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**Logics of Welfare Bricolage among UK  
Service Providers**

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## **Abstract**

This working paper focuses on the challenges faced by health care providers in delivering services in two superdiverse neighbourhoods (Handsworth and Edgbaston) in Birmingham, UK. The paper explores the nature of the local population / clients living in such areas and the types of health problems that providers seek to address. The degree to which neighbourhood superdiversity has shaped the nature of provision is explored, as well as challenges to service delivery such as language, culture and traditions, transience and transnational health seeking. Through drawing on the concept of 'bricolage', the paper subsequently highlights the strategies that providers have developed to overcome service delivery challenges in rapidly changing and highly complex superdiverse environments.

## **Keywords**

Superdiverse neighbourhoods, service delivery challenges, welfare bricolage

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## Context

This working paper is based upon analysis of in-depth interviews conducted with 24 providers offering different types of health services in the super-diverse neighbourhoods of Handsworth and Edgbaston, Birmingham, UK. The primary purpose of the working paper is to i) develop a profile of the local population / clients living in such areas, the types of typical health problems that exist and the degree to which services offered meet local need; ii) critically evaluate the challenges of delivering services in superdiverse areas; iii) explore the approaches to service delivery adopted by providers; and iv) assess the implications for strategies of 'bricolage'.

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*. From a service delivery perspective, the concept of bricolage draws attention to the ways in which service providers may creatively mobilise, utilise and / or re-use different resources – including knowledge and ideas, networks and materials to respond to different health concerns (Phillimore et al. 2017). Bricolage is particularly useful to consider when focusing on superdiverse neighbourhoods as by definition they may be complex, transitional and transnational, and are often 'resource-poor' environments. Consequently, such neighbourhoods may present particular challenges to service providers in terms of the targeting and tailoring of their services, and the ability to respond to evolving needs.

Furthermore, whilst the concept of bricolage has been used widely, it has yet to be applied in relation to studying access to healthcare in superdiverse areas. It is also possible to distinguish between bricolage as a process of mobilizing resources and overcoming constraints and the role of the bricoleur as a resourceful mediator between different kinds of resources (Halme et al., 2012). Both are of relevance in relation to this paper. Bricolage involves creativity and innovation: discovering under-utilized, hidden or merely 'at-hand' resources, and combining or re-combining them to meet particular challenges.

More broadly, the neo-liberal emphasis on competition and choice in the UK (and beyond), the wider context of public sector austerity, and a renewed emphasis on citizen empowerment also shapes the context for bricolage. Restrictions of access and entitlement to particular services according to legal status also inform strategies of bricolage for service providers and local residents – migrant and non-migrant - alike.

## 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 NHS is 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, 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 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, 2011). 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 (Esping-Andersen 1990, 1999), Leibfried (1993), 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 can 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. (Mladvosky 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 illustrated how liberal regimes such as the UK show low rates of de-commodification in the labour market (indicating lower levels of wealth redistribution) and higher rates of de-commodification 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. 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 undocumented migrants whose right to free care is in doubt. This draws attention to the UK's immigration regime, how it 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). 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.*).

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 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 recent government approaches in the UK, there have been repeated commitments to reduce net migration to the “tens of thousands” to the UK. In 2016 the EU referendum – and the renegotiation of the UK's position with the EU – was at least 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, with the UK agreeing to accept 20,000 additional Syrian refugees by 2020 (*ibid.*, p.18).

Changing demographics presents challenges for policy makers, researchers, and health and social care providers to provide high quality, accessible health and preventive services. Existing multicultural models of service provision have been challenged in the context of the increasing migration-driven superdiversity of populations (Phillimore 2010, Phillimore et al 2015). The scientific and policy challenges emerging from the complexity associated with delivering welfare in an era of superdiversity have been noted (Vickers et al. 2012; Ahmed and Craig 2003; Law 2009; Vertovec 2007) as providers struggle to communicate with, understand and meet the needs of service-users. After decades of failing to address inequality effecting minority populations and deprived areas, the emergence of superdiversity and associated fragmentation and transience of new migrant populations have compounded problems faced by providers who lack the knowledge to collaboratively design and deliver services that promote equal outcomes (Vickers et al., 2012). Declining resources associated with austerity, combined with the backlash against multiculturalism (Grillo 2010) means that it is politically, financially and practically impossible to offer tailored welfare services for everyone in superdiverse areas.

With the increasing number (and different types) of immigrants, relatively little attention to date has focused on the key challenges facing the providers of health services in delivering services in 'superdiverse' neighbourhoods (Vertovec, 2007) – both for migrants and non-migrants. Consequently, this report identifies the different challenges and constraints that providers encounter in maintaining the health of their service users and the ways in which they address such challenges in superdiverse areas. Understanding the role of providers in meeting needs in complex environments



will help to shape future services, and provide new knowledge about how welfare can be reconstructed. It will also support the development of new networks and partnerships that can collaborate to meet need at a local and national level.

In addition, through utilising the concept of welfare bricolage, it is possible to explore how service providers may creatively mobilise, utilise and / or re-use different resources – including knowledge and ideas, networks and materials to respond to different health concerns (Phillimore et al. 2017). This is important as from a client / resident perspective bricolage has been 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*” (ibid). Hence there is a need to consider the superdiverse neighbourhood context within which clients / local residents may engage in different practices of bricolage. But crucially - and in respect of the focus of this paper – it is also imperative to investigate how providers engage in practices of bricolage with local residents and / or other providers to tailor and target their services appropriately, and in order to address particular health concerns in superdiverse areas.

Indeed, the concept of bricolage has been used widely but has yet to be applied in relation to access to healthcare in superdiverse areas. Introduced to the social sciences by Lévi-Strauss, developed by Derrida and widely adopted, bricolage is an analogy referring to the pragmatic deployment and redeployment of materials and ideas, re-patterning daily life beyond structural or systemic intention or ideology. In the context of i) changing political and policy contexts of health provision – and the neo-liberal emphasis on competition and choice; ii) a renewed emphasis on localism and community-self-help; iii) on-going public sector austerity (in the UK and beyond); and iv) questions over access and entitlement to health services according to migration / legal status, bricolage is of increasing relevance to health providers and the nature of their responses.

In summary, bricolage has a strong resonance with superdiverse neighbourhoods as by definition they may be complex, transitional and transnational, and are often ‘resource-poor’ environments. As a result, such neighbourhoods may present particular challenges to service providers. In the sections that follow, the types of health problems that exist in superdiverse areas and some of the key challenges of service delivery are discussed. The degree to which providers change the way that they deliver services, or re-use, re-order or re-mix their services (with others) to overcome knowledge, network or resource constraints is also considered, as are attempts to innovate and improve the delivery of existing services.

## **Methods**

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 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 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.

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

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 and has more than doubled in size since 1991, growing from a population of 66,110 to 144,627 (119% increase). There has also 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 born in China, Nigeria, Zimbabwe and Iran three 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%) 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 Eastern Europeans include smoking, poor diet, heart disease and mental health issues resulting from social isolation (Birmingham City Council, 2010).

Individuals from non-EU communities also have particular health issues. 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).

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<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.

Two superdiverse neighbourhoods in Birmingham were selected to investigate the roles service providers adopt, and challenges and opportunities they face: 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. 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 accommodates residents from 170 different countries (Phillimore, 2013).

Edgbaston, on the other hand, is more recently diversifying, and where new migrants outnumber old residents. 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).

With reference to the sampling frame for health providers and the selection of interviewees, this was primarily informed through a sequential research methodology adopted for the overall research project. First, an earlier research phase involved a comprehensive street mapping exercise of both neighbourhoods, and which led to the development of a virtual database of health provision. This was broadly differentiated according to sectors / types of provision available in Handsworth and Edgbaston. Second, 40 in-depth interviews in total (20 per neighbourhood) were conducted with residents living in each area. Analysis of this material highlighted the types of provision that residents were accessing from within and beyond the neighbourhood, as well as the perceived importance of such provision.

A combination of the street mapping database plus resident responses led to the targeting of particular types of service providers. Given the centrality of the NHS in the UK, a particular emphasis was placed on securing interviews with other types of providers either supplementing or offering an alternative to formal NHS provision (see Table 1 below). Nevertheless, a number of interviews were also conducted with formal health care providers (such as GPs and nurses) as well as an individual involved in the development of health policy / allocation of healthcare resources at the city level (Clinical Commissioning Group (CCG) lead). In total, 23 service providers were interviewed; 14 were from Handsworth, nine were from Edgbaston and with one interview being more ‘strategic’ (the CCG lead), and whose remit encapsulated both neighbourhoods.

Semi-structured in-depth interviews were conducted with individuals to initially capture more information about the role and remit of their organisation; their client base; the types of individuals using their services and the types of health problems that they addressed. Subsequently, the challenge of providing services in superdiverse neighbourhoods was discussed, as well as issues such

as organisational and structural challenges. The ways in which providers had sought to overcome particular problems of service provision were also focused upon, including new / different ways of working and the nature of collaboration with others.

All of the interviews took place between August 2016 and February 2017. Written consent was gathered from participants to utilise anonymised extracts from transcribed interviews. Interviews were digitally recorded with the participants' permission. All recorded interviews were transcribed verbatim. Transcribed interviews were coded and analysed using MAXQDA qualitative data analysis software.

**Table 1: Categorisation of the UK providers**

<b>Category</b>	<b>Provider title</b>
General/ specialist health provision	General Practitioner
	Midwife
	Pharmacist x2
	Podiatrist
	Orthodontist / Dentist
Alternative/‘complimentary’ provision	Acupuncturist
	Ayurvedic practitioner
	Yoga Centre manager
Faith provision (all impact on health and wellbeing)	Church minister
	Buddhist monk
	Manager of a faith-based community centre
	Director of faith organisation neighbourhood scheme
Mental health provision	University counsellor
	Mental Health Support Officer x2
Community provision (all impact on health and wellbeing)	Leisure Centre supervisor
	Community Interest Company Manager
	Exercise class community organiser
	Project worker at drug and alcohol organisation
Migrant/refugee/asylum provision (with focus on health and wellbeing)	Asylum Centre Health Co-ordinator
	Refugee Health and Asylum Seeker Officer
	Manager of refugee lunch club
Strategic policy-maker/ commissioner	Clinical Commissioning Group lead

## Analysis and discussion

### *Neighbourhood context*

Regardless of the type of service provider, all of those who were interviewed highlighted how they served an increasingly diverse population according to characteristics such as age, gender, ethnicity, migration status, religion, education and employment status. Many argued that the city – and the respective neighbourhoods of Handsworth and Edgbaston had become increasingly ‘superdiverse’ over the last ten to fifteen years, and particularly since EU enlargement in 2004. Individuals from all over the world were now identified as residing in both neighbourhoods:

“It is probably the most diverse that you could possibly have.....you have like Pakistani or Bangladeshi.....a mixture of Afro Caribbean.....it is across the board, so diverse. Because it’s near the centre of town, I see a lot of Eastern Europeans.....so Vietnamese, Filipino, Chinese, lots of Chinese postgraduate students, African, different parts, different countries in Africa. Quite a lot of Saudi Arabians, yeah.” (Interview 15, Midwife, Handsworth)

and

“I would say it is a very diverse population; you have got more Eastern Europeans now compared to the Asians that were here before and the Black community. So it is getting heavily Eastern European.” (Interview 9, Community Pharmacist, Handsworth).

Thus the arrival of people from Eastern Europe and Asia were commonly referred to, although those involved in the provision of services in the Edgbaston area also noted that there had been a substantial increase in the number of international students living in the neighbourhood, and who were attending the nearby University. Interestingly, providers also noted the ‘layering’ taking place within Handsworth and Edgbaston – in essence there was a continual churn of individuals moving in and out of each neighbourhood, along with those who had remained. This meant that they had to respond to both ‘old’ (existing) needs, as well as ‘new’ needs associated with those who had moved more recently into the area. Differences in the way that individuals accessed services were commonly discussed – and with legal status and ‘newness’ appearing to be of importance in shaping different strategies to accessing services:

“Yeah, of course, there will always be changes.....so people will have grown older, people will have had an uptake of training, qualifications, career progression.....what that means then is the understanding, the awareness and the way they perceive things changes. So communities are always growing, transforming.” (Interview 12, Refugee and Asylum Seeker Health Officer, Handsworth)

and

“Since 1998 we now have more Eastern European people.....ten years ago we had a load of Somalian refugees. So there was a time when we didn’t have any Somalian refugees and now we do.....they access healthcare in a different way to our Polish population. We have had more Polish people .....and they access healthcare in a different way.” (Interview 7, CCG lead, Handsworth/Edgbaston)

Indeed, as individuals’ legal status may change over time, providers serving refugee and asylum seekers noted how this may subsequently impact upon their standards of living; their ability to

remain healthy and the need for the way in which they provide their services to evolve. ‘Evolution’ rather than ‘revolution’ was a key point that was made in respect of the delivery of services:

“I’ve been working here seven years. Recently I would say there are a lot more Albanians, Albanian women, Eritreans – hopefully, as they get their papers, their lives improve.....they might now have children, they might now have their papers, you know, we’ve aged together.” (Interview 22, Manager of a refugee lunch club, Handsworth).

Providers also pointed out that the changing population profile of each neighbourhood meant that they had now expanded their services to encapsulate wider aspects of diversity, such as age or gender. For example, some services which used to be limited to a certain gender or age group had now been widened:

“The younger guys aren't coming in so much, and so now (we’ve expanded) and we're seeing more of the older people....(also) our female usage has gone from sort of 25% to 49% in the last sort of – I think it's six months.” (Interview 19, Leisure Centre supervisor, Handsworth)

But as many individuals moved between different neighbourhoods (and indeed beyond the city), they often lost their links with existing providers. This was a major challenge to service providers and indeed may impact on patients’ health as individuals may miss appointments when they change their address. The problem was particularly obvious among those seeking asylum.

However, on the other hand, there was some evidence that a number of individuals – despite moving away from Handsworth and Edgbaston - returned to the neighbourhood to access services on the basis of trust in existing provision and / or because they lacked knowledge of where else to go to find alternative provision. One example of this was cited by a dentist who identified that some of their patients travelled 40-50 miles to their practice for dental surgery

#### *Client profile, health problems and services offered*

The profile of service users varied according to the type of service provided. Interestingly, demands on services – and especially ‘alternative’ / ‘complimentary’ provision - emanated from beyond the superdiverse neighbourhoods of Handsworth and Edgbaston. Many providers noted how they served international clients who had travelled for support from different parts of the world, as well as from other parts of the UK. This highlights the porosity of neighbourhood boundaries and the need for a relational – as well as territorial – view of place. In turn, it also means that the nature of services provided may evolve as a result of ‘beyond the neighbourhood’ influences, as well as from within the neighbourhood. As such, increasing superdiversity elsewhere can impact on the nature of service provision at a more local level, and the competing demands placed on providers to serve those living in the neighbourhood as well as beyond.

As people are becoming more confident in using the internet, technology-supported consultation is being increasingly considered as a solution to the growing challenge of providing healthcare to increasingly diverse populations (Greenhalgh et al., 2016). This was evident amongst some of the providers who were interviewed in Handsworth and Edgbaston, and who had started to offer remote consultations rather than traditional face-to-face appointments:

“A lot of international clients.....people travel to us from Spain. We (also) have a lot of Skype consultations. People travel to our clinic from all over the country. You’ll be surprised; people

access our services from Dundee,; London is very common too. People travel from Bristol, London, Leeds, Coventry, Derby etc.” (Interview 8, Ayurvedic practitioner, Edgbaston).

However, due to the specific nature of service provision, in some instances this inevitably meant that providers served certain groups of users (such as women, young adults etc) while other providers served a more diverse population. This is interesting. Whilst areas such as Handsworth and Edgbaston had become increasingly superdiverse, in reality what this meant were contrasts emerging in respect of the need to address specific sets of issues concerned with particular populations, whilst at the same time acknowledging that there were needs of relevance to an increasingly superdiverse population as a whole.

“We’ve got the young peoples’ drug and alcohol contract of Birmingham....I don’t know much about their clients and diversity really. Yeah, I mean I’ve noticed that my other colleagues’ caseloads are much more White, whereas, yeah I just tend to have a bit more diversity. I’m not sure how it’s split between male and female, I’d say yeah slightly more male clients than female.” (Interview 24, Project worker at drug and alcohol organisation, Handsworth)

In addition, the existing literature suggests that young women are the most frequent users of alternative medicine (Kristoffersen et al 2013). This was evident in our sample as some alternative health services were more popular among women than men. Such providers were therefore reluctant to recruit males given that their clients preferred ‘women-only’ services:

“So mainly women....in a class of about 40 people there would be no more than six or seven men, physical class. And we haven’t done that much to promote men, mainly because I wanted to provide a safe, welcoming space for women when we started out.” (Interview 14, Yoga Centre manager, Edgbaston)

Nevertheless, providers highlighted how certain groups of service users were unable to access the services that they provided due to problems of accessibility – and more specifically accessibility infrastructures of particular buildings from which services were being provided: *“We’re not situated to do very much for disabled people....we’re at the top of a staircase.....there is no access for anybody that’s in a wheelchair to get upstairs”* (Interview 19, Leisure Centre supervisor, Handsworth). Other barriers to accessing services were noted as cultural and religious. For example, some providers noted how women belonging to certain ethnic minority groups did not leave their home very often due to cultural norms and / or family commitments. Indeed, a number of community-based providers highlighted how they struggled to engage with Muslim women in Handsworth, and that they were having to re-think their outreach strategies as a result:

“Muslim women are going to be the hardest to hit (through cuts to services and the ability to engage) really because they tend to be at home and they don’t come out.” (Interview 19, Leisure Centre supervisor, Handsworth).

There is great linguistic diversity in the two neighbourhood areas and language was cited as another common barrier to individuals accessing services. The increasing proliferation of different languages being spoken in superdiverse neighbourhoods meant that service providers were often struggling to ‘keep up’ with the emergence of new languages, and ensuring that they were able to communicate with new arrivals. This barrier was particularly evident for providers offering services to asylum seekers and refugees, and where translation facilities were limited:



“I think, if there are people with language needs for example, that cannot speak English, we are not going to help and support them because our practitioners, our volunteers don’t speak as many languages; they (only) speak English or a few of the other languages....maybe French and a few African languages.” (Interview 12, Refugee and Asylum Seeker Health Officer, Handsworth).

Thus a number of providers emphasised that those who were unable to speak English did not get the optimal care they required and were more susceptible to racism and prejudice (also see following section). Providers suggested that techniques to improve communication and build trust with such patients could involve the use of eye contact, using simple supportive words, and the use of self-explanatory illustrations.

Various types of health problems were noted by different providers. For example, a GP interviewee identified that they had dealt with a variety of health problems ranging from a common cold, varicose veins, sebaceous cysts, different types of cancers and mental health problems. Those individuals dealing with asylum seekers highlighted common problems of sexual trafficking, domestic violence and communicable diseases such as TB, as well as dental and mental health problems (such as anxiety, stress and depression). A University Counsellor also argued that they were more likely to see individuals who were presenting with mental health problems related to stress, such as those with eating disorders as well as individuals with suicidal tendencies.

Providers offering specialist services – for example, the podiatrist – observed more specific health problems such as corns and verrucae, Athlete’s foot, in-growing toenails and sport injuries. Problems related to immunisation were also identified by providers offering services to immigrants:

“We’ve got a problem, like immunisations, because not everyone’s immunisation schedule is up to date. And you find you keep getting a lot of outbreaks of different illnesses which are preventable. And we know why. It’s because of (a lot of) migration, because some people, they don’t get proper immunisation. So that’s a preventable disease. So we’ve gone through all those things with the families to make sure that the children are up to date with their immunisation.” (Interview 1, Asylum Centre Health Co-ordinator, Edgbaston).

Other services provided included mental health services, treatment for alcohol and drug addiction and children’s assessment services - and which were particularly aimed towards families recently arriving in the UK. Services were also being directed towards more complicated issues such as infertility and Irritable Bowel Syndrome (IBS), Crohn’s disease and Colitis. Some providers also supported local running groups and dance and fitness classes. The ambition of many faith providers was to promote a healthy lifestyle in order to prevent symptoms emerging at a later date. Indeed, they also offered services to those who were unemployed to help such individuals to look for jobs and to maintain / improve their health:

“We did try to organise a health and happiness class, to improve participants’ wellbeing...so we did have a small group of women meeting and exercising, keeping fit and active....so they would go for walks, they would do exercise and they would then discuss nutrition and diet, healthy eating and how to lead a more healthy lifestyle....,the group was really good, they bonded really well, it was a good atmosphere.....and they were discussing how a certain recipe can be prepared so that it’s more healthy.” (Interview 17, Manager of a faith based community centre, Handsworth)

*Challenges of provision in the context of superdiverse neighbourhoods – language, culture and transiency*

In the superdiverse neighbourhoods of Handsworth and Edgbaston, providers argued that there were an increasing number of users whose first language was not English and that women and first generation immigrants had particular problems in speaking English. More than half of all of those who were interviewed explicitly noted how language was a major challenge to individuals accessing their services and that in some instances individuals were discriminated against as a result. Problems were also noted in respect of booking an interpreter and ensuring continuity of service through using the same interpreter over time:

“(Many) people don’t speak English very well, especially from the first generation Sikhs, (so) that’s the point of having bilingual workers.” (Interview 23, Community Interest Company Manager, Handsworth)

and

“I think if you don’t speak English you suffer all sorts of kind of like indirect racism and prejudice and that affects the care that you have. You see it on the wards. I remember when I was a student, seeing it with, you know, midwifery assistants.....(they) just didn’t treat people the same, you know .” (Interview 15, Midwife, Handsworth).

Cultural beliefs about illness and appropriate forms of treatment can also be a barrier to accessing health care provision. Service providers suggested that many clients lacked familiarity with Western diagnostic techniques and treatments and thus were apprehensive about accessing their services. Indeed, the existing literature suggests that health care providers' ignorance of non-Western cultures can interfere with communication with patients, and result in culturally irrelevant services or the misinterpretation of the side effects of medicines (for example, see Uba, 1992):

*“You see certain cultures who maybe would not prioritise their antenatal care as much, possibly because culturally it’s not such a norm. So like Saudi Arabians.....when they realise they’re not coming for a scan, they don’t see the point in coming for a check.”* (Interview 15, Midwife, Handsworth)

In addition, providers argued that there was a stigma associated with accessing particular services among certain groups. For example, those involved with delivering services focused on addressing alcohol misuse stated that Punjabi women were less likely to engage, and therefore problems often remained hidden:

“It remains hidden because people just don’t want to talk about it. (It is) even more of a social taboo because women aren’t expected to drink and it’s quite a patriarchal society.” (Interview 23, Community Interest Company Manager, Handsworth)

Stigma associated with accessing mental health services was also noted by providers, whilst a number of others commented that they had to address misconceptions that their services only targeted particular groups such as the White population or Christians.

In relation to the issue of trust, there was a mixed range of responses: some felt that their users utterly trusted the services they provided whilst others felt that this was an area that they needed to improve. Meeting clients’ expectations was perceived as a major determinant of gaining trust. Most

providers commented that White patients were more likely to trust their service than other ethnic groups. However, nearly all of the providers agreed that the longer they served their users, the more they were trusted.

On a related point, different perceptions of the British healthcare system amongst certain immigrant communities was highlighted as a key challenge in terms of the access and utilisation of health care services (also see NICE, 2012). According to those interviewed, many migrants simply did not know how to access different types of provision offered through the NHS, whilst others did not trust their GP to provide an accurate diagnosis of their health problem and wanted to be referred to a specialist:

“There is a definite perception by other European nationals that they must see a specialist. And the GP’s role they sometimes see as really just a referral, a person sitting there to refer you.” (Interview 2, GP, Handsworth)

and

“There are a huge number of immigrants who may have health issues but do not know how to access healthcare and I’m sure that there’s a huge demographic who are, perhaps recent arrivals or perhaps who are here illegally - asylum seekers - who probably feel disenfranchised.” (Interview 6, Pharmacist, Handsworth).

Users’ expectations also represented a challenge for those providing NHS services, and with such expectations varying considerably and impacting upon the degree to which individuals were satisfied with service provision: *“depending upon which part of Africa they’re coming from, they’ll have different expectations and different healthcare systems in their own country”* (Interview 6, Pharmacist, Handsworth). Furthermore, it was identified that a number of more affluent migrants had accessed private health care in the UK (and elsewhere) and therefore expected similar types of treatment through the NHS. This inevitably led to frustration and disappointment where appointments to see a GP or referral to specialists (for example) involved lengthy waiting times.

A related issue in respect of cultures, traditions and beliefs related to transnational health seeking and (non-)compliance with medications. Two providers (a dentist and a pharmacist) drew attention to the practice of individuals in superdiverse areas seeking health care from abroad, and the existence of a culture of self-medication involving the use of medicines brought from outside of the UK. For some, this was inherently problematic due to individuals taking – in the view of the providers – inappropriate medication and which subsequently impinged on their long term health outcomes. Language barriers and individuals’ different perceptions of healthcare, as well as the relative value of different types of medication were given as key reasons behind the lack of compliance:

“So people go to India, they just get this medication, they get diagnosed there – which is same as diagnosis here – but they get this (different) medication. Come back here, start eating it, right, it is not doing anything for them, they have stopped the other medication. They go for their regular six monthly or annual diabetic check and that’s it, their leg’s ruined.” (Interview 6, Pharmacist, Handsworth).

However, providers made little reference to international medical tourism where individuals go abroad to seek specialised healthcare. In contrast, more discussion took place of how those with links

to their countries of origin sought medication from outside of the UK. One dentist noted that some clients used dental tourism for services that were not provided on the NHS such as cosmetic surgery.

In terms of mobility challenges, service providers also encountered challenges dealing with the needs of asylum seekers, including access to healthcare, housing and financial advice. To a considerable extent – and reflecting the transiency associated with superdiverse neighbourhoods – such problems related to the temporary nature of accommodation and strategies of dispersal that meant individuals could be re-located to other parts of the UK at relatively short notice. In turn, this impinged on the referral process and the ability of providers to work with individuals to address their health concerns over time, such as immunisation. The latter was noted as a particular concern as a lack of immunisation can lead to the spread of diseases such as Measles for those living in hostels.

“While (they are in) temporary accommodation.....it becomes difficult because (they’re) not guaranteed to stay in Birmingham.....when you make a referral today, that person could be moved tomorrow or they could be moved (by) next week. And the time the referral gets picked up and they get booked onto the system, they’ve gone to another county. Then it means that you have to start again.” (Interview 12, Refugee and Asylum Seeker Health Officer, Handsworth).

#### *Other challenges – resources and mind-sets*

Two other specific challenges were also referred to by health service providers – but which have a broader resonance beyond the superdiverse neighbourhood context. These relate to resources and individual mind-sets.

With reference to resources, this was highlighted as a major challenge by providers, and particularly for those who were dealing with asylum seekers and where the availability and suitability of particular property was an on-going difficulty. Limited resources were also viewed as impinging on the amount of time that was available for undertaking one-to-one consultations. Whilst both issues arguably apply in a variety of contexts, it can be noted that due to cultural and language barriers of relevance to individuals residing in superdiverse neighbourhoods, the lack of time to undertake consultations may be more problematic, and particularly when interpretation is needed as this requires longer consultations. As such, it can take providers more time to engage with individuals and to understand the health concerns being presented. In addition, the fact that many superdiverse neighbourhoods are ‘resource poor’, and which suffer from high levels of socio-economic deprivation means that there are more pressures placed on NHS services as individuals are less likely to be able to pay for private health care or medicine:

“There is a beautiful crisis going on in this moment in time where we have not trained enough GP’s, we have not trained enough practice nurses, the funding can’t increase because we haven’t got enough, there is not enough pound in the budget to do that.....and despite that NHS growth goes on at 60% a year relentlessly....because that’s the way it always has done.....and we always have more specialisation of medicine which means more gets done in primary care.” (Interview 7, CCG Policy-maker, Edgbaston/Handsworth)

A lack of funding was also affecting the recovery of individuals who were reliant on sustained support / intervention over a longer period of time. Again, this is of relevance more widely but particularly problematic for those in superdiverse neighbourhoods who may be less likely to engage with certain

services – such as drug and alcohol services - due to cultural norms / barriers. As stated by one interviewee:

“This relentless cutting of benefits.....is interrupting their recovery.....if people were given a fairer shot at, a period of financial support while they’re recovering..... they would have time to relax and engage with services more effectively.” (Interview 24, Project worker at drug and alcohol organisation, Handsworth).

The lack of resources was also deemed to be problematic in the context of a ‘management by targets’ culture in the NHS and beyond (for example, those promoting healthier lifestyles and specific groups of young and older people). Health education sessions and awareness raising campaigns to improve health amongst a diversity of different patient groups had been cut due to funding pressures. Such targets may therefore be more difficult to achieve in the context of superdiverse areas given the lack of engagement of some groups – as highlighted earlier – in formal mainstream provision, as well as the propensity of certain immigrant groups to access particular forms of provision, such as Accident and Emergency services:

“NHS strategy has to say that 95% of people have to deliver their care in four hours. But the issue is that if you have got more and more people going to A&E, then you will still not hit the target.” (Interview 7, CCG Policy-maker, Edgbaston/Handsworth)

Some providers - such as pharmacists - noted that a change in funding regimes meant that they now had to bid for funds in order to provide certain services to different clients. It was claimed that this had led some smaller pharmacies to close and which had detrimentally impacted on the ability of migrants living in Handsworth and Edgbaston to access such services (and who were frequently reliant on this form of provision to address their health concerns).

Beyond resources, a further challenge identified by providers referred to the mind-sets of individuals, including individuals’ perceptions of service provision and their propensity to access such services. Differences in mind-sets can be related to different cultures and their health seeking behaviours and perceptions of healthcare, including trust in service provision. Socio-demographic variables such as age, education and ethnicity are strong predictors of patient perception of healthcare quality and in turn their satisfaction and trust of their providers (Alrubaiee and Alkaa'ida 2011). Johnson et al. (2004) found that ethnic minority respondents were more likely to perceive bias and a lack of cultural competence in service provision than the white population when seeking healthcare. Such perceptions persisted, even after controlling for demographic factors such as health literacy and health status. In the context of superdiverse neighbourhoods, such issues were particularly notable – according to providers - among newcomers to the UK who had higher expectations and different perceptions of service provision:

“....Some, when they come in, they expect, “oh, the minute I come into the UK everything’s like laid out and I get a house, I get this and that. I get hospital. I get treatment. I see a doctor today, tomorrow I’m getting my operation for my back which has been hurting me for the last six years”. And you’re like, “No, it doesn’t work like that.” Then they’re like, “How come?” because that’s the impression in their minds - the minute you come in, everything, it’s sorted.” (Interview 1, Asylum Centre Health Co-ordinator, Edgbaston)

### *Addressing challenges of provision in superdiverse neighbourhoods*

In this section, the discussion explores the ways in which providers have engaged with local residents and other providers in an attempt to tailor and target their services appropriately.

To begin, those interviewed highlighted how they had developed a number of approaches in order to overcome challenges of provision in the context of superdiverse neighbourhoods. Whilst some were fairly obvious – for example, focusing on the provision of translation services, improving the targeting of specific groups and developing more tailored provision – the importance of building trust with individuals also emerged.

In relation to building trust, providers stressed the importance of maintaining a good relationship with service users to both secure and retain their trust over time, and in order to generate a better understanding of individuals' needs. The importance of language and confidentiality were frequently referred to as being important in building trust, along with listening skills, being open and non-judgmental and having a sense of humour. The latter was viewed as essential where there were language barriers:

“We talk about whole person care, so you know, it isn't just, this is a benefits issue, or this is, they need a school place and then we tick, yes we've done it, actually no, this is a person and this is their family and this is their character or their nature, or their struggles and their health is, it's a whole person healthcare.....Yes, it's the physical but it's the mental, it's the spiritual, it's the emotional health, so it's kind of seeing the package.” (Interview 21, Church minister, Edgbaston)

and

“If you can get someone to laugh with you, it warms the situation up and.... just, you know, saying, “You look well,” you know, or, “You don't look well,” or, you know, like I'm looking at you, I'm engaging with you, I'm looking after you.” (Interview 15, Midwife, Handsworth).

Building trust, according to interviewees, could also be strengthened through using interpreters and multilingual volunteers. Such support was often being provided 'in house' through the use of existing staff in order to try and develop relationships with clients through using the same individual over time: *“I've got the names of all our staff members here that speak different languages, so if we have a problem with language barriers, we'll try to get people to come back on a day when one of our staff members are here that can help* (Interview 19, Leisure Centre supervisor, Handsworth). Some providers also recruited community facilitators/volunteers as they were perceived as having a more nuanced understanding of particular communities.

Attempts to develop trust and improve communication also shaped the ways in which providers were making on-going attempts to engage with 'hard to reach' groups, including those with special needs. Again, women were highlighted as one such group – and particularly those from certain ethnic minority communities. In such cases, specific forms of targeted provision were being made available to try and improve the uptake of services:

“Once we're getting them into the facility, even if it's not coming for the gym, we can then sort of go, “Have you seen that we do ladies only? Have you seen that we have ladies only swimming.....And when they come to them, then we can grab their information and their details, you know, who they are, so it boosts our engagement with them.” (Interview 19, Leisure Centre supervisor, Handsworth).

Providers also stated that they were using a range of other methods to access particular groups such as displaying flyers at local schools to encourage children to bring their mothers along to particular

events, organising activities in line with religious festivals such as Vaisakhi, and using a mutual aid approach in order to bring together people with similar problems, and who worked with each other in an attempt to resolve such issues.

In the superdiverse neighbourhoods of Handsworth and Edgbaston, service providers stated that they had additionally offered more tailored services to meet the needs of individuals. These extended beyond approaches focused simply around ethnicity and were often one-to-one in nature:

“So we run an LGBT support group, and that's often full of international students from some pretty dire sounding home environments. So, you know, there's a lot of anxiety and a lot of distress about what they're going through. I mean, I guess we are a counselling service.” (Interview 3, University counsellor, Edgbaston).

Other providers used community leaders from a specific ethnic group to encourage those with similar ethnicities to engage with particular services: “*The Saheli Outreach is run by Muslim women and they're funded by an Islamic society to get Muslim ladies into the community – they teach them conversational English* (Interview 19, Leisure Centre supervisor, Handsworth).

Issues around service accessibility were being addressed through greater flexibility of provision – for example, home visits, developing a new phone service (for example, a Sikh helpline) and early morning, evening and weekend appointments to integrate with clients diaries: “*At the moment, we are heavily involved in the flu vaccination so if people cannot get to their doctors, we can do them in house here*” (Interview 9, Pharmacist, Handsworth). Those involved with mental health noted how they had also extended the availability of consultation and support for those who required it (but within the context of resource pressures). Moreover, there was evidence that a number of organisations were developing a more holistic view of health. As such, they were offering services that sought to address users’ physical, mental, emotional and spiritual health. This was through bringing different services together, as well as different individuals:

“We looked at elderly care.... (some) who are on their own and they have no-one to communicate with. So symptoms of depression, social isolation is what I’m trying to say. And this was a way of tackling that, along with heart disease and lack of exercise and diet. We formed an exercise clinic – an exercise class on a Thursday afternoon, which is still running.” (Interview 2, GP, Handsworth)

and

“We also have a group of ladies that meet every Wednesday....they are all about sixty I would say, so they meet, cook, bake, yeah....But it’s not about what they do, it’s really about bonding with each other and just relaxing and leaving the world outside, outside, and just coming here and being themselves and being with each other.” (Interview 17, Manager of a faith based community centre, Handsworth).

The idea of a single ‘wellbeing hub’ bringing together a number of services in the neighbourhood – and, for example, linking into GP surgeries or integrating physiotherapy, emotional and mental support services – was also referred to, and which would involve utilising both formal NHS provision and ‘alternative’ / complimentary provision. In addition, basing activities for adults and children around a local park (i.e. ‘Active Park’) was perceived as being a useful way of addressing physical and mental health needs.

Finally, and with more specific reference to the concept of bricolage, a focus can be placed on the way that providers had collaborated with others involved in the provision of health-related services, and through mobilising or mediating between different sets of resources in order to meet health concerns. In this respect, new networks had emerged between organisations, and with knowledge of different working practices associated with different organisations being shared in order to generate a better understanding of the needs of particular groups, as well as developing better referral processes:

“So the idea of the network is for organisations supporting vulnerable groups of people to come together around a table; to share information about what they do.....so then we can then observe trends and share information on how we work, how somebody else works..... so that we can refer service users.....so it benefits the service users and benefits us as well, because then we get a clear picture of what other organisations are doing. And we may get to learn how other organisations.....are addressing health issues.....for the benefit of service users.” (Interview 17, Manager of a faith based community centre, Handsworth).

Furthermore, some providers offered both space and training to other organisations in their area in order to improve collaboration and draw upon different resources. Indeed, those working with asylum seekers and those organisations supporting individuals with mental health challenges particularly welcomed the development of new collaborative approaches in order to mobilise and mediate between a wider set of resources – for example, health, financial and social:

“.....There's a range really. I mean different agencies. So, the Rape and Sexual Violence Project would be one. The LGBT Centre in town would be another. Birmingham Healthy Minds, we might refer people there.” (Interview 3, University counsellor, Edgbaston).

‘Alternative’ – yet existing - resources in the local neighbourhood, such as allotments were increasingly being used by mainstream health providers to improve mental health. More extensive use of local parks was also perceived as integral to maintaining and improving the health of individuals in the case study neighbourhoods. However, collaboration between GPs, mental health workers and those dealing with newly arrived migrant communities was noted as being insufficient at present and requiring further attention. In this context, and on a more positive note, there was some evidence that ‘third sector’ individuals working beyond the formal health system were indeed adopting ‘bricoleur’ practices to mediate between different types of resources:

“We were working with a family and they had a relative arrive who was in quite a complicated situation, age disputed, sort of minor and therefore was really struggling to get medical support. So our Children and Families worker was working with the GP surgery to try and kind of overcome those barriers to actually accessing primary healthcare....., you know, they didn’t have a GP, they weren’t in the system and it was kind of working to try and enable them....so she was able to kind of work with the GPs at the health centre to get that in place and then was obviously kind of liaising back and forth and providing updates.” (Interview 21, Church minister, Edgbaston).

In summary – and through drawing on the concept of bricolage - the degree to which providers had sought to mobilise or mediate between different types of resources to address individuals’ health concerns was becoming more apparent in the context of funding cuts. Some had started to seek other sources of funding to maintain their services. This included partnership with private agencies outside of the neighbourhood. Other providers had pro-actively engaged by giving talks in local



community centres and using media such as a local TV channel and radio. Further ideas to improve engagement included an outreach bus to deliver midwifery services with other providers, and to offer more home visits - where providers could explore the wider health needs of their service users - and to subsequently link such needs to other service providers.

Additionally, the role of third sector organisations in mediating and 'gap filling' should not be underestimated. Drawing on the example of the Children and Families worker discussed above, it is clear that such organisations are increasingly the social glue which connect individuals with complex problems to different service providers. At the same time, they continue to provide social and emotional support to those with physical and mental health problems and help to address gaps in formal service provision. Local charities were frequently called upon to help asylum seekers and their families, including organising appointments and securing referrals to hospitals. They also provided advice to refugees and asylum seekers on managing their finances. A collaborative approach was evident in a number of instances between third sector charities and local churches in respect of the support on offer, and which acted as a preventative intervention to reduce the subsequent burden on formal health services (for example, less visits by individuals to the GP or the Accident and Emergency department of the local hospital).

## **Conclusion**

In the superdiverse neighbourhoods of Handsworth and Edgbaston, providers addressed a wide range of health problems – from the common cold through to more complex physical and mental health problems such as cancer and depression. They also dealt with an increasingly diverse range of individuals, and with Eastern European immigrants becoming much more evident in both areas since EU accession in 2004. Such changes in each neighbourhood meant that they had to respond to both existing and new / emerging needs through developing an evolutionary (rather than revolutionary) approach to service provision.

Population churn in superdiverse areas also impacted on the extent to which different groups engaged with health services, and with 'newness' and legal status being of importance in shaping service access, as well as language, local knowledge and trust in services being provided. Frequently, providers noted that they were struggling to 'keep up' with the emergence of new languages. Difficulties were also identified in terms of individuals using transnational medication, and which, it was argued, could impinge negatively on a prescribed course of treatment and especially where such medication was deemed to be less appropriate for addressing a particular health condition.

Consequently, serving superdiverse communities creates specific challenges for providers. Some challenges relate to individuals' legal status and their transience (for example, asylum seekers), and which can make continuity of treatment a problem. Other challenges relate to issues such as language and cultural beliefs (for example, first generation immigrant communities) and the uptake of particular services on offer. Cuts in funding were also making it more difficult for providers to effectively engage with diverse communities – migrant and non-migrant alike, and to address issues of stigma and trust, as well as managing users expectations. The ability to undertake consultations was also referred to as being increasingly problematic. This was due to the tension between creating service efficiencies on the one hand and the extended time that was often required to assess clients concerns due to language and cultural barriers on the other.

Providers had developed a number of approaches to address the challenges of provision in superdiverse neighbourhoods. The recruitment of interpreters and the use of available volunteers had been undertaken to address language barriers. In so doing, it was claimed that this had also helped to build trust with service users. Continuity of provision and engagement with users over a long period of time had also helped to improve levels of trust. In relation to mental health, a range of innovative approaches had been taken forward within the local community, such as the use of local parks and allotments and holding group meetings around activities such as cooking. The emphasis was on developing highly individualised / personalised care and with third sector providers (in particular) acting as navigators to facilitate connections to multiple agencies, and helping to construct an integrated package of provision.

Furthermore, interviewees stressed the importance of collaboration with both users and other service providers in order to bricolage resources that were available, and in an attempt to offer the best service for their clients. From a provider – user perspective, there was evidence of bricolage practices in terms of community leaders associated with particular ethnic or migrant groups being used by providers to co-design and co-deliver services to improve engagement with those who were argued to be more difficult to reach.

In terms of links between different providers, collaboration was identified as being essential in coordinating services for vulnerable people and in subsequent referral processes. Collaboration was also noted as being important in the current austerity environment, and where services would otherwise be cut due to a lack of funding. Bringing together ‘traditional’ (formal NHS provision) and ‘alternative’ / complimentary provision in a more integrated way was therefore suggested by a number of interviewees. One or two interviewees also highlighted how they were acting as bricoleurs between traditional and alternative provision in order to secure different resources for their clients.

To conclude, the drivers for bricolage by health service providers were pragmatic in respect of securing resource efficiencies, as well as being informed by a desire to secure service improvements and to target their services in culturally and socially appropriate ways and differentiated according to age, gender, socio-economic status etc. Importantly, there was no obvious evidence that new attempts at bricolage were being used to withdraw services or restrict entitlement; rather it often emerged in response to restricted resources. In this sense, the emphasis overall was on (re-)mobilising, mediating and / or combining services with others in order to improve provision and to ensure services were ‘fit for purpose’.

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