adopted earlier to contain religious differences (Bruquetas-Callejo et al. 2011).

14 https://www.rijksoverheid.nl/documenten/kamerstukken/2013/05/28/kamerbrief-over-inzet-tolken
On the topic of health, the recommendations of the 1979 report were limited. Existing policies in relation to interpretation, health education, and integrated services were noted approvingly, but no other concrete measures were recommended to adapt services to the increasing diversity of their users.

The 1979 report was only translated into policy four years later, in the Minderhedennota of 1983. While the 1970’s had been dominated by the left, the centre-right cabinet which came to power in 1982 after a period of recession and political instability was inspired by the Reagan-Thatcher policy of cutting back government spending. Nevertheless, the new government continued to endorse the philosophy of social inclusion underlying the policies of the 1970’s, including multiculturalism. The Dutch government, in collaboration with the WHO Regional Office for Europe, organised in 1983 the first European conference on migrant health in The Hague (Colledge et al. 1986). A national conference was also organised, which to this day has been held as an annual event.

In this early phase, developing ‘cultural sensitivity’ was mainly seen as a matter of acquiring background knowledge about the cultural characteristics of ethnic minority groups. Two things have perhaps reinforced this tendency; one is the legacy of ‘pillarization’ (which classified people into mutually exclusive social categories), the other is the fact that most migrants in the 1980’s could be fitted into one of four major groups. ‘Culture’ came to be seen as a static, homogeneous framework of values, customs, and ideas that determined the behaviour and mentality of all people from a given country.

Over the past 40 years, however, migration has become much more diverse; the major Dutch cities currently harbour over 150 different nationalities. Even if one were to accept the notion of ‘culture’ that underlay early ideas about ‘cultural sensitivity’, it would be impossible for health workers to acquire the necessary information about all these different groups. In any case, however, this use of the term ‘culture’ came under sustained attack from cultural and medical anthropologists, who started to work in healthcare settings in increasing numbers.

These critics argued that there is no simple correspondence between countries and cultures, and that cultures are neither static nor homogeneous. To think this is to fall into the trap of ‘culturalism’, which is only one step removed from racism. This does not mean that the concept of culture is useless; however, the only way to really get to know a person’s culture is to get to know the person. That implies an attitude of openness and humility, rather than the presumption of expertise. Above all, it requires reflexive insight into one’s own culture and prejudices.

Moreover, ‘culture’ may not be the most relevant issue that the health worker needs to bear in mind; socioeconomic position, living conditions and legal status, for example, may be much more important. There are few European countries where the debate about ‘culture and health’ has been conducted so passionately, and at such a sophisticated level, as in the Netherlands.

Yet although creative ideas and forward-looking local initiatives on migrant health flourished during the 1980’s and 1990’s, giving the Netherlands a reputation as pace-setter in this field within Europe, no overall policy in support of multicultural health care was adopted at government level during this period. Government initiatives were confined to strengthening and financing the provisions for interpretation and health education set up in the 1970’s, as well as one-off initiatives such as a project to improve mental health services for migrants in the four largest cities (1986-1991) and the setting-up
of Pharos as a ‘support centre for refugee health’ in 1993. (Pharos, incidentally, was one of the few exceptions to the general rule against categorical initiatives, along with other centres specialising in trauma and organised violence).\(^\text{15}\) From 1995 onwards the national research agency NWO launched an ambitious research programme on ‘Culture and Health’. In the title of this programme we see again the strong emphasis on ‘culture’ in Dutch work: indeed, the whole process of adapting health care to the needs of migrants was referred to by the term ‘interculturalisation’, introduced according to Van Dijk (2009) in 1989.

Without firm support from the government, however, creative ideas and one-off projects were not enough to rectify the structural shortcomings of service delivery for migrants and ethnic minorities. During the 1990’s the lack of central government support for ‘interculturalisation’ was increasingly complained about by workers in the field, and in 2000 two highly critical reports by the Council for Public Health and Health Care (RVZ 2000a, 2000b) confronted the government of the day with a call for strong leadership.

This call received a positive response from Health Minister Els Borst-Eilers, herself a doctor with experience of the issues. In 2001 a five-year Action Plan for ‘intercultural mental health’ was launched, as well as a centre of expertise on this topic (Mikado) and a Project Group to advise the minister on migrant health policy.

These initiatives hardly had a chance to get under way before they were overtaken by the changes in the Dutch political climate described in Section 2. Whereas enthusiasm for cultural diversity was once ‘politically correct’, for a politician to voice such sentiments in this climate was now to commit political suicide. As Penninx (2006: 11) put it:

> The tone of policy management is authoritarian and policies are more and more mandatory, laying the burden of integration unequally on the shoulders of immigrants...... Such a policy polarizes, sustains and increases the divide between natives and immigrants.

The central theme of the populist movement which took off in the early 2000s was that multiculturalism is the result of a conspiracy by the élitist politicians of ‘The Hague’ to ignore the will of the people. Academic theories or data, whether they concern migrants, drug policy, criminality or climate change, are regarded as products of the same treacherous élite. (The similarities with the movement that brought Donald Trump to power in the USA in 2016 are striking.) Populist politicians therefore call for an end to what they call ‘uncontrolled mass immigration’ and what they regard as the ‘mollycoddling’ of migrants and minorities. Muslims, in particular, were regarded as a threat to western civilisation. In fact, the backlash against multiculturalism had already started in the 1990’s: in 1998 the government required newcomers to learn Dutch and follow integration courses. Multicultural policies have come to be defined as the problem, not the solution. By allowing migrants to maintain their own cultural identities, these policies are alleged to have removed the incentive to integrate.

Clearly, these developments do not bode well for efforts to adapt health services to the needs of migrants. In the Netherlands, they have ushered in a period during which the government not only...

\(^\text{15}\) Another exception was the centre for migrant mental health set up in 1983 within a community mental health care centre in Rotterdam (Riagg Rijnmond Noord West), which survived until the centre went bankrupt in 2016.
failed to introduce new initiatives for ‘interculturalisation’, but systematically dismantled many of those that were already in place.

At the same time, the health system has become increasingly ‘marketized’. Health service reform was guided by the philosophy that new directions in health service provision should be a response to ‘market forces’ rather than government directives. In March 2004 the Health Minister, Hans Hoogervorst (a banker by profession) announced the withdrawal of most government support for ‘interculturalisation’ (VWS 2004). Three months earlier, the Project Group set up by the previous minister had already resigned because of disagreements with Hoogervorst. In March 2004 this minister placed the onus firmly on migrants to overcome any barriers to accessing health care that might exist. It was their responsibility to find out how the Dutch health care system worked and to become sufficiently fluent in Dutch to use it. In a subsequent debate he claimed that if migrants made less use of mental health services, this was because their own communal resources for solving problems were adequate – just as they had been, according to him, for Dutch people in the 1950s and 1960s.

Since 2006 there has been a new development in health care for migrants and ethnic minorities; the setting-up of separate, categorical service providers. Such institutions existed on a small scale before (in particular, refugee care and old people’s homes specialising in care for particular ethnic minorities). After 2006, however, the purchaser-provider split made it possible for enterprising organisations to compete for the market in health care for allochtonen. A considerable – and still growing – number of service providers now target patients with a migrant background.

The objections to categorical care had already been pointed out by the Dutch Health Ministry in 1976; migrants are scattered across the country, while within this population itself there is enormous diversity. But if mainstream providers are not going to make a serious effort to develop ‘diversity-sensitive care’, such developments are perhaps inevitable. The largest groups (e.g. people of Turkish or Moroccan origin in the Randstad) may even benefit, though it can hardly be seen as furthering their integration in Dutch society. (More than half of these two groups aged 55 or older make use of health care in their country of origin, in part because of lack of trust in the Dutch services.) However, it is hard to see how separate health care provisions for the largest ethnic groups can help smaller ones, or people who do not live within easy reach of such services (May & Ingleby 2008; Van Dijk 2013).

Nevertheless, not all of the developments in policies governing service provision should necessarily be regarded as negative in their consequences for migrants. As in many other countries, increasing emphasis is being placed in the Netherlands on the importance of ‘person-centred’ care (to some extent reflecting the influence of the Joint Commission International, a widely-used accreditation agency). This concept stresses attention for all aspects of a patient’s situation, including their cultural background as well as issues such as their socioeconomic and legal status or educational level. And as in the field of education, the targets of government policy increasingly concern not so much groups as specific needs, for example concerning language proficiency and literacy. Such approaches are intended to avoid stigmatisation and stereotyping of particular groups and to confine interventions to those who need

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16 Brief van de minister van VWS d.d. 16 maart 2004 inzake allochtonen in de gezondheidszorg (29 484, nr. 1)
19 http://www.jointcommissioninternational.org
them. Symptomatic of this shift is the fact that in 2013 the knowledge centre Pharos, previously known as ‘The National Knowledge and Advisory Centre on Migrants, Refugees and Health’, was renamed ‘The Dutch Centre of Expertise on Health Disparities’.
4. USE OF DETENTION

Cornelisse (2014) argued that the Dutch government frames immigration detention not as an exceptional measure, but as a routine instrument of large-scale immigration control. However, in response to severe criticism from human rights organisations, its use has now been scaled down (from about 6,000 cases a year in 2011 to 2,000 in 2015), while new legislation has been drafted.20

Current legal framework. In the Netherlands, the Ministry of Justice is the main institution responsible for immigration detention. Within the Ministry, two entities are particularly relevant:

- The Immigration and Naturalisation Service (IND), which enforces immigration law in the Netherlands;
- The Directorate for Detention and Special Facilities of the National Agency of Correctional Institutions, which is responsible for the administrative detention of migrants.

The Aliens Act of 2000 established the legal basis for detention, the issuing of residence permits, and the deportations of rejected asylum seekers and irregular migrants.

The Aliens Act established two detention regimes:

- **Detention pending deportation**: this can be used for the purpose of deportation of unlawfully residing residents, including rejected asylum seekers. It is in line with the EU Return Directive, according to which detention shall be used as a measure of last resort, be proportional, and is only justified when less coercive measures are insufficient; and cannot exceed 6 months, though this can be extended by a maximum of 12 months.

- **Border detention**: for immigrants to whom entry in the Netherlands has been denied. Denial can be due to “lack of valid travel documents and or/visa, posing a threat to the public order or national security, or insufficient means to defray costs of staying in the country”. Detention at the border cannot exceed six weeks.

The Juvenile Penitentiary Principles Act of 1999 (*Beginselenwet Justitiële Jeugdinrichtingen*) lays down the standards covering the detention of irregular migrants under the age of 18. In response to criticisms in 2008 by the European Committee for the Prevention of Torture of the practice of detention of migrant children with their families and unaccompanied minors,21 the government has drafted a new law (*Wet terugkeer en vreemdelingenbewaring*) to regulate immigration detention. In addition, after criticism of the routine use of border detention for families with children (AI 2015), especially at Schiphol airport, the law provides that children will no longer be detained at the border except in exceptional circumstances. Families and children will be submitted to a brief screening to assess the credibility of family ties, the risk of trafficking or child smuggling and the risk of violation of public order, and in most cases transferred to an open centre. However, the new legislation will not be debated until a new government has been formed later in 2017.

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21 [https://rm.coe.int/168069780d](https://rm.coe.int/168069780d)
Detention facilities. In the Netherlands a number of facilities are used to house or detain asylum seekers and irregular migrants: ‘application centres’, ‘reception centres’, ‘expulsion centres’, ‘detention boats’, ‘asylum seeker centres’, and ‘detention centres’. According to the Global Detention Project, the boundaries between secure and non-secure facilities are frequently unclear.

As of 2015, nine immigration detention centres and a secure ‘application centre’ could be identified. In addition to officially recognised detention centres, a number of facilities with various degrees of security could also be identified. Of three application centres for asylum seekers in the Netherlands, the one operating at Schiphol airport could be considered a secure detention site.

Conditions of immigration detention. In relation to border detention, a Council of Europe enquiry showed that this type of mechanism was routinely used for asylum seekers arriving at the external borders, who are detained under article 6 of the Aliens Act for a period of up to 14 days (CoE 2014).

Regarding detention pending deportation, Amnesty International and the Council of Europe have highlighted the fact that the Penitentiary Principles Act, developed essentially for criminal detention, also governs immigration detention pending deportation and therefore “irregular migrants and rejected asylum seekers are subject to the same penitentiary rules and regulations as remand prisoners” (AI 2015:7). The government’s new draft law on migration detention is intended to take account of these criticisms.

Health care. The Council of Europe’s Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) makes periodic visits to prisons and detention facilities in all Member States and has voiced criticisms of various aspects of detention in the Netherlands, in particular the adequacy of health care. The Human Rights Commissioner has also indicated that improvements are needed in access to health care, in particular regarding mental health (CoE 2014). Health problems of detainees are underestimated and treatments that are necessary from a medical point of view frequently do not take place.

A particularly flagrant example of procedural failures was the suicide of the Russian opposition activist, rocket scientist and asylum seeker Aleksandr Dolmatov in January 2013, while in custody prior to being deported to Russia. Inquiries by two government agencies found that Dolmatov was unjustifiably detained in the first place, due to incorrect instructions for using the computerised administration system, while inadequate medical supervision was provided despite a suicide attempt the day before. The police officers and the lawyer on duty displayed a “strikingly passive attitude”. In spite of this damning indictment, the responsible Minister survived a parliamentary motion of no confidence.

The detention of vulnerable groups has been particularly criticised. In 2016 a special facility was opened in Zeist for the detention of unaccompanied children and families with children. However, no comparable measures exist for other vulnerable groups, such as victims of torture and/or persons with serious physical or mental health problems (AI 2015).

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22 A list of CPT reports and the government’s responses to them is available at http://bit.ly/2sM5n96
5. ENTITLEMENT TO HEALTH SERVICES

Score 78  Ranking ⚫⚫⚫⚫⚫

A. Legal migrants

Inclusion in health system and services covered

Under the 2005 Law on Health Insurance (Zorgverzekeringwet), participation in the national system of basic health care insurance is a right and an obligation for all legal residents, including third-country nationals within four months of being granted a residence permit. Until they participate, a migrant must be covered by another form of insurance. Migrants from EU/EFTA countries may continue to be covered by the system in their homeland. In addition, residents were automatically insured until 2015 under the Algemene Wet Bijzondere Ziektekosten (AWBZ), which covers long-term nursing and care. (In 2015, when long-term care was taken over by local authorities, the AWBZ was replaced by the Wet Langdurige Zorg.) In the context of the same reallocation of responsibilities the Wet Maatschappelijke Ondersteuning (WMO), covering social support, and the Jeugdwet, covering youth care, were also introduced in 2015.

Entitlement to health care is independent of descent or country of birth. A residence permit and registration as a legal resident (ingesetene) are required before obtaining Dutch health insurance. A burgerservicenummer (BSN – Citizen Service Number, a unique personal number) must also be obtained from the local authority. A policy can be taken out with one of nine insurance companies, which are subject to government regulation but offer different premiums and variations on the basic package (e.g. with or without free choice of service provider).

The contents of the basket of ‘basic care’ are defined annually by Parliament and are intended to cover all services that are ‘medically necessary’. Supplementary health care insurance is voluntary; in 2013 it was used by 83% of households. Persons with low income (including students, disabled people and the unemployed) can obtain a partial refund of health insurance premiums (zorgtoeslag), although this does not cover the premiums completely. In principle, health service users are obliged to pay the first €385 (2017 figure) of health costs themselves (‘mandatory deductible’ or eigen risico), but some policies may offer higher or lower deductibles.

Special exemptions

As coverage is complete, exemptions from restrictions are not necessary.

Barriers to obtaining entitlement

Administrative procedures for obtaining entitlement to health services are the same for legal migrants and citizens. Migrants must register a legal address, obtain a Citizen Service Number (which requires

26 http://wetten.overheid.nl/BWBR0018450/geldigheidsdatum_11-01-2016
27 http://www.government.nl/issues/health-insurance/health-insurance-and-residence-permit
28 http://wetten.overheid.nl/BWBR0002614/geldigheidsdatum_11-01-2016
29 http://wetten.overheid.nl/BWBR0035917/2017-07-01
showing a valid identification document), and take out health insurance. These procedures should not constitute a barrier for legal migrants.

B. Asylum seekers

Inclusion in health system and services covered

Asylum seekers are entitled to health care according to a special arrangement (*Regeling Ziektekosten Asielzoekers, RZA - Regulation for Care of Asylum Seekers*).\(^{30}\) Health care is covered by an agreement between the Central Agency for the Reception of Asylum Seekers (COA), which is responsible for the accommodation of asylum seekers, and a single insurance company (Menzis).\(^{31}\) From January 1st 2018 the responsible company will be *Arts en Zorg*.

Asylum seekers are entitled to the same basic package of care as Dutch citizens, with the exception of nine conditions (including *in vitro* fertilisation (IVF), cochlear implants, and sex reassignment surgery). Entitlement ends at the moment the asylum request is denied, unless permission is given to await the outcome of an appeal. The award of a residence permit brings with it the same rights and obligations as for a legal migrant. Unlike national citizens and legal migrants, asylum seekers are not subject to the mandatory deductible.

Except for children, asylum seekers are not entitled to dental care except in a few circumstances, and only to a limited amount of physiotherapy. Routine dental care is not included in the basic basket of services to which all residents are entitled. A high average level of dental health among Dutch adults encouraged the government to abolish these entitlements in the 1990’s. Unfortunately, for migrants (as well as for socially disadvantaged Dutch citizens), the same high level cannot be assumed.

Since 2009, asylum seekers living in an asylum-seeker centre (AZC) access health care directly after consultation with a nurse, contracted by Menzis and working at the centre in close collaboration with a general practitioner. Outside working hours, asylum seekers have to contact a call centre.

Special exemptions

As coverage is virtually complete, exemptions from restrictions are not necessary.

Barriers to obtaining entitlement

Coverage is automatic and does not have to be arranged by the asylum seeker. Access to a GP usually requires the cooperation of the AZC nurses, and there have been complaints about refusal of onward referral in cases of genuine need. Although such situations have sometimes even resulted in deaths, the Health Care Inspectorate (*IGZ*) considers such occurrences to be incidental rather than structural in nature.\(^{32}\)

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\(^{30}\) [https://www.rzasielzoekers.nl/home/zorg-voor-asielzoekers.html](https://www.rzasielzoekers.nl/home/zorg-voor-asielzoekers.html)


C. Undocumented migrants

Inclusion in health system and services covered

Since they are unable to obtain a Citizen Service Number (BSN), undocumented migrants cannot obtain health care insurance in the Netherlands, even if they have the means to pay for it. They are ‘involuntarily uninsured’ and – in principle – have to pay for their health care costs at the point of use.

However, efforts to recover these costs are usually confined to sending bills. For those who do not or cannot pay their bills, a measure has been in force since 2009 (Artikel 122a) to reimburse service providers for the costs,33 implemented by the Dutch Healthcare Institute (Zorginstituut Nederland), a government organisation. (On 1st January 2017 this task was taken over by the Centraal Administratie Kantoor, CAK).34 Service providers that can be accessed directly, such as GPs and Emergency Departments, can apply for reimbursement of 80% of the costs (for pregnancy and delivery 100%). In the case of hospitals and pharmacists, reimbursement is restricted to a limited number of contracted providers, who however receive 100% reimbursement.

Only care which, in the opinion of the responsible physician, is ‘medically necessary’ can be reimbursed. The law also allows cost factors to be taken into consideration when deciding what is ‘medically necessary’, but this is also the case for other patients. The radical step which Article 122a took was to give a precise and generous definition of the forms of care that may be reimbursed. These comprise all care which is included in the basket of basic health services defined annually by Parliament. This includes for instance high-cost medication in case of HIV, though restrictions apply to dental care and physiotherapy.

Even today, not all managers and health care providers seem to be aware of the above regulations, or willing to implement them. In some years, even the limited funds available for reimbursement (e.g. €28.590.000 in 2013) have not been fully used. The latest estimate of the number of UDMs in the Netherlands (Van der Heijden et al. 2015) is around 35.000: the available funds per migrant in 2013 were therefore less than half the average annual health costs per person in the Netherlands (€2.186).35

Another reason why the funds have not always been fully used is that many UDMs get a bill for the full costs of treatment and pay it. This may be either because they have sufficient means to do so, or because they do not know of the exemption for those whose means are inadequate, or because the service provider (wrongly) insists that they must pay. In any case, since 1 January 2014 they have to pay €5 for each prescription.

Special exemptions

Undocumented children are exempted from restrictions.

Barriers to obtaining entitlement

The only legitimate administrative discretion that exists in the case of UDMs is the freedom of the service provider to decide how much effort will be devoted to recovering the costs of treatment.

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34 https://www.hetcak.nl
contrast to the situation in many other countries, Dutch law allows no room for service providers to take the migrants’ legal status into account when exercising their clinical judgement: care must be ‘medically necessary’ according to generally accepted professional standards. The care does not have to be ‘urgent’ or ‘essential’ or ‘emergency’ – concepts that give rise to much uncertainty in other countries. The law makes clear that the criteria for ‘medically necessary care’ do not differ between undocumented migrants and other users of the health care system, though coverage is limited to the basic basket of services.

Regrettably, however, some organisations offering information to UDMs about their rights fail to make clear that service providers are required to use the same criteria for UDMs as for any other patient, stating only that “the doctor decides”. The government website on health insurance creates the same misleading impression, by stating that UDMs “will receive any medical care considered necessary by the attending physician”. Such incomplete information reinforces the already widespread misconceptions among both migrants and professionals about the discretion service providers have in providing or denying care to UDMs (see Ingleby 2010).

37 The service provider may take into account the fact that the patient might only remain in the Netherlands for a limited period. However, because it is nearly always impossible to predict how long this period will be, this provides uncertain grounds for making clinical judgements.
38 See e.g. Dokters van de Wereld: http://www.lampion.info/documents/doc/folder_medoc.pdf
39 https://www.government.nl/topics/health-insurance/health-insurance-and-residence-permit
6. POLICIES TO FACILITATE ACCESS

Score 55    Ranking ☐☐☐☐

Information for service providers about migrants’ entitlements
For insured legal migrants and asylum seekers, entitlements are defined by the contents of the basic care package laid down annually by parliament, as well as any supplementary insurance they may have. This information can be obtained from internet or by a phone call to the insurance company.

Uninsured legal migrants fall under the same regulations as uninsured nationals, and these rules are also readily available. However, information on the rights of undocumented migrants is not effectively communicated either to service provider organisations or to their staff. Some service providers have been known to inform their staff incorrectly.

Information for migrants concerning entitlements and use of health services
The Health Ministry, insurance companies, and health care providers disseminate information for migrants on these issues via brochures and websites. Information for asylum seekers is disseminated in the centres.

Information about entitlements and use of health services is sometimes available in English, e.g. at https://www.cz.nl/english. Translated policy documents and brochures in other languages are seldom available. (Since 2016, however, there is a site for Syrians, in Arabic and Tigrina). Some health care providers include information in foreign languages about entitlements and use of the health system in the information they disseminate on their websites, but this is very limited.

Informing asylum seekers after arrival in reception centres about their entitlements is part of the policy of the COA. Interpreters are provided free of charge for asylum seekers, and it may be assumed that those who do not understand Dutch or English receive (limited) information about health services in their own language. Information about entitlements for undocumented migrants is only available in Dutch and English, and they would have to know where to look in order to find it:

- www.lampion.info/information-in-english

Health education and health promotion for migrants
Health education policy varies between municipalities. From 1976-2003 targeted information for particular groups was encouraged and supported by the government, but from 2003 onwards this policy was reversed and programmes using different languages, content, and methods of dissemination

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40 www.coa.nl/en/asylum-seekers/living-at-a-reception-centre/medical-care (English)
started to be phased out. Austerity policies have accelerated this process. At local level and to a limited extent some such programmes may still exist, but their funding is often uncertain.

For **specific diseases in specific locations** there are a variety of local projects and programmes aimed at health education and health promotion for specific populations. These projects, too, may be of limited duration. Examples:
- Diabetes mellitus for people of Surinamese-Hindustani descent
- Hemoglobinopathy (e.g. thalassemia) for people of African descent
- Suicidal behaviour for people of Surinamese-Hindustani descent
- Depression for people of Turkish and Moroccan descent
- Hepatitis for people of Chinese descent.
- Stress and psychosocial problems for asylum seekers
- Unexplained bodily pain for women of Turkish descent
- Stopping smoking for Turkish speaking persons.

Most health education programmes are aimed at legal migrants, with a limited number for asylum seekers. We are not aware of publicly supported information programmes for undocumented migrants.

**Provision of ‘cultural mediators’ or ‘patient navigators’ to facilitate access for migrants**
Cultural mediators (voorlichters eigen taal en cultuur) are available in a few major cities, provided by the municipal public health service and funded by the health insurers. However, these services are currently extremely vulnerable to cuts. Two examples are:

Only in a very few General Practices are cultural mediators available. Despite the positive experiences in almost all centres, these services have been lost due to cost reductions.

**Is there an obligation to report undocumented migrants?**
There is no relevant legislation, but medical code of practice (beroepsgeheim) prescribes confidentiality.

**Are there any sanctions against helping undocumented migrants?**
Officially there are no such sanctions, but implicitly, some professionals in (mental) health care are discouraged by their managers from providing care to undocumented migrants. Time pressure, additional paperwork, and unawareness of the possibilities for restitution of costs are even more effective in discouraging health professionals. As mentioned above, there have also been cases of organisations providing incorrect information about the rules to their staff.

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41 See also [https://www.loketgezondleven.nl/leefstijlinterventies/interventies-zoeken](https://www.loketgezondleven.nl/leefstijlinterventies/interventies-zoeken)
Interpretation services

From the mid-1980s until 2011, the national government funded the provision of qualified interpreters in health care. In 2011 the Minister of Health, Welfare, and Sports decided that it was up to migrants themselves to provide an interpreter in case of communication problems. The use of qualified interpreters dropped sharply in the following years, although the Minister claimed that this had not led to any reduction in quality of care. In general practice and hospital care, there was already gross underuse of professional interpretation services before this change in policy. Scrapping the funding, of course, did not help to combat the underuse: it sent the wrong signal.

Because in most cases migrants cannot afford to pay for qualified interpreters, most health care providers cover the costs themselves, while limiting their use. For some GPs in disadvantaged regions (achterstandsgebieden) and in most hospitals, there is funding available for mediation or professional interpretation services from a special foundation (the ‘achterstandsponds huisartsen’) or hospital budgets, respectively. However, underuse remains the rule (see e.g. Van Rosse 2015, which reports that in 566 cases of hospitalized non-western migrants, professional interpretation services were used in only two cases).

Care providers face a dilemma; on the one hand they are legally obliged to inform the patient about diagnosis and treatment in a language that is understandable to both parties in order to obtain informed consent, on the other hand the provision of interpreters weighs heavily on the budget of health care services. Recently the Kwaliteitsnorm tolkgebruik bij anderstaligen in de zorg (Quality standard for the use of interpreters in case of non-Dutch speaking patients in health care, 2014) was endorsed by the major national organisations of health care professionals. According to the standard, it is up to the care provider to judge whether a qualified interpreter is needed in order to ensure care provision according to professional standards.

Methods used at present (apart from informal interpretation) include:

- face-to-face interpretation;
- telephone interpretation;
- interpretation by videolink (pilot);
- credentialed volunteers (incidentally);
- employment of competent bilingual staff;
- employment of untrained bilingual staff (not trained in interpretation).

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43 [https://www.rijksoverheid.nl/documenten/kamerstukken/2013/05/28/kamerbrief-over-inzet-tolken](https://www.rijksoverheid.nl/documenten/kamerstukken/2013/05/28/kamerbrief-over-inzet-tolken)
44 [http://www.achterstandsfondsen.nl/wijkzorg](http://www.achterstandsfondsen.nl/wijkzorg)
Requirement for 'culturally competent' or 'diversity-sensitive' services

Several organisations of mental health care professionals, such as psychiatrists and psychologists, have developed guidelines for appropriate intercultural mental health care delivery, so-called ‘intercultural competency profiles’. See e.g.

- http://www.vgn.nl/media/download/index/mediaid/51b97c362ce50

However, compliance is not monitored by a relevant authority. In all new and revised guidelines for general practitioners, ethnic and cultural differences are incorporated, and in 2016 a book on migrant care in primary care was published by the Dutch College of General Practitioners together with Pharos (Van den Muijsenbergh & Oosterberg 2016). In hospital care, no standards or guidelines for diversity-sensitive services are implemented on a large scale or widely recognized, although ‘person-centred care’ is encouraged.

Training and education of health service staff

Training and education of health service staff in migrant health care is not an obligatory and integrated part of every professional degree course. In general, attention is paid to intercultural aspects of health care delivery, but only occasionally and on a voluntary basis, as an additional element of professional education with a limited investment in time.

Topics such as ‘cultural competence’ or ‘diversity-sensitive care provision’ are included in the learning objectives (eindtermen) of the bachelor and master medical degrees in the Netherlands, as well as in the learning objectives of vocational training for GPs and for medical specialists (see Raamplan 2009). However, during visitations, medical faculties are not held to account if their curriculum does not address these topics. In most undergraduate medical education, there is limited and unstructured attention paid to ethnic and cultural health differences. Nevertheless, in all vocational training for GPs there now exist programs on this topic, and teachers on migrant health care in vocational training meet in a special working group on diversity and international health of the Dutch College of General Practitioners (DIGH). Many GPs in deprived areas have followed courses on migrant care and health disparities as part of continuous medical education, but this is not obligatory.

Medical specialist education does not structurally contain courses on diversity-sensitive care, with a few exceptions. There is an initiative in paediatrics (INVEST, Lucas Andreas ziekenhuis Amsterdam), but this is only locally and partially implemented (in one hospital) and not evidence-based. There have been relevant courses in rehabilitation medicine and occupational healthcare, but these have ended in the past few years. Occasional courses have been held, for instance on intercultural communication or palliative care and migrants, but not at a structural basis. Even in the education of public health physicians, the two-day course and training on diversity-sensitive care is an elective.

Involvement of migrants

Migrant involvement in research is explicitly encouraged by policy measures, but is not a prerequisite for funding for the development of health education programmes or research. Diversity is one of the core themes of the major research institute (ZonMW, The Netherlands Organisation for Health Research and Development). ZonMW published a guideline to involve migrants or their organisations and a checklist *Attention for diversity in research*. However, the obligation to include migrants in research is seldom tested by ZonMw.

In the Netherlands, patient participation in information provision, service design and delivery is, although increasing, still underdeveloped in general; it is not common practice, and this also holds for migrants. Most healthcare organisations have a Client Council to represent patients and future service users; in these, migrants are seldom represented. More often staff and researchers with a migrant background are involved, rather than migrant organisations.

Migrant organisations are seldom explicitly and structurally consulted on service design and delivery. Rather, individual experts and centres of expertise may be consulted, such as Pharos and (until their closure due to lack of funding in 2013 and 2014 respectively) Mikado and Forum.

Encouraging diversity in the health service workforce

There are no national recruitment measures that encourage participation of people with a migrant background. Recruitment policy is left to local health care organisations. Previous measures were abolished in the period 2005-2010.

Development of capacity and methods

In mental health care the *Trimbosinstituut* (National centre of expertise on mental health and addiction) develops intercultural addenda to the multidisciplinary guidelines for specific mental health disorders. Intercultural addenda are available for depression and schizophrenia, as well as anxiety disorders (developed by Mikado intercultural mental health centre of expertise). Since 1 January 2015 the Network for Quality Development in Mental Health Care has been working on quality standards for improving responsiveness to diversity.

The need to adapt guidelines for *general practitioners* is demonstrated and stressed in several publications based on empirical research, and gradually all professional and scientific guidelines for GPs pay attention to ethnic and cultural/socioeconomic health differences. The Dutch College of General Practitioners (NHG) together with Pharos have developed several diagnostic instruments for culturally competent care (for instance the above-mentioned book, the website *www.huisarts-migrant.nl* and a tool for the care for migrants with medically unexplained symptoms).

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49 [www.zonmw.nl/nl/themas/thema-detail/diversiteit/thema-detail](http://www.zonmw.nl/nl/themas/thema-detail/diversiteit/thema-detail)
50 [http://www.pharos.nl/nl/home](http://www.pharos.nl/nl/home)
51 [https://www.trimbos.nl](https://www.trimbos.nl)
53 [https://assets.trimbos.nl/docs/97fab014-4311-4585-95f9-b9de4050bcb9.pdf](https://assets.trimbos.nl/docs/97fab014-4311-4585-95f9-b9de4050bcb9.pdf)
54 [http://www.mikadonet.nl/publicatiegedetail.php?id=100](http://www.mikadonet.nl/publicatiegedetail.php?id=100)
55 [http://www.kwaliteitsontwikkelingggz.nl/project/generieke-module-diversiteit](http://www.kwaliteitsontwikkelingggz.nl/project/generieke-module-diversiteit)
Treatments are developed for (mental) health problems specific to certain migrant communities, for instance complex post-traumatic stress in refugees and asylum seekers,\textsuperscript{56,57} treatment of multi-problem families with a migrant or refugee background, or transcultural systemic treatment of migrants and their families.\textsuperscript{58} Standard treatments for routine health problems are adapted to migrant populations on a limited scale and ad hoc, for instance intercultural interpersonal therapy or treatment for hypertension and diabetes in migrants. Furthermore, a Cultural Interview has been introduced in health care to improve the cultural sensitivity of diagnostics in various health care settings.\textsuperscript{59} This was introduced as part of standard procedures by the service provider Parnassia Group in 2006.\textsuperscript{60} A website providing specialised advice on migrant health problems for GPs is also available.\textsuperscript{61}

Despite all these promising development, in guidelines for specialist healthcare developed by the Wetenschappelijke Verenigingen\textsuperscript{62} (Scientific Associations of the Association for Medical Education) there are hardly any specific adaptations to ethnic or socio-economic diversity. The guiding principle seems to be to provide equal (i.e. the same) treatment to all.

\textsuperscript{56} http://www.centrum45.nl/nl/voor-wie/vluchtelingen-en-asielzoekers
\textsuperscript{57} https://www.ggzdrenthe.nl/centrum/de-evenaar
\textsuperscript{58} https://www.i-ps.nl
\textsuperscript{59} https://cultureelinterview.nl
\textsuperscript{60} https://www.parnassiagroep.nl/wie-we-zijn/nieuws/-/-ruimte-voor-patient-om-ziin-verhaal-te-doen-cultural-formulation-interview-vast-onderdeel-van-intake
\textsuperscript{61} http://www.huisarts-migrant.nl
\textsuperscript{62} http://www.nvmo.nl/links/wetenschappelijke_verenigingen
8. MEASURES TO ACHIEVE CHANGE

Score 42   Ranking 🌑🌑🌑🌑◯

Data collection

Databases containing information on health can be linked with databases containing information about country of origin. However, ethnicity or country of birth is almost never registered. It can be linked afterwards, but the procedure is not easy and has serious limitations, especially in migrant populations. In general, registration of ethnicity (place of birth of respondent and of his or her parents) is forbidden with the exception of registration aimed at identifying and diminishing ethnic disparities (Wet Bescherming Persoonsgegevens art. 18). The government’s standpoint\textsuperscript{63} is motivated by the desire to prevent the exploitation of ethnic data for political ends.

Legally residing migrants were included in two recent national surveys on health and use of health care (NEMESIS I and II, Netherlands Mental Health Survey and Incidence Study)\textsuperscript{64}, although respondents with limited knowledge of the Dutch language were systematically excluded.

In mental health care, registration in medical records is limited to the place of birth of the patient and of his or her parents. Registration is on a voluntary basis, and often to a significant level inaccurate or lacking. Registration in primary healthcare patient records depends on the health professional, but often place of birth and ethnicity are recorded by GPs. The NHG and Pharos have made a guideline for recording of relevant context data including ethnicity, language, and migration history. In hospital care there is no routine registration of ethnic origin or country of birth or language mastery in patient files (see Van Rosse 2015).

The RIVM (National Institute for Health and Environment) maintains extensive data on ethnic differences in its database Volksgezondheidenzorg.info (VZinfo.nl), which since 2016 amalgamates information from five earlier databases. It presents a large amount of epidemiological data on an easily accessible platform.

Support for research

ZonMw (Netherlands Organisation for Health Research and Development) has funded research on occurrence of health problems among migrant or ethnic minority groups, social determinants of migrant and ethnic minority health, issues concerning service provision for migrants or ethnic minorities, and evaluation of methods for reducing inequalities in health or health care affecting migrants or ethnic minorities. Other funding bodies also fund research (KWF Kankerbestrijding, Nederlandse Hartstichting, Diabetes Fonds, etc). The Nederland Hartstichting contributes to the funding of the HELIUS study on ethnic health disparities in Amsterdam.\textsuperscript{65}

In the period 2009-2013, at least 23 PhD studies on these topics were completed.

\textsuperscript{63} https://www.rijksoverheid.nl/documenten/kamerstukken/2011/05/27/kabinetsstandpunt-etnische-registratie
\textsuperscript{64} http://www.nemesis.gfk.nl, http://www.nemesis-2.nl
\textsuperscript{65} http://www.heliusstudy.nl/en/home
"Health in all policies" approach
The impact on migrant or ethnic minority health of policies in sectors other than health care is not structurally considered. A limited number of studies have been carried out into the effects of the asylum procedure on the mental health of refugees (adults as well as children), but it is not known whether they have influenced policy.

Whole organisation approach
Until 2005 most mental health institutions in the Netherlands invested in some way or another in the development of more culturally sensitive health services according to the principles of an integrated approach, therein supported by government policy and funding. In the last ten years the commitment of health care organisations weakened considerably, and several categorical mental health organisations specialized in providing care to culturally different patients came into being. Although government policy stresses the participation of migrants in Dutch society, claiming that not origin (afkomst) counts but future (toekomst), the number of categorical mental health institutions rises. Regarding hospital care, little systematic attention is being paid to migrants or ethnic minorities at organisational level. Some hospitals in the inner cities of Amsterdam, Rotterdam and The Hague, as well as the Radboud University Hospital in Nijmegen, have organisational provisions in place to accommodate their services to the needs of migrants.

Leadership by government
No explicit plan for action on migrant health has been formulated and implemented since 2004, with the exception of plans on female genital mutilation and honour-related domestic violence.

In general the government considers the development of accessible and (cost-) effective health care for nationals as well as for migrants a matter for the health insurance companies, health care providers, and consumers in their market-oriented interaction with each other.

Involvement of stakeholders
There is no advisory body or centre of expertise promoting cooperation amongst stakeholders on migrant health policy, with the exception of Pharos,\textsuperscript{66} the centre of expertise on health disparities, which can be considered as the major agent promoting equitable access to health care (the other two having been eliminated by withdrawal of their subsidies). All advisory bodies in the field of migrant health policy or migrant policy in general have been abolished.

Migrants’ contribution to health policymaking
Migrant organisations are involved in health policy making only through ad hoc cooperation on national and local level. In 2005 the Dutch government stopped funding the national Advisory Board on Health Care and Multicultural Society (founded in 1972). In 2015 the same happened to the Landelijk Overlegorgaan Minderheden (National Board of Minorities, established in 1997) and the migrant organisations participating in it.

\textsuperscript{66} http://www.pharos.nl/nl/home
CONCLUSIONS

Whereas few would disagree that the Netherlands led Europe in the last quarter of the 20th century in developing policies to adapt health services to the needs of migrants and ethnic minorities, successive Dutch governments in the 21st century have put this process into reverse gear. This about-turn was not confined to the health sector: multicultural policies in general have been rolled back, as political attitudes have hardened against migrants and cultural diversity. Nor is this phenomenon confined to the Netherlands – a backlash against migration and multiculturalism, to a greater or lesser extent, can be observed in the politics of many western countries.

Nevertheless, the overall picture is more nuanced than this suggests. Support for ‘intercultural health care’ was always ambivalent and wavering; to a large extent, the policy changes since 2002 reflect general shifts in the way Dutch society is governed, rather than specific attitudes to diversity. In nearly all sectors, ‘top-down’ government control has been relaxed and services have been devolved to lower levels of government and/or commercialised. Faith in ‘market forces’, and blindness to their limitations, reflects the growing influence of neo-liberalism in 21st century Holland – indeed, throughout the West.

Stimulating private initiatives has led to the creation of separate health services for migrants and ethnic minorities, as the (already weak) obligation to mainstream ‘interculturalisation’ has been removed. If the Dutch system remains relatively responsive to the needs of migrants and ethnic minorities, this has more to do with efforts at local and individual level than with the influence of the Health Ministry, which has dismantled one by one the multicultural policies developed in the 20th century.

Despite this unpromising situation, the country gains relatively high scores on the MIPEX Health strand. Entitlements for migrants are particularly good: only France obtains a higher score. The legislation on health care for undocumented migrants introduced in 2009 is among the most progressive in Europe, which is particularly surprising in view of the political climate in which it was adopted. However, its implementation has been flawed and the government has taken no steps to remedy this. The government’s attitude that migrants are responsible for their own integration has undermined efforts to teach them how to use the health system and take better care of their own health. The prolonged recession and austerity policies since the financial crisis have also played a role in these cutbacks.

Financial considerations clearly played a role in the 2011 decision to abolish government-supported interpretation services, which provoked virtually unanimous opposition from the health sector. However, the argument that expensive healthcare resources are wasted when doctors and patients are unable to communicate properly fell on deaf ears. The development of standards and training for dealing with patients from diverse backgrounds has continued, though perhaps motivated more by a drive to increase professional standards than by political ideals of equity and inclusiveness. Concerning the last dimension of the Health strand (‘Achieving change’), although governance structures have been dismantled, both the quantity and quality of research on migrant and ethnic minority health remains high. It remains to be seen how much momentum can be maintained by the supporters of ‘diversity-sensitive’ health care in a political context that currently shows few signs of becoming more favourable.

67 http://bit.ly/2tYG1FQ


CoE (2014) *Report by the Commissioner for Human Rights Mr Nils Muižnieks following his visit to the Netherlands from 20 to 22 May 2014*. Strasbourg: Council of Europe.

https://rm.coe.int/16806db830


