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Health providers as bricoleurs

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Health providers as bricoleurs: an examination of the adaption of health ecosystems to superdiversity in Europe

Abstract

This paper examines the ways in which healthcare providers from a mixed economy of welfare operating in superdiverse neighbourhoods connect and innovate across the healthcare ecosystem to meet diverse and complex needs. Moving beyond a health systems approach which siloes different types of provision we use the concept of bricolage to make visible the work undertaken by providers across the ecosystem. While we show that public, private and civil society provision all adapt to meet complex and diverse needs to some degree, we highlight the importance of inter-connectedness between providers and note the role of civil society in addressing gaps and cracks in provision. The importance of adopting a whole ecosystem approach and focusing on the actions and interactions which enable the ecosystem to function in complex demographic environments is highlighted before we stress the dangers of over-reliance on civil society.

Keywords: health providers, health ecosystem, superdiversity, bricolage, Europe

Introduction

This paper introduces a new original analytical construct to thinking about how healthcare providers bricolage to adapt their services to address complex needs. Its originality also lies its focus on a healthcare ecosystem constructed from a mixed economy of provision in superdiverse neighbourhoods, Urban neighbourhoods are frequently at the front-line of increasingly complex demographic changes. Many have ever more superdiverse populations accommodating both old ('established') and new ('more recently arrived') immigrants from multiple countries of origin, as well as non-migrant populations (Author and Author, 2016). Such places are fast changing and often resource poor. Welfare restructuring in superdiverse neighbourhoods occurs to different degrees and in different ways according to national health and welfare regimes with the most marked effect on those residents perceived as undeserving. In parallel, the neo-liberal emphasis on competition is re-focusing on the local while stressing provision through a mixed economy of welfare based on the notion of self-help. This means that healthcare providers in superdiverse neighbourhoods are frequently expected to do magic: achieve more with less.

There is little knowledge about the ways in which healthcare ecosystems adapt to the demographic changes playing out in neighbourhoods characterised by superdiversity. To explore the approaches adopted by healthcare providers to help meet residents' healthcare needs we use the concept of bricolage – the agentic but often invisible creative mobilisation, use and re-use of wide-ranging resources, including multiple knowledges, ideas, materials and networks. We begin by exploring the advent of superdiversity in European cities before briefly examining the current context in terms of diversity and healthcare provision, arguing the need for a whole healthcare ecosystem approach that enables better understanding of the ways that provision can be improved to account for demographic complexity. We set out our methods before outlining findings structured into the key challenges faced by different type of providers and the ways in which they try to

address those challenges. We argue that our use of the concept bricolage makes visible providers' actions across the ecosystem. .

The advent of superdiversity in European cities

Across Europe, there has been a major demographic shift, with migrants arriving from outside Europe increasing significantly, a trend epitomised by the so-called migration crisis (Scholten and van Nispen, 2015)ⁱ. There has been a marked shift from (old) post-colonial and bi-lateral agreement migration to new migration streams, wherein people arrive from many different countries, embodying different immigration and employment statuses, faiths, levels of education, ethnicities, rights and entitlements and spatial distributions, as we enter an era of superdiversity (Vertovec, 2007)ⁱⁱ. While the term superdiversity has received considerable criticism, particularly around its theoretical limitations, it has been widely adopted as a demographic descriptor. Hence, processes of superdiversification have intensified the levels of demographic complexity and pace of change in urban areas.

Many urban neighbourhoods have multi-layered populations accommodating both old and new immigrants, as well as long-standing but often dwindling and/or ageing non-migrant populations (Author and Author, 2016). Such neighbourhoods change quickly with some arrivals settling, while others move on. Frequently, these localities lack the critical mass of individuals from a single ethnic or country of origin group, which previously used to enable the provision of specialised services in some countries (Author, 2015a). Both, new arrivals and healthcare providers frequently encounter 'novelty' (i.e. new cultures, ideas and service cultures) and 'newness' (i.e. ever-changing populations) (Author, 2015b), which makes ensuring equitable access to services challenging. This is particularly the case for healthcare, which has consistently failed to resolve inequalities of outcome and inequity of access in areas with high levels of diversity (Hernandez-Plaza et al 2014; Padilla et al 2018).

Diversity and the healthcare ecosystem

Scholars of health management alert us about the importance of healthcare systems, which is defined as *"the combination of resources, organization, financing and management that culminate in the delivery of health services to the population"* (Roemer (1993:7). While portraying healthcare as a system accounts for involvement of multiple stakeholders, it does not consider the dynamic environment in which the system operates which includes the actions of patients, interconnections between providers, the socio-economic aspects and other contexts shaping behaviours and interactions (Lee et al. 2013). Asakura et al (2015: 43) argue *"ecological frameworks for understanding human interaction with the world, including values, principles and ethics, need to be revived and renewed"*. Kernick (2002), using an ecological framework, contends that state healthcare provision is an ecosystem consisting of multiple providers learning to adapt within an environment constructed of multiple ever-changing parts.

Building on Kernick's ideas we argue that a healthcare ecosystem might be considered a complex network or interconnected system operating within a dynamic neighbourhood which moves beyond public healthcare provision (PHP) to include the mixed economy of healthcare provision and the interactions and interconnections of residents with diverse healthcare and welfare providers. Encompassing the mixed economy of provision within the

healthcare ecosystem, that is public, private and civil society sectors, together with their interconnections, captures some of the diversity in provision (Dwyer and Hardhill 2011). Attending to the networks and processes which facilitate interconnections is necessary if we are to highlight the multiplicity and innovation characterising provision in complex settings (Kernick 2002). Using such an approach we bring new knowledge about healthcare provision in fast-changing and complex superdiverse settings by exploring the approaches by which multiple providers adapt to challenging circumstances. We focus on the healthcare ecosystem at the scale of neighbourhood, and how providers respond to the healthcare needs of local residents¹, in order to develop a detailed understanding of actions undertaken to meet complex need.

While research on healthcare-seeking behaviours of diverse groups, often focusing on single ethnic groups, notes the tendency to seek across sectors, most research has looked at interaction or provision within single sectors or systems rather than adopting an ecosystem approach. Further, research on the adaptation of health systems to population diversity has focused on different aspects of public healthcare provision, examining the efficacy of approaches such as increasing the proportions of professional and support staff from diverse backgrounds (Bischoff et al. 2006), introducing cultural mediators to help newcomers develop cultural health capital for access (Lizana 2012); developing neighbourhood hubs offering multiple services (Duckett 2013); or combinations of these approaches.

Much of the interest in diversity and access to healthcare services has come from health sciences with some emphasis on outcomes by group, with the nature of the “group” varying according to how minorities and migrants are defined in different countries. Less comparative work has been undertaken across groups or healthcare systems. With the advent of austerity and marketisation of welfare services in some European countries most social policy attention, in terms of diversity and healthcare, has been upon public health systems (PHS). Conceiving of providers as functioning within an ecosystem made up of dynamic interconnecting public, private and civil society providers enables us to understand how different types of provision operate, interact and innovate in an attempt to meet the needs of complex superdiverse populations.

We employ the concept of bricolage to explore how such providers respond to the healthcare needs of individuals and the challenges associated with meeting those needs. Although widely used, bricolage has not been applied to diversity or healthcare. The term has described processes, institutional change and broader social and economic transformation in society (Campbell 1997; Cleaver 2001; Andersen 2008). Bricolage has been applied to evolving logics to optimize the use of available resources (De Certeau, 1984), where knowledge and resources are employed to reduce uncertainty (Vanevenhoven et al., 2011) or agency enacted to creatively mobilise resources (Deleuze and Guattari, 1972). Bricolage is frequently a response to a lack of resources (Halme et al., 2012) and a way of overcoming challenges, through mobilising, mixing, re-assembling and re-using

¹ Note we use the term resident rather than patient to reflect that not all those with healthcare needs attend state services and that our focus is on provision for those who live within the superdiverse neighbourhoods which function as our case studies

resources to develop solutions. We view bricolage as a hermeneutic term, which makes visible otherwise unseen actions (see author et al. 2018).

Current political and policy contexts suggest there is potential to use the concept of bricolage to examine how providers in a healthcare ecosystem respond to diverse needs. A combination of the neo-liberal emphasis on competition and choice and self-help, increased managerialism, the re-focus on the local, austerity cuts and push for ever-greater efficiencies, also imply a need to bricolage. Further, restrictionism and protectionism have targeted those perceived as undeserving because they do not belong or have not contributed sufficiently. Using the notion of bricolage helps us focus on process, innovation and interaction to uncover how providers within a dynamic healthcare ecosystem utilise networks and combine resources, knowledges, and creativity to address complex needs. A bricolage approach avoids both the limits of a focus on special provision for pre-defined “groups” and siloed healthcare systems to understand the tactics providers employ.

Methods

The paper draws on data from the XXXX project which developed the concept of welfare bricolage to understand the ways in which healthcare was accessed in two superdiverse neighbourhoods in four European cities: Birmingham, Bremen, Lisbon and Uppsala, each located in countries with different health, welfare and migration regimes (see Table 1). The project used multiple methods including interviews with residents and providers, neighbourhood mapping, ethnography and a residents’ survey. The neighbourhoods were all superdiverse with different patterns and histories of migration and socio-economic trajectories. Full details of neighbourhoods and methods are available elsewhere (see Author et al., 2015). The project received ethical approval from the relevant committees in each study location².

Table 1: Characteristics of the comparison countries and neighbourhoods³

	City	Health and welfare regimes
Germany	Bremen: 10 th largest city 554646 residents, 30% people from migrant background (deprived and skilled) from 162 countries.	Conservative welfare regime Universal, corporatist health care system, decentralized and self-governing. Compulsory health insurance based on income covers 85% of the population. Direct access to services with choice of provider. Migrants receive a health insurance card allowing access to medical help for acute illness, pain and pregnancy. Without insurance, people must pay or use volunteer doctors, CSOs and welfare organizations. There is no functioning interpretation system. The healthcare ecosystem is very complex so people struggle to understand entitlements. The ecosystem has been transformed into a competitive health market with statutory health insurers behaving as competing corporations. Medical professionals are supposed to report irregular migrants to immigration authorities.

² Authorisation code for Project Lead ERN_14-1111B terminology vary by country so data are not comparable.

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

Data for Portugal: migrant definition: foreign born and ethnic minorities

Data for Sweden: foreign born and ethnic minorities

Data for the UK: 2011 Census

Portugal	Lisbon: capital & largest city 547733 residents, housing migrants from 172 countries, recent arrival of refugees	Southern European welfare regime Health system is comprise of multiple sectors including a universal national health service (NHS) with co-payment scheme and exemptions for certain populations. Health subsystems include health insurance for public servants, a growing private insurance health sector and the lottery funded charity-led parallel health service of Santa Casa da Misericordia (SCML) for vulnerable populations. The economic crisis affected provision and quality of health services as TROIKA imposed severe. Most irregular migrants' exemptions were removed making access problematic. NHS professionals cannot report irregular migrants to authorities due to professional ethics.
Sweden	Uppsala: 4th largest city. 202625 residents, people from migrant background from 174 countries (deprived and skilled)	Social Democratic welfare regime Comprehensive universal system. Equity is prioritised through redistributive policies in the form of statutory and municipal taxes, benefits and services aimed at mitigating the damaging effects of poverty. The system of fiscal and non-fiscal universal benefits, distributed with little means-testing imply extensive public-sector employment in health and social care. Healthcare and welfare available to whole population for a small fee. Only immigrants with legal rights of domicile can access non-urgent care. Very limited private sector. Provision through for-profit corporations increasing. Limited austerity since Sweden's major financial crisis and contraction of the welfare state occurred in the 1990s. Emphasis on individual responsibility, healthy living and active lifestyles.
UK	Birmingham: 2 nd largest city. 1073045 residents, 22% foreign born, 47% ethnic minorities from 187 countries.	Liberal welfare regime The UK's NHS introduced as a universal system with primary and secondary healthcare free to all. The past 20 years have seen constant attempts at restructuring to slow down spiraling costs. Shortages of doctors and nurses with the system said to be in crisis and Government refusing to increase the budget . Restructuring in 2013 introduced service commissioning to introduce competition, reduce costs and offer choice for health "consumers". Widespread concerns about capacity to meet rising demand, the exacerbation of recruitment difficulties, reduced investment, long-term under-funding of mental health provision and cuts in public health and social care budgets. Immigration legislation denies undocumented migrants and failed asylum seekers free access beyond emergency care. NHS workers are expected to report and refuse to treat undocumented migrants.

This paper describes findings from 76 interviews with providers undertaken by a multidisciplinary research team (see Table 2). Given the different health and welfare regimes shaped by differing policies, practices, and welfare ideologies in the four countries, their health ecosystems differed markedly (see Table 1). We initially identified providers in each ecosystem, through ethnographic mapping, locating providers, and identifying "hotspots" of activity. We then interviewed 160 residents to explore how they addressed health concerns exploring with them the providers they had used. Having identified providers through ethnography and resident interviews, we interviewed a selection of public, private and civil society providers in each ecosystem focusing upon locally distinctive approaches to healthcare. While PHS were important in each case study, respondents also identified interactions with wide-ranging providers who helped them address their health concerns. Providers were approached for an interview by e-mail or in person. Potential respondents read a participant information sheet and signed a consent form. All interviews were recorded and transcribed in full. Data were coded using a systematic thematic analysis approach (Guest 2011) to identify the key issues raised by respondents. This

involved interpretive code-and-retrieve methods wherein the data were transcribed and read by the research team who together identified codes and undertook an interpretive thematic analysis. A shared codebook was devised between teams in the four countries using MAXQDA software. The project lead (Author 1) checked inter-coder reliability across sites. Quotations used herein were selected to be illustrative of themes emerging from the analysis.

Table 2: Respondent profile

Birmingham	Bremen	Lisbon	Uppsala
Asylum seeker health advisor	Paediatrician	Doctor Public Health Centre (PHC)	CSO manager
Drug & alcohol worker	GP, Family doctor x 3	Nurse PHC	Community education officer
Counsellor and manager	Community run service (CRS) for senior migrants	Nurse hospital	Allied Healthcare
Podiatrist	CRS community health	Nurse PHC	Day-care provider
<i>Dentist</i>	Gynaecologist	Social worker PHC	Children's information & education officer
<i>Pharmacist x 2</i>	CRS for undocumented	<i>Pharmacist</i>	Allied Healthcare
General practitioner x 2	Dentist	<i>Pharmacist</i>	CSO
<i>Ayurvedic Practitioner</i>	<i>Home based care organization</i>	<i>Dentist</i>	Healthcare professional - tertiary
<i>Pharmacist</i>	<i>Alternative practitioner</i>	Receptionist PHC	Healthcare manager
Diabetes mental health worker	Street worker (Church Welfare Organization)	Nurse Misericordia	Children's CSO
<i>Acupuncture</i>	Emergency department	Nurse Misericordia	Youth educational services
Asylum health practitioner	Pastor	Social worker CSO	Youth club leader
Community manager	<i>Pharmacist</i>	Social worker CSO	Old People's home manager
<i>Yoga practitioner</i>	<i>Physiotherapist and gymnastic centre</i>	Nurse mobile unit CSO	<i>Pharmacist</i>
Midwife	Home for alcoholics (Church Welfare Organization)	Psychologist	Infant-parent care provider
Mental health practitioner	Child psychiatrist	Nurse School	
Manager of a faith based project	Mobile psychiatric and social care	Educationalist	
CSO focusing on wellbeing x 2		Educationalist	
<i>Leisure centre supervisor</i>		<i>Chinese Doctor</i>	
Buddhist monk		<i>Chinese Therapist</i>	
Church Minister		Nurse PHC	
Manager refugee lunch club			

Civil society organisations (CSO) and Community Run Services (Germany) (CRS) in **bold**. Private sector in *italics*

Findings

In the first part of this section we briefly outline some of the challenges faced by providers in superdiverse environments where they operated.

Superdiversity

The neighbourhoods were characterised by different levels of superdiversification. Language and communication were key challenges facing providers across the study. In Uppsala and Birmingham interpretation is provided by state healthcare providers but some languages were not available, or interpretation was of low quality. In Bremen and Lisbon interpretation was available but rarely provided. Some patients were sent away to find their own interpreter, but recent arrivals often lacked networks making access to informal interpretation impossible:

This complete speechlessness is just recently, so to say, something that, that just now with this wave of asylum seekers and hmm refugees from, from Syria, wherever, just so to say, happens because they come here without any (..) whatsoever form of network. (Gynaecologist, Bremen)

Illiteracy was noted as a challenge in Lisbon, particularly with older people and some migrants, with some providers dismissing patients for having inadequate or highly accented local languages. Not being familiar with the Western/Latin alphabet was often perceived as illiteracy. A Bremen General Practitioner (GP) stated that some patients could not follow instructions on their medication.

Providers in Bremen and Lisbon highlighted problems accessing the elderly, who feared being institutionalised, and homeless people, whose chaotic lives and/or addictions impeded contact with state providers. In Lisbon, several state and CSO services highlighted the situation of elderly people “stuck” in housing and completely dependent on CSOs to access healthcare and social services, while CSOs invested in interventions for hard-to-reach populations (i.e. addicts, sex-workers), health promotion and screening activities. In Uppsala some of the associations, clubs and day care centres that encouraged active citizenship for health promotion reported that migrant parents were reluctant to engage. New migrants tended to be less aware of available services than long-term residents.

In each city, some providers associated certain challenges with the “culture” of residents. In Birmingham and Uppsala women wearing burka or hijab were said to be less inclined to exercise, and vulnerable to Vitamin D deficiency. Generalisations about migrants included them being less likely to attend appointments (Education Psychologist, Lisbon), less punctual (Midwife, Uppsala), with irregular mealtimes (Education organisation, Uppsala) and “unusual” ideas about health (GP, Bremen). Faith was said to hold some individuals back from exercising and attending facilities run by/in churches (Minister, Birmingham).

Shim (2010) and others (Author 2015) have written about how patients are expected to possess cultural health capital to negotiate health services. In Bremen, Birmingham and Lisbon health professionals expressed frustration at migrants’ lack of knowledge about how state health systems work. Providers described patients’ “unrealistic” expectations and “demands” for services or medication. A paediatrician in Bremen spoke of some patients expecting they could bring several children to a consultation:

Well, it means one patient registered and then there are six people in the room. That's quite extreme but not rare. Often there is really one registered patient, four people in the waiting room, that's not rare, also all the siblings who are then also brought along.

Concerns that migrants' misuse of Emergency services were common across the four cities, with a Lisbon GP noting this was not an exclusively migrant phenomenon, since acute care represented a rapid route for accessing diagnostics for all. Our interviews with residents reported elsewhere (Author 2017) highlight the use of transnational health services and medicines purchased from countries of origin. One pharmacist in Birmingham stressed the dangers associated with such approaches, especially if medical professionals were not informed.

In Birmingham, Uppsala and Lisbon, respondents explained how migrants had no concept of health prevention, adding to comments about poor diet and lack of exercise. However, our residents' interviews provided no evidence of such problems (see Author 2017). Pharmacists expressed concern about dependency on medication or migrants taking the wrong dose. In Birmingham and Lisbon, pharmacists emphasised how migrant customers used their services in preference to state provision because they spent time building relationships and gave "straight advice" in a timely fashion.

In Bremen and Lisbon PHPs explained how the pressures of working with patients whose expectations about engagement contravened those considered "normal", sometimes spilled over into anger and stereotyping. In Uppsala, a migrant association said health professionals often had negative attitudes towards migrants. The Community Midwife in Birmingham noted

I think if you don't speak English you suffer all sorts of kind of like indirect racism and prejudice and that affects the care that you have. You see it on the wards.(they) just didn't treat people the same, you know (Midwife, Handsworth).

In Birmingham, a GP highlighted professionals' frustration at not being able to meet health needs effectively. Shortage of doctors in both Bremen and Birmingham and intense stress was said to have contributed to providers resigning from their posts, likewise, in Lisbon, cuts in human resources were equated with frequent burn-out among public health employees.

Austerity, restrictionism and restructuring

Poverty, unemployment and poor living conditions were key aspects of individuals' lives simultaneously impacting upon the healthcare ecosystem. Such structural factors apparently underpinned individuals' mental and sometimes physical health problems. In Lisbon respondents described exacerbating problems since the financial crisis.

There are also other applications that people can do like housing support; debt problems; the crisis also brought problems to people to have food; eviction orders. People sometimes come to the doctor and talk about it (Lisbon, PHC social worker)

Structural issues were particularly problematic for undocumented migrants and some asylum seekers who were excluded from services in each country. In Lisbon staff working in primary healthcare (PHC) struggled to identify who they could serve and a migrant CSO recalled spending much time attempting to evidence individuals' eligibility.

Furthermore, in all the studied cities providers talked about difficulties experienced supporting people with chaotic lives – mental, physical, financial and social problems intertwined and created challenges that could be overwhelmingly complex, with no viable solutions available from state services. Health was not a priority for those who needed to resolve an asylum claim or find somewhere to live. While poverty was a key feature of each ecosystem in the Bremen, Birmingham and Lisbon neighbourhoods, providers raised additional concerns about people with addictions who also faced multiple social and structural difficulties. Austerity cuts to social support were said to have a detrimental effects

This relentless cutting of benefits ... is interrupting their recovery ... if people were given a fairer shot a, a period of financial support while they're recovering ... they could have time to relax and engage with services more effectively (Drug and alcohol project worker, Birmingham).

Private practitioners such as a homeopath (Bremen), Chinese Doctor (Lisbon), Dentist (Lisbon) and Yoga Teacher (Birmingham), noted that some people wanting to use their therapies could not afford the fees.

In Birmingham and Lisbon respondents talked about the impact of cuts on their ability to meet need. A lack of mental health professionals was a common theme which in Uppsala and Bremen resulted from increased demand following the arrival of many refugees. In Lisbon, some professionals' working hours had been reduced leaving them unable to meet the full extent of need but lacking alternative mental health services to refer clients on to. CSO respondents, particularly in Birmingham, noted lack of time, money and space:

We are now currently overwhelmed with the space, we don't have enough space ... current spaces we have cannot accommodate, not big enough, so yeah, it all goes back to resources and main, main being money (Asylum health practitioner, Birmingham).

Lack of resources was mentioned by a range of providers from each city. In Uppsala, this was mainly in the form of space to expand activities (day-care, migrant association, sports association) to meet demand. Lack of space was also a problem for CSOs in Birmingham where cutbacks meant that even communal public spaces were increasingly unavailable. In Uppsala and Birmingham professionals noted a shortage of staff able to deal with complex mental health needs of refugees. In Lisbon pressures meant there were insufficient staff, time and money to deal with acute or complex problems.

The increasingly managerialist approaches implemented in each of the ecosystems made delivering services problematic for state providers. In Birmingham and Uppsala, the rules around funding eligibility meant that some areas, activities or groups could not be supported. In Lisbon, the pressure to meet indicators, mainly by restricting consultation times, led to increasing unmet needs. Providers also struggled to deal with the bureaucracy associated with accessing funding or assessing individuals' entitlements. Time allocations were often seen as inadequate for dealing with migrant patients. In Birmingham, small organisations noted the governance requirements associated with state funding were too onerous, preventing them from applying for support and leaving them reliant on *ad hoc* grants and donations.

Addressing the challenges

Communication and Collaboration

Providers often bricolaged to improve communication. PHPs in Bremen employed multilingual staff where possible. Multilingual hospital doctors were asked to interpret in the Emergency department. Pharmacists in all cities often employed multilingual assistants and shared them with other pharmacies and local doctors. A pharmacy in Uppsala, part of a national chain, had a list of employees' languages and used telephone interpretation across branches when needed. In Birmingham CSOs relied heavily on multilingual volunteers. Without access to interpreters, smaller enterprises and CSOs in Lisbon and CRS in Bremen had to make do with "hands and feet" and Google translate. In Bremen, the paediatrician and physiotherapist used pictures and mime, as did an allied health worker in Uppsala and a nurse in Lisbon:

we have some files where we need to give people some nutrition classes for their babies, we work with images to teach the people the recipes. It can be difficult without the language. Sometimes we use the technology to translate but sometimes the translators don't really help (Nurse, Lisbon)

Sometimes patients were asked to supply their own translator, and where this was not possible professionals sought alternatives, which in Bremen meant asking a local shopkeeper for assistance. A multilingual driver doubled as interpreter at the CSO-run mobile health unit in Lisbon.

By far the most common approach to bricolage was collaboration across the healthcare ecosystem. Cross-referral was important to health professionals in Lisbon and Bremen and the main way in which they dealt with complex problems. This occurred between state health service providers, for example a Portuguese Educational Psychologist referring to a paediatrician, but also to CSOs. Informal networks with CSOs and particularly the parallel charity system Misericordia were critical in ensuring vulnerable clients' access to support.

CSOs were critically important in helping to alleviate the social and structural problems experienced by the elderly, undocumented migrants, homeless people and substance abusers. In Uppsala, collaboration was mentioned less often – a CSO working on mental health issues said it was difficult to know how to work with the state health service. In

Birmingham, the two migrant health specialists (community midwife and migrant health centre specialist) connected to services such as foodbanks. CSOs viewed their knowledge about, and connections to, wide-ranging providers within the healthcare ecosystem as crucial in their ability to bricolage to address complex physical and mental health problems and accompanying social and structural difficulties.

In Bremen, most respondents said they connected with local networks, for example GPs, pharmacies and physiotherapists. CSOs elsewhere including the migrant centre and the health promotion initiative actively met with others in the ecosystem bricolaging to create collective endeavours, to share and exchange ideas. In Bremen and Birmingham particular individuals who were active locally, having identified needs in the ecosystem, reached out to providers to persuade them to offer specific services. Alternative or traditional providers used their knowledge of the ecosystem to refer people back into biomedicine or to other providers as necessary.

Reaching out and bringing in

Outreach or in-reach services were frequently the outcome of networking, bringing providers together across the ecosystem. In Uppsala, the mental health CSO ran a project in the local labour offices while the cultural centre organized workshops in different locations. In Birmingham, the leisure centre reached out from its premises to offer classes in a variety of locations to contact hard-to-reach communities. The Community Manager was forced to reach out as he had no dedicated space, so he ran coffee mornings, music and physical activity events in conjunction with the library, to reduce isolation and encourage local people to improve their health. One of CSOs attended events that brought together a range of providers across the ecosystem:

But generally working holistically does involve work with the GPs but also other kind of health exchange agencies, charities that may be around, that kind of do the Health and Wellbeing days (CSO, Birmingham).

In Bremen, outreach was less common and concerned only the drug and alcohol workers who routinely left their offices to connect with clients in their homes or on the streets. Social workers operating with similar clients in Lisbon mainly worked from a van befriending the vulnerable to build sufficient trust to encourage access to basic healthcare, and providing free testing and needles. Misericordia (Lisbon) were frequently invited to different groups and organisations:

They see that there is a need so they contact us to make partnerships. They know that the Santa Casa is a very open institution, so they contact us for very specific things. A nursery can contact us for example to do a workshop about baby hygiene (Misericordia nurse, Lisbon)

In terms of in-reach, several Uppsala providers welcomed experts to come and speak with their constituents. For example, the day-care centre invited dentists to discuss the causes of tooth decay while the education organisation hosted a talk on health promotion. In Birmingham, the faith organisation for women hosted Suicide Watch while a physiotherapist

network organised talks for their clients. CSOs known for working with certain client groups were approached and asked if they could run workshops:

Agencies tend to come to us and say, oh I hear there's a group, can we talk to them, and it's like, yes, yeah, please do. (Drug and Alcohol CSO, Birmingham)

In Lisbon, the school coordinator invited different sports clubs to organise activities to attract parents, using these opportunities to discuss healthy lifestyles. Some providers organised events to raise awareness about how to live healthily. This was important in Uppsala where much emphasis was placed on prevention and events were often organised around healthy food and could involve cooking food together (Education organisation) or sharing a meal (afterschool club).

In Bremen, the Hospital Nurse arranged disease prevention classes for residents, many of them migrants, while in Lisbon a Social Worker offered education around health practices. These approaches sought to address the perceived lack of cultural health capital across the ecosystem.

Innovative ways of working

In a bid to make themselves more attractive to clients, providers innovated to make their services more flexible. In Uppsala, the midwife offered drop in courses as she found migrants often did not come to pre-arranged sessions. Pharmacists in Birmingham extended their opening hours to fit around locals' long working hours. In Bremen, the mobile nursing service avoided prayer times for Muslim patients.

Resource restrictions were approached in two ways. First, providers tried to extend their reach by providing group rather than one-to-one sessions (University counsellor Birmingham, Midwife Mental health CSO, Uppsala) often relying heavily on volunteers. Second, providers identified ways to help clients lacking resources to access services. In Lisbon, the Dentist offered treatment options or spread payments, while the Chinese Doctor gave discounts for buying multiple sessions, and the pharmacist allowed residents to have an open account, paying in instalments or once a month. The Leisure Centre and Buddhist Temple in Birmingham offered free sessions while the Yoga centre, a social enterprise, offered sessions at reduced cost for those on low incomes.

A scheme in Portugal, relying on donations from across the healthcare ecosystem, was notable in its provision of free medication for those in need:

The medicine we have is donated. Sometimes it comes from the pharmacy, sometimes from the laboratory and sometimes it is given to us by people who have it at home, don't need it anymore and it is still valid. (Social worker mobile CSO, Lisbon)

Some providers acted when they realised how impoverished their clients were. A German GP found that a woman patient was too embarrassed to attend her appointment because she didn't have clean nappies, so made free nappies and donated baby clothes available. In

Uppsala, the day-care centre offered breakfast to those children who were not fed at home while the Sports club bought shoes and lunches for children without them.

In Bremen, having realised that advice given to migrant families about eating for diabetes was ineffective, providers connected instead with the family member who did the shopping and cooking. In Birmingham, new routines saved doctors' time enabling them to spend more time with patients. One GP employed a nurse to triage patients, reducing the numbers needing a GP appointment. They also used a pharmacist rather than a doctor to review prescriptions. A pharmacy in the same neighbourhood worked with GPs to offer a minor ailments scheme, encouraging fewer doctor visits.

CSO's critical role in the ecosystem

As noted, many providers outlined difficulties faced when addressing problems that combined medical, social and structural issues. Most state health professionals dealt with such complexity by referring across the ecosystem, mainly to CSOs. CSOs adopted a person-oriented approach using bricolage to identify solutions to help vulnerable people. They spoke of getting to know people, building trust and creating personalised solutions. For example, a Minister in Birmingham ran a weekly lunch club for asylum seekers using volunteer befrienders. Isolation was reduced through home visits, support with attending medical appointments, opportunities for exercise and self-actualisation provided through renting an allotment and sharing gardening equipment. Over the years the project had helped many asylum seekers to deal with health problems:

Actually, we don't just want to be looking at that medical condition, but a person is made up of these very different paths. Yes, it's the physical but it's the mental, it's the spiritual, it's the emotional health, so it's kind of seeing the package (Church Minister, Birmingham).

A community run service (CRS) in Bremen working on mental health issues offered demand-led socio-therapy in which clients experiencing severe difficulties could have multiple appointments in one week - an intense intervention unavailable elsewhere. This organisation's knowledge of the healthcare ecosystem was at the heart of its ability to bricolage, identifying solutions by networking across sectors as an important tactic:

one has to look individually with the one who comes ... and as we are well-connected, as we have loads of information concerning what is possible in the neighbourhood... there's always a solution.

In Lisbon, several CSOs provide follow up to older people preventing isolation and addressing poverty, securing health services and social support. Such is the extent of isolation, unemployment and deprivation in some of the neighbourhoods that solutions were not always possible. In these situations, providing access to food, healthcare and a friendly face was attempted, but not always successfully.

Bending the rules

While CSOs had the flexibility and connections across the ecosystem to bricolage to address the complex needs of patients, professionals working in PHS had fewer options. Nonetheless, as residents observed in interviews, some providers bent the rules to allow individual access to care. At the hospital in Bremen, the manager was not prepared to send away seriously ill patients because they lacked health insurance. Other doctors worked voluntarily with unregistered clients even purchased medication from their own funds, often after a referral from a CSO aware that the doctor was “flexible”. The CSO tried to share the burden by dispersing such clients around different “flexible” GPs in the ecosystem. In Lisbon, some health units allowed registration for patients who would normally be ineligible.

A Birmingham community midwife, although able to access resources such as baby clothes for newly arrived asylum seekers through collaboration with CSO, was unable to accelerate the GP registration process. Without a GP, women could not access antenatal care. The midwife “stretched the truth” about women’s conditions to ensure they urgently received scans and tests.

Discussion

Using the concept of bricolage and focusing on the entire ecosystem introduces an original approach to analysing the actions of healthcare providers. The providers we interviewed were functioning in complex environments, faced with a multifaceted mix of superdiversity, austerity and restructuring, albeit to different degrees. There were some common challenges faced in all four cities: struggles around communication, denial of services to some migrants, complicated and intertwined health, structural and social problems, the expectation of doing more with less, or at least no increase in resources, and the inflexibilities of formal provision, designed for a more homogenous population. Superdiversity implied many challenges for providers, ranging from migration status to residents’ age, level of education and social problems, including isolation, addiction and unemployment. The diversity within diversity that Vertovec (2007) sees as the defining feature of superdiversity was very much in evidence.

Building on Kernick’s (2002) notion of healthcare ecosystem to include what has been termed the mixed economy of provision: public, private and the third sector, we highlight the sheer diversity of organisations, roles and actions which constitute that mixed economy. Our work suggests that reducing this wide range of actors into three categories is somewhat reductive. Indeed, elsewhere we highlight how residents’ bricolage extends beyond national and spatial boundaries to include transnational and virtual resources (see Author 2017). Using the notion of mixed economy to highlight the range of actors beyond PHS enables us to show how providers connect and innovate to address pressing and complex health concerns. The concept of bricolage allows us to make visible how multiple types of provider interconnect dynamically across the ecosystem. By understanding the challenges faced and examining the interactions, innovations and creative adaptations enacted to address challenges, we learn how providers attempt to respond to diverse and complex needs within the ecosystem.

Providers bricolage to different extents and in different ways. Many CSO and CRS respondents could be described as archetypal bricoleurs treating people as individuals, trying to identify, resolve or at least alleviate intertwined social and structural problems through networking and using their detailed knowledge of the ecosystem to tailor help, generally using voluntary support, pre-existing and new collaborations, and donated resources. As noted elsewhere, ecosystem knowledge, low bureaucratic and governance burdens freed CSOs up to be “fleet of foot” – highly adaptable to changes in need (McCabe & Phillimore 2013). CSOs had the flexibility to innovate focusing heavily on network-building. In the absence of adequate resources they depended upon their connections across the ecosystem to meet need. To some extent CSOs alleviated the pressures on state services by providing somewhere to refer individuals whose underlying problems could not be resolved by the state, and where immigration status was largely irrelevant for access. In Sweden, with state services decentralised and local, there was less opportunity for CSO activity. State providers lacked scope for creativity and connection expressing frustration at their inability to remould vulnerable clients to access services in the expected way. Many did not see system reform or adaptation as their responsibility.

Private providers, including pharmacies and complementary practitioners, had considerable freedom to bricolage which they observed was not possible within the state system. Relationships built over time meant complementary therapists could focus on the “whole person”; the connection between psychological, physiological, and physical. They knew their services reached only those who could pay and while some did not seek wider engagement, others offered flexible services or payment, and/ or referral across the ecosystem. Pharmacists, as has been found elsewhere (Author et al. 2015) frequently operated as hubs of activity both bringing in services that were needed, and reaching out to customers. Like CSOs they were knowledgeable about the ecosystem and used their knowledge and connections to support vulnerable people. In Portugal and the UK, they saw their role as taking the pressure off the state and providing their diverse clientele with information, advice and guidance on symptoms and medications, often sharing their resources with other providers.

State providers were under great pressure with little room for manoeuvre. Greater levels of stress were evident in UK and Portugal where austerity measures combined with the effects of superdiversity and restructuring. The scope for state providers to bricolage was constrained by inflexible systems. Nonetheless some providers sought to address complex problems by bending the rules and relying on CSOs – acting as bricoleurs creatively connecting multiple resources across the ecosystem. Many wanted to do more or to operate in different ways. Healthcare providers in superdiverse neighbourhoods are at the frontline of the consequences of inequities wrought by immigration rules, inequality and failure to invest in the poor. Sweden’s redistributive welfare state meant poverty was less evident but existed nonetheless, particularly for migrants. While the purpose of this paper is not to examine the impacts of austerity and restrictionism on healthcare, it was evident that they placed state providers under great pressure. Health and social care professions face multiple stressors (Kinmen & Grant 2010) including time and workload pressures and the need to fulfil multiple roles (McCann et al. 2013). Most PHPs recognised the right to

health with a few remarking on pressures which fuelled racist treatment of some patients, a practice we do not condone.

Conclusions

This paper is original in its focus on provision across the ecosystem and the use of bricolage to understand actions and interactions. The notion of bricolage has considerable potential to refocus research around access to healthcare beyond the somewhat siloed approaches utilised to date. It does so by focusing upon the *processes* of providing healthcare in complex ecosystems. Bricolage highlights how providers adapt, connect, innovate and resist. Focusing on bricolage renders visible the often invisible actions that facilitate the functioning of such ecosystems. Such an approach is likely to be effective in ecosystems beyond the superdiverse neighbourhood.

Through our use of bricolage we highlight how CSOs, with their flexibility to be creative with meagre resources – donated time, materials, space and knowledge of the ecosystem - attempt to fill cracks in state provision, connecting across the ecosystem. However, their ability to fill gaps generated by the withdrawal or inflexibility of the state cannot be assumed. Further investment in CSOs tackling the complex problems that are beyond the current remit of state services is needed. Such investment would be ineffective if accompanied by the bureaucratic or governance burdens that reduce the ability of PHS providers to meet diverse need.

To focus all attention upon the flexibility and readiness of CSO provision is to ignore the failure of the PHS to cope with the pressures wrought by structural factors and to adapt to the complexities of superdiversity. PHS institutions need the freedom and flexibility to bricolage across the healthcare ecosystem as a strategy to respond to complex need. The failure of PHSs cannot be excused or condoned, given that meeting needs is their responsibility. Across Europe, health and social care are built on assumptions that are professionally-centred and managerialist, militating against flexibility in the face of changing patient profiles. Building organisational cultures that can evolve sustainably to address the causes of poor health and promote good health, as well as treat health problems, is an ideal. Strikingly such cultures have not been achieved in any of the four settings studied, despite the differences in healthcare regimes. Our work suggests that the best hope to achieve a sustainable form of flexibility lies in attending to and building upon the ways that providers bricolage across the ecosystem and not just within specific sectors. More research is needed to identify ways in which such flexibility can be introduced into the PHS and how fruitful partnerships can be promoted across sectors.

ⁱ Also known as the ‘crisis of solidarity and of racism’ to emphasize the failure of host populations’ response.

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