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Welfare bricolage in different health regimes: motivations, logics and tactics

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Abstract

This paper provides an overview of the findings from interviews with residents in four different European cities: Birmingham UK, Bremen Germany, Lisbon Portugal and Uppsala Sweden. It examines the actions that individuals take, in order to address a health concern, setting out the catalysts for seeking healthcare, the types of resources accessed and the reasons why individuals seek to use different combinations of resources. The paper outlines the different courses of action that individuals take including remaining within the public health system, bricolaging within that system, adding to the system, using entirely alternative systems or using no resources whatsoever. The ways in which they combine resources across different sectors and international borders is discussed alongside the use of virtual and social resources.

Keywords

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

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Introduction

The term bricolage has been used extensively to produce non-reductionist and realistic descriptions of the ways in which individuals or organisations make use of available tools, knowledge and support to solve a problem or complete a task. As yet bricolage has not been used in relation to access to welfare. In the existing literature which focuses largely on subculture, enterprise and institutions there is a clear emphasis upon making do, restricted resources, innovation, imagination and necessity, but also on reordering, re-using, subversion and transformation. Bricolage is seen as a predominantly local practice able to respond quickly to changing circumstances. Opinion is divided on whether bricolage represents the early stages of a response to a challenge or the second-best option – a cobbled together solution to a problem that is less than optimal. Much emphasis is placed upon the skilfulness of the bricoleur, whose activities to recombine resources and ideas frequently defy any simple idea of “fit”, “synthesis” or “integration”. Bricolage is invariably considered to be a process that is centred on finding a solution to a particular problem. For the purpose of this working paper we define bricolage in a non-normative way – neither thinking of it as necessarily second best nor as a good or even ideal solution. Bricolage is a frequently messy, but structured process of addressing one or several health concern(s). Understood as a process, bricolage is neither inevitably linear nor necessarily without interruptions. Time and again it addresses the tensions between restricted possibilities to deal with a health issue and the concern to attain the best possible care and outcome either for oneself or for family members and close friends. Our focus is specifically upon this field of tension in accessing health concerns and health care.

Within the process of bricolaging for health care access, several types of practices can be identified, ranging from the initial acknowledgment of a health concern, over activities geared towards overcoming perceived or real barriers and constraints and the search for information and navigational knowledge to the mobilization of support and resources, and to practices of combining, reordering or reconfiguring them. The aim of the paper is to identify the resources and practices respondents brought to bear in relation to health concerns. The paper focuses on patterns of activities in the sense of “logics” that govern individual’s attempts to respond to their health concerns. It also starts to explore how such activities varied according to the characteristics of the national health and migration regimes; the nature of their health condition and their social and / or demographic characteristics. The paper briefly sets out the methods used to analyse data (see Phillimore et al 2015 for a full description), the “triggers” that initially lead people to become aware of and acknowledge a health concern, the resources they enact to address the concern and the actions taken with those resources. The paper then focuses on the different motives and motivations residents put forward for doing or not doing bricolage across the four countries before identifying and describing six processes of accessing health care. It represents a first attempt to identify the logics of bricolage that pattern and governs individuals’ tactics and strategies.

The UPWEB project

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 & 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 sometimes transience of new migrant populations, have compounded problems faced by providers who lack the knowledge or political will to collaboratively design and deliver services that promote equal outcomes (Phillimore 2011; 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 difficult to offer tailored welfare services for everyone in superdiverse areas. A new approach to apprehending needs and developing solutions is required to reshape the future of European welfare in an era of unprecedented population change.

The UPWEB project seeks to reconceptualise welfare theory by asking how individuals and groups living in superdiverse neighbourhoods access healthcare. Superdiversity refers to increased diversification of diversity. It is often closely associated with globalised mobility, focussing on new patterns of movement generating greater population complexity and heterogeneity, and a faster pace of change than ever before (Vertovec, 2007; Arnaut 2013). Superdiverse neighbourhoods are frequently “arrival zones” (Robinson et al. 2007) receiving large numbers of recently arrived residents, and established minorities alongside a less-mobile majority group, often impoverished and/or elderly (Boschman 2012; Laurence 2013). Such areas often experience high levels of churn as new arrivals move in, then some move out, as they find their feet in the city and move elsewhere for better employment and/or housing possibilities. Superdiverse neighbourhoods might also attract individuals seeking the anonymity of a very diverse area (Pemberton & Phillimore 2016). Whilst diverse areas are not always impoverished, more often than not they are poorer than others. Welfare provision research has tended to neglect diversity (Craig 2007) and where considered, has predominantly focused on ethnicity (Berg & Sigona 2013). With diversity increasingly represented across a combination of variables: age, class, religion, length of residence, immigration status, and gender must be considered when re-thinking welfare for times of economic and demographic change. Interrogating welfare theory with empirical evidence that makes visible formerly under- or unrepresented forms of practice, struggle and work in accessing health care services and operationalizing the concept of bricolage and the process-description of superdiversity, allows the development of new welfare-access models, using health as a key example of service provision. Insights into the processes of welfare bricolage are intended to insert new thinking into welfare state futures with societal, practical, political and policy relevance.

The UPWEB project seeks to bring new conceptual and practical insights into welfare bricolage focusing on health. Introduced to the social sciences by Lévi-Strauss, developed by Derrida, de Certaut and others and adopted in a range of cultural and social settings, but not yet welfare research, bricolage is a metaphor referring to the pragmatic deployment and

redployment of material and ideas re-patterning daily life beyond structural or systemic intention or ideology. To promote a shift beyond the reification of ethnicity (Bradby 2003), often treated as an essentialised cause of poor health (Bhopal 2012), we propose superdiversity and change as further key features of welfare research which demand new ways of thinking about welfare delivery.

The populations of superdiverse areas are multi-layered and complex, hosting established residents (majority and minority) and new residents - people with a migrant background and others (Padilla et al 2014). Residents' experience of accessing healthcare in their current neighbourhood and elsewhere, varies, with a range of previous experiences, needs, knowledge sets, rights and entitlements and approaches to identifying and utilising healthcare (Phillimore 2011). Most previous research exploring healthcare amongst diverse groups has focused on service provision by sector; the role of the state (van Houtum and Pijpers, 2007; Rothgang et al 2010), third sector (Crampton et al 2001) or to a lesser extent small-scale private provision (Cant & Sharma 1999; Green et al 2007) and good practices on health provision to people with a migrant background considering a wide diversity of interventions from state to NGOs (Padilla et al 2009). Additionally, research tends to have focused on specific ethnic groups (Clark and Drinkwater 2007) rather than migration status or place (Jayaweera 2010) with little attention to informal (Krause 2008) and internet provision (Barker 2008; Gundersen 2011).

To avoid both reification and essentialism in conceptualising specific dimensions of diversity, we have sampled at the local level by neighbourhood and focused on a number of characteristics of relevance for people with a migrant background such as country of origin, ethnicity, race, migration status, as well as a broader range of characteristics of relevance to all populations, such as age, gender, socio-economic status, length of residency, among others. Thus, a key question which we seek to address is how and why do all types of residents in superdiverse neighbourhoods negotiate access to healthcare within and between different sectors? In addition, we also wish to explore how services are co-produced and how those excluded from formal provision locate alternative support via cultural mediators (e.g. Falge et al. 2012), via NGOs (in the context of exclusion; see Padilla et al 2012), through other forms of navigational support (Green et al 2014), or even work alone? Indeed, such questions are pertinent given the limited attention to date on the role of health, migration and welfare regimes in shaping access to healthcare for all types of residents living in superdiverse neighbourhoods.

Welfare theory and diversity

Welfare theory has dominated welfare policy analysis (Arts & Gelissen 2002), with debates around fitting countries to typologies (see Esping-Anderson 1990; Stephens et al. 2010; Isakjee 2016, Ferrera 1996) indicating that few national systems possess the internal consistency necessary to validate regime theory (Kasza 2002). Instead, typologies may function as a heuristic tool for comparison (Ferragina & Seeleib-Kaiser 2011) or an ideal type for analysing attributes of welfare states (Rice 2013). Furthermore, analysis must shift from social transfers (Jensen 2008) and the national level (Rice 2013) to local exploration and

specific services (Powell & Barrientos 2011), ensuring that diversity, long neglected, (Saxonberg 2013), is included.

Local welfare states have increasingly become the focus of welfare theorists, partly in response to the critique of welfare regime typologies, but also representing an ideological shift towards localism implying a focus upon place. The history, socio-economic and socio-demographic features of a locality and the way these shape service development and delivery are crucial when exploring the unevenness of outcomes (Andreotti et al. 2012). The rationale for localising welfare systems responds to the argument that as societies become more complex, individual needs are best met through empowering residents to work with local actors to tailor services to meet individual needs (Andreotti et al. 2012). The increasing importance of civil society (De Corte & Verschuere 2013), the emergence of specific demographic configurations such as superdiversity, and the imperative to reduce costs, all support a shift to the local where messy, complex, unexpected forms of everyday strategies combine, mix and link different resources. Such trends therefore need to be investigated and understood, given that they imply the concept of bricolage.

The emergence of welfare chauvinism as a tool of immigration control (Sales 2002) has the potential to exclude some residents, which may be particularly pertinent in superdiverse localities which have higher concentrations of non-citizens whose access to services may be shaped by immigration regimes linked to welfare inclusions and exclusions (Morissens & Sainsbury 2005; Sainsbury 2006). The challenge for local systems is to provide good quality, accessible welfare services for those in need, without reverting to re-familiarisation processes thereby increasing inequality and vulnerability (Andreotti et al. 2012) whilst implementing national regimes. Such actions have implications for neighbourhood sustainability and public health.

Healthcare and welfare bricolage

Neither regime nor local welfare state theory have focused in depth on healthcare (Bambra 2005b) although a body of work, with mixed findings, focuses on the relationship between income inequality and public health (see Wilkinson & Pickett 2005; Brennenstuhly et al. 2012), wherein health can stand out as uncharacteristic, particularly at the local level. The shift from social citizenship to active inclusion and individual responsibility underpinned by an increasing use of welfare chauvinism, means that even social democratic welfare regimes have 'insiders' and 'outsiders' with people with a migrant background and minorities most likely, although not exclusively, to be excluded (Bambra 2011). If we are to understand the impact of welfare states upon health, and the potential to meet the health needs of complex populations in superdiverse neighbourhoods, we must explore how access and experience vary by both national welfare state characteristics and local experience (Lundberg 2008) as well as the different worlds of welfare chauvinism that emerge from immigration regimes (Van der Waal et al 2013).

Focussing on the everyday experiences of all residents accessing healthcare, enables the development of new models of welfare bricolage by studying the process whereby all residents of a locality combine informal, formal and internet provision (where possible) in an

attempt to meet needs. Bringing superdiversity and bricolage together alerts us to the importance of context, and the difference that residents make to the practices of welfare systems. Welfare bricolage can be viewed as a fluid, relational, hybrid process, defined and operationalised from (inter)connections with elsewhere as well as from within. De Certeau's (2011) work on the "practice of everyday life" also – by implication - suggests an exploration of how the tactic of bricolage may be utilized by residents accessing different forms of healthcare.

The overall aim of the UPWEB project is to develop the concept of welfare bricolage to understand how residents of superdiverse areas access healthcare. We focus upon individuals' self-defined health concerns rather than specific diseases or conditions. We encompass the experiences and approaches of all residents in superdiverse areas and examine the role of providers including formal, informal, public, private, third sector and virtual. The objectives of the project are

1. To examine residents' experiences of accessing and communicating with providers and the approaches residents take to negotiate their access to healthcare. Enabling us to identify the wide range of healthcare that people use and to develop an encompassing, non-sectorial picture of provision and how individuals attempt to meet needs.
2. To investigate the factors which influence people's access to, and experiences of, healthcare including national welfare states, health and migration regimes. Enabling us to identify the wide-ranging and interacting variables that influence healthcare access, offering a nuanced understanding beyond the limitations of inequality or ethnicity.
3. To explore the ways in which different types of providers identify need and investigate the roles they adopt, and challenges and opportunities they face. Enabling an exploration of the challenges and solutions from providers' perspectives, interrogating how they respond to superdiversity.
4. To use the experiential knowledge of providers and residents to develop new models of provision and test the applicability of these models to a wider population. Resulting in the development of welfare bricolage models to inform policy and practice of welfare provision, offering a new framework and agenda for welfare futures research promoted through the dissemination of findings to local, national, and European stakeholders.

This paper primarily addresses Objectives 1 and 2.

The case studies

We used welfare regimes as a heuristic device to select countries of four different "ideal types" (Rice 2013) (see Table 1), with each case study country being sufficiently different to allow comparison (Yin 1994). The emergence of superdiversity across neighbourhoods offers commonality (Mahoney & Goertz 2004). Contrast between two superdiverse neighbourhoods in each city in terms of deprivation-level as well as their histories of immigration enables the comparison of national welfare systems and inequality.

Table 1: Characteristics of the comparison countries and neighbourhoods¹

	City	Selection criteria	Neighbourhood
Germany	Bremen: 10 th largest city 550406 residents, 24.54% PMB (deprived and skilled) from 162 countries.	Corporatist/Conservative regime. People with a migration background must prove lawful residence. Universal Health care regime, co-payments and private health services dependent on income.	Gröpelingen: 15705 residents, 44.1% PMB, 2 nd highest number welfare dependants (33.3%) within the city of Bremen, high deprivation. Long history migration. Increasing welfare dependency. Neustadt: 43699 residents, 26% PMB, students, people with a migrant background and middle-class. Decreasing welfare dependency with early gentrification. Long history migration.
Portugal	Lisbon: capital & largest city 547733 residents, housing half Portugal's people with a migrant background from 100 countries	Mediterranean or Southern Europe regime High levels of austerity & cuts. Residents pay fee for health coverage, redeemable with proof of economic need. Bureaucratic barriers to access.	Lumiar: 25.000 residents, 15 % people with a migrant background or PMB, high welfare dependency, high deprivation. Mouraria: 15000 residents, people with a migrant background from 30 countries since the 1970s. Welfare dependency paired with gentrification.
Sweden	Uppsala: 4th largest city. 202,625 residents, PMB from 174 countries (deprived and skilled)	Democratic, universal regime. Impermeable to irregular people with a migrant background. Minimal austerity cuts.	Gottsunda: 9924 residents, 53% PMB, high welfare dependency. Long history migration. Significant municipal investment addressing social problems. Sävja: 5330 residents, 39% PMB, pockets of deprivation and affluence. Few municipal resources. Occasional social unrest.
UK	Birmingham: 2 nd largest city. 1,073,045 residents, 22.2% FB, 46.9% EM from 187 countries.	Liberal approach Austerity cuts. Restructuring of welfare state. Healthcare free except irregular people with a migrant background. Increasing welfare chauvinism.	Lozells and East Handsworth: 31074 residents, 44.9 % FB, 89.2% EM, 5 th most deprived ward. Long history migration with recent increases and diversification. Edgbaston: 24426 residents, 29.2% FB, 42.2% EM, 34 th most deprived ward. More recent history migration.

¹ Abbreviations: PMB: Person of Migrant Background, FB: Foreign Born, EM: Ethnic Minorities, IM: immigrant background – definitions and terminology vary by country so data are not comparable. Table is intended to give an overview of characteristics

Data for Germany: 2012 national census and Arbeitnehmerkammer: Bericht zur sozialen Lage 2013

Data for Portugal: migrant definition: foreign

M3n born and ethnic minorities

Data for Sweden: foreign born and ethnic minorities

Data for the UK: 2011 Census, migrant definition: FB: Foreign born, EM: ethnic minorities

Method

We broadly adopted a community research approach established in the UK wherein poly-lingual local residents received research training (Phillimore et al. 2009; Goodson & Phillimore 2012) and were initially paired with academic researchers to identify respondents and undertake interviews. These community researchers (CRs) were recruited via community organisations, universities and local networks, using a formal process (job description, application, short-listing, and interviews). The CRs utilised their language skills, local networks and knowledge to identify services, access respondents, and help shape research tools. The approach that is established in the UK had to be adapted considerably to local realities in terms of recruitment, training and local residency across the four countries.

A total of 160 interviews was undertaken with residents in the eight neighbourhoods (see Table 2) some of which were undertaken as paired interviews between a community researcher and one of the research team and others by a community researcher alone. Interview questions asked respondents to describe a recent and their most serious health concern that they had felt needed addressing since moving to the neighbourhood and examined where possible in chronological order the actions individuals took to address that health concern. Some respondents had several health concerns needing attention whilst others reported on just one concern. Where individuals did not have a concern, they were asked to report on the health concern of a dependent and how they had been addressed.

Residents were identified through multiple mechanisms including researchers' networks, community organisations, word of mouth, approaching individuals on the street and snow-balling, with sampling undertaken according to maximum variation approaches (see Phillimore et al 2015). The methodology employed was approved by all relevant ethical review committees. Each respondent gave informed consent and all data were treated as confidential. Interviews were undertaken in multiple languages working in the chosen language of respondents. Interviews were then transcribed in full by researchers and a sample of at least 20% of transcripts translated into English. A case study summary was completed for every interview which outlined the nature of individuals' health concerns, the actions they took to address that concern, the resources employed and the reasons why they took particular courses of action. This working paper is based upon the systematic thematic analysis of 160 case studies from the eight neighbourhoods in the four cities participating in the study. The analytical framework was designed collectively and implemented in MAXQDA.

	Portugal	UK	Germany	Sweden	Total
Number of case studies	43	40	41	36	160

Findings

The remainder of the paper outlines the main findings from interviews with residents focusing upon identification of common and contrasting experiences. We begin by examining the "triggers" or catalysts that made residents aware of a health concern and take action about their health concern. We proceed to discuss the resources enacted, the nature of the actions

taken, motivations for acting and the barriers and opportunities residents faced before thinking about how and why individuals did or more or less bricolage in particular ways and whether it is useful to talk about not doing bricolage at all. Note we use local respondent codes to denote which respondents we are referring to in our narrative.

“Triggers”

This section briefly explores the catalysts that made respondents aware and concerned about some aspect of their health of and of the need to do something about it.

The majority of respondents waited to address a health concern in the early stages after the emergence of symptoms although those who spoke about their children’s health concerns often waited less time, if at all, before seeking help. Thus, with the appearance of pain, dizziness, bleeding, nausea, a lump or tiredness they initially watched and waited to see what happened. If the symptoms intensified or did not subside after a period of time they sought to address the concern, most frequently after consulting with a friend or family member either living nearby or more distant: elsewhere in the country or abroad, in the case of people with a migrant background.

On other occasions concerns were revealed as part of a routine check-up perhaps related to an individual’s age. Some health concerns were diagnosed when another medical problem was being checked. High blood pressure and diabetes were frequently diagnosed in routine checks. The emergence of allergies, often to something unknown, and symptoms such as itching, rashes or sneezing, also led to individuals seeking a resolution. Others spoke of feeling weak, experiencing numbness, losing weight unexpectedly, digestive problems, urinary problems, recurrent headaches, thinning hair, fainting or having difficulty sleeping or eating.

Some of the residents we talked to and interviewed outlined their responses to addressing long-term conditions including persistent pain, disability or congenital problems. Addiction and obesity were also raised as health concerns requiring attention. These conditions may have been present before respondents moved to their neighbourhood, and for some people, from birth. We explored the actions they took to live with or resolve (if possible) such problems.

More urgent action was taken in the event of an accident – transport to the emergency clinic could be by ambulance, taxi or being driven by a friend or neighbour. Emergency situations such as a collapse, paralysis or major breathing difficulties were frequently addressed in the same way as accidents. Some respondents talked about their actions around pregnancy or post-partum complications or upon their concerns about their children’s health. A small number of people talked about addressing the health concerns of their elderly relatives. A small number of patients outlined health concerns relating to the side-effects of biomedicine. Others talked about problems with their vision or tooth pain.

Stress, anxiety and depression were conditions frequently raised across the four countries. These could be associated with loss of someone they cared for, to migration, isolation (particularly for elderly), difficult living conditions, exhaustion, uncertainty about their future and other concerns. Frequently psychological conditions appeared to be connected with, or

possibly the underlying cause of, physical problems. In the UK and Portugal, the psychological dimension of complex problems appeared to attract very little attention from mainstream services. In Germany and Sweden there were more services but these often had a lengthy waiting list.

Resources

This section categorises the types of resource that respondents reported using to address their health concerns which we have categorised into nine separate categories (see Table 2). These resources range from formal resources which we define as those which are provided within state healthcare systems (the availability and definition of which varies between health regimes) over social, complementary and spiritual resources to online and offline information and life style changes. It is important to note that not all resources were available in every country. In Sweden and to a lesser extent Portugal, state services attracted a routine charge, yet there are exemptions available for certain populations. In the UK all formal services had to be accessed via the General Practitioner unless respondents went directly to emergency services and their health concern was deemed serious enough to warrant direct referral to a specialist. Most individuals eligible to access the NHS were attached to a particular healthcare practice which they are compelled to use unless they de-register and then register with an alternative practice. In the other three countries the extent to which individuals were able to access “a family doctor” with whom they were able to develop trust and understanding varied.

In Portugal family doctors were in short supply so those who had such a doctor tended to remain registered with them even if they have moved some considerable distance from their healthcare centre. For specialists, the NHS in the UK offers options in hospitals and consultations are generally accessed by the referral of family doctors. In Portugal there are sub-systems of the NHS meant for public servants, the armed forces and the police, which function as insurance, whose beneficiaries may access private doctors, clinics and hospitals. The NHS, its subsystems and private schemes have different level of access to alternative or complementary therapies (i.e. physiotherapy, psychology, etc.). In Germany, where almost everybody has health insurance, the costs of which are deducted from wages, individuals had considerable choice regarding their doctor but also specialists and could select their own specialists, avoiding those recommended by their general practitioner, should they wish. Accessing a second opinion about a diagnosis is routinely available in Germany, whereas in the other countries the case for another opinion would need to be made convincingly by patients. A wide range of services could also be accessed via health insurance in Germany including physiotherapy, acupuncture, homeopathy and spa treatments, even so these treatments must be partly paid for in addition to the regular insurance fees.

In Sweden wide-ranging services were available and in theory residents could elect which to use. Some of the non-formal resources utilised may have been approached on the advice of a doctor. However, in practice there was a triage service at many healthcare centres, which determined which services residents could access and meant that healthcare professionals had a considerable amount of discretion in terms of who accessed services. This - coupled with lengthy waiting times - pushed some respondents with more pressing problems to

attend a privately funded emergency walk-in clinic where they could access a doctor without going through triage on a same-day basis.

Sometimes respondents were encouraged by a medical professional to drink tea to help recover from a virus whilst on other occasions they imported teas from relatives “back home” which they imbibed on their own initiative to promote good health or to address other health concerns. Thus, it is important to note that there is considerable blurring of boundaries between different resources. Some individuals used multiple resources at all stages of addressing health concerns while others focussed on particular types of resources at different stages. Formal resources were most frequently used – in some cases these were the only resources employed but often they were used in combination with other types of resource. The ways in which individuals act in relation to health concerns with combinations of resources listed below is discussed in the next section.

Table 2 – Types of resources used to address health concerns

Resources provided by the official health system	GP, healthcare centre, public and private hospitals, A&E, midwives, osteopath, physiotherapist, medication, interpreter, pharmacy, nutritionist, walk in medical centre, scans, mental health clinic, psychologist, gynaecologist, paramedic, ambulances, cardiologist, orthodontist, nurse, podiatrist, pharmacy, prescription medicines, blood tests, urine test, MRI scans, X-rays, NHS or equivalent helpline, check-ups, participating in medical research, private emergency healthcare centre (Sweden), Misericordia (Portugal),), hearing specialists, official interpreters, day care centre, rehabilitation centres (residential and day), state provided carer, dentist, optician, counselling, eye hospital, carers at nursing home, transcultural psychological support clinic (Sweden), arthritis school (Sweden)
Over-the counter remedies	Painkillers, cold and flu remedies, flight socks, unspecified over the counter medicine
Social resources	Friends, family, medical professionals in network, Church, self-help groups, Chinese Cultural Centre, local associations, local meeting places, Vegan Society, formal carers, Skype conversations back home, social worker, informal interpretation, neighbours, medicine exchange, social activities organised within the community, friends and family as unofficial interpreters, financial assistance from friends/family to cover treatment costs
Alternative/complementary resources	Chinese Medicine, herbs, teas, ice, drinking water, acupuncture, massage, supplements, vitamins, cream, compression socks, Hakeem, reiki, traditional remedies, oils, Ayurveda, yoga, cupping, meditation, homeopathy, salt

	water, music therapy, special fruits, shiatsu, fasting, ginger, homemade medicine, sauna NGOs, anti-racist and refugee-networks, funded by donations, catering for undocumented, “illegalised” people with a migrant background (see Castandea 2008, Castaneda 2013)
Spiritual resources	Prayer, Shaman, spiritualist, Hakeem, healers
Transnational resources	Consultations in former home countries or other countries of former residency, medicine sent from other countries, specific foods, teas and spices, advice from friends and family back home, going overseas (but not home) for treatment, Skype consultations, health holidays for people with MS
Lifestyle	Diet change, specific diets, exercise regimes for fitness, specific exercises to address pain in particular part of the body, relaxation, drinking water, eating oranges, milk and honey, honey and lemon
Information sources	Internet – especially Google and Youtube, chatrooms, Chinese social media, online advice, TV programmes, health magazines from various countries, UKVI provided information, medical books (from case study country and from overseas for people with a migrant backgrounds), scientific articles, talk shows, HIV tests in NGO, radio.
Other	University counselling services, privately paid rehabilitation, voluntary support system for sans papiers people with a migrant backgrounds (Germany)

Actions

In this section we focus on the different factors that can influence individual’s ability to mobilise resources. Once conscious of a health concern, respondents mobilised some of the resources set out above in an attempt to first understand their concern and get a diagnosis and second to address that concern. A generalised overview of the multiple processes enacted to respond to concerns is set out below – it’s important to note that responses to concerns depended very much on the nature of the health concern but also upon the health beliefs, ability to mobilise resources, levels of agency and knowledge of how to use the health system, the accessibility and approachability of the health system and barriers faced by individuals.

In the beginning

In the first instance after the emergence of symptoms a period of orientation and observation was common except for those with acute or very serious health concerns— often advice received from others sparked a trip to the doctor (Gotts 01 S2). People with a migrant background appeared more likely to wait – perhaps not sure when they should go (UK35 UK6). Some were spurred to visit a GP after a deterioration of symptoms (UK18 UK4). If a concern was non-urgent there was a tendency to wait to see what happened next. Some respondents just waited while others self-treated using over-the counter medications, traditional remedies (people with a migrant background and established populations), food as medicine, rest or particular exercises. The internet was widely used – one 82-year-old woman from Mouraria (Lisbon) was a competent user seeking as much information as she could find in order to take control of her treatment. The majority of respondents used the internet to find information about their concerns. Young people were most likely to use the internet “*of course the internet!*”. Most of those unable to use a computer or without access to Wi-Fi had access to a relative, usually a son or daughter, who searched for them. Some chose not to use the internet and appeared a little fearful of it. A woman from Handsworth (Birmingham) explained how she continued to use it even though it could sometimes make her feel even more anxious. A substantial minority of individuals lacked internet access (even ability to use a computer), knowledge about health systems and support networks and were particularly isolated and uninformed about how to address health concerns.

Pharmacy use was also typical in the early stages of a concern. Pharmacies were used to purchase medicine – even in Sweden, with universally accessible neighbourhood-based primary care, individuals chose to go to the pharmacy and self-medicate rather than go to the doctor. Extensive pharmacy use was observed across countries but most of all in Portugal. For those with few resources or little time the pharmacist was seen as an alternative to attending the healthcare centre. They did not have to pay for a consultation, only the medication, and they did not have to spend hours waiting for an appointment. Time was particularly important for those working long hours. In Portugal several respondents expressed a preference for the pharmacy over the doctor. Those from India and Nepal felt that a certain pharmacist had developed a good understanding of their communities and was considered more trustworthy than doctors at the healthcare centre who were experienced as dismissive of their problems

The question of whether or not to seek mainstream medical attention frequently involved family and friends – mostly those in the immediate neighbourhood. However, there were instances where individuals waited months before acting on a health concern. For example, one migrant from Uppsala did not recognise that her problem required attention until she went back home and her sister, a nurse, diagnosed fibroids and told her to see a doctor.

Seeking some treatment

After a period of watching and waiting and/or self-treatment many people sought formal medical attention. In Portugal some respondents went to the emergency department in hospitals for bad flu or gastroenteritis - one respondent reported doing this because medical

attention in the emergency room at the public hospital was faster and free whereas he would have to pay a fee to get an appointment at the local healthcare centre, wait longer and probably not get tested. Other respondents, if they had free access to health care (UK) or health insurance (Germany) went to see a doctor, often just to seek reassurance that there was nothing serious wrong with them (UK 21 UK5). Some respondents were told by their doctors that they needed to instigate dietary and lifestyle changes. Many also identified the need for change themselves and reworked their lifestyles in an attempt to address a health concern (Devi P5, Max G2).

Across all countries, but less so in Sweden, there were individuals who favoured self-treatment in all except emergency situations. They often tried to self-diagnose using medical books or the internet or alternative or traditional practitioners such as a Chinese medicine practitioner (UK6 UK2). Many spoke with friends whom they trusted with their health and who shared their beliefs around self-care and prevention. While some individuals felt they were better placed to be the expert in their own bodies and health concerns than their doctor, through undertaking intensive, sometimes highly technical research into their symptoms, others did not have faith in, or had lost trust in, biomedicine after experiencing some kind of problem or misdiagnosis. Those individuals made concerted efforts to avoid mainstream services. Many of the approaches of these individuals were informed by beliefs about the importance of adopting a natural, holistic approach which treated the whole body and dealt with the cause rather than, as was claimed for biomedicine, the symptoms of an illness. In Portugal and Germany there were examples of individuals who self-treated because they could either not afford medical attention, felt excluded by the service because of perceived discrimination, inability to understand what was going on and/or communication problems. In all countries except the UK some respondents were excluded by the system because of their immigration status. These individuals had little choice but to self-treat. In Germany one individual used his doctor to get a diagnosis and some sick leave. He then self-treated. Several respondents across all countries made an active decision to decline treatment offered, not take medicine or to take a different dose – largely, in the case of medication, without the knowledge of their doctor. There were also examples of medication exchange where respondents took medication that had been prescribed to their peers. Some purchased medication from abroad or were sent it by people in their transnational networks.

Some individuals across all countries had access to a friend or family member who was a medical professional. They would often communicate with this person about their problems before seeing their own doctor or in parallel with consultations so that they could arrive informed or check on suggested treatments or medicines. People with a migration background frequently connected with professionals from their country of origin or with individuals who had migrated elsewhere (i.e. USA). Individuals such as Nagette (G5) in Bremen had little choice but to self-diagnose or speak to friends to try and collectively diagnose a health concern as she had no health insurance and was for some time unaware of services run by anti-racist and refugee networks, financed by donations, which could offer treatment to the uninsured and undocumented.

In Portugal the elderly and disabled were frequently assisted by navigators from social services or associations. This was observed to a small extent in the UK (UK 10 UK2) where local faith-based organisations were very helpful and Sweden where two elderly Iranian women were helped by the local association. They also accessed a particular health clinic because a Persian-speaking doctor was employed there. Elderly and frail respondents in Mouraria brokered support from parallel systems such as Misericordia so they could access free medications and be helped to reach services. Volunteers collected them and drove them for medical attention. In Lumiar respondents living in a residential home for the physically disabled received much help from carers without whom they could not reach medical attention given that few facilities in the neighbourhood were wheelchair friendly.

People with a migrant background with basic host country language relied heavily on informal interpretation in all four countries. The lack of ability to communicate could prevent individuals trying to access care – this was observed in Germany, Portugal and UK (UK 40 UK6).

Most respondents' non-serious health concerns were resolved pretty quickly by themselves, after self-treatment (sometimes referred to in medical education as the symptom ice-berg which does not arrive at a clinical consultation), or a trip to the doctors. Others had to address more persistent concerns.

Addressing a persistent concern

Diagnoses could be elusive or treatment ineffective so that health concerns continued without resolution or sometimes deteriorated. These longer-term or more severe concerns were largely directed towards a consultation with a physician. As noted above in Portugal some individuals went directly to emergency services at the public hospitals and from there were referred to specialists, often in different public hospitals, for attention. Referrals to specialists were made more readily in Portugal and Germany – frequently after one trip to the doctor with waiting times highlighted as a problem in Sweden. Some Swedish respondents got around waiting times and a triage system that they felt prevented them from accessing a doctor, by going to the private emergency healthcare clinic. In Germany individuals did not necessarily go to the specialist or hospital suggested by their GP – some followed the recommendation of a friend (Bim G1) or tried several specialists until they found a specialist they liked (Olga G3) – the system allowed repeated consultations on the same issue with different specialists.

Doctors in the UK frequently adopted a wait and see approach. There were many examples (reflecting our earlier research in the UK) of the “paracetamol service” – individuals were prescribed painkillers or, in a number of instances, were told to buy their own and come back if their condition did not improve. There were several examples of individuals making multiple visits before getting a referral. Whether or not individuals were referred to a specialist quickly seemed to depend on their being persistent and assertive (UK8 UK2, UK28 UK5). In all countries knowing the system: described by Shim (2010) as possessing cultural health capital, a strong idea of what they wanted as an outcome of a consultation with the doctor and preparedness to request a consultation, were more likely to result in a referral than waiting for the offer of seeing a specialist. In the UK there were examples of services

which lacked approachability and where individuals were not referred despite quite serious and enduring symptoms. These individuals were often deferential to their GP, and / or were not supported to understand how to utilise the system. While some were people with a migrant background and communication barriers were part of the problem, some elderly people did not ask for a referral so were not offered one. In Germany and Portugal there appeared to be considerable choice available to respondents – if they had health insurance or money. In Portugal it is common that residents go to the family doctor in order to get doctors' prescriptions at a discount prices. Those who have good relations with the local pharmacist may even buy the medicines and later provide them with the mandatory prescriptions, usually in case of long term illness or treatment (PMou05).

For the most part German respondents received treatment within the system whereas in Portugal individuals those who could sometimes paid for private care if they had little faith in the state system or were not prepared to wait. Many individuals lacked resources to pay for accelerated access to services and faced long waits such as a one month wait for an appointment about a chronic back condition which prevented the respondent from working. In Sweden and the UK people were most likely just to use the formal system but systems were complex and often access was aided by someone to advise them informally or offer some type of navigation support. The languages spoken by medical professionals often shaped decisions about where to seek care in Sweden, Portugal and Germany. In the UK respondents had little choice about who they saw and often used an informal interpreter, in the form of a friend or relative, to communicate their problem. Formal interpreters were available but often said to be unhelpful – they would sometimes not attend the appointment leaving the respondents without interpretation or they would speak a different language or dialect to the respondent or respondents did not know about the availability of interpreters as a resource.

Once in the specialist system people received tests and scans depending on the nature of their problem. Diagnoses were often accompanied by the prescription of medication or referral for further treatment (i.e. physiotherapy) or surgery. Not everyone took the medication they were offered or followed instructions expressing concern that the medications were designed for ethnic Europeans who were perhaps heavier. Some questioned the dosage and looked online to check if they should take less medication or worked out their own ways of taking it that might reduce the intensity of side-effects. Others looked for alternatives that would resolve their problem but without side-effects (GGro31-Musikus). In Portugal people negotiated different medications from hospital and local doctor trying to access what they prefer. Some rejected the medication offered by their medical professional (Gotts 5 S1; Check) and others took biomedicine sent from the country of origin or abroad (GGro10_Bati, Leonora G3; PMou03) or purchased their own medications (GNeu05; UK33 UK5). Several respondents refused surgery preferring to treat their conditions in a less invasive way (i.e. Sebastien P5, Jay G2; UK36 UK6).

Some of our respondents had severe, intractable or chronic conditions that could not be resolved quickly, if at all. The slowness of the system, misdiagnoses (GGro01-Kerstin; PMou03), or the enduring nature of the problem could all contribute to slow or no resolution. In these situations, many people tended to look for other solutions becoming highly skilled in

finding information about their conditions and exploring possible treatments – largely using social networks and the internet. Those with transnational connections spoke with friends and family overseas, took the opportunity to get a consultation when they were on holiday back home (UK8 UK2) or even consulted a medical professional via telephone. Several people talked of having medicines sent from other countries either by friends and family but also sometimes by family who were medical professionals. Others searched the internet and experimented with other systems. Reiki, acupuncture and Chinese Medicine were most popular but homeopathy and herbalism were mentioned too (UK7 UK2, UK36 UK6). Some individuals used multiple systems. For example, Pedro in Lisbon was diagnosed with tinnitus at the age of 26. Once told by the hearing specialist that his condition was incurable he set about systematically seeking a resolution by informing himself online, returning to Mexico for treatment, consulting friends and family, taking teas and balms from his Pakistani and African neighbours and trying Chinese Medicine and spiritualism while taking the magnesium supplement he was prescribed by the hearing specialist in Portugal.

Many people with an intractable condition expressed the desire to seek more alternative treatments - especially acupuncture or herbal medication (UK 11 UK3) but lacked money to pay for alternatives. A small number of individuals elected to accelerate access to care by purchasing private medical insurance (No title G5, PLum34). Most people depended heavily on the state system even though they believed it was not working for them (UK22 UK5). A small number of individuals went abroad to seek treatment of a condition that could not be resolved (PMou03) or because they were excluded from the system (Gotts 03 S1).

Those with personal social networks that include a medical professional used that professional to check on their treatment (Mahmoud G2, No title G5, Gotts 4 S1, Gott11 S3, UK9 UK2) or diagnosis (PMou03). Others checked up on their care using the internet or advice from friends or family who did had the same condition (Gotts 4 s1).

Mental health problems were frequently raised, sometimes connected to physical health problems, but rarely treated (Gotts 03, 02 S2, UK 37 UK6). There was a long wait for psychological treatment in the UK, Sweden and Germany. One respondent chose to go to a self-help group in Bremen whereas elsewhere individuals tried to make themselves be sociable to overcome depression – rather than take the anti-depressants offered by specialists. In Portugal a number of respondents highlighted anxiety or stress as major problems in their lives but appeared to have no access to treatment. In Portugal it is common for doctors to prescribe antidepressants but there are few other services available.

Throughout the study we identified individuals who were extremely pro-active in their actions to address health concerns. The internet, advice from friends and family and medical professional acquaintances played an important role from the emergence of symptoms to dogged attempts to access multiple resources to deal with intractable problems. However, in every country there were individuals who we might describe as “loyal users of the system”. Such individuals attended their appointments, accepted their diagnoses (or lack of), took their medication and followed the advice of their medical professionals largely unquestioningly even if they did not understand what was happening to them. While some of these individuals did achieve a resolution, others continued to attend treatments despite little progress or gave

up hope that their health concern would be addressed. Elderly people, those with low levels of education and some people with migration backgrounds were most likely to persevere with a health professional even when they had little faith in the service they were receiving.

Perceived difficulties and opportunities

Individuals' ability to access different health resources was shaped by a range of perceived and real barriers and opportunities. These are discussed below.

Lack of trust in the system

Lack of trust in the services provided by the official healthcare system was discussed extensively across all four systems particularly in light of healthcare reforms. Not being able to access a familiar healthcare professional who knew your medical history and who you felt had some kind of vested interest in your care made individuals feel that they were "just a number". It is very difficult to identify the implications of lack of trust in terms of access to the wider formal healthcare system. Respondents felt that it was an indicator that they were not getting an optimal service, or they had been misdiagnosed or mistreated. There is no doubt that this feeling led some people to seek access to other kinds of resources: to pay for a second opinion (although in Germany this was routine and not a signifier of dissatisfaction), to check up on their diagnosis, seek a different specialist or treatment or to opt out of the system altogether.

Lack of confidence or assertiveness

In every country there were individuals who were unhappy with the formal services they had received, perhaps even convinced that they had been misdiagnosed or actually had been misdiagnosed, yet were not feeling secure enough or did not find sufficient confidence to voice complaints about the service they received or to assert their needs to their doctor. In Germany where it is easy to change doctor, people continued to see the same doctor even if they felt he or she had made mistakes. For some this was a matter of not being confident about how the system worked so not feeling sufficiently confident to offer their own views about what "should" happen to them. In other cases, individuals were unhappy with treatments, had an idea about what they felt they should be offered, yet did not feel they could assert their needs or express their ideas. It appeared that services were less approachable for people with a migration background, those with lower levels of education or income and the elderly. It was evident that some providers were inattentive to some patients perhaps being too stressed or lacking the time to engage with them in a meaningful way.

Communication

Health systems appeared unable to communicate with people who did not speak the majority language or English. Respondents recounted inability to communicate effectively with providers as an important barrier to accessing the formal healthcare system (UK 1uk1, UK 2, & 3; UK8 uk2; UK12, 34; 35, Gotts 7,11,13, Tinka El Condor PMou08-Tanvir, PMou01-Neeta, PMou12-Dimple, PMou13-Sonia, PMou17-Norma, PLum36-Iva, Plum37Eurico). Interactions between professional and patients with a migration background were less than perfect, yet

poor communication extended beyond people with a migrant background. Numerous respondents, particularly the elderly, those with lower levels of education or confidence (UK11, 12; 18) outlined being unable to understand the technical language used by medical professionals. Thus Plum37-Eurico whose five-year-old son had a condition known as Peter's anomaly, and was his full-time carer, explained that he did not know very much about his son's condition or the specialist treatment required. Eurico managed to get some help from a specialist association but it was not adequate to support him through multiple interactions with professionals. The inability of health care professionals to communicate important aspects of his son's condition and Eurico's inability to understand what was offered to him as an explanation may have implications for his son's care.

Elsewhere individuals complained of medical professionals either not being caring enough to communicate or not having time to communicate. Those without confidence in their understanding the system and/or in communicating with professionals in situations with profoundly unequal power relations reported confusion when confronted with situations where they saw communication as not possible. These were the individuals who would not ask for further information or assert the need for a specialist referral (UK 16 & 18; 28; 37; 40; PMou13-Sonia). It was evident that few attempts were made to help them understand complex health systems. A set of expectations of possessing the cultural health capital necessary to engage with health professionals and the health professional was expected of patients to ensure communication. These residents often left the interaction dissatisfied and feeling hopeless. It is possible that those with lower levels of education and confidence were the least likely to know how to access information and alternative resources elsewhere. Further research is needed to understand why some interactions are unsatisfactory.

Knowledge

Communication and knowledge go hand in hand – lack of communication meant insufficient (or not sufficiently understood) knowledge about procedures and treatments (Gotts 4). In Germany this appeared particularly problematic for recent people with a migrant background or refugees and people with a migrant background without very good German language competency – certainly Bati and Tinka reported not being given enough information about their concerns. In addition, many lacked information about entitlements while health professionals or staff were said to be reluctant to provide that information or uncertain themselves. For example, Ols was unaware that she could access midwives to help monitor her pregnancy (provision of such care is closely linked to reductions in maternal and infant mortality rates (see Phillimore 2016)). Further she did not know that she could be offered home help in the days after delivery. Some wanted to use more alternative resources but did not know how to find out about them (Leonora) or where to access particular kinds of herbs (Nagette). Individuals with small or no networks were in the weakest position in terms of accessing information – word of mouth was probably equally important as the internet in information provision (UK4 uk1). However, as we establish above, inability to use the internet was also problematic for some people. The movement of much knowledge and information online is problematic for some respondents – they need to have awareness of search terms and locations as well as access to appropriate equipment and Wi-Fi.

Time

Waiting times were highlighted as problematic in all countries but especially the UK and Portugal (plus Gotts5, 12, 7). The length of wait led to some individuals reporting giving up on getting access to formal resources. For example, in Germany Max apparently decided not to bother with the pain clinic despite being in permanent pain because the wait was too long. In Portugal several respondents reported walking out of hospital despite not feeling well because they could not wait any longer. Individuals incapacitated by pain had to stay off work for longer and in the end many were driven to seek alternatives, either instead of state provision, or as a stop-gap while they waited. Reiki, Chinese Medicine and acupuncture were very popular gap fillers with varying degrees of satisfaction reported.

Time was also important in two other dimensions. Several respondents reported having insufficient time to spend with their doctor which they believed may have led to misdiagnosis (UK10 uk2; 28, Leonora, GGro01-Kerstin Germany). The overall feeling of being rushed enhanced the sense that they were unimportant at a human level and were instead a unit or number that the professional had to process. Finally, some respondents, particularly in Portugal, outlined working very long hours or having small children and not being able to wait for medical care. Hence the strong reliance on self-treatment and pharmacy care.

Exclusion and discrimination

Healthcare systems themselves could exclude individuals. As noted above those with the wrong immigration status were overtly excluded. But bureaucratic rules and regulations concerning proof of entitlement were onerous in Portugal and Germany with Adele, PMou03-Isabella and PMou08-Tanvir struggling to prove that they were allowed to use the system. El Condor in Germany tried several doctors before he could find one prepared to register him.

As noted above several respondents, mostly in the UK and Germany but also Portugal and Sweden highlighted how as “foreigners” they were treated differently. PMou07-Zahid, an HIV positive man, explained how medical professionals discriminated against him when he went to A&E having had a heart attack. Whether this discrimination was because of his migrant origin or HIV status is unclear but the outcome according to Zahid, was that denial of the right emergency services reduced his heart capacity by 33% and he had subsequently not returned to the hospital for check-ups to monitor his heart disease. In Mouraria, some people with a migrant background complained that doctors, even if they mastered the English language, did not want to carry out the consultation in English because in their opinion people with a migrant background should learn Portuguese. In Savja, Sav 11 cited both his own, and his mothers’ experiences in Accident and Emergency care as problematic. Both argued that ethnic Swedes were given priority treatment with his mother ignored until she collapsed. As a result of these experiences he tries to avoid state provision preferring self-treatment or self-funding private care. In Lumiar, Plum26-Emmanuel and Plum30-Magda, both wheelchair dependent, outlined that they were treated differently by medical professionals: they felt patronised and pitied which undermined their confidence. Further medical services had made no concession to wheelchair accessibility. This too was a problem for elderly and frail Portuguese like PMou10-Florida and PMou11-MSantos. They and respondents with

disabilities were entirely dependent on volunteers and associations to help them to access care – unable to be independent. This problem was not evident in any other country.

Unmet expectations

Healthcare centres in superdiverse neighbourhoods worked as foci (in UK, Portugal and Sweden) in which people from many countries with different health experiences and expectations attend with those originating in the country, to seek help for their health concerns. Some respondents were used to different systems and wondered at the lack of routine check-ups or absence of certain equipment or testing abilities. Further, some people with a migrant background worried that GPs lacked knowledge about people from their background – should Chinese people take the same dose of medication as white British (UK15)? These concerns were not expressed to medical professionals so respondents tended to make their own decisions about medication dosage – using the internet or their own intuition. In Germany the loss of local services following centralisation was highlighted as problematic (Ludwig), specifically by older respondents. In Portugal concern was expressed about the lack of personnel who had knowledge about disability or some congenital diseases. Such concerns could rarely be addressed by seeking resources elsewhere. In all of the countries some respondents reported strong and enduring relationships with specialists who helped them to deal with long-term conditions but also helped with other health concerns when individuals asked for assistance because they either did not trust their regular doctors or faced a long wait to see them. Rather than go to a general doctor for a new medical problem those individuals frequently raised their new health concern with their specialist who would then refer them to the appropriate treatment.

Poverty

Many of our respondents talked about the different resources they used to address their health concerns as outlined in the actions section. Yet many would have liked to engage more with alternatives while some could not afford any at all (UK5 uk1; UK17 UK22 &33 &28; Adele PMou01-Neeta, PMou19-Anu, Emmanuel PMou22-Sebastian PMou21-Pedro). Further many respondents knew that they should be eating fresh food and taking exercise but lacked the time and the resource to change their lifestyles. Indeed, some people with a migrant background described jobs, often in catering, with long hours and poor working conditions that they perceived to be direct contributors to, or causes of, their health concern. UK35 reported long-term problems with back pain and a frozen shoulder which he was working through because of his need for an income. It was also clear to our interviewer that he was very stressed about his work and long hours and this was related to his physical problems. He repeatedly visited his GP and waited before being referred to a specialist to request a referral at an earlier stage. He had no time or money to see a private physio while waiting. His wife helped him to navigate the system as much as she could as her language was better than his. She located some exercises on Youtube to help him release his frozen shoulder. Over a period of months in constant pain he was beginning to experience a little relief. Several residents working in catering services reported health conditions (back pain) as a consequence of poor working conditions and faced problems to find solutions due to lack of financial resources to cover treatment (physiotherapy is not covered in services) or lack of time.

In Portugal paying for private medical insurance to access better facilities or professionals quicker, or paying directly to use those facilities was an option which some respondents enjoyed. Some invested in private insurance because they felt despite its costs, it would actually be effective – having lost faith in the NHS. Others highlighted how their inability to afford such services left them with sub-standard care (PMou08-Tanvir).

Opportunities

Certain characteristics and resources offered people an advantage in accessing healthcare. Those individuals with cultural health capital to navigate the system, or who knew someone who could do this for them were in a far better position to optimise their use of resources than those without. In particular NGOs, foundations and associations focusing on particular interest groups: the elderly, particular language groups or the disabled were able to access resources because that access was facilitated by these organisational navigators. Without such provision it is hard to know how they would have fared. In addition, individuals who had access to a medical professional as part of their social network, a social worker or well-informed friends or family were also facilitated to navigate the system. There were many examples of this across all countries – in Sweden and Germany, both offering more comprehensive services than Portugal and the UK, having someone to facilitate access to the full range of opportunities appeared to be the best way to access the widest range of entitlements. Living in superdiverse neighbourhoods, even if those neighbourhoods were relatively deprived, could provide opportunities. Several respondents were able to gain different perspectives on their health concerns from neighbours originating in different countries. They were offered teas, medicines and suggestions about diet or healthy activities. Some such as Isabela in Mouraria, Lisbon, used local facilities such as Chinese and Ayurvedic medicine that was available locally.

The range of resources open to individuals was increased for respondents with transnational connections. Individuals with family or friends either in their country of origin or in other countries of migration were a rich source of information, alternatives, foods, medication and sometimes treatment. Similarly, those who had disposable income could spend it on private medical care (in Portugal and one in UK) or on gap-filling services that could mitigate waiting times, offer alternative diagnosis, hope for incurable conditions and alleviation of symptoms. Money coupled with education and confidence to navigate multiple systems (with the aid of extensive networks and the internet) meant that some respondents were highly competent negotiators of multiple systems creating their own personalised health services through mixing and matching. Their creative use of different resources, mixing them to address their particular needs mean such individuals might be described as archetypal bricoleurs. In some communities with low levels of financial resource, friends or family lent or gave money so that an individual could receive treatment. Occasionally health providers broke the entitlement rules and treated those who were not permitted to access services free of charge without expecting payment. For example, in Sweden a dentist gave a young woman asylum seeker from Syria a permanent filling, even though the rules state that she was only meant to offer a temporary one.

How and why bricolage?

In the beginning of this paper we defined welfare bricolage as a messy, but structured process of combining resources and support for the purpose of addressing and possibly solving a health concern. We have established that individuals across the four countries use wide ranging resources and that the nature of the resources they can access depends on their knowledge that they are given, the extent to which they have sufficient financial resources to pay for treatment alternatives, their beliefs about what will work for them, the availability of networks (including transnational) to support them, the approachability of different healthcare services including the ability of those services to communicate linguistically and their modes of operation, access to the internet and the nature of the local and national health regimes (including the nature of local provision, the use of administrative discretion, discrimination and rights and entitlements). It is important to note too that the approach individuals adopt depends very much on the nature of their health concern. Trauma and heart attacks for example, were treated as emergencies with respondents rushed to hospital and having very little flexibility about treatment options. In these situations, the potential and necessity to bricolage was rather low. However, after leaving hospital their approaches and options for recovery differed widely. Bricolage tended to occur more for minor, misdiagnosed and / or long-term conditions.

In the final part of the findings from the case studies we outline the different approaches to bricolage identified in each country before moving on to experiment with a number of factors and dimensions as possible foci of the next stage of qualitative analysis. The table given below is not intended to generate quantitative data but to generate questions and to compare and contrast the different ways of doing welfare bricolage and the possible reasons for such differences. It is important to note that in what follows we use “the system” as the focus of our tentative table which makes an assumption that all activities are based in some way on, or around the official health care systems, i.e. that part of health care that is organized by the state. By system we mean formal health services. These differ across the four case study countries. In the UK we are referring to the NHS, in Germany we refer to any health care services that can be accessed via the health insurance system (which is in itself diversified and sometimes denoted as a “two class system”: Compulsory insurance (Gesetzliche Krankenversicherung) for a majority and private insurance (private Krankenversicherung) for people whose gross earnings are above a fixed threshold), in Sweden we refer to state provided services (including at regional and municipal level) and in Portugal the NHS and its subsystems that include state provided services offered to civil servants, armed forces and the police, even if subsystems work as private insurances. The centrality of “the system” in the analysis is a heuristic mechanism to enable comparison between the four countries. There are respondents who do not place the system at the centre of their repertoire of health resources despite having full access to it. These are generally those who we have categorised as using alternatives to the system. They may not always avoid using the system but their starting point when addressing health concerns is not the system per se.

Sticking with the system

In each country there were individuals who very much remained within the system². Some respondents automatically visited their GP once they had a health concern that they felt needed treatment (generally after some waiting or a little self-care). They then followed the advice and the treatment path advised by health professionals without deviation.

Some individuals were highly satisfied with the system and saw no reason to look elsewhere or change any aspect of their care. Often individuals used only the formal health system choosing to remain within it because they trusted it (UK1, UK5,11-13 Gotts11,13, Säv 02) or at least trusted their own GP whom individuals in the UK in particular had known for years (UK1, UK16) and was occasionally described as “a family friend”. Others such as Olga and Ols did not so much express trust but were clearly highly competent and confident users of the system able to navigate around it and get their requirements met without the need for additional resources. Others talked about having good experiences which meant they did not need to seek alternatives (Elsa p5; UK17 uk4; UK21 uk5). In Sweden there were more individuals who were very satisfied with the system and felt that all their needs were met than in the other case study countries.

Others remained in the system despite disappointing outcomes or misdiagnoses or because they were not offered knowledge or resources to enable them to obtain supplementary care or go elsewhere. Individuals who experienced a health emergency: whether an accident or sudden onset of serious symptoms used formal services to address this concern although once they received immediate relief with their concern they may then combine with additional resources according to the nature of their problem. A further group might be described as stuck in the system: they had no choice but to use the formal system because they were not able to access knowledge to seek or use other kinds of resources (Emmanuel p5; Christina p6 Iva p6, Eurico & Firmino p7; UK33 uk5; UK35 uk6 Gotts 5 s1). Some, particularly in the UK, and, to a lesser extent the other case study countries, reported repeated visits to their doctor without reaching a resolution. Frequently these individuals were not empowered to request particular tests or referrals. Individuals reported being in pain for months, being misdiagnosed or being refused treatments but they kept returning to the doctor with the same problems despite the lack of a resolution.

Other than some initial low-level self-treatment for minor conditions, seeking information from multiple sources and gaining help from navigators there is relatively little bricolage going on with those sticking in the system. It is important to note that some of those individuals sticking in the system particularly in Portugal and the UK, where formal provision is less comprehensive and more prone to lengthy waits, would like to seek alternatives and to augment public with some private or other gap-filling but were unable to do so because of a lack of resources including networks or knowledge about how to bricolage.

² (UK1, UK 6 uk2, UK18 & 20; 35)(Sw savja 8,9, 10 gotts 4, 5, 7, 12,) Filipa Devi

Working with the system

While those outlined above stuck with the system and used it more or less as it was offered to them, another type of user might be described as skilled workers of the system. Such individuals needed: (1) high levels of cultural health capital – they have to understand the system in order to be able to work it; (2) they needed motives and reasons to work the system – motivations frequently included exhaustive knowledge about the system, the belief that they were well informed and knew what was needed or that they would not get optimum service unless they asserted specific requirements; (3) and they needed to be empowered to assert their expectations to a medical professional.

The wide range of choices available in the formal system in Portugal and Germany enabled some individuals to use information and selectivity to choose the services they wanted to use in quite a strategic fashion. This might mean travelling some distance or trying several providers until they locate someone they trust. Time, knowledge and inclination are required to play the system. While choice is possible in Sweden it is only a relatively recent initiative and may not appeal to residents. In Germany, change of specialists is widely normalized within the formal health system.

In the UK choice is theoretically possible but the GP acts as gatekeeper to all services and must be convinced of need. We saw few examples of a respondent changing health professional: one moved to a new physiotherapist after the failure of the first to address a serious problem. The ability of respondents to be referred beyond primary care appears to depend heavily on their feeling sufficiently empowered to convince their GP of the need for a specialist to accelerate progress beyond waiting or taking pain relief. In Sweden working within the system was also limited but here as in Germany some individuals built a good relationship with a specialist and then worked with that specialist to renegotiate the rest of their care. This often means moving doctor or changing other specialists. In all countries there are some people who refuse treatments or self-medicate and change the dosage of medication they are offered by the doctor on grounds such that the doctor has not taken account of their size and weight or that their children have grown.

Respondents used different strategies so that they could operate agency within the system and actively negotiate the field of tensions between constraints and best possible care. For PMou14-Joao (P3) this meant avoiding the healthcare centre and going straight to hospital where he didn't have to pay. His knowledge of the way things worked and the availability of time to wait for attention meant he could realise this option. Individuals with private medical insurance such as Plum28-Gastao (P6) identified what he perceived to be the most convenient, effective and efficient services: either public or private and used whatever suited a particular health concern. In Portugal and Sweden individuals reported using emergency services to access a specialist more quickly than waiting for a doctor's appointment and then hoping for a referral.

In Germany Bim (G1) was unhappy with the way his wife was treated when she was taken into hospital by ambulance after an allergic reaction. The next time she experienced an allergic reaction Bim decided not to call an ambulance and instead drove her to a different

hospital where she received treatment that they considered to be more satisfactory. Change and choice of doctor, hospital and specialist and even sometimes providers such as acupuncturists, that were considered alternative in other systems, was available within the formal system in Germany. A number of respondents, notably Jay G2, Olga g3 and Leonora G4 put much work into identifying the right specialist. Leonora returned to her home town where she knew the doctors and felt she would get a better service than in Bremen where she was not known. Ludwig developed a good relationship with his dermatologist over two decades of treatment and used him for referrals to the services he needed rather than seeing a GP about his hernia. Two elderly women in Uppsala with little knowledge of the system heard there was a Persian speaking doctor in their healthcare clinic and, with the aid of their meeting centre, always ensured that they consulted him.

Residents in the category of “working with the system” are active bricoleurs, but constricting the resources they use to what is available within the system – a kind of internal bricolage. Included under this category might be a further set of respondents who relied heavily on formal services but required extra information to make the most of the service – which they sought from friends, family or NGOs. Some required a navigator to help them to grasp the scope and range of possibilities and to know how to seek to meet their needs. These respondents were sometimes accompanied to the services by individuals who knew how to make demands appropriately, while others were merely advised but not accompanied by a navigator (UK13). Others used additional sources of information – from books, internet and social networks – to shape their responses and requests within the system. A final set of people reported that their healthcare professionals effectively bricolaged for them within the system by offering an unusual referral or a sideways move.

Adding to the system

Many respondents added to the formal system in some way. Such expansions frequently occurred when individuals did not trust the system yet were reliant upon it to deliver the majority of their care (UK7, 9, 10 uk2, UK36 Anastasia, Bati). This approach was extremely common in Portugal and the UK and common in Germany but used only tentatively in Sweden. There were several reasons for augmenting formal services with other forms of knowledge, support, medicine and care:

- To augment gaps in state provision i.e. when certain services are not officially available
- To resolve minor problems without formal intervention
- To check on treatments or diagnoses
- To treat in a way that better fits with an individual’s outlook on the world after receiving a diagnosis (which in itself was often a check that there was nothing more serious or wrong)
- To take control of one’s treatment
- To fill in gaps in care or seek redress while waiting for formal care
- To get a diagnosis when formal systems had failed
- To get treatment when formal systems had failed
- To improve quality of life by reducing symptoms or side-effects
- To seek a cure for a condition considered incurable by formal providers
- To optimise formal treatments and generally improve health

The relative absence of this approach in Sweden may relate to high levels of trust and resources in the formal system although it was clear that some people are augmenting the system particularly for counselling or for physiotherapy. Some individuals with a migration background in Sweden add in dietary or traditional remedies. Individuals augmenting the system were often competent users of formal services who placed considerable energy into looking for additions. Many people with a migrant background across the case study countries fell into this category and seamlessly combined traditional or biomedical treatments from countries in which they had lived before with those on offer in their current country of residence. Those adding to the system are bricolaging often with very wide-ranging resources and in different ways for different concerns. They largely have the resources they need to bricolage: time, money, knowledge although this is not always the case – some bricolaged with very little.

The main addition used by many people was that of different sources of information and knowledge about their symptoms or their condition. This frequently involved a combination of the internet, friends, family, neighbours, known health professionals, medical books (Norma p3 Savja9 s1, Savja8 s1; UK2 UK1; UK20 uk4) and (largely in Germany) visiting a different health professional or an alternative provider to get a second opinion (PMou01-Neeta, p1). While we may argue that adding resources to the formal system usually engenders some kind of agency there were individuals who were clear that information seeking was something they needed to do to retain control over the treatment of their health concern, sometimes so they could communicate effectively with their doctor and know whether they were getting the correct treatment (PMou11-MSantos P2 jay g2, Mahmoud g2, Musikus g3)

Discrimination played a role in some individuals' choices to look elsewhere for additional treatments. People from a migration background argued that they were not taken seriously by their GPs with Bim, PMou07-Zahid and UK16 perceiving that "foreigners" were not treated well. Others lost faith in the system when it did not work for them or when they were misdiagnosed (PMou11-MSantos; PMou12-Dimple; GGro07-Anastasia & GGro10-Bati; GGro01-Kerstin). While some used the formal system to get a diagnosis (UK22&38; GGro31-Musikus) and then used other systems to address the problem diagnosed, others used alternative systems to get a diagnosis when the formal system had failed (UK8 uk2). Some individuals gradually added in additional non-formal resources when it was clear that formal treatments were not working (PMou03-Isabella P1, PMou21-Pedro p5, UK11 uk3; UK28) or to speed up treatment delayed by bureaucratic processes or lengthy waits (UK6 uk1). Some felt that mixing formal with informal treatments would enhance the effectiveness of treatment overall (UK22, Plum35-Ivone). Finally, in the UK, UK15 sought treatment elsewhere because doctors did not understand her vegan diet – lack of understanding of vegetarianism was expressed in Portugal too.

For some there was an element of desperation in their attempt to mobilise non-formal resources as they sought to do anything possible to resolve or manage their problem (UK13, uk3, PMou07-Zahid). This appeared to be the case for women trying to tackle obesity problems with associated ill health implications (PMou04-Joaquina). Others sought

alternatives to help reduce or alleviate the side effects of biomedicines (Pmou07-Zahid P1, Anastasia g1; Gotts4). Only one respondent directly mentioned culture as being key to their choice to look outside the formal system and utilise traditional medicines: in Zahid's case using Ayurvedic medicine. It was clear though that the approach taken by others was heavily informed by their health beliefs.

All of our respondents lived in superdiverse neighbourhoods inhabited by people from old and new migration backgrounds, with different legal statuses, levels of education and access to resources. In Portugal and the UK businesses had been established to offer alternative or traditional healthcare to the diverse local population. Respondents living in the neighbourhoods accessed such care from time to time. The use of Chinese and Ayurvedic medicine was common not just in the Indian and Chinese communities but also amongst residents born in the country or who migrated from elsewhere. Further respondents reported adding to the system through using remedies shared with them by neighbours originating elsewhere. The use of reiki and other complementary therapies was also raised by respondents in Germany, although the presence of practitioners in the neighbourhood was not as evident than in UK and Portugal. In Sweden respondents were much less likely to add to the system and if they did they used paid-for additions such as psychotherapy or physiotherapy rather than alternative or complementary therapies.

Aspirant bricoleurs

Some respondents aspired to add to the formal system or to take a different route. It is important to emphasise that not every respondent was able to access the resources they wanted to use – for example Nagette (GNeu21) could not access the herb which she was confident could resolve her concern. Others spoke of how they could not afford additional treatments such as acupuncture and physiotherapy – this was a particular problem in the UK where individuals often paid for one or two treatments whilst waiting for additional NHS treatments or hoping their GP would offer them a solution to their problem. Despite finding some relief from out of pocket treatments they lacked the resource to continue. Other respondents expressed an interest in trying to add to formal services but lacked sufficient knowledge to identify the type of treatments that might be effective for their condition. Others simply lacked the resources to “add” to formal systems although they may try something low cost such as teas or particular foodstuffs.

Alternatives to the system

Respondents taking this approach were identified in all countries except Sweden. These individuals favoured a naturopathic holistic approach to health often self-diagnosing, undertaking regular health-maintenance rituals, actively seeking out certain herbs and other treatments and frequently mixing multiple traditional and alternative treatments.

Alternative-orientated respondents expressed that they believed in prevention and self-treatment (Adele G1; GNeu35-Bonny; UK7 uk2; UK38 uk6; GGro25-Cheick) and actively sought to use alternative approaches in preference to formal health provision – notably they did sometimes engage with formal provision if a problem was enduring or serious. Some focused upon becoming experts in their own bodies trusting themselves more than formal

care (UK36 uk6) and using a combination of preventative approaches (i.e. drinking urine to avoid getting tonsillitis) and treatments often expecting slower but more sustainable improvements than with conventional medicine. Others preferred to deal with their own minor problems (PMou16-Fatima p3; PMou02-Devi p5) or believed in mixing different resources (PMou19-Anu p3; PMou22-Sebastian p5) or avoiding invasive treatments (PMou24-Paulo p4). No individual in Sweden reported using alternatives to the system. Whether respondents would persist with such an approach in the event of an emergency or critical condition is unknown. None expressed such an anti-formal ideology that they gave the impression they would avoid the system at all costs. These individuals generally bricolage because they believed in alternative systems.

Avoiding the system

While some had not lost faith in the state-funded healthcare systems and did not necessarily believe in other approaches there were individuals who actively avoided such systems. In Portugal a number of respondents with a migration background expressed their desire to seek treatment outside of state-funded systems to avoid having to wait for appointments (PMou08-Tanvir, PMou12-Dimple). Communication barriers meant some respondents felt happier using a pharmacy or self-treating whenever possible. Several respondents from Nepal felt that doctors in the system did not understand their needs at all and relied heavily on one pharmacist who had begun to specialise in treating Nepalese combined with ayurvedic and homemade medicines. In Germany avoidance appeared to relate to being treated badly (GGro27_Tinka; GNeu06_Jay). A further German respondent appeared to avoid the system because of a dislike of biomedicine combined with problems communicating. Certainly people with a migrant background had the opportunity to revert to an alternative formal health system back home and get treatment elsewhere with which they felt more comfortable and more respected. Just one respondent each in Sweden and the UK intentionally avoided the formal system (excluding those who favoured alternative approaches). The “avoider” in Sweden felt the system had discriminated against him and his parents so tried not to seek any healthcare at all. In some cases it is almost impossible to draw a line between “avoidance” and “exclusion”. In the UK a refugee without any support networks could not communicate with the doctor so gave up trying and left his condition untreated. Yusuf avoided the system simply because he had no idea how to engage with it after it failed to resolve his breathing problems and an administrative error left him without his prescribed medication. Unfortunately, as a relatively newly arrived refugee with a very small social network and no resources Yusuf had nowhere to go and lacked support to seek a solution. Avoiders bricolaged because they needed an alternative to the system.

Excluded from the system

To some extent those individuals discussed above were in theory able to access the system but gained no meaningful result because of communication problems so could be argued to be excluded despite their rights of access. However, in Germany and Sweden there were some respondents who could not access care. In Germany and the UK individuals were excluded by lack of knowledge of alternative systems or the inability of formal providers to communicate with them – indeed professionals making very little effort to meet needs. In

Germany, Bati (GGro10) had no health insurance despite being temporarily allowed to reside in the country. This legally excluded her from accessing the system – she would have needed to pay all services privately, which is not an option for many people due to the very high costs involved. Nagette (GNeu21) was initially in a similar position. Neither were aware that they could access alternative provision.

In Sweden those without legal right to reside could access minimalist emergency care but felt excluded from everything else. This led Gott03 to have permanent nerve damage to his hand – something that will impact his future employability as a manual labourer. He sought financial help from his social networks and then travelled overseas to have his hand properly treated. In the UK recent regulations deny undocumented people with a migrant background all but basic emergency care unless they can cover costs. In Portugal the undocumented migrant respondent was in a worse position than those who were documented in that he had to pay much higher fees to use formal public services.

Excluded individuals may bricolage because they have no choice although those who are particularly under-resourced and unconfident may be outside of formal and informal systems.

Discussion

Defining what constitutes welfare bricolage is not straightforward. If we consider bricolage to be only the mixing of tangible health resources, then only those who add to or avoid the system or use alternatives may be included. Yet there are clear differentiations in the ways in which individuals use formal systems that might be considered within-system bricolage or possibly the system simply working as it should. It is evident that some individuals actively and intelligently manipulate the system using information from various sources and advice from friends and family (some of whom may be healthcare professionals) to ensure they meet their personal goals. Others utilise the system with support from social networks – without the support of that network its most likely that their ability to use the system would be reduced or that they may not be able to use it at all. The concept of bricolage has proved to be especially helpful in making visible such often invisible acts of translation, navigation and support. Further many people either self-treat minor ailments that would not normally involve engagement with the formal system or self-treat during a “wait and see” phase before deciding that a concern requires formal attention. At what point does self-treatment, which is expected of individuals to relieve the pressure on under-resourced health systems, become bricolage? Does this occur when self-treatment or use of non-formal treatments either replaces some or all of the formal system? This is a tricky question since it relies on our being able to define what we mean by the system, which, it is stated above, is a term that is being used as a heuristic device.

The question of what does not constitute bricolage aside, the paper now moves on to outline a potential typology – some types of which encompass bricolage.

Within formal health systems, these individuals believe predominantly in biomedical systems

1. The satisfied health system user – finds everything they need within the formal system and has no need for alternatives or additions or to play the system in any way.

2. The bearing with the system health user – uses the formal system following the advice and path determined by health professionals regardless of levels of satisfaction. They may be unguided or they may have navigators to assist them but they do not find a resolution to their problem or are dissatisfied with the service they receive but do not complain or seek formal or informal alternatives.
3. The reflexive health system user – uses the formal system with the use of information from multiple sources perhaps to check on diagnoses or treatments or to identify the best course of action or preferred specialists – either sticking in the system or working the system. Actions may include refusing surgery or medication or asserting the need to access specific treatments without “wait and see”. These individuals are largely satisfied with the system and mostly trusting of it although they may have a strong sense of what they want from the system and actively seek that course of action.

Alongside formal health systems

4. Augmenters – two types
 - a. Improvers (or mixers) - use the formal system but filling in the cracks and fissures with multiple resources sourced sometimes from multiple systems and countries. They actively seek to improve their quality of life, to reduce symptoms and minimise side effects and have an interest or belief in complementary therapies.
 - b. Desperate augmenters – use anything and everything to try to achieve diagnoses or find a cure when the formal system has failed them regardless of the health beliefs.
5. The aspirant bricoleur– these individuals have restricted possibilities and while their health beliefs might orientate them towards complementary therapies they lack resources largely in terms of money but also sometimes knowledge of alternative options despite aspiring to mix complementary and biomedical approaches.

Predominantly outside the system

6. The alternatives – they believe that the biomedical system is flawed and bricolage to identify multiple ways to prevent illness, promote well-being and treat the whole person – this type could be separated into two – the preventers who focus on well-being and treaters who patiently seek to treat a concern – frequently individuals do both. These individuals believe in holistic approaches.
7. The excluded – this group includes the avoiders and the excluded
 - a. Avoiders - individuals who bricolage with multiple resources either because they choose to avoid the system having experienced failure to meet need or racism
 - b. Excluded - exclusion may include regulatory exclusion or the belief that they cannot get treatment within the system because of the extent of barriers experienced

The above typology is tentatively based on the how and why (or why not) of bricolage rather than the with what. It's clear from our work that approaches to bricolage are contingent on

the nature of the health concern that requires addressing but also upon the healthcare regime in which services operate. This paper has not compared the approaches of those with or without a migration background although it is clear that those born, or with connections, abroad appear to have access to more kinds of knowledge and resources (although they may not be the resources they aspire to and these may not necessarily lead to better solutions): traditional remedies, food as medicine, alternative medical and other biomedical systems but may have less in-depth knowledge of the biomedical system in the country that they reside. Yet individuals with migration backgrounds are not the only users of these resources. We found examples of individuals living in superdiverse areas using the health resources offered by businesses or neighbours with a migration background – perhaps because they were able to choose to use such resources rather than feeling compelled to use them by an unapproachable formal health services.

There were also a small number of examples of ethnic European individuals travelling overseas for medical care or seeking alternatives from overseas. It is worth noting that there were no clear associations between having a migration background and the types of bricolage or non-bricolage used – some people with a migrant background only used formal healthcare and actively rejected alternatives while some natives rejected the formal health care system. There is further analysis to be undertaken regarding how levels of cultural health capital (see Shim 2010) vary or do not vary depending on length of residence or access to knowledge. Initial analysis points to the failure of health providers in superdiverse areas to make their services approachable and accessible to those who have not been in residence for lengthy periods but also for elderly long-term residents who do not appear to receive support to enable them to navigate increasingly complex systems.

Bricolage Practice is situational, contextual and specific to certain moments thus it does not make sense to classify individuals as types of bricoleur but rather to identify types of bricolage that might be undertaken at particular moments, in particular regimes, for particular health concerns and are likely to be shaped by the availability and approachability of healthcare services at local and translocal levels as well as to some extent the social and demographic characteristics of neighbourhoods. It is likely that an individual will engage in more than one type of bricolage depending on the particular circumstances of their concern. Their health beliefs, that is whether they are open to using biomedical, complementary or alternative systems and their ability to access resources may shape their preferences in different ways at different times.

It is clear that the nature of individuals' relationships with the system: whether they are entitled to access formal healthcare, if they have to pay, the extent to which they can choose doctors, tests and specialists, waiting times and levels of discrimination shape engagement in, and types of, bricolage. Thus, while almost all types of bricolage are evident in each of the case study countries (with the exception of 'alternative' in Sweden) different types predominate under different healthcare and immigration regimes. Sweden's comprehensive welfare system which provides wide ranging services such as specialist rehabilitation for Multiple Sclerosis patients and an arthritis school for those newly diagnosed, extensive home help and social opportunities to help isolated people avoid mental health concerns clearly

had the highest level of individuals who were entirely satisfied with their care. Yet at the same time Sweden was the only country that completely excluded an individual from treatment based on their immigration status not even allowing them to pay for care. Every country had some individuals who did not actively engage with their formal systems clearly indicating that more action is needed to make services approachable and to encourage individuals to voice concerns rather than perhaps pushing them out of services to seek alternatives when they feel they are not taken seriously. While there were signs of reflexive formal system usage in all countries, choice was clearly embedded into the German healthcare system and benefitted many residents – not everyone was empowered to assess the suitability of options available to them. All countries' formal healthcare systems were augmented with additional health services by some respondents, but such approaches were much more dominant in Portugal and the UK where waiting times could be lengthy and there was less choice or flexibility around access to services than in Germany and services were less comprehensive than in Sweden. The seeking of solutions to intractable health concerns emerged in all countries and may be the outcome of desperation in the absence of solutions in long-term or chronic conditions or urgent need for a diagnosis rather than a response to particular types of healthcare system.

Engagement in alternative rather than biomedical approaches was evident in all countries except Sweden and appeared to represent the expression of an individual's beliefs in prevention and holism rather than a response to a particular type of healthcare system excepting that biomedicine was rejected as being epistemologically flawed. More research is needed to learn whether wholesale rejection of biomedical epistemologies were occurring in all circumstances (i.e. for acute as well as minor concerns). Alternatives were evident more in Portugal than elsewhere – the reasons for this are unclear excepting that a group of respondents from India and Nepal expressed preferences for self-treatment and avoidance of formal services partly because the long waits involved was incompatible with their work patterns but also because they did not find the NHS approachable. Further the preference for alternatives by such individuals as well as some Portuguese born respondents may instead be a type of avoidance responding to a belief (gleaned by word of mouth rather than experience) that health professionals did not know how to meet their health needs. Avoidance of health system occurred to some extent in all case study countries and was a strategy used by individuals who either felt discriminated against or who had little success engaging with systems they did not understand and where health professionals appeared to make little effort to engage. Finally, with the exception of Portugal there were a small number of instances of exclusion from formal health services in all case study countries. Exclusion occurred when individuals from a migration background did not have the appropriate immigration status, or sufficient evidence of their status, to utilise formal healthcare systems or when doctors refused to speak a common language such as English during consultation and, in the case of Germany and Sweden, were unaware of the availability of alternatives provided for example by NGOs and anti-racist movements.

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