

**Typologies and Logics of Welfare Bricolage in
Portugal: Lisbon case study**

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Abstract

The Welfare Bricolage project (UPWEB) will reconceptualise welfare theory through responding to the question of how all residents living in superdiverse neighbourhoods put together their healthcare. Increasing population complexity, heterogeneity and pace of change under globalisation has provoked a need to rethink welfare design, alongside issues of engagement, approachability and effectiveness. This report focusses on the welfare bricolage of residents in Lisbon, Portugal, highlighting how they access healthcare and the barriers they face within the healthcare system.

Keywords

Welfare bricolage, healthcare, migration, superdiversity, NHS, UPWEB

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Introduction

Portugal is a centralised country in terms of administrative and political organisation, which is relevant for the design of health, migration and welfare regimes in place in the country. The 1976 Constitution set the climate for rights and public services, however, since Portugal's incorporation to the European Union, many legal frameworks and policies have been adjusted, some to respond to what has been called Europeanization of public policies, even if there is room for differentiation across member states and policy fields. In this sense, the "existence of a unique and shared European social model has rightly been contested" (Hemerijck 2002, cited by Adão e Silva 2011), while there is more agreement in the field of economic and market policies, less consensus has been reached with regards to social policies. There has not been a convergence towards a social model (Adão e Silva 2011) and authors attribute this to different factors: resilience of the nationally-based welfare state (Ferrera 2005), institutional and political diversity (Esping-Andersen 1990), the limited weight assigned to the social field during the European integration process (Geyer 2000; Hantrais 2000; Kleinman 2002) and the co-existence of several instruments and the diversity of European authorities in any given social policy-making area (Rhodes 2005). However, more recently, European social policy has become more relevant and adjustments of a national welfare model are underway, mainly due to crisis and changes in political climate, both at the EU and the national level.

In Portugal, recent changes have been shaping social policies, some introducing structural reforms and others as a consequence of the economic crisis. For example in the field of health, there have been changes in the National Health Service (i.e. organisation of primary care) as well as measures in response to the financial crisis, mainly due to the TROIKA Memorandum of Understanding (cuts in services, increase in user's fees). In any case, changes in the field of health have impacted on the welfare model.

Because Portugal is organised as a centralised administration, most policies are set at the national level, mainly those on migration, health and welfare. Regional or local differences can be found in terms of availability of resources and some local programmes aimed at the integration of immigrants or outreach services that target specific populations. Thus, some conditions derived from the territory and its population may be relevant for some governmental policies as well as for the interventions of non-profit and other local organisations.

Welfare model in Portugal

In his original work on welfare state models, Esping-Andersen (1990) left out Portugal as well as the rest of Southern European countries. Criticism of his models was followed by the development of a fourth ideal-type known as the Southern European, Mediterranean or Latin Rim model referring to Italy, Greece, Spain and Portugal (Siaroff 1994; Ferrera 1996; Boboli 1997; Capucha et al. 2005; Adão e Silva 2002; Arts and Gelissen 2002).

Several authors have outlined features of the Southern European Model. Maurizio Ferrera uses the concept of “safety net” associated with a specific moment, around 1960-70, of the welfare state in Europe when a new generation of social assistance schemes and benefits were developed aimed at a) filling coverage gaps, mainly for specific groups of vulnerability and new types of needs, and b) establishing a minimum guarantee understood as a safety net for all citizens, below which nobody should fall (Ferrera 1996: 2). What distinguished this type of welfare from previous provision was its nature as a “right” rather than discretionary social assistance (although this situation in Portugal is less obvious). To access those rights, dual criteria applies: a) eligibility (individuals in need) and b) residuality (individuals which cannot cope with their own resources), based on subjective and judiciable rights and codified administrative procedures. Ferrera pointed out that traditionally targeted groups for welfare included the poor elderly, the long-term unemployed, the disabled with special needs, single mothers and needy students, generally guaranteeing a minimum income. Immigrants were not even considered among the target groups as they were not defined as citizens with rights, a situation that impacts on their ability to access different types of services, including health.

According to Ferrera, the most relevant features of Southern Europe that shape the welfare model are: the central role of the family, the incidence of the irregular and underground economy and low administrative capacities mainly at the end of the State apparatus (5). These features reinforce one another, as families need to find their own informal solutions to their problems, producing the familiarization of social assistance. The Portuguese case falls under this model or ideal type, yet a historical interpretation allows for a better understanding and for identifying more specific features, including where Portugal stands today.

Pereirinha (2009) believes that three periods can be distinguished when thinking of the national welfare state: 1) initial social provision during Estado Novo which included some measures to compensate social risk (retirement, disability and unemployment); 2) the welfare state development following the 1974 Revolution, which enlarged social rights based public spending and fiscal solidarity; 3) Europeanization of the welfare state.

However a deeper analysis of changes over the last two periods is necessary in order to understand the current state. The foundations were set by the 1974 Carnation

Revolution, ending the longest authoritarian regime in Europe, mainly by the approval of the 1976 Constitution which recognised several social rights in the field of social security, health, housing, environment, family, among others, starting a new era. Nevertheless, the legacy from the previous decades carried on in many ways, giving the Portuguese welfare state some unique features, many of them embedded in society.

According to Santos (1991), the Portuguese state is a quasi or lumpen welfare state, but its deficit in welfare is covered by a strong welfare society. The 1974 revolution translated into the nationalisation of industry, insurance and banking systems, among other changes, dismantling the authoritarian state and simultaneously leading to a crisis of institutions. During this time, the State produced important labour and social legislation such as autonomous labour organisations, right to strike, social benefits, employment stability, minimum wages, collective contracts, restrictions to layoff and dismissals, among others, which were non-existent before, as benefits were understood as the gift from a beneficent state (Estado Novo) and not as a right. Yet, this social welfare regime had a short life; soon after joining the EU many changes were introduced. In 1989 a revision of the Constitution removed all socialist elements in order to emulate Western European models (Santos 1993). Santos stated that the Portuguese welfare state is not technically a welfare state, arguing that its “deficit is compensated by social welfare rich in relations of community, inter-knowledge and mutual help” (1991: 33), which he called “welfare society”. In our understanding, a consequence of welfare society is that exceptions and discretionary power are used on a daily basis by public servants to create a sense of responsiveness case by case, which has been naturalized both for the state and for people.

Another distinguishing feature of the Portuguese system in comparison to other European models is that public welfare administration did not internalize the conception of public welfare as a right, but instead, it is seen as a benevolent state, following the tradition of the Estado Novo. In fact, the revolution left public administration untouched, thus its action translated “into discretionary and privatistic behaviour that allows for serving differently according to informal connections” (Santos 1994: 34). These features in many ways can be sensed today, as discretionary power is a dominant characteristic within public administration, and in some cases is allowed and promoted by the law.

Pereira (2008), thinking about poverty relief, believes that in Southern European countries social policies have not addressed poverty alleviation. She argues that this is explained by factors such as limited state accountability, the prominent role of families in welfare provision, high levels of tolerance in relation to inequality and poverty, and, in broader terms, in attitudes toward inequality and poverty

embedded in social and political practices. Alves (2015) argues that despite comparative improvements in some social domains such as healthcare, poverty alleviation, unemployment protection, problems of inequality remain deeply embedded in the country's social and institutional structures, affecting the level of wellbeing.

Pereirinha (2014) believes that at present, social policies are predominantly shaped by a model of welfare-mix in which the role of the state is diminished, allowing and promoting more intervention from the private sector (profit and non-profit) in the provision of welfare. This shift has also implied the development of what is called the social economy and the emergence of the third sector, even if the literature differentiates between Francophone and Anglophone schools of thought.

At present, welfare provision has been further eroded by the crisis, with the signature of the Memorandum of Understanding (MOU) in 2011 with the TROIKA (FMI, European Bank and European Commission,) which introduced tough austerity measures to reduce the deficit, cutting social programmes and benefits (Legido-Quigley et al 2016). Even if officially the conditions imposed by TROIKA ended in 2014, its consequences and some measures are still in place, and the pressure from the European Commission (EC) and the others EU institutions are frequently used to control the path taken by the Portuguese government, at present the opposition to the one that signed the MOU.

Health system in Portugal

The National Healthcare System in Portugal is composed of three coexisting systems: the National Health Service (NHS), special social health insurance schemes for specific populations (health subsystems, i.e. public servants have ADSE, as well as armed and police forces etc.) and voluntary health insurance (private and mutual funds). In addition, in some territories, the Santa Casa da Misericórdia, mainly the one in Lisbon (SCML) is engaged in health care services provision (in addition to social provision) to specific populations, mainly the disenfranchised, and thus can be seen as a parallel system. In relation to SCML, social workers act as “gate keepers” to decide which persons are in or out of the system (based on proven financial needs), even for accessing health services.

The Portuguese constitution of 1976 recognised health as a social right (see text box) in article 64, more specifically health was to be provided by a NHS with universal health care coverage. Yet, it was only in 1979 that the NHS was created and in 1990, the Health-Base Law was sanctioned, opting for a universal system, free of charge (covered by taxes), although over time, user fees have been introduced. Fees

charges have increased drastically since the crisis. The Ministry of Health is responsible for developing health policies and managing the NHS.

Article 64 of the Constitutions states that:

1. Everyone has the right to the protection of health and the duty to defend and promote health.
2. The right to the protection of health shall be fulfilled:
 - a) By means of a universal and general national health service which, with particular regard to the economic and social conditions of the citizens who use it, shall tend to be free of charge;
 - b) By creating economic, social, cultural and environmental conditions that particularly guarantee the protection of childhood, youth and old age; by systematically improving living and working conditions, and promoting physical fitness and sport at school and among the people; and also by developing the people's health and hygiene education and healthy living practices.
3. In order to ensure the right to the protection of health, the state is charged, as a priority, with:
 - a) Guaranteeing access by every citizen, regardless of his economic situation, to preventive, curative and rehabilitative medical care;
 - b) Guaranteeing a rational and efficient nationwide coverage in terms of human resources and healthcare units;
 - c) Working towards the socialisation of the costs of medical care and medicines;
 - d) Disciplining and inspecting entrepreneurial and private forms of medicine and articulating them with the national health service, in such a way as to ensure adequate standards of efficiency and quality in both public and private healthcare institutions;
 - e) Disciplining and controlling the production, distribution, marketing, sale and use of chemical, biological and pharmaceutical products and other means of treatment and diagnosis;
 - f) Establishing policies for the prevention and treatment of drug abuse.
4. Management of the National Health Service shall be decentralised and participatory.

During the 1990s there was a clear shift towards adopting more restrictive measures and selectivity within a formally universal system, implementing cost-sharing (co-payments) and a sliding process of privatisation (or subcontracting) in the NHS, producing welfare for the private and the non-profit sector (Campos et al 1986, Carapinheiro and Pinto 1987). Transfers of public services to the private sector have, since then, increased and taken several forms (privatization, cost-sharing, subcontracting, etc.).

Since its creation, trends within the NHS have changed with regards to universality, charges and decentralisation. Because Portugal is a centralised country, the decentralisation of its political-administrative organisation has been difficult. However, a major change was introduced by creating a system based on Health Centre Districts, named ACES, in 2007/2008. ACES (Agrupamentos de Centros de Saúde) enjoy administrative autonomy, comprising a set of health centres that

include Family Health Units, Community Care Units, Public Health Units, Personalised Health Care Units and Shared Health Resource Units. At the same time, ACES are part of different Regional Health Authorities distributed across the country's regions. The logic behind this reorganization is to hierarchically organize health centres, introducing competition, promotion and relegation among units, in order to reach objectives and indicators. One central element within this type of organisation is having access to a "family doctor", however, a large portion of the population does not have a family doctor, and the rules and process to be granted access to a family doctor are unclear. Even if the overall design of the Portuguese NHS was based on the British model, the figure of the Family Doctor (FD) is not equal to General Practitioners (GPs), as Family Doctors only work at Health Center Clusters (ACES).

Because legal frameworks were clear enough about the meaning of citizens as users, when migration became an issue, more clarification was needed about specific entitlements and access, especially regarding both regular and irregular migrants. Thus it was only in 2001, coinciding with a large legalization programme, that Health Ministry Internal Order Nº 25360 (Despacho Nº 25360/2001) was issued to guarantee health access to legal migrants on equal footing with nationals, including the possibility of gratuity due to financial needs. This order also gave undocumented migrants a possibility of free access, if a certain procedure was followed. In 2009, this measure was clarified to reinforce its application and implications, by issuing Internal Act Nº12/DQS/DMD 07/05/09 (DGS or General Directorate of Health). These two pieces of legislation are usually cited as migrant friendly.

Since the turn of the 21st century, there has been an increasing production of more restrictive legal frameworks (laws, decree-laws, internal acts, normative and informative circulars or letters, guides) creating some confusion and contradictions. Since the Memorandum of Understanding with the Troika in 2011 other documents have become relevant, such as Decree-law 113/2011 (about fees and exemptions), which are less migrant friendly. Moreover, in 2013, the Ministry of Health issued a new official document to clarify measures on to migrants' access to the NHS including payments issues (Manual de Acolhimento). To improve the triage system, through Dispatch 4835-A/2016, NHS beneficiaries are encourage to use the hotline "24 hours" or primary care before going to hospitals, by doing so, they have priority and pay no user fees.

Migration

Traditionally and historically, Portugal was a country of emigration, until the late 1990s, when it became attractive for immigrants. More recently, and since the world financial crisis of 2008, which in the country was felt later in 2010/11, emigration

trends started to increase, surpassing immigration substantially, thus at the current time net migration is negative.

The first migration waves came from the Portuguese former colonies in Africa (Cape Verde, Angola, São Tome & Príncipe, Guinea Bissau, Mozambique), some of whom came after independence, arriving with the thousands of Portuguese returnees. Later, other migrant groups increased significantly: Brazilians and Eastern Europeans (from Ukraine, Romania, Moldavia, Russia and Bulgaria). In addition, migrants from Asia have become more numerous (from China, India, Pakistan, Bangladesh and Nepal). More recently, due to the so-called refugee crises, relocated refugees and asylum seekers from other EU countries and camps have arrived.

Since 1992 several regularization programmes or mechanisms have been granted (1992, 1996, 2001, 2003, 2005 and 2007). Thus, in the last decade the profile of migrants has changed becoming more mixed and diversified, shifting from postcolonial migration towards diversification. The largest immigrant communities residing legally in Portugal are from Brazil (22%), Cape Verde (10%), Ukraine (10%), Romania (8%), China (5%), Angola (5%), United Kingdom (4%), Sao Tome & Principe (3%), Spain (2%), and others (26%) (SEF 2014). However, considering the last year, new residency titles were given to French citizens, whose presence had increased by 174.5%, probably associated with their real estate investments in Portugal. In terms of gender, 51.5 % of migrants are female and 48.5% male, but if considering newly granted residency titles, the distribution is evenly distributed. Geographic distribution indicates that most of the immigrants (69%) live in the littoral region, with about 50% living in the Lisbon Metropolitan Area. The 2014 Report of the *Serviço de Estrangeiros e Fronteiras* (SEF or Immigration and Border Service) indicated that there were 395195 legal foreign residents in Portugal, illustrating a reduction in numbers since 2010. However, statistics obscure the total number of individuals born overseas, as immigrants who have become citizens and those who stay without authorization are not included.

The 2015 MIPEx (Migrant Integration Policy Index) using United Nations and Eurostat data indicates that Portugal has been an immigrant country since the 1990s, reporting about 3% of non-EU citizens, 8.4% of foreign born population, with 75% out of those being non-EU foreign born, 25% are non-EU university educated, and 70% come from countries considered low or medium-developed (HDI). While Portugal was ranked second (after Sweden) with regards to overall migrant integration policies, in the field of health, the situation is less favorable, ranked 22 among 38 countries (Huddleston 2015). The MIPEx health strand assesses four dimensions (entitlements, access policies, responsive services and mechanism for change, each measured with several indicators).

The rapid changes in immigration flows registered since the late 1990s until 2010, translated into a new legal framework regarding migrants, concerning laws to regulate migration flows (including regularization) and integration measures to incorporate newcomers and their families into the host society. Integration policies for migrants also include health policies.

A relevant aspect of Portuguese migration policies was that migrants and asylum seekers & refugees were overseen by different governmental agencies, however, recent changes in the organisational structure and mission of the governmental body that oversees migration, the High Commissioner on Migrations (ACM), has responsibility for new target populations: refugees and emigrants.

At present, Portuguese Migration and Asylum Policies are structured around five axes as defined in the New Strategic Plan for Migrations 2015-2020 (Resolution of Council of Ministers Nº 12-B/2015): a) Immigrant Integration Policies, b) Policies to promote the integration of new nationals, c) Coordinating Policies of Migration Flows, d) Policies strengthening the legality and quality of migration services and e) Policies of incentives, monitoring and supporting of emigrant national citizens. This new policy framework replaced the previous framework solely dedicated to immigration policies and asylum that focused on Migration flows regulation, promotion of legal migration, the fight against irregular migration, and integration policies. The implementation and monitoring of migration and asylum policies involved several governmental agencies: Internal Affairs through SEF (Immigration and Border Service), the Presidency of the Ministries Council (Integration), Foreign Affairs Ministry (visa and representation of emigrants), the Ministry of Solidarity and Labour (employment policies, qualification and social security). More recently, the High Commission on Migrations (ACM) has taken over coordination of actions and policies for Refugees and Asylum seekers, which was not included in their duties before.

Selected neighbourhoods

In Portugal, two neighbourhoods located in the Municipality of Lisbon were selected for the UPWEB project: Mouraria and Lumiar/Alta de Lisboa. Each one has different characteristics in terms of superdiversity, although an adjusted maximum diversity sample was applied in each. Interviews were undertaken by community researchers in conjunction with research fellows. Community researchers from Brazil, Nepal, India, Mozambique of Indian origin, Luxemburg and Portugal were employed; most of them holding a university degree.

Table 1: Characteristics of the selected neighbourhoods- Mouraria & Lumiar

| | Mouraria | Lumiar/Alta de Lisboa |
|------------------------------|---|---|
| Location | Downtown, historic district | Less central, well connected |
| Territory | Small, compact | Large, spread out |
| Public space | Limited availability of public space, narrow streets, no green areas | Public space available, in different conditions (parks, plazas, abandoned urbanized slot with public health risks) |
| Immigrants | Diverse origin; EU and non EU; diverse in SES; newcomers & settled; | From PALOPs; settled & descendants; |
| Autochthonous | Elderly; young professionals; | Elderly; middle & upper class |
| Housing | No social housing; private rent; variable conditions, badly maintained & recently renovated | Social housing & relocation; gated community |
| Health infrastructure | Served by several health centres One public hospital; SCML health centre; Mutuality Health clinic, several private practice and alternative medicine options; several pharmacies | Health centre and one extension; One public hospital (others nearby), many private clinics; several pharmacies but more spread out |
| Networks | Many associations but not working together | Local community organized network working together |
| Interventions | Many interventions, some overlapping, target groups: elderly, immigrants, | Some overlapping interventions (addictions/HIV) |

Profile

A total of 45 interviews were carried out in Lisbon/Portugal, 25 in Mouraria and 20 in Lumiar/Alta de Lisboa. In the sample, maximum diversity was sought, considering country of origin, gender, and socio-economic status. Comparing neighbourhoods, data suggest that Mouraria is more diverse in most of the aspects (variables) considered. Main socio-demographic aspects of the interviewees follow in Table 2.

Table 2: Superdiversity features in neighbourhoods

| Superdiversity features | Mouraria N=25 | Lumiar/Alta Lisboa N=20 | Total=45 |
|--------------------------------|----------------------|--------------------------------|-----------------|
| Average age | 43 | 45 | 45 |
| Oldest | 86 | 72 | 86 |
| Youngest | 21 | 24 | 21 |
| Gender | | | |
| Male | 8 | 10 | 18 |
| Female | 17 | 10 | 27 |
| Natives from | 11 | 3 | 14 |

| | | | |
|---------------------------|---|--|--|
| Portugal | | | |
| Other countries of origin | Nepal, Brazil, Colombia, India, Mozambique, Cape Verde, Bangladesh, Italy, Mexico, Spain, China, Pakistan | Sao Tome & Principe, Angola, India, Mozambique | Nepal, Brazil, Colombia, India, Mozambique, Cape Verde, Bangladesh, Italy, Mexico, China, Spain, Sao Tome & Principe, Angola, Pakistan |
| Dual citizenship | 1 | 5 | 6 |
| Education | | | |
| BA | 8 | 2 | 10 |
| High School | 7 | 3 | 10 |
| Less High School | 6 | 12 | 18 |
| No schooling | 2 | 0 | 2 |
| No collected | 2 | 3 | 5 |
| Employment | | | |
| FT | 10 | 11 | 21 |
| Student | 1 | 0 | 1 |
| Retired/disability | 4 | 4 | 8 |
| Unemployed | 6 | 5 | 11 |
| Stay home | 3 | 0 | 3 |
| Limited language | 6 | 1 | 7 |
| Irregular/UDM | 1 | 0 | 1 |

How do they bricolage?

Residents tend to bricolage with resources they have at hand, be those formal or informal. Out of the formal resources, many use the NHS (such as Family Doctors or FD in Health Centres and Public Hospital), Misericordia or SCML (doctors, nurses, medicine and other support), private system (private insurance, cooperative/mutual funds and subsystems such as ADSE (General Direction of Social Protection to Public Employees)¹, armed & policy forces, pharmacies (medicines, advice, screenings, etc.), mobile units and non-traditional options, among others.

Table 3: Formal and informal resources in bricolage

| Formal Resources (Several schemes of formal agreements between systems) | Informal Resources (Variety of resources out of the formal system) |
|---|--|
| NHS (Health centres, public hospitals) | Advice from friends & family in host country |

¹ ADSE is a subsystem within the NHS for public employees.

| | |
|---|--|
| Santa Casa da Misericordia (SCML) | and abroad |
| Private insurance (Private hospitals, clinics, private consultations) | Internet (skype conversations & web information, television shows) |
| Low cost health insurance | Home remedies & medicines |
| Cooperative (clinics) | Food as medicine |
| Public subsystems (ADSE, etc.) | Medicine ordering from abroad |
| Pharmacies | Local NGOs |
| | Chinese Medicine |
| | Ayurvedic, massages |
| | Healers |

Formal resources

Within the NHS, people use family doctors (FD) in health centres when available, referrals, second opinions, hospitals (emergency and specialty consultation) and pharmacies; depending on health need and previous experience. Some people, even bricolage using all resources in a complementary fashion. When FD are well regarded by users, the role of this health professional is key (based on trust) because they operate as a guide into bricolaging within the system. However, when FDs are not available or are not trusted, other strategies emerge due to frustration and/or dissatisfaction with the NHS. For example, some interviewees purposely avoid the NHS at all cost, mainly those who have previously had bad experiences. Emergency care is used to get rapid responses, given that long waiting times to get a consultation at health centres are common. Some people use emergency care also as a second opinion, and because emergency consultations in general offer the whole package: testing, diagnosis and treatment. The NHS also offers a telephone line “24 Hours Health” which some interviewees mentioned, in some cases for paediatric care. More recently, the NHS has promoted the use of the “24 hours line” as a faster track to access health services in public hospital including a fee waiver.

Misericordia is also used as a separate or complementary resource, including consultations with doctors/nurses, medicine provision (free of charge), visitations and home support (mainly elderly or disabled). Santa Casa da Misericordia de Lisboa (SCML) functions as a parallel system accessed via referral processes (usually provided by social workers from SCML at the local parish), so users tend to be the most disenfranchised. Until recently, immigrants, especially irregulars, were excluded, however since the 2008 financial crisis, irregular migrants have become common users of SCML services, especially since they became more excluded from the NHS.

Pharmacies are valuable health resources, not only to buy prescribed medicines, but as an additional resource and referral to get advice that ranges from medicines (biochemical and alternative), quick diagnosis and treatment, and also to discuss any health concerns. The pharmacist is often a trusted actor with regards to responding to individuals' health concerns; many interviewees mentioned having a known pharmacist to whom they frequently highlighted their concerns and sought advice knowing they could receive an immediate solution. This was particularly emphasized by some Asian interviewees who prefer approaching pharmacists because they are more helpful.

“The staff from pharmacy help a lot and they tell us what we should take. The staff from the pharmacy are the doctors for those suffering health problems.” (PMou08-Tanvir, 29 male from Bangladesh)

Pharmacies are also used for some quick testing such as measuring blood pressure, cholesterol, among others, but when it comes to HIV testing, the pharmacist recommends patients to use other resources (i.e. mobile unit, specific NGOs).

Private practice (either doctors or private hospitals) is used mainly by those with private health insurance, or public servants (who have a differentiated public health coverage with access to private options). Some residents opt to pay for private health insurance, but in most cases, the health plan is offered by employers, so private doctors and hospitals are used depending on health needs, although it is common that for medications, private practice use the prescription/credentials of the NHS to benefit from a discount in price. Some immigrants also used private consultations as a quick way to solve a health concern, mainly when this practice is common in the country of origin or when patients have resources available (Brazil, Italy).

Both neighborhoods have mobile units. These are integrated into the NHS or coordinated by other entities (Doctors of the World, SCML, Crescer na Maior, etc). Mobile Units provide different types of services: Testing for HIV and STIs, blood pressure and diabetes measurements, needle exchange, and free medicine support among others.

Informal resources

Considering informal resources, people's options ranged from material to virtual resources. Material resources range from non-Western alternative medicines and treatments provided in private clinics and spas, to free testing/screening (HIV, Hepatitis) provided by local NGOs.

The use of alternative medicines and treatments found are mainly Chinese medicine & therapies, healing baths, oils and massages. Some of the interviewees who prefer these options are immigrants but Portuguese and EU residents also use them. However, some interviewees expressed that they would like to access them but they cannot due to financial limitations, as in general these therapies tend to be expensive.

The use of local resources (NGOs or entities) by the interviewees is mainly undertaken because those services are free of charge. Some used them for testing/screening (HIV, Hepatitis), to access free medication or free food (baby food & milk) for pregnant women and small children.

The virtual resources include advice from friends and family, internet search, skype conversations with health professionals, friends or family abroad, TV shows (usually in their mother tongue), preparation of home remedies, ordering known medicines or specific herbal, food supplements or treatments by mail from abroad, creams, herbal teas, using healthy and nutritious food, among others.

In general, Internet, skype, and TV or getting therapies from abroad were strategies more used by immigrants, although there were some exceptions. Immigrants also sometimes use informal translation, which tended to be provided through two different approaches. One is by bringing their own friends or relatives to serve as interpreters; the other is the use of apps and technologies such as mobile phones and internet to access google translation as a way to describe and explain their health concern.

Bricolaging

Overall, interviewees bricolaged combining different types of resource, either resources within the NHS, with other systems (NGOs, private) and/or mixing formal and informal resources. Among interviewees both natives and immigrants used a preventative approach that we named healthy life-style. However, among the healthy life-style bricoleurs, there were some that mainly focused on healthy habits (physical exercise, eating healthy, use of herbal teas, etc.) due to financial limitations, while others in addition to healthy life-style used alternative therapies, which tended to require knowledge, cultural/social capital and financial resources because the costs of non-Western medicines are not covered by the NHS. Additionally, some immigrants followed traditional beliefs from home, yet if questioned about what type of medicine they preferred, they tended to choose Western medicine if they are sick, especially for their children.

Immigrants facing language barriers tended to use family/friends as translators, or even Google translation, and rarely, telephone translators offered by the CNAI

(National Immigration Support Center). Some immigrants complained about having difficulties in consultations or in accessing health mobile units because there was no translation service available. Others simply did not know about the existence of mobile units because information was not shared among those unable to speak Portuguese. Sonia (PMOU13-Sonia, 45 female from India), for example, used her son as translator, bringing him with her to the doctor or pharmacy when needed.

Elderly residents with mobility difficulties depended upon the assistance of social workers from NGOs or Misericordia. Some interviewees had developed close relationships with social workers particularly where family members were not available or willing to help. For example, Florida (PMOU10–Florida, Portuguese, 86 years old) became depressed after the death of her husband, and was fully dependent on an NGO for solving all her health and social concerns: mobility, age, loneliness, lack of financial and family support.

International health seeking was identified among some interviewees, including visiting a doctor/specialist at the country of origin (when visiting home), using medicines from home country, and in a few cases, going home to visit a healer (in Africa). Maria Alice (PLUM27-Maria Alice, 38 female from Sao Tome & Principe)) and Manuel (PLUM34-Manuel, 36 male from Mozambique) engaged in healing rituals when visiting home.

Finally, some interviewees bricolage to avoid using the NHS or going to the doctor, and tried to solve their health concern with other treatments, only using the NHS or doctor as a last resort. PMOU13-Sonia (female from India, 45) is a good example of bricolaging with different resources (pharmacy, internet, TV, advice from friends at home and abroad, traditional medicine and allopathy along with conventional medications). PMou04Joaquina (female from Portugal, 45) with obesity problems avoided the NHS, and followed the advice of a pharmacist and family members, even buying a diet kit on TV, although she had not been successful in losing weight.

Why do they bricolage?

Interviewees had different reasons to bricolage. One common reason for bricolage was either lack of diagnosis or unsuccessful treatment, triggering actions leading to getting a second (or third) opinion, searching for alternative answers or different approaches to a given health concern (alternative therapists and medicine), holistic approaches and even spiritual healing. Another trigger for bricolage was waiting time, as in many cases scheduling a consultation or a needed procedure (i.e. surgery) may take weeks or months (even years for surgery list), so when this happens and users can afford other options, they used them (private, NGOs, ADSE). In this sense, barriers to accessing health care services prompted residents to bricolage.

Additionally, we identified cases in which bad experiences within the NHS (unresolved health concerns) conditioned future actions by prompting residents to diversify their healthcare seeking strategies, looking for different responses or a combination of responses, depending on the health concern (herbs & teas, massage, etc.), healthy life styles or other systems (private or other referrals).

Last but not least, lack of financial resources was an important factor shaping decisions about what strategies could be used to solve health concerns.

Typology

From strategies identified through interviews and fieldwork, we propose a tentative typology, although for a comprehensive classification and assessment of bricolage, multiple typologies may be more appropriate.

Bricolage within the NHS: this category is much used to a great extent as in general people are dependent upon the NHS for solving their health concerns, and because using the public system is a culturally and socially embedded action, mainly among Portuguese and immigrants, especially among those with very limited resources (although there are exceptions). The NHS bricolage or internal bricolage under the NHS umbrella includes several possible mixes such as using health centres and hospitals for consultations, for emergencies, and for second opinions in case of failed first responses or in the event of a complex diagnosis. NHS bricolage could also include other services within the system such as the hotline “Health 24 hours”, pharmacy, and special services even if subcontracted (dentist check). The extent to which these mixing of formal resources might be classified as bricolage is questionable given that to some extent the NHS was conceived to enable people to search for more options depending on the health problem and its complications yet some individuals were far more resourceful or creative when undertaking this “within system” bricolage than others.

This was probably the most common approach to solving health problems, mainly among those with long-term illnesses or chronic diseases, in cases of severe problems and complex health problems. Thus in many cases, users felt they did not have other options. Financial issues play an important role (but not only) as a determinant of NHS use.

Ivone (40 female from Portugal), for instance, was faced with several health concerns so has a multidisciplinary team within the NHS that follows her case in two different public hospitals and with different teams, however, she is still waiting for a final resolution:

I am being guided by one obesity team, because I weighed hundred and forty two kilos in July of this year. I am been being monitored in the Pulido Valente and Santa Maria Hospitals for three years now at the Obesity and Pulmonology sections. At the age of forty, they discovered that I have allergic asthma, thus, I have suffered asthma for three years. As I was already on several waiting lists for the stomach reduction operation or placement of the gastric band or whatever, when I had the first problem of shortness of breath, I was admitted for fifteen days...The obesity team has one surgeon, one psychologist and a dietitian. Within the pulmonary team there is a lung specialist. Since the beginning, for the obesity consultation, I had to do the diet before the operation, so that a dietitian could assess whether I followed what they had asked me to do; I did the consultation with a psychologist, before the surgery, so that he could give the permission for the surgery. Meanwhile, I was added in the waiting list, it's been 1 year now in March, but I am still waiting. (PLum35-Ivone).

Maria (female, 78 from Portugal) suffers from several bone problems (eg. arthritis, leg cancer, cyst, etc.) mainly related to legs and knees. She is followed by the FD regularly, and also seeks the FD for medicine prescriptions and referrals to the hospital (for specialist treatment) when her health problems get worse. On some occasions, visits to the specialist at the hospital ended in surgeries and in the use of additional services, such as physiotherapy. Additionally, she uses the pharmacy to buy the prescribed medicines with discounts and to purchase other medications without prescriptions (eg. paracetamol) (PMou05-Maria).

As part of the NHS, another interviewee used the Hotline Health 24 hours, to solve her baby's health problems:

"When I have a health concern I call the emergency line that is 808242424 and based on what they tell me to do; then I report back my child's reactions. If they feel that it is better to take her (baby) to the doctor, I bring her. If they feel that the baby is fine and I see that she is better, then I can take care of her at home" (PMou17-Norma, 33 female from Brazil).

Many interviewees trust the Pharmacist as a main actor for solving health concerns both within the NHS and in a broader sense. Even if pharmacies in Portugal are private businesses, they work in collaboration with the NHS by offering discount prices for medicines and prescriptions which fall under the agreement between NHS and pharmacies. Pharmacists are perceived as an ally to people's health problems and are used in several ways: to buy medicines with discounts and over the counter, as a strategy for getting a quick answer about a health problem, to get screenings and advice, among others actions. The following testimony illustrates one case:

“If I feel something is wrong in my body, then I go (to the pharmacy) to checkup my blood pressure (...). In the pharmacy they have services provided to check pressure and diabetes (...), they have that machine. And when you request that you need a checkup, then they will say ok and do the checkup (...) 4 euro and 50 cent. To check pressure, it is one euro and for diabetes it is 4 euro 50 cents. (PMou02-Devi, 42 female from Nepal).

Tanvir, 29 years old from Bangladesh, avoided going to the healthcare centre or to the emergency room due to previous bad experiences, instead seeking health advice by approaching the pharmacist. He uses the pharmacy in combination with internet search to get a better understanding of his symptoms. According to him, pharmacists are the doctors of his community, they can be trusted. He prefers to go the pharmacy also to avoid long waiting times for getting nothing:

“Staff in the pharmacy are the doctors for to those suffering health problems. They help a lot. Pharmacies are always crowded in Martin Moniz, while if you go to the hospital, there are no Asians there.”(PMou08-Tanvir)

Mixed Bricolage: this category involves using the NHS, the Misericordia (SCML) and/or NGOs assistance, the private sector or even a healer (either in the country of destination or in the home country). In the case of those using Misericordia, accessing this resource is orientated towards those with low incomes, as only poor people are eligible. NGOs support also tends to be for people with fewer resources but they do not necessarily exclude other users (especially for screening or testing HIV, STIs). Inclusively, some NGOs or associations have been created to respond to a very specific situation (i.e. for those with cerebral palsy or very serious health problems). However, most of the cases with very serious health problems tend to be more dependent on the NHS in combination with some associations and with social security (disability assistance which is not part of the NHS but closely connected).

On the other side of the spectrum lie those who have access to private insurance or are public servants with differentiated services (i.e. ADSE), that have the option to mix health seeking actions. Admission to the provision of private services is achieved through different paths: having a private insurance (pay by user or given by employer), a cooperative service (such as São Cristovão Clinic, pay voluntarily by user) or by ADSE or similar (the subsystem for public employees). In general, this path may seem orientated towards middle/upper class, but it is not necessarily because it includes all public employees whose socio-economic status comprise different social classes.

Maria Alice (38 female from Sao Tome & Principe) represents a complex case who combines NHS, SCML and private health insurance. She uses the NHS to deal with her chronic disease (HIV) because it offers the best treatment. She also used the

SCML for oral health given serious complications with her teeth. Furthermore, she made a deal with her employer in order to access a private health insurance so they split the cost (60% employer and 40% herself). She uses private services for her children, but for herself she prefers the NHS. Her case also illustrates issues of trust, as she combined consultations and follow-ups in the health centre and the hospital, but after her FD retired she preferred the hospital, where an interdisciplinary team follows her case and knows what medicines she can take. Moreover, when visiting her home country and to make her mother happy, she also went through a traditional healing ritual based on “body washes” and tea drinking, prepared by the wizard, in the middle of the jungle (PLum27-Maria Alice).

Maria(PLum40-Maria, 55 female from Portugal) suffers from migraines, depression and fibromyalgia; she uses a combination of resources between the NHS and the SCML. She does have a FD in the NHS and is followed in a public hospital for her depression, and in addition she used Misericordia services to get a referral to do a sleeping electroencephalogram.

Renato (34 from Portugal) used NHS and private insurance. When experiencing a urinary infection, he went to the public hospital but the prescription given by the doctor did not work. He then went to a private clinic to seek a second opinion, where the doctor ordered tests and prescribed antibiotics which were effective. After that bad experience with the NHS, when he has health concerns, he avoids public services, opting for private clinics with specialists as he has subsequently done for a knee injury (Plum42-Renato).

Manuel (36, from Mozambique) had problems and injuries related to playing football (broken jaw and fibula). He used private health insurance he had from work because the facilities were closer to his job and more convenient. He also avoids the NHS due to trust issues. Even if for treatment he uses private doctors and treatment (physiotherapy), he also uses the pharmacist’s advice for minor health concerns and used spiritual healing. The following excerpts illustrate his views:

“I am not a kind of person who goes to family doctors to ask something, I think he does not even know me (...) There is always a mysticism about African culture, you go to the doctor and then you go to the healer. The healer is for the spiritual. The doctors talk to you in a more scientific way and the healer helps you psychologically (...) I don’t deny this, I have visited one and it is natural, it is like when you go to the church and you listen to the priest.” (PLum34-Manuel).

The following testimonies illustrate how residents use SCML or low cost private insurance in combination with NHS. Filipa (64 female from Portugal) is unemployed, living alone and uses the NHS for FD appointments and specialized medical appointments in public hospitals (mental health and bone diseases). In addition, she

has medicine support and is followed by doctors of the SCML health unit. This extra support has helped her in improving her quality of life, as she is able to save medicine money. She commented:

“The help they (SCML) gave me with medicines, I am satisfied, it is a very good help. Now I can eat better and treat myself better.” (PMou09-Filipa).

Tavir (29 male from Bangladesh) has access to the NHS but due to previous bad experience, avoids hospitals and the health centre, instead he bought a low cost private insurance.

“I am taking care of my health and I did a health insurance which I pay 10€ (...) I never needed to use it yet.” (PMou08-Tanvir).

Moreover, in addition to using the NHS, some interviewees depend on the support offered by local NGOs even as facilitators or mediators to access other types of care, as the case of Florida, an elderly native resident with very limited mobility who is unable to read or write, shared with us:

“My social worker is the one that takes care of everything. She does everything to help me”. “They go with me to the doctor, to the hospitals and Mariana (Social Worker) comes here on Wednesdays, to be here a bit with me. I could not get better than that” (PMou10-Florida, 86 female from Portugal).

Alternative/holistic bricolage: this category involves bricolage that comprises the use of alternative medicines and other therapies, avoiding doctors from the NHS (even if they have to use them sometimes), even though they sometimes use services that are not legally approved. It is the case of Aurora (female, 53, China) that after seeking healthcare at the public hospital to treat a lung infection and having little success, she decided to approach an illegal Chinese practitioner:

“Once I went to the hospital because I thought I had something in my lungs, when I came back I was feeling bad, so after that I went a Chinese practitioner. This one is not legal (...) but I went there to get the treatment (...) a lot of Chinese go there (...)” (PMou23-Aurora).

The use of this type of bricolage is sometimes based on the central notion that adopting health promotion behaviours and a healthy way of life are the best solution. As result some interviewees prefer to use different types of non-conventional medicines/treatments. For instance, every time Anu (female, 29, Brazil) has flu or a chest congestion she prefers to drink herbal teas based on what she learnt through alternative medicine.

“I make these teas and I believe that these alternative methods which I follow are more efficient than the traditional (conventional medicine) methods” (PMou19-Anu) (29 female from Brazil).

This testimony also highlights the high level of trust that interviewees have in these alternative medicines and in the actions undertaken by the alternative practitioners. This is also the case of Sebastian (male, 46, Spain, dancer) who said he does not believe in conventional medicines, preferring the health prevention when possible or alternative therapies to treat his severe spine problems.

“I think the best treatment is always prevention.(...) I have spine problems which is related with muscles, tendons, skeleton, it is something easier to treat with other alternatives therapies such as acupuncture, osteopathy or physiotherapy or homeopathy, or cranial sacral massages. It depends on what you believe” (PMou22-Sebastian) (46 male, from Spain, dancer).

Avoidance of NHS with miscellaneous mix: in this category people avoid using the NHS (even if they have to use it as last option) but use a mix of strategies to treat their health concerns. However, their health issues are minor, and the majority of the cases in our sample were young males who in general tended to avoid doctors. For example, their strategies involve the use of home remedies, or self-medication, which may include the use of the pharmacy or alternative practices. For instance, Firmino (49 years old, Portuguese) argued that he has not been to the health centre for many years. Usually, he tries to solve his health concerns at home, then if he needs medical assistance, he goes to the local pharmacy to get advice and only in the cases of extreme urgency, would he go to the health centre or the hospital (PLum39-Firmino). Ramires takes on the same approach with regards to sinusitis.

“To treat sinusitis I go to the beach and wash my face with sea water, if it does not pass and gets worse, I go to the Hospital of Santa Maria. I always go to the hospital as a last option” (Plum41-Ramires, 24 male from Portugal).

Based on the presented cases, we identified a bricolage typology around the following categories: exclusive use of NHS or not, use of conventional medicine, as table 3 illustrates.

Table 4: Bricolage typology

| | NHS only | NHS not exclusive |
|-----------------------------------|-----------------------|--------------------------|
| Conventional medicine only | Bricolage within NHS | Mix bricolage |
| Conventional and other | Avoidance of NHS with | Alternative / holistic |

| | | |
|----------|-------------------|-----------|
| medicine | miscellaneous mix | bricolage |
|----------|-------------------|-----------|

However, coming up with one typology for bricolage is not necessarily the best way to classify the richness of data found in the field. Thus, we suggest, in Table 4, a set of possible typologies that result from considering different dimensions regarding bricolage strategies. We believe it makes more sense to relate different types of bricolage depending on the dimensions that are taken into account. In this way, it is possible to identify bricolage depending on the type of system under consideration, or on the approaches to health and medicine, or the type of health behavior carried out, or considering the barriers faced by users and finally, the determinants of bricolage depending on the regimes prevailing in the field of migration, welfare and gender (the table should be read by column from top to bottom).

Table 5: Dimensions for typologies of bricolage

| Type of provider | Type of medicine | Type of health action | Type of barriers | Determinants of Bricolage |
|---------------------------|----------------------|-----------------------|-------------------------------|---------------------------|
| Public / NHS | Bio-medicine | Curative | Financial | Health |
| Misericordia/ Parallel | Alternative/holistic | Preventive | Cultural (language) | Immigration |
| Private/ cooperative | Traditional Healing | Healthy life-style | Administrative | Welfare |
| NGOs / Associations | Avoidance | | Discrimination | Gender |
| | | | Communication/ information | |

Discussion

The analysis of residents' interview data, offers a range of interpretations. One is that the intersection of health and welfare regimes in a given country offers a multiplicity of options for bricolage. Second, that the existing health and welfare regimes, because they are intrinsically embedded in each other, shape people's responses and their overall approach to acting in a certain way when a health

concern or problem arises. Thus, it may be that the health and welfare regimes themselves reinforce a particular response. So, the question is whether it is possible to think of a mind-set for common responses depending on predominant health and welfare regimes? Up to what extent does such a mind-set condition a normalized response? And, is that relevant for immigrants and foreigners too?

Interviews have illustrated very different responses both, for nationals and migrants residents; however, some general trends emerge from the data. Overall, there is a tendency among users to favour the NHS, sometimes with some internal bricolage or mixed use of NHS and other services. The predominance of the NHS is contradictory, because if it is true that residents identified many flaws such as waiting time and limited infrastructure, when health concerns are perceived as serious or complex, the NHS is expected (and recommended by doctors and health authorities) to provide the most sophisticated and accessible services. Thus in cases dominated by complexity and severity, the NHS is perceived as the best option, even if in certain occasions additional services or treatment from other sources are also used (holistic therapies, healthy life-style, NGOs, etc.). In addition to complexity, another factor that explains the preference for the NHS is financial limitations, thus when residents (native and foreigners) cannot afford immediate out of pocket expenses, they use the NHS even if that implies lengthy waiting times.

In the case of immigrants, if financial constraints are not an issue, some adopt the behavior that was common in their country of origin which varies broadly. For example, Brazilian respondents enroll in a health insurance or pay for private consultations, Chinese respondents commonly use Chinese medicine even if the entity that provides care is not officially recognized or licensed, and respondents from PALOPs (African Countries of Official Portuguese Language) where national health services are incipient or do not exist appreciate health services that would be considered poor for others. In this sense, respondents' experience of the health system in their country of origin plays a role in the way they behave in the host country. As a consequence, migrants tend to have different expectations about health services, mainly those provided by the NHS, depending on the performance of the health system in their country of origin. This is also applicable to EU citizens, who may have different expectations about the quality and gratuity of services provided. In addition, foreign residents seem to have more proclivity to use alternative or holistic therapies and healers.

In the case of foreigners, being third country nationals or EU residents may influence the way they assess health services, and thus, their options to find solutions for their health concerns. In this sense, legal status is relevant as a consequence of a set of factors. For example, regardless of the attitude of doctors and staff in health centres, immigrants, mainly irregulars, tend to be afraid of using public services as they may

not be aware of their rights; or simply they may avoid going to the doctor because they do not speak Portuguese. On the other hand, EU residents tend to be more assertive and know they have rights because they are EU citizens, and usually have their European health card. Overall, immigration regimes may be inclusive yet immigrants may still be excluded from the system.

In Portugal, the health system includes the NHS and some subsystems (such as ADSE or similar for police and armed forces), a parallel system known as Misericórdia, and the private insurance scheme including cooperative and low cost insurance. The NHS covers a large portion of the population, including migrants, mainly legal residents who have contributed to social security, but the NHS, when justifiable by law, also serves irregular migrants. Also, certain types of employment provide access to differentiated subsystems when private companies contract with private health insurance to provide coverage to their workers. In addition, Lisbon residents, natives and migrants, who can prove to be poor, have access to health and social services from Misericórdia.

Thus, residents who belong to the upper and middle classes as well as those of lower socio-economic status, access differentiated health services apart from the NHS. On one extreme, private health providers serve privately insured residents as well as public employers who through ADSE access the same services and health infrastructure such as hospitals, clinics, etc. (due to agreements between ADSE and health insurances companies). On the other extreme, residents living in poverty have access to SCML that provides several services, which include health services, free medication, specialty consultation, home help and visitation, and psychological support among others.

In addition, in cases of severe health problems, mainly disability, residents may access support from social security in terms of pensions (or employment leave) and other support such as transportation, housing adaptation, living in a secure and supported residence, etc. In this sense, social security complements health services. According to the current legislation, legal migrants and EU residents are able to access the same services as Portuguese nationals.

The analysis of actions taken by residents suggests some common trends. On the one hand, misdiagnosis regarding some health concerns has led residents to mistrust the system (doctors) and to get solutions through alternative strategies either within the NHS, private or mixed actions.

Self-medication was identified as a common practice among native and migrant residents. Overall people rely on their pharmacists (who they trust more than doctors) or on other therapies that include herbal teas, and food to solve their health problems. In addition, when things go wrong, those who have sufficient funds

use homeopathy, massage, and holistic practices. Immigrants and EU residents tend to use alternative medicines & therapies more than Portuguese.

Different practices of transnational health seeking are common and may include visits to the country of origin or other countries in search of Western or alternative medicine to solve an unresolved health issue, the use of internet, TV and other virtual resources in order to identify alternative solutions or to hold a consultation via internet, among others. This behaviour is more common among immigrants. However, using the internet for simple informative purposes was also found among Portuguese nationals. Using transnational health resources was common in situations such as: getting a second opinion after diagnosis or treatment failed, lack of trust in conventional medicine or in available health professionals, limited communication skills or language barriers, or simply higher levels of trust in the medical approach used in their home country. Transnational health resources are sought by internet, phone, skype, traveling to the home country to visit doctor or healer, sending/receiving medicine with friends and family members, among others. As transnational health seeking may take different paths, financial limitations are not always relevant in choosing this solution, as creativity plays an important role, people use community, and family resources in very resourceful ways.

Conclusion

The analysis of the 45 interviews carried out with residents of Mouraria and Lumiar provides evidence about the bricolage strategies commonly used to solve health concerns. These strategies are shaped by different factors such as the existing welfare state models for health and social security, the existing model of health and welfare in the country of origin, the previous health experience with the NHS, the level of health literacy, life style which varies according to age, origin, education, gender among others. Altogether these factors led residents to bricolage differently. Many opted for doing NHS internal bricolage (in cases of serious illness, limited health literacy, limited resources, etc.). Others used mixed bricolage to solve their health concerns by mixing NHS, Santa Casa da Misericórdia (common among the low income residents and elderly), private practice and/or NGOs. Another strategy identified involved the use of mixed alternative/holistic bricolage that in addition to using non-conventional medicine, practice a healthy life style and healthy behaviour. Finally, some people usually avoid doctors and the NHS, using a mix of other practices (alternative therapies, self-medication, etc.), usually after bad experiences with the NHS.

Richness of experiences identified in their narratives suggested creativity as a common approach to solving problems. However, the narratives also allow us to identify that often the drivers of such creativity are also diverse. For some residents,

desperation, frustration and not being able to solve their health problems were a trigger for seeking solutions locally and/or abroad. For others, health professionals who know the complex paths of the NHS were the ones suggesting, facilitating or enabling possible additional solutions, either by using other resources within or outside of the NHS, putting to work partnerships and formal or informal networking.

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