

**Typologies and Logics of Welfare Bricolage in  
the UK**

Simon Pemberton and Arshad Isakjee

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## **Abstract**

This working paper focuses on identifying the different types and rationales for bricolage being undertaken by residents in two superdiverse neighbourhoods (Handsworth and Edgbaston) in Birmingham, UK. It explores how residents may bricolage to i) achieve health and well-being; and ii) to address a specific health concern. In particular, actions and resources that individuals used to address a health concern are discussed, as well as the reasons why individuals engaged in bricolage activities. These include a lack of confidence in formal (NHS) provision, to secure more culturally appropriate care, to seek reassurance and to supplement formal provision. A number of barriers / impediments to bricolage are also highlighted. The report concludes by setting out the different types of bricolage in evidence in the case study areas.

## **Keywords**

Superdiverse neighbourhoods, welfare bricolage, typology

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## **Context**

This working paper is based upon analysis of in-depth interviews conducted with 40 residents living in the super-diverse neighbourhoods of Handsworth and Edgbaston, Birmingham, UK. The primary purpose of the working paper is to identify the different types and rationales of bricolage being undertaken by residents to i) achieve health and well being; and ii) to address a specific health concern.

In the context of the research, bricolage is defined as "*the process by which individuals enact wide-ranging intellectual, social, material and affective resources in order to be healthy or to address a health concern*". Bricolage has not been used to date in studying access to healthcare. However, it may help to highlight individuals' agency in seeking healthcare services. As such, it involves the creative mobilisation, use and re-use of resources, knowledge, ideas, materials and networks to respond to health concerns (Phillimore et al. 2017).

The typology that is set out in this working paper – and based upon the analysis of resident interviews - has subsequently informed the methodology and questions explored in a broader household survey conducted in the neighbourhoods of Handsworth and Edgbaston. The results of this work are published elsewhere.

## **Literature review**

In the United Kingdom (UK), the National Health Service (NHS) was established in 1948 as a national system available to all legal residents, mainly funded through taxation and mostly free at the point of use (Boyle, 2011). Over time, health services have increasingly shifted away from hospitals and into the community, although high bed occupancy rates continue (NHS England, 2014). Whilst numbers of nurses remain above the EU average (870 per 100,000, 2013), the number of doctors remains below (278 per 100,000, 2013) and with international recruitment being intensive from time to time (Addicot et al., 2015).

The UK's National Health Service (NHS) is therefore a prime example of a National Health Service system (as opposed to other types of health system that exist elsewhere, such as National Health Insurance, Social Health Insurance etc.; Bohm et al., 2013), and as such the state retains the responsibility to govern the relations between the main actors in health care.

Since 1997, responsibility for healthcare in the UK has been devolved, and with England, Scotland, Northern Ireland and Wales each having their own systems of funding and provision, and with differing policies and priorities (Cylus et al., 2015). Nevertheless, in practice there is a mixed picture. For example, a range of regulators exists for the health system in the UK. Some of these – for example, health professional groups - oversee all of the UK, whilst others - such as quality of care providers - more specifically relate to each devolved territory (Bevan et al., 2014).

In England, market forces have played a greater role in shaping the English health system than elsewhere (Bevan et al., 2014). The main emphasis has been towards decentralisation, more localised decision-making and reinforcing the internal market and competition (Cylus et al., 2015). There is also a split between the purchasers and providers of services existing in England and Northern Ireland (*ibid.*). Wales and Scotland – in contrast – have kept power more centralised (Ham et al., 2013).

In terms of the provision of health services, Public Health England (and equivalent organisations elsewhere in the UK) is responsible for co-ordinating and strengthening health protection and health improvement, as well as reducing health inequalities (NHS England, 2014). Reducing health inequalities is an increasing concern given increasing disparities between different groups (European Commission, 2013). Since 2012, local authorities have regained responsibility for commissioning public health (NHS England, 2014). Primary care – as a response to a health concern and as a gateway to more specialised care - is mainly provided through practice-based general practitioners. Specialist doctors and others working in state-owned hospitals provide secondary care. Tertiary services offer more specialised interventions concerned with more complex problems and treatments (*ibid.*). An increasing emphasis is also being placed on integrating health and social care to reduce demand on primary and secondary care services (Ham et al., 2013).

In overall terms, the demands of an ageing population, treating individuals with chronic conditions and meeting patient expectations in the UK are key challenges within a context of finite resources (Boyle, 2008). This, in turn, also leads to a focus on the role and importance of welfare and immigration regimes in the context of healthcare provision.

With reference to welfare regimes, social policy analysts have often used broad typologies in order to frame their discussions. Esping-Andersen is one of the best-known scholars in this context (Mohan, 2003). Indeed, through a variety of different models of welfare regimes (Andersen 1990, 1999), Leibfried (1992), Castles and Mitchell (1993), Ferrera (1996), Bonoli (1997), Korpi and Palme (1998), Pitruzzello (1999), Korpi (2000), the UK regime is classified as ‘liberal’. In general, ‘liberal’ regimes are associated with lower levels of state intervention, the market establishing a level of social security and the state undertaking modest re-allocations (Andersen, 1990). Such re-allocations are often subject to strict entitlement criteria and recipients may be means-tested and stigmatised (Bambra, 2011). A clear division may often exist between those who rely on state support and those who are able to afford private provision (*ibid.*).

Pose and Tselios (2012, p.126) highlight how the UK’s welfare system is also the most market-oriented of different welfare regimes that exist across Europe and with less emphasis on addressing inequalities. However, it has been argued that welfare systems based on a ‘communitarian’ or ‘difference based’ approach to diversity, such as in the UK are more inclined to incorporate migrant-friendly health policies than systems based on a ‘republican’ or ‘difference blind’ logic. (Mladovsky et al., 2012, p.2).

Notwithstanding this, the relationship between welfare regime and healthcare outcome is not well defined in the main. For example, Eikemo et al. (2008) conducted a study to investigate whether self-perceived health was determined by welfare regime type. Their

study identified that only ten per cent of the variation of self-perceived health could be explained by regime-type; more largely it was found to be correlated with individual factors.

Bambra (2006; 2007) has also conducted research into the connections between welfare regimes and health outcomes. She has illustrated how liberal regimes such as the UK show low rates of decommmodification in the labour market (indicating lower levels of wealth redistribution) and higher rates of decommmodification in its healthcare system, representing a more universalist and redistributive healthcare system than would be expected of a liberal welfare regime (Bambra, 2005).

However, austerity and welfare chauvinism has led to a considerable restructuring of the welfare state in the UK in recent years. Indeed, whilst healthcare is still free at point of access for most, there has been a tightening of rules in respect of eligibility for non-UK citizens, and particularly visitors and non-legal migrants whose right to care is in doubt. This draws attention to the UK's immigration regime, how this is evolving over time, and the relationship with health and welfare systems.

Immigration has been an increasingly important political issue over the last fifteen years, and particularly since EU enlargement in 2004 and the substantial influx of EU migrants to the UK (Katwala and Somerville, 2016). A variety of migration typologies have been developed covering immigration control on the one hand and settlement on the other (Boucher and Gest, 2014, p.7). However, most studies remain within the field of social policy and welfare (rather than in the field of immigration) and draw on Esping-Andersens' welfare regime typology to consider the rights of immigrants according to different visa categories (*ibid.*, p.11).

Ford et al. (2015) identify three immigration policy regimes in the UK over the last 30 years. The first (1982-1997) involved policymakers facing relatively few constraints in responding to public views on migration (which were largely ambivalent), and with immigration being tightly controlled by both the Margaret Thatcher and John Major conservative governments.

The second policy regime from 1997-2004 involved migration policy being selectively liberalised in response to a number of pressures (economic migration for work and study), and which produced increasing inflows of immigrants and growing demands by the public to restrict such movement. The third policy regime, from 2004 onwards, has involved on-going demands by the public to restrict immigration but with policy-makers experiencing significant constraints in responding, partly due to earlier decisions on EU accession in 2004 and a lack of restriction on labour migration from Eastern Europe (*ibid.*).

The arrival of increasing numbers of EU accession migrants in the UK from 2004 onwards led to the phasing out by the Government of a number of (traditional) low skill immigration schemes for individuals from other parts of the world (Home Office, 2006). In 2005 the government set out a five-year strategy for asylum and immigration, which made it clear that employers would be expected to fill all of their low-skilled vacancies with workers from within the enlarged EU (Home Office, 2005). Within this context, a new Points Based System (PBS) was introduced in February 2008 to manage migration from outside of the European

Economic Area (i.e. the EU-27 countries plus Norway, Iceland and Lichtenstein). In summary, the PBS consisted of five tiers:

- Tier 1: Highly skilled individuals to contribute to growth and productivity)
- Tier 2: Skilled workers with a job offer to fill gaps in the UK labour force)
- Tier 3: Limited numbers of low-skilled workers needed to fill specific temporary labour shortages (suspended due to influx of EU accession migrants to fill such posts)
- Tier 4: Students
- Tier 5: Youth mobility and temporary workers (applying to those travelling from Australia, Canada, Japan, Monaco and New Zealand)

Source: Control of Immigration Statistics (2009) cited in Migration Advisory Committee (MAC, 2010).

A number of ‘tools’ were also of relevance to the imposition of the PBS. The first was the ‘Resident Labour Market Test’, which requires employers to demonstrate that they have filled vacancies from within the UK and the EEA before they are able to recruit from outside Europe. The second relates to the need for employers to register as a ‘Licensed Sponsor’, and indeed the concept of sponsorship lies at the heart of the PBS.

However, given ongoing concerns over the impact of migration on the UK, in June 2010 the Coalition government introduced a temporary cap on the number of non-EEA migrant workers allowed into the UK (UK Border Agency - UKBA, 2010). Under the Coalition government, there was an aim to reduce net-migration to fewer than 100,000 per annum by the 2015 General Election. Nevertheless, given the difficulties in restricting EEA migration (due to EU laws protecting the freedom of movement), the government instead focused on restricting non-EEA migration, including closing routes intended for non-EEA high-skilled workers (Rienzo and Vargas-Silva, 2015). Hence new rules were introduced in 2011 on family union, student visas, and reducing the number of work visas. Attempts were also made to encourage unauthorised migrants to voluntarily leave the UK. The 2014 Immigration Act formalised such an approach by seeking to impose restrictions of unauthorised migrants’ access to health and other services; by making it mandatory to check their immigration status and by reducing appeal rights for unauthorised migrants (*ibid.*, p.16). However, such measures were viewed by some as posing a wider threat to the health of both migrants and the wider population, as well as increasing costs from delayed care and infringing on international human rights agreements (Steele et al., 2014).

With reference to the current Conservative government, this has reiterated its commitment to reduce net migration to the “tens of thousands” to the UK by introducing the Immigration Bill (2016), which has aimed to step up enforcement and to reduce access to services for unauthorised migrants. It also delivered a manifesto promise to hold a Brexit referendum, and a renegotiation of the UK’s position with the EU in part focused on reducing welfare entitlements for EU migrants (Katwala and Somerville 2016, p.13). But in the context of the Syrian refugee crisis, there has been an expansion of the Vulnerable Persons Relocation program, and with the UK to accept 20,000 additional Syrian refugees by 2020 (*ibid.*, p.18).

Such features therefore provide the context for the different ways – including the opportunities and constraints that are of relevance - in which individuals seek to maintain their health or seek to address their health concerns.

## Methods

A mixed methods cross-sectional research design combining qualitative and quantitative methods was adopted for the study. Birmingham was selected as the case study city in the UK due to the super-diversity of its population. It is the largest local authority area in Europe, with a population of 1,073,045. The overall size of the city's population has increased by 9.8% between 2001 and 2011, an increase of 96,000 (Birmingham City Council, 2013a). The city has a long history of immigration and which has occurred in three main phases: the arrival of post-commonwealth migrants in the 1950s to 1970s, the dispersal of asylum seekers from 1990 to the present day, and arrivals of European Accession country migrants from 2004<sup>1</sup>. While the established minority population of Birmingham is expanding, the city is becoming increasingly diverse.

The nature of Birmingham's super-diversity is visible in a variety of statistics. For example, 22.2% of its residents were foreign born, and with 42% from ethnic minority communities. The population with ethnic background other than white (White British, White Irish and White Other) has grown in the last decade by 12%, and has doubled in size since 1991 from 21% to 42%. The Pakistani ethnic group has grown faster (39%) than any other ethnic group in the last decade. It has more than doubled in size since 1991 growing from a population of 66,110 to 144,627 (119% increase). There has been a rise of 70% in the number of people identified with a 'Mixed' ethnic category since 2001 (Birmingham City Council, 2013a).

Countries new to the twenty most reported countries of birth for Birmingham residents since 2001 include, Iran, Zimbabwe, Philippines and Romania. The most marked increases were seen amongst Romanians, rising from 66 in 2001 to 1,433 in 2011. People born in Poland and Somalia increased nine fold and those in born in China, Nigeria, Zimbabwe and Iran 3 fold (Birmingham City Council, 2013a). Recent GP registration data<sup>2</sup> also shows that 41,318 migrants moved to the city from 187 different countries between 2007 and 2010.

With reference to religion, 46.1% of residents said they were Christian in 2011, a decrease of 13% from 2001 and with those reportedly of Muslim religion increasing by 7.5%. Where English is not the main language in the household, the most commonly spoken were Southern Asian languages (Urdu – 2.9%; Panjabi – 2.1%; Bengali, 1.4%; Pakistani Pahari – 1.1%) (Birmingham City Council, 2013b).

By ethnicity, the Mixed ethnic group recorded the highest proportions identifying they were in Very Good Health (88.68%), followed by Other (84.58%), Asian (82.40%), Black (81.84%)

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<sup>1</sup> Accession countries are those Eastern and Central European countries which joined the EU in 2004.

<sup>2</sup> GP registration data is not complete. Migrants generally choose to register with a GP only if they need medical attention. Undocumented migrants are reluctant to register at all. Furthermore the database only includes those migrants who have registered directly after arriving from overseas. Nonetheless GP registration data is the best source of data for identifying the nature of the new migrant population. It should be viewed as partial and a picture of the minimum levels of diversity.

and White (76.82%) (Office for National Statistics – ONS, 2011). In addition, recent analysis suggests that Eastern European communities in the city are increasingly subject to homelessness, and with alcohol and drug dependency becoming more evident. Other key health issues for this group were considered to be around smoking, poor diet, heart disease and mental health issues resulting from social isolation (Birmingham City Council, 2010).

It has been argued that individuals from non-EU communities also have particular health issues. Some evidence suggests that those originating from South Asia are more likely to have a poor diet and a higher incidence of smoking than the general population. Infant mortality and low birth weight babies are also a problem. However, the adoption of a superdiversity lens helps to identify that there may be considerable variation within such groups, and consequently there is a need to avoid pathologising whole communities. Equally, whilst it has been stated that Chinese communities may experience a higher incidence of unwanted pregnancies as a result of not accessing contraceptive advice, this too may vary according to the characteristics of individuals. Concerns in relation to Sub-Saharan African communities include HIV, sexual health and tuberculosis, as well as mental health issues. But again this may vary according to other variables of superdiversity, such as economic status, education, legal status etc. Finally, Somali and Eritrean communities may also exhibit ‘within group’ variation in relation to issues of diet, hypertension, diabetes, female genital mutilation, women not accessing ante and post-natal care, substance misuse and smoking (Birmingham City Council, 2010).

Two superdiverse neighbourhoods in Birmingham were selected to investigate how residents access healthcare: Handsworth, which has a long history of immigration and with high levels of socio-economic deprivation; and Edgbaston, which is more recently diversifying, with less deprivation and an upward trajectory.

In Handsworth, superdiversity is particularly apparent. For example, there has been a rise of 70% in the number of people identified with a ‘Mixed’ ethnic category since 2001, whilst people born in Poland and Somalia increased nine fold and those born in China, Nigeria, Zimbabwe and Iran three fold between 2001 and 2011 (Birmingham City Council, 2013a). Some 88% of the population identifies as minority ethnic with key languages spoken (in rank order) including English, Bengali, Panjabi and Urdu, Pakistani Pahari, Polish and Somali (ONS, 2011). Two-thirds of the resident population are Muslim, followed by Christian (21%), No religion (5%) and Sikh (4%) (ONS, 2011). 44.9% of the population (13,859) were born overseas and the neighbourhood now houses residents from 170 different countries (Phillimore, 2013).

Edgbaston, on the other hand, is more recently diversifying where new migrants outnumber old. The proportion of ethnic minority residents is similar to the city average – 42%. The White ethnic group constitutes 59% of the total population. The next largest ethnic minority group is Asian (25%), followed by the Black population (8%) and then Mixed (4%). The Indian population is particularly evident constituting 12% of the total ward population (ONS, 2011). Key languages spoken include English, followed by Chinese, Urdu, Persian, Polish and Panjabi. Just over 40% of the population are Christian (41.8%), followed by 26.1% stating ‘No religion’ and 11.2% stating Muslim. 29.3% of the population were born overseas. Of those

not born in the UK, the majority arrived between the ages of 20-24 and 25-29, followed by 30-34. Edgbaston is unusual in that ‘new’ migrants outnumber ‘established’ migrants (the only other wards that have a similar pattern are Ladywood, Nechells and Selly Oak) (Birmingham City Council, 2013a).

A maximum diversity sampling approach (a small number of units or cases are selected that maximize the diversity relevant to the research issue) was used to select the 40 interviewees (20 per neighbourhood) that participated in the research. Thus individuals were selected on the basis of difference not their ethno-national identity (however ethnic diversity was apparent within the sample). Both migrants from within the EU and beyond the EU were included in the sample, and from main country of origin groups (such as Pakistan, India, Eastern Europe) and smaller populations (for example, Rwanda, USA and Hong Kong).

Variation was also evident in terms of gender, age (from 19 years to 81 years), religion (for example, Christian, Islam, none), employment (self-employed, full-time, part-time etc.), profession (including skilled and unskilled), languages spoken, housing tenure type (for example, private rented; living with parents etc.), time in the UK and neighbourhood (from 1 year to over 60 years) and whether they had experienced a long term illness (around 50% of sample).

Individuals’ self-identified health concerns varied considerably. Some highlighted serious issues related to strokes, heart problems, aneurisms, hernias and internal bleeding. Others highlighted less serious problems such as coughs / colds and headaches. Joint / muscle pain, circulatory issues and skin conditions were a third set of issues highlighted by respondents. Finally, mental health conditions were frequently evident in respect of responses, including issues relating to stress, depression and anxiety.

## Results

### *(i) Introduction - triggers for action*

The triggers for action taken to respond to a health concern can be divided into two. First those which emerged suddenly and which were unanticipated – for example, a stroke, a sudden panic attack, a foot injury at work or playing football. Second, those conditions which had emerged more gradually, for example, continual tiredness, on-going migraines, continuing depression and anxiety.

With reference to triggers which emerged more gradually, the initial reaction was to ‘wait and see’ if the problem would subside. Some would discuss their problem with a friend or member of the family if in close proximity, or via Skype if their relations were more distant. Only in a relatively small number of instances were concerns revealed as part of a routine check-up or in relation to other medical investigations being carried out. Mental health issues were perceived by interviewees as being particularly challenging. The lack of mainstream provision and perceptions of a general lack of empathy and / or support meant that there was often a significant time lag between the on-set of a problem and actions undertaken in an effort to resolve such issues.

### *(ii) Actions and resources used to address a health concern*

Regardless of whether triggers for action emerged suddenly or more gradually over time, each generally resulted in the use of two pathways to care: the General Practitioner (GP) and Accident and Emergency (A&E) departments within hospitals. In this way, the key actions taken by individuals to address their health concerns were not particularly variable:

*If you have a health problem then you go straight to the Doctor or to the hospital rather than try and sort it yourself... so explain to the doctor what's wrong and the doctor knows best, because he's studied for it, spent time studying so he knows best...(Interviewee 1, Pakistani born male, Edgbaston, aged 44)*

and

*I come straight to the doctor and I wait till I'm seen. I never leave anything, even if it's a twinge or a headache, I come straight to the GP and if they're closed, I'll go straight to A&E....For myself I don't ever leave anything to chance (Interviewee 13, White/Pakistani British born female , Handsworth, aged 36)*

For emergency scenarios in which serious treatment was needed very quickly, interviewees highlighted how they would go straight to an A&E department of the local hospital. Depending on the perceived severity of a situation, this journey would be completed in an ambulance, or in vehicles of close relatives who would act as facilitators for such a pathway to treatment. All those who went to hospital in an emergency scenario would be fully embedded within the formal health system, and motivation or opportunities for bricolage would be very limited. It is also worth noting that in relation to questions of trust, specialist doctors in hospitals and consultants were often singled out for praise by interviewees. Usually in this scenario, intensive treatment would be delivered by doctors at the hospital and within a short period of time from arrival.

Whilst in hospital, social support structures can be useful to ensure patients are relatively relaxed in the company of friends and family. However, such narratives were not common amongst interviewees. Nevertheless, in relation to leaving hospital, utilising informal support networks were identified by interviewees as being important in facilitating the recovery process. Indeed, where physical mobility was restricted by illness, patients highlighted their need assistance for everyday activities. Furthermore, such rehabilitation was – according to interviewees - occasionally supplemented with lifestyle changes (but recommended by formal providers; also see below).

For problems that were not so acute, the majority of respondents highlighted how they used the GP as a first point of call in addressing their health concerns. The GP was used in order to try and diagnose the health problem in some instances, to treat the health problem in others, and to seek a referral to more specialist provision for a number of individuals.

Exceptions to this rule were in cases where illness was not considered too serious, such as experiences of cold or flu symptoms.

After GPs and the subject themselves, friends and family were cited as the most trusted individuals in terms of health provision. However, even when family members or friends were medical professionals, their networks were used largely to reassure and to check that the formal treatment being provided by their GPs was correct:

*Hmm, I trust the most - it'll be my GP. Because he will refer me on after seeing me a couple of times. If I consult a friend, it's just talking; and after talking about it a couple of times, I start to worry I may be troubling them too much* (Interviewee 35, Hong Kong-Chinese born male, Edgbaston, aged 58)

Perhaps more significantly, the internet was a source of information about health conditions for many. The ubiquity of the Internet meant that for some (especially younger respondents), 'googling' a problem was an instinctive initial or early step. It was used to check a diagnosis or the treatment being given for a condition, or to simply learn more about the kind of treatment that they might expect within the formal health system. Internet searching was not undertaken extensively in order to obtain a second opinion. But those who did use the Internet to check and assess professional medical advice could be interpreted as having relatively high 'cultural health capital' (Shim, 2010; see below for a further discussion). The most frequent use of the Internet as a health resource, however, related to a few interviewees who noted that they required help or support with chronic and/or long-term conditions. In this respect, Internet resources provided advice on pain relief in relation to everyday activities or exercises, as well as providing support forums for those experiencing illness:

*My wife searched on YouTube the word 'frozen shoulder', so there were pictures of different types of exercises recommended for frozen shoulder; so I followed those and I did daily exercises. This was after seeing my GP* (Interviewee 35, Hong Kong-Chinese born male, Edgbaston, aged 58)

and

*For medical professionals to not know what a brain aneurism is, is quite worrying. There are brain aneurysm forums from MIND [mental health charity]. [They] haven't actually got centres for you to go to but they've got ...I can't remember but it's like a forum....like a chat room really*(Interviewee 13, White/Pakistani British born female, Handsworth, aged 36)

With reference to variability in actions according to the characteristics of individuals, the nature of the maximum diversity sampling approach meant that this was often difficult to identify. However, four broad generalisations can be made.

First, there was some evidence that migration status informed the extent of trust in NHS provision. Those individuals from EU-15 countries (member countries of EU prior to accession in 2004) and indeed those from the EU-8 accession countries (which joined the EU in 2004) were less trusting of NHS provision than non-EU migrants and therefore utilised

other sets of resources to address their health concerns. This included transnational health seeking in terms of securing advice and medicines, as well as using the internet in an attempt to resolve a health problem:

*I will try to go to the doctor but usually the doctor is not really helpful here. They are saying 'research online'.... I once had a situation where the doctor was in front of me googling, and I thought 'all right.....I'll look on-line and elsewhere'* (Interviewee 7, Lithuanian born male, Edgbaston, aged 24).

Second, elderly participants were more deferential to formal advice provided by GPs or consultants and were less likely to use resources such as the Internet to either attempt an initial self-diagnosis or to corroborate or challenge a prescribed course of action by the GP. As stated by one interviewee: "*I trust my GP.....I've been with him since 1955/56*" (Interviewee 14, Black Caribbean born male, Handsworth, aged 79).

Third, those with lower socio-economic capital and / or cultural health capital were less likely to challenge the nature of provision or treatment that had been offered (or indeed had yet to be offered). There were several examples where individuals had waited for a substantial period of time to secure a referral from a GP to a specialist, or where their condition had deteriorated despite the treatment they had been receiving. As such, some did not have the confidence to make demands to their GP or challenge the nature of the treatment or provision that had been prescribed:

*I don't have other people to help me; so I book to see my GP, tell him my problems, and he gives me prescriptions and I get it from the pharmacy, very simple. So the first thing I do is to see GP. If he can help, he'll help; if I can't be helped, I leave it and I will gradually recover* (Interviewee 28, White British born male, Handsworth, aged 32).

Finally, those who were less conversant in English and who experienced language barriers that impinged on their ability to communicate were also more restricted in terms of the resources that they could access and the actions that they subsequently undertook to address their health concerns. In particular, those with very poor language skills often struggled to communicate their health problems to GPs or indeed were not aware of where or when they could access formal state provision. This also reflected the fact that they had lower levels of cultural health capital: "*Sometimes, when you are ill, you don't understand what it is; I'd say it's the language problem that is the biggest barrier*" (Interviewee 37, Chinese born female, Edgbaston, aged 29). In turn, this meant that they engaged in transnational health seeking to secure information on their condition, as well as to secure medicines (in some instances) as a result.

### *(iii) Why do individuals bricolage?*

A number of common features emerged in respect of why individuals engaged in bricolage activities. A key reason highlighted by a majority of interviewees related to a lack of confidence in the NHS, GPs or the formal medical system to both understand and address their health concerns. In particular, this related to migrants who applied different

'transactional' logics to the way in which – in their view – a healthcare system should operate, and often based upon their experiences in their home country:

*When you got to hospital [back in countries of origin] you are treated and you pay the money, you get the medication that you want and then you come back home* (Interviewee 30, Black African born female, Handsworth, aged 45)

Second, respondents identified that providers frequently struggled to provide culturally appropriate care for people who followed what in the UK might be considered as 'non-mainstream' lifestyles, or who had beliefs about health that involved the use of pharmaceutical medication as being a last resort. A number of interviewees – and particularly those born outside the UK - therefore identified that they used natural remedies for less serious conditions:

*If it looks serious then I am just going to the doctor and talking to the doctor. If it is not so serious I am firstly reading how to treat it with herbs or whatever, in a natural way* (Interviewee 7, Lithuanian born male, Edgbaston, aged 24).

Indeed, natural / alternative medicines were frequently identified as being an important resource to address 'low-lying' conditions such as colds or coughs, along with combining such resources with a change in lifestyle (for example, rest etc.). This was particularly evident in respect of Eastern European migrants, and who identified that they would not use a GP "*unless absolutely necessary.....I take lots of herbal tea with lemon and honey.....I collect my own in Poland - mint, nettle, lime...whenever I am ill I can have my own tea*" (Interviewee 26, Polish born female, Edgbaston, aged 23).

However, others explicitly stated their scepticism about the use of traditional medicine: "*I think I would stick to the mainstream treatments. I don't think there is much in homoeopathy...no, I don't think I would bother with them*" (Interviewee 21, Scottish born male, Handsworth, aged 71).

Third, bricolage was undertaken by interviewees in order to try and resolve chronic and long-standing medical conditions, and where pain, discomfort and suffering were prolonged: for example, if a health problem was on-going and involved managing a health condition, rather than the resolution of such a problem. This frequently involved individuals attempting to seek alternatives alongside more formally prescribed treatment, and which would provide pain-relief in everyday life:

*I was in so much pain I wanted to find an alternative to painkillers and medication... I did my aromatherapy [course] in 1999 and my Indian head massage in the same year... I was able to move, I felt more relaxed in my body. I had been so uncomfortable just sitting and standing for so long and it was just nice to be able to feel comfortable in my body. It really was....I have got to smoke my weed. The two go hand in hand, I believe it is pain relief. I feel relaxed. I think if I didn't have it I would be grumpy because I would be uncomfortable* (Interviewee 23, Black Caribbean born female, Handsworth, aged 45)

Fourth, some interviewees sought to access private provision in order to obtain a second-opinion and / or to seek a diagnosis where one had not yet been provided by formal health services (often they would then be referred back to the NHS for the resolution of the problem). This was often the case where there were long waiting times, and hence individuals highlighted how they may bricolage through using other treatments alongside formal provision. Through such activities, individuals also sought reassurance that existing treatments were valid and appropriate. However, cost was often a barrier and subsequently impinged on the ability to persevere with private provision. For example, one interviewee noted that the long wait for a physiotherapy appointment had led to them paying for two private practitioner appointments. Such a course of action was deemed to be expensive. As a result, the interviewee discontinued this approach and subsequently waited several more months before securing a physiotherapy appointment free-of-charge on the NHS. Nevertheless, they commented that they had found the private appointments useful in respect of the fact that they independently provided (and reinforced) the diagnosis she was subsequently provided through the NHS:

*I went with [the private physiotherapist] ..... I paid £60 for that session... it was a bit out of desperation that I went to two before my NHS appointment*  
(Interviewee 6, Chinese born female, Edgbaston, aged 33)

A number of other participants noted how they had made lifestyle changes (such as healthy eating, regular exercise or abstention from smoking). But such changes had often been recommended by their GPs or other formal providers, and were undertaken alongside their formal treatment.

Finally, individuals identified that they had undertaken practices of bricolage through using transnational networks to supplement formal NHS provision, and in order to secure medicine to address a health concern. Nevertheless, few interviewees identified that they had gone abroad specifically to seek treatment for ill-health, although two EU migrants asserted that they would do so if they had a serious condition as they trusted their 'home' health systems more than the British NHS. In one instance the motivator was pain-relief as they noted that they were unable to find a particular painkiller-cream in the UK. Another interviewee sourced medication from abroad, as it was restricted in the UK:

*Sometimes when the medication is not available in the UK - because in some research it is harmful or something like that - you can get it in Poland. So I ask my grandparents to buy it - its just over the counter medication.....Somebody from Poland brings it to my parents in Sweden and then my parents bring it over when they are here or when I go there I take it* (Interviewee 26, Polish born female, Edgbaston, aged 23).

and

*[Because] my fiancée is a doctor, he prepped me with a big bag of medication.....it is very difficult to get antibiotics here. (But elsewhere) we prescribe them like Mentos or Strepsils. In Jordan, its just like gum. So you can*

*buy them off the counter in Jordan, so I have a huge bag of antibiotics [laughs]*  
(Interviewee 27, Jordanian born female, Edgbaston, aged 29)

#### *(iv) Impediments to bricolage*

Individuals who had recently arrived in each of the neighbourhoods, who were from poorer socio-economic backgrounds and who had poor language skills were less likely, on average, to engage in various practices of bricolage. This was due to their lack of awareness and understanding of what services were available and where and when they could access such services, as well as their lack of financial resources. For example, one interviewee (who was originally from China and who had long-standing chronic conditions and associated pain) expressed a desire to try Chinese massage and acupuncture to ease their symptoms, but could not afford to do so:

*.....Of course I wish to. Chinese medicine, for example, I have back pain and leg pain; for these types of pains, Chinese massage and acupuncture treatments work particularly well. Yet because of financial constraints I cannot afford it at all in this country* (Interviewee 8, Chinese born female, Edgbaston, aged 64)

Compounding such issues – for some – were a lack of personal networks (for example, family and friends) that also impinged on the ability to combine different sets of resources to address their health needs:

*My friends can offer me nothing, but I need to be familiar with what is going on with me.....I have to go to the GP....[but] I'm not familiar with the Internet at all. So I can't use it and so I am not sure what services are available [to me]*  
(Interviewee 40, Sudanese born male, Handsworth, aged 19)

Moreover, the presence of a “digital divide” means the internet remains a socio-economically unevenly available resource, with the computer illiterate or those on low incomes often ‘locked out’, and this could be evidenced from the data gathered. A young asylum seeker interviewee described how he did not know how to use the Internet, despite owning a smartphone. In addition, several respondents explicitly stated that they avoided using the internet for supplementary health advice, as they believed that contradictory information and worst-case-scenarios would not help address any problem they had. Rather, it would simply increase their anxieties:

*Yes, I talk to people who have it (condition). I don't search about it on Internet because I don't want to be scared* (Interviewee 22, Bosnian born female, Handsworth, aged 46)

and

*No! I don't like to be my own doctor. Because the Internet sometimes exaggerates things. Because I think most of the symptoms are common with other diseases and illness so I'll think I have cancer or something and it is*

*probably a common flu... my sister is crazy about that stuff, I'm like, pfft you are blowing things way out of perspective* (Interviewee 27, Jordanian born female, Edgbaston, aged 29)

Crucially, it was evident that a lack of cultural health capital can prevent interviewees from advocating (and bricolaging) within and beyond formal the NHS system to meet their health needs. In contrast, it was evident that those with higher levels of cultural health capital actively demanded treatment and specialist referral:

*I was referred to the physiotherapist. He tested how high I could raise my arm, and how much I could turn my arm; he tested me very professionally. Then he concluded that I had frozen shoulder....But I had to go to my doctor again and again....he only referred me to the physio on the third time I saw him* (Interviewee 35, Hong Kong-Chinese born male, Edgbaston, aged 58)

and

*I consider that everybody has got a caseload that is perhaps too heavy... You have to push everything; my lad has autism and since he has been diagnosed with it you have to push for everything, everything. Everybody needs a little push....For me, they are not barriers because I am finding ways around. I can see that they are barriers but they are not barriers that are going to stop me achieving what I need to...so I find another way around the system really. The GP isn't a barrier because I can get to speak to him when he calls back...and I've asked him to go away and research, get back to me and give me the option for my occupational therapy, and to make a referral etc.....* (Interviewee 23, Black Caribbean born female, Handsworth, aged 45)

Nevertheless, the above narrative also demonstrates that those with cultural health capital can struggle to be treated how they would like – and treated effectively - if resources are restricted. Notwithstanding this, a lack of cultural health capital is a key feature in explaining why individuals may not engage in practices of bricolage within the NHS system. Indeed, a lack of confidence led to some acquiring a somewhat ‘fatalistic’ or naïve attitude, and placing a great deal of trust in the way in which the formal NHS system operated:

*If I get sick now, I cannot phone anybody else like my sister or parents to tell them I have this problem. I have to phone my GP to help. There are not many options, there is only one way. At the end of the day, only your GP can help you with your health problem* (Interviewee 33, Ghanaian born male, Handsworth, aged 44)

Notwithstanding such arguments, there may be instances in which even those with relatively high levels of education and cultural health capital take advice which is strongly contradicted by health professionals. An example of this related to an interviewee who refused to have root canal treatment, citing a notion that cancers were linked with root canals:

*I then did some research and found that 86% of people that have had a root canal treatment later developed cancer. And this is apparently something that*

*has been known for quite some time but the dental profession likes to cover this over because where they make the most money in the dental profession is in root canal treatment. Okay, after learning this news I thought I don't want root canal treatment....what are my options? And my only options were to have the tooth removed which was really sad because it is right at the front of my mouth.....but I had it removed* (Interviewee 36, British Jamaican born female, Edgbaston, aged 37)

(v) *Levels of satisfaction in the context of bricolage*

In relation to the degree to which individuals expressed satisfaction with their treatment, this varied considerably. Across the sample, there were no discernible patterns between socio-demographic characteristics and levels of satisfaction or dissatisfaction with their treatment. However, there were two main exceptions: those who were born in the UK were slightly less satisfied with their treatment, whilst those who were older were more inclined to be satisfied. The satisfaction of the latter group was on the basis that such individuals had secured a formal diagnosis of their health problem and had then managed their condition through the use of herbal and alternative medicines.

The degree to which bricolage featured in discussions was sporadic and in the majority of instances individuals focused on specific instances relating to diagnosis or particular forms of treatment that did not always require the enactment of a (wide) range of resources. Two trends were also apparent in this respect. First, where individuals presented with a serious illness or concern, satisfaction was discussed in relation to the provision of NHS services. Second, where issues were chronic or more long-standing, satisfaction was dependent on individuals' perceptions of the extent to which informal / alternative provision had helped to manage a particular condition. In this respect, some were less satisfied on the basis that health care professionals had prescribed treatment that conflicted with their health beliefs, use of alternative medicines and/or their diet:

*Why aren't GPs educated in these different diets? Most vegans that I know do not go to the doctor.....if they give me ibuprofen or cough medicine it will normally have gelatin or lactose in it. So I cannot take it. And they will not give you an alternative* (Interviewee 14, Black Caribbean born male, Handsworth, aged 79)

Problems of diagnosis, misdiagnosis and indeed continuing misdiagnosis had also been experienced by a number of respondents over an extended period of time, and heightened levels of dissatisfaction: "*I was in and out of hospitals (for four years), three different hospitals and each of them said there was nothing wrong with me*" (Interviewee 11, British Pakistani born male, Handsworth, aged 23). In addition, the time that individuals had to wait for a referral to a specialist or in respect of seeing a doctor if their condition was urgent was also highlighted: "*It is the wait. I think that the GP made the referral the day that I went to see him but the waiting list is eight-months long*" (Interviewee 23, Black Caribbean born

female, Handsworth, aged 45). Problems were also noted of sourcing diagnosed medicines that had been prescribed:

*So they wrote a prescription and then off I went on this incredible journey to try and find this drug because they said that they would have to order it.....finally I went to Boots (pharmacy) in Harborne and they said it was going to take a week and so I went back a week later of it. So this was like multiple trips, a whole saga* (Interviewee 31, Hungarian / American born female, Edgbaston, aged 63)

Finally, the inability to address issues concerned with mental health was a source of dissatisfaction for a substantial number of respondents. Whilst more informal provision was often combined with (limited) formal resources in an attempt to address mental health problems, in the main such services were seen to be deficient in respect of responding effectively to resolving individuals' mental health problems:

*I think I should have had some sort of counselling or therapy because I had nothing and it hit me like a ton of bricks and even now they say there's no one. They say go to your GP, my GP is a great GP but he's not the best counsellor, so it's not always possible* (Interviewee 12, Pakistani/ Chinese born male, Handsworth, aged 76)

For those who were more satisfied, in general this related to those individuals who had engaged in fewer aspects / practices of bricolage and who had presented themselves with more serious health conditions. For example, those that had been rushed to hospital with a suspected heart attack or who had fractured a bone were very pleased with the outcome of their treatment and the fact that their condition had either been resolved or that they could cope with any on-going conditions that had arisen as a result:

*The doctors saw me - it's a fracture - and they said, 'sorry, we are going to have to operate' and they put two metal plates, one on either side..... they kept me in for just over a week....and they gave what is called a 'Beckham boot' and a pair of crutches.....It was amazing, yeah, brilliant* (Interviewee 5, Indian born male, Handsworth, aged 46)

Beyond these individuals, it was also apparent that those who had been diagnosed in respect of an on-going condition were also reasonably satisfied with the treatment and support that they were receiving: "*(I have been taking) regular medication for about 30 years....they reckoned taking that tablet leads to swelling of the feet, so they changed it*" (Interviewee 4, Black Caribbean Jamaican female migrant, Handsworth, aged 81).

### Typologies of Bricolage

Generalising different types of bricolage is difficult given the spectrum of actions and resources that individuals used. However, from a detailed analysis of interviewee material, the importance of formal NHS provision frequently emerged in the UK, although the importance of alternative treatment and the blending of formal and informal resources were also apparent. Furthermore, it is possible to identify that over and above eligibility to state provision, bricolage was regulated by cultural health capital, including (i) the passivity or assertiveness of individuals as health service users; (ii) their knowledge and ability to communicate effectively with providers; (iii) their socio-economic capital; (iv) their health-related social networks and (v) their beliefs or levels of trust in health systems. Such relationships are detailed further in Figure 1.

Consequently, the following typology reflects the ways in which individuals in the UK case study area have engaged in activities of bricolage relative to their engagement with formal state resources, and with the typology incorporating differential levels of cultural health capital:

#### *A. Receptive Recipients*

Groups / individuals who are eligible to access formal state services but who are heavily - if not solely reliant - on formal state provision to address both serious and less serious health concerns and who undertake relatively little bricolage as a result. Such individuals are passive or 'receptive' recipients of state services and often wait a considerable period of time to secure a diagnosis, referral or appropriate treatment. They may also be less confident in pressing for solutions from the GP, and may again trust the nature of advice and provision received without question. Older respondents generally appeared to fit into this category.

#### *B. Active Formal Users*

Individuals who are eligible to access formal state services and who are generally reliant on formal state provision to address both serious and less serious health conditions. However, they are pro-active users who bricolage multiple sources of information, advice and treatment – and have the knowledge and communication skills to negotiate the formal system according to their needs. Generally, they have high levels of trust in state services but also have knowledge of both their conditions and the system to advocate for what they believe would be the best course of action. As such they tend to have medium-high levels of social capital, even if they may not have the economic resources to afford private healthcare insurance.

#### *C. Supplementers*

Groups / individuals who supplement state provision with alternative non-state resources to address a range of health concerns – and they supplement healthcare to different degrees. In many instances such influences include: i) seeking reassurance to formal diagnosis; ii) supplementing formal treatment; iii) securing additional social support for accessing state care / to recover following state care; iv) supplementing state care with other forms of pain-

relief, especially in relation to chronic conditions; and v) seeking non-state alternative therapies or medicines in desperation.

These individuals are eligible to access formal state provision: they tend to be active rather than passive users and have varying levels of trust in formal and non-formal provision. They have medium to high socio-economic capital and reasonable knowledge of state systems of provision; they are also able to communicate reasonably effectively with a range of providers and they have a flexible approach.

#### *D. Predominant Privateers*

These individuals have sufficient socio-economic resources and cultural health capital to directly access alternative (private) pathways of provision to address serious and less serious health conditions. Such individuals may use private services to address their health concerns entirely - from diagnosis to treatment and recovery; or to supplement other state and non-state provision - for example: i) to expedite access to state provision; ii) to confirm diagnosis; iii) to secure alternative diagnosis; and iv) to recover following private treatment. They are often less trusting of the quality of state provision in comparison to private provision.

#### *E. Excluded*

Those who lack eligibility to access formal provision or who may have a severe lack of knowledge of eligibility with regards to NHS provision. This group also has poor communication skills and an inability to advocate for resources to address their health concerns. By virtue of their exclusion from health services, they are also likely to have fewer social networks for support, advice and guidance, and low levels of financial capital to help them in finding alternative care.

	<b>TYPE Receptive Recipients</b> <b>A</b>	<b>TYPE Active Formal Users</b> <b>B</b>	<b>TYPE C Supplementers</b>	<b>TYPE D Predominant Privateers</b>	<b>TYPE E Excluded</b>
<b>i. Eligibility</b>	Eligible to formal NHS provision	Eligible to formal NHS provision	Eligible to formal NHS provision	Eligible to formal NHS provision	Ineligible to formal NHS provision or unaware of eligibility
<b>ii. Levels of advocacy (Active/Passive User)</b>	Low levels of advocacy: passive consumers of state-care who do not feel the need or have the ability to press for provision or referrals to specialists	High levels of advocacy; individuals are active in identifying multiple forms of provision at all stages of treating a health condition	Variable levels of advocacy	Reduced need to advocate within the state system due to ability to pay for private insurance	No right to advocacy
<b>iii. Knowledge and Communication</b>	Less able to understand NHS pathways to care and / or mechanisms to maximise care quality	Able to communicate effectively with professionals and understand language and discourse	Variable levels of knowledge and communication.	Likely to have high levels of knowledge and communication skills.	Little knowledge of NHS pathways to care and poor ability to communicate in English
<b>iv. Socio-Economic Capital</b>	Generally low levels of socio-economic capital	Generally medium-high levels of socio-economic capital	Medium-high levels of economic resources	High levels of economic capital	Low levels of socio-economic capital.
<b>v. Social and Support Networks</b>	Less likely to have networks providing ad-hoc guidance and advice	More likely to have support networks to provide ad-hoc guidance and advice	More likely to have support networks to provide ad-hoc guidance and advice	Variable social support networks	Less likely to have supportive social networks
<b>vi. Beliefs and Trust</b>	Medium-high level of trust in the formal system, including GPs / consultants and NHS provision	Medium-high level of trust in the formal system, including GPs / consultants and NHS provision	More likely to trust alternative sources of healthcare	More likely to trust quality or speed of the private healthcare system over the NHS	Variable beliefs and trust in the formal system

## **Conclusion**

Analysis of interview material from the two case study neighbourhoods in the UK reveals two broad triggers for action in the context of a health concern – the sudden onset of a problem which required immediate treatment and conditions which emerged more gradually over time, and where a ‘wait and see’ approach became less viable as symptoms intensified. Each trigger resulted in the use of two primary routes to treatment: the General Practitioner (GP) and Accident and Emergency (A&E) departments within hospitals. The latter was particularly important for those presenting with a serious and immediate health problem, and where subsequent opportunities for bricolage were limited – at least until the recovery phase. For those with a less acute problem, the GP was invariably the first point of call in order to try and diagnose / resolve a health problem; where this was not possible most individuals were referred to more specialist provision.

Key reasons for bricolage which were cited included i) a lack of trust in formal (NHS) provision, ii) as a response to a lack of availability of culturally appropriate health care, iii) to manage long-standing (chronic) health problems, iv) to obtain a second opinion / diagnosis and v) to supplement formal provision (often through transnational networks). However, supplementary actions and activities – such as consulting family / friends, the use of the Internet etc. - were generally a second set of resources that individuals ‘bricolaged’ with those available from the GP or hospital. Moreover, whilst it was not unusual for individuals with high levels of cultural health capital to combine three or four different types of resources to address their health concerns, the importance of the GP or hospital remained predominant, and especially if individuals perceived that they had a serious health concern.

The research also highlighted that there were also a number of impediments to bricolage. It was clear that for some interviewees, a lack of cultural health capital (and often combined with a lack of socio-economic capital) meant that they were less likely – rather than more likely - to engage in bricolage practices. Furthermore, those whose legal status restricted access to welfare had relatively few options available to them. As a result, they either had to cope (as best as possible) with their medical condition, or rely on any developing / emerging relationships with other individuals to help secure informal support in order to address their health problems.

The typology of bricolage set out at the end of the report identified the importance of agency and advocacy, knowledge and resources – both formal and informal – capital and eligibility, as well as beliefs and trust in shaping different types of bricolage. Whilst five broad types of bricolage are identified, there is scope for further development of the typology, and particularly in relation to the ways in which individuals may bricolage ‘within’, ‘alongside’ and ‘outside’ the formal health system in the UK (and beyond). Such a focus is developed through bringing together the results from the UK with those from other partner countries (Germany, Sweden and Portugal) and is reported elsewhere.

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