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DOI:

[10.1016/j.healthplace.2018.12.003](https://doi.org/10.1016/j.healthplace.2018.12.003)

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Document Version

Peer reviewed version

Citation for published version (Harvard):

Pemberton, S, Phillimore, J, Bradby, H, Padilla, B, Lopes, J, Samerski, S & Humphris, R 2019, 'Access to healthcare in superdiverse neighbourhoods', *Health and Place*, vol. 55, pp. 128-135.

<https://doi.org/10.1016/j.healthplace.2018.12.003>

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Publisher Rights Statement:

Checked for eligibility: 17/12/2018

Publisher's version at: <https://doi.org/10.1016/j.healthplace.2018.12.003>

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Access to healthcare in superdiverse neighbourhoods

1. Introduction

This paper provides original and significant new insights into the ways in which features of superdiverse neighbourhoods shape local residents' access to healthcare. First, it highlights the importance of super-diversification and the need to expand upon existing studies focusing on individual ethno-national groups and their health concerns (for example, see Clark and Drinkwater, 2007). Second, it considers the features of superdiverse places and how they shape the healthcare-seeking practices of local residents in distinctive and important ways.

Research concerned with diversity of populations and health has generally adopted an ethno-national focus (Bécares et al., 2009; 2013). Ethnic or national groups have been perceived as internally homogenous and externally bounded (Brubaker, 2006), and with a focus on how the spatial concentration of minority populations may shape health outcomes and access to healthcare services (Bécares et al., 2009; Halpern and Nazroo, 2000). Research often examines geographical variations in health according to the relative importance of 'context' (features of the neighbourhood) and 'composition' (the people who live there; Macintyre et al., 2002). Bernard et al. (2007) developed a framework exploring how the availability of, and access to, health resources are regulated according to a number of 'rules' – such as proximity to resources and rights of entitlement – which give rise to a number of domains (for example, economic, physical, institutional) cutting across neighbourhood environments. However, to date processes of healthcare-seeking in superdiverse neighbourhoods have not been scrutinized, and new explanatory frameworks exploring how superdiversity may impact on healthcare-seeking have not been developed (see Vertovec, 2007).

Drawing on research conducted in eight superdiverse neighbourhoods in four European cities, the paper considers the respective importance of the differing features of superdiverse neighbourhoods in shaping access to healthcare. Section 2 of the paper discusses how diversity has been treated in relation to access to healthcare, the pre-eminence of an ethno-national focus and the idea that single ethnic groups make place (Massey and Denton, 1993). Section 3 sets out details of the research design and methods. Results and analysis are presented in Section 4 and a new conceptual framework developed. This extends Bernard et al.'s (2007) work. Section 5 draws out some wider implications considering the contingency and relationality of superdiverse neighbourhoods and the ways they shape healthcare access.

2. Superdiverse places and access to healthcare

2.1 Diversity, access to healthcare and place

Critical accounts of the implications of diversity in healthcare have been slow to emerge (Ahmad, 1992; Ahmad and Bradby, 2007). Migrant and minority health needs were often viewed as 'special', requiring separate services and/or

temporary interventions fitting migrants into existing models of provision. This has supported a model of migrant or minority pathology, blaming individuals for their own poor health outcomes (Rocheron, 1988). Epidemiological comparisons of the relative risks for diseases in different populations have focussed on excess morbidity, mortality, or deleterious health behaviour. Focussing on diseases and conditions peculiar to minorities has meant that both the health issues that concerned the communities themselves and the diseases that affected the largest absolute number of a minority have been neglected (Ahmad and Bradby, 2007). Research into minority groups' access to healthcare has often focussed on translation, interpretation and mediation. Despite progressive intentions to eradicate racism and address unmet health needs, by persistently locating health problems in the minority itself - and often at an individual level - the need to consider the structural under-pinning of inequality such as poverty, racism and discrimination has often been absent (Bhopal, 1997). In addition, this has served to generate rigid and reductionist approaches to healthcare provision in terms of the fixed homogeneity of categories such as ethnicity, race, migrant background or country of birth, used as proxies for diversity in different countries (Stronks et al., 2009).

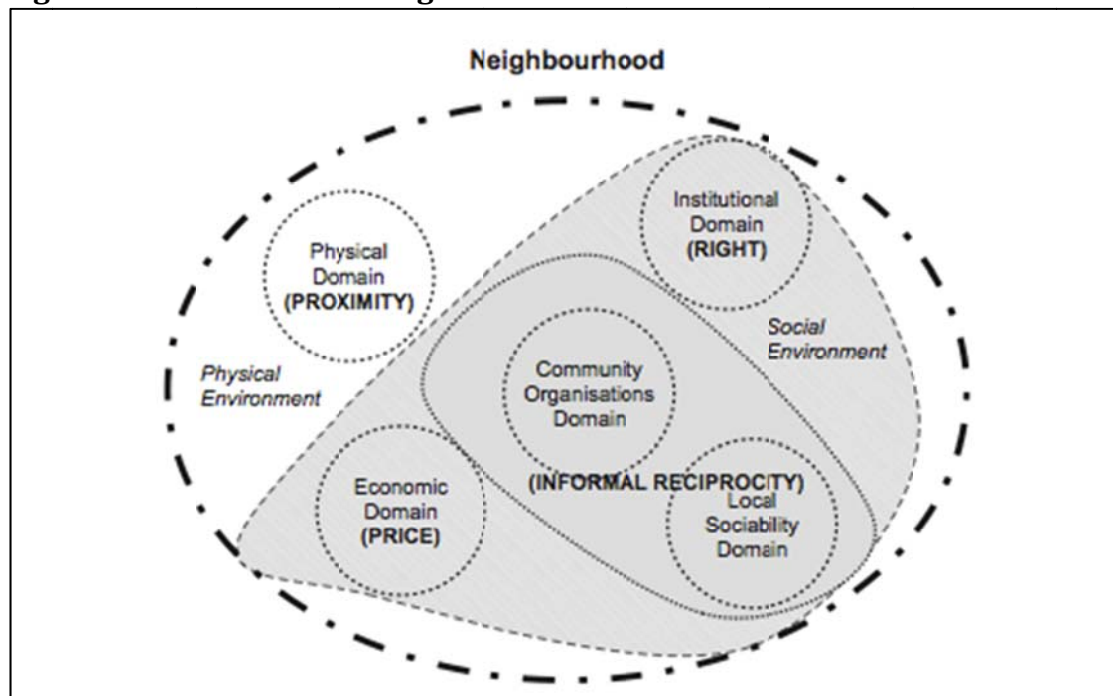
Within this context, there has been an increasing interest in the importance of place for health (Macintyre et al., 2002). This includes the way in which different places shape health outcomes and healthcare-seeking behaviours (Tunstall et al., 2004; O'Campo et al., 2015); and the appropriateness of approaches to neighbourhood healthcare provision, which have traditionally emphasised within group homogeneity (Clark and Drinkwater, 2007). Neighbourhoods can be presented as bounded territories (or 'absolute space') for political and administrative purposes and frequently (but not always) for the organization and delivery of health services (Bennett and McCoshan, 1993). But they can also be viewed as 'relative spaces' whereby boundaries are "fuzzier", contingent and indeterminate, with neighbourhoods connected to, and shaped by, processes from within and beyond (Jones and Woods, 2013). Others have argued for a relational perspective whereby 'neighbourhood' is expressed territorially and shaped relationally, acting as a node within wider networks of interactions (Katz, 2001; Heley and Jones, 2012). These conceptions treat the neighbourhood as an object from which individuals, both within and outside, can draw resources in order to address a health concern - rather than as a unit of analysis.

A 'context' and 'composition' dichotomy can also be identified in research on health and neighbourhood that considers the degree to which spatial variations in health outcomes are informed by people or the places they live in (Macintyre et al., 2002). Three types of explanation have emerged: compositional, contextual, and collective (Macintyre et al., 2002). *Compositional* explanations focus on the characteristics of individuals concentrated in particular places. *Contextual* explanations refer to opportunity structures in the local physical and social environment. *Collective* explanations focus on the socio-cultural and historical features of communities (Macintyre et al., 2002).

All three features have informed the work of Bernard et al. (2007), who argue that neighbourhoods essentially involve the availability of, and access to, health-

relevant resources in a geographically defined area. They propose that availability and access are regulated according to different 'domains' of neighbourhoods (Figure 1): *physical* (including neighbourhood facilities and infrastructure), *economic* (types of enterprises in the neighbourhood, such as supermarkets), *institutional* (amount and quality of public services offered by public authorities), *community* (community organisations) and local sociability (social networks). Such domains are influenced by a number of intersecting 'rules of access' which shape access to healthcare services. Rules include *proximity* (physical proximity to positive or negative health-related resources), *prices* (availability and affordability and accessibility to resources in the economic domain), *rights* (state influencing and regulating rules of access according to an individual's rights in the institutional domain) and *informal reciprocity* (the extent to which health-related resources may be given freely by individuals to others in the community and local sociability domains).

Figure 1: Domains of the neighbourhood and rules of access



Source: Bernard et al. (2007)

2.2. Superdiverse places and access to healthcare

At a neighbourhood level, approaches to healthcare provision, which have focused on singular groups with common ideas about healthcare, have been challenged in light of emergent population diversity and transnational healthcare-seeking (Authors, 2011). The diversification of diversity associated with globalised mobility - involving increased diversity both within and between groups - has generated greater population complexity and new patterns of movement, with individuals increasingly moving between changing settings (Rutter et al., 2008; Karel, 2013). Furthermore, the notion of superdiversity - which describes socio-cultural and demographic complexity driven by international migration and internal differentiation within societies - is

associated with intra- and extra-group heterogeneity (Goodson and Grzymala-Kazłowska, 2017). As such, individuals may differ and identify by characteristics such as immigration status, rights and entitlements, gender, age, faith, reason for migration, class, education levels and more (Wessendorf, 2014).

The term 'superdiversity' has been criticised as no more than an amplification of multiculturalism (i.e. 'more ethnicities'; see Back, 2015) or as overly focused on immigrant populations at the expense of the host population, thereby concealing structural inequalities while offering individualizing explanations for inequality, discrimination and labour market exploitation (Sepulveda et al., 2011; Raco et al., 2014). However, if applied appropriately – and with an awareness of such concerns – a focus on superdiversity can extend intersectional approaches to population diversity by highlighting economic, social, legal and political drivers of diversification (Meissner and Vertovec, 2015). In addition, superdiversity can highlight the importance of place in shaping experiences of diversity and difference (Berg and Sigona, 2013), as well as the need to move beyond existing ethno-national approaches to service delivery (Clark and Drinkwater, 2007). This is important for healthcare, as reflected in new efforts to deliver neighbourhood-level services in diverse settings, such as increasing the cultural competence of professionals (Balcazar et al., 2010); developing outreach services (Mladovsky et al., 2012); using cultural mediators to help newcomers access mainstream services (Lizana, 2012); and neighbourhood hubs offering multiple services in one location (Duckett, 2015).

Pride (2015) has highlighted a number of different 'domains' of superdiversity. Whilst the 'individual' domain (e.g. personal characteristics), 'migration' domain (e.g. immigration status), 'socio-economic' domain (e.g. occupation and income) and 'household' domain (e.g. languages spoken) are all important in constituting population superdiversity, he also signals the importance of the 'space-place' domain and how it intersects with the other domains. In terms of space-place, superdiverse places contain people from many different countries forming less of a critical mass than the concentrated ethno-national groups often associated with previous migrations. Superdiverse neighbourhoods encapsulate different ethnic constituents and diversity within groups, as well as exhibiting variety in respect of religion, socio-economic status, education outcomes, deprivation levels and rates of population turnover. Little is known about how such dimensions of superdiverse places shape healthcare-seeking behaviours.

Arguably a number of intersecting features of superdiversity set such neighbourhoods apart, with potential to shape healthcare-seeking and service access in distinctive ways. Such neighbourhoods are fast changing: areas of transience for those passing through and "arrival zones" for new migrants from multiple countries of origin (Robinson et al., 2007). Thus, they are characterised by 'newness' (Authors, 2015a) whereby such churn means a proportion of residents are perpetually new. Newness can create challenges in terms of a lack of knowledge about, and access to, resources within and beyond the neighbourhood.

Superdiverse neighbourhoods accommodate migrants and longer established minority groups and non-migrant residents, including gentrifiers who may be attracted by the superdiversity of the neighbourhood. Such individuals engage in different practices of healthcare-seeking, sometimes local, sometimes transnational, with varying degrees of mobility or fixity (Boschman, 2012; Laurence, 2013). In this context, superdiverse neighbourhoods are characterised by *novelty*, with healthcare providers being subject to novel encounters with new migrants. However, expectations placed on providers (for example, by the state) have been slow to adapt, which has meant that time or training to develop their own, or new migrants' cultural health capital has been unavailable (Authors, 2014; Shim, 2010).

Some newly arrived migrants are unable to navigate the institutional cultures of healthcare providers having never encountered such systems before (Afridi, 2015; Authors, 2015a). The combination of churn, novelty and immobility may lead to individuals seeking new ways to respond to their health concerns.

Finally, superdiverse neighbourhoods are inherently *diverse*, whereby no ethnic group predominates and *diversity* itself may become the predominant identity. Such diversity attracts some individuals who feel able to 'blend in' (i.e., gentrifiers), but deters others (Authors, 2016). The proliferation of individuals with differing languages, country of birth, legal status, employment status, educational attainment etc. may provide opportunities for new forms of formal and informal healthcare provision to emerge (see Duckett, 2015).

Other aspects of population diversity are also important. For example, superdiverse neighbourhoods accommodate individuals with *different legal statuses and associated rights and entitlements* which create barriers to access for those without formal entitlements or who are uncertain about their rights (Authors, 2014). Healthcare professionals unsure about individual entitlements may inadvertently exclude individuals with rights to state provision. Such neighbourhoods are also multi-lingual. Language barriers may reduce accessibility and effectiveness of health services (Bischoff and Hudelson, 2010).

Individuals can also have abilities to operate at different scales – both within and beyond the neighbourhood (Chimienti and van Liempt 2015, p.19). They may possess a range of 'contact zones' (Pratt, 1991), 'neighbourhood orientations' (Cieslik, 2015), 'activity spaces' (Massey, 1995) and / or 'healthscapes' (Vallée et al., 2010), offering a proliferation of connections from the local to the regional, national and transnational. Such perspectives reinforce the importance of both relational and territorial understandings of superdiverse neighbourhoods (Jonas, 2012).

In the sections that follow, we identify the distinctive features of superdiverse neighbourhoods, namely newness, novelty and diversity considering how such characteristics inter-relate with the neighbourhood domains and 'rules of access' to shape processes of healthcare-seeking.

3. Methods

Two superdiverse neighbourhoods – selected for their complex diversity among new migrant, minority and resident populations, as well as contrasting deprivation levels and histories of immigration - were nominated in four cities (Birmingham, UK; Bremen, Germany; Uppsala, Sweden and Lisbon, Portugal; Table 1). The superdiversity of each neighbourhood comprises a quantitative dimension in terms of the increase in arrival of migrants from a wider range of ethnicities and/or countries of origin and a qualitative dimension encapsulating intra- and inter-group diversity.

Table 1: Characteristics of the comparison countries and neighbourhoods¹

	City	Neighbourhood
Germany	Bremen: 10 th largest city. 550,406 residents (2012), 24.54% 'Persons of migrant background (PMG)' from 162 countries (2013).	Gröpelingen: 15,705 residents, 44.1% PMG (2013). High numbers of welfare dependents. High levels of deprivation and long history of immigration. Neustadt: 43,699 residents, 26% PMG (2013). Mix of students, migrants and middle-class non-migrants. Decreasing welfare dependency with signs of gentrification. Long history of immigration.
Portugal	Lisbon: Capital and largest city. 547,733 residents, (2014) accommodating 50% of Portugal's total migrant population from 100 countries (2014).	Lumiar: 25,000 residents, 15% PMG (2014). High levels of welfare dependency and deprivation. Mouraria: 15,000 residents (2014). Migrants from 30 different countries over the last 30 years. High levels of welfare dependency and signs of gentrification.
Sweden	Uppsala: 4 th largest city in Sweden - 202,625 residents (2014), PMG from 174 countries (2014).	Gottsunda: 9,924 residents, 53% PMG (2014). Long history of immigration and high levels of welfare dependency. Sävja: 5,330 residents, 39% PMG (2014). Pockets of deprivation and affluence.
UK	Birmingham: 2 nd largest city . 1,073,045 residents, 22.2% foreign born; 46.9% of individuals have an ethnic minority (BME) background from 187 countries (2011).	Lozells and East Handsworth: 31,074 residents, 44.9 % migrants and 89.2% of individuals BME (2011). Long history of immigration and deprivation. Edgbaston: 24,426 residents, 29.2% migrants and 42.2% BME. Low levels of deprivation. More recent history of immigration.

¹ Definitions and terminology vary by country so data are not comparable. Table offers an overview of characteristics.

Full details of research methods are published elsewhere (Authors, 2015b). The research adopted a parallel sequential methodology across the four countries with each phase providing data shaping the development of the next. Throughout each phase, emphasis was placed on exploring the range of resources from different neighbourhood 'domains' that individuals could access, and how the domains intersected with the distinctive features of superdiverse neighbourhoods to shape practices of healthcare-seeking. The intention was not to compare these neighbourhoods directly with other types of neighbourhoods but to explore how healthcare seeking was shaped in superdiverse neighbourhoods *per se*.

First, the research teams in each city spent time walking around the selected neighbourhoods, noting and mapping types of healthcare provision (i.e. state, private, non-governmental organisation, informal), talking to providers and residents to get a sense of what kinds of provision were important. This ethnographic mapping phase enabled us to know the physical neighbourhood, helpful when interviewing residents and providers, but also to make connections that might later lead to interviews.

Second, a total of 160 interviews (conducted by academic researchers and / or trained community researchers; see Authors, 2012) were undertaken with individuals resident in the neighbourhoods and broadly reflective of the superdiversity apparent (see Authors, 2015b). Maximum variation sampling was used to ensure heterogeneity in the composition of the sample in terms of origin, age, gender, education levels, income, ethnic and linguistic backgrounds. This is a form of comparison-focused sampling which selects cases to compare and contrast with a view to identifying factors explaining similarities and differences (Patten, 2001). The shared aspects that emerged, despite the many intersecting axes of difference, hold increased authenticity and validity because they do not result from sampling by pre-determined characteristics in a pre-defined informant group (Authors, 2018). Interviewees were identified during the mapping stage, through community researchers' networks, community organisations, approaching individuals on the street and snowballing.

In summary, across the sample respondents were aged between 18 and 80 (the majority were aged 30-59) with 56% female and 44% male. The largest proportion of respondents were employed (49%), followed by 21% unemployed and 11% retired. The majority lived in private rented accommodation (52.5%), a tenure that dominated in Portugal (67%) and Germany (60%). In addition, varying proportions of respondents in each country were born overseas. The UK (70%) had most born overseas followed by Sweden (66%), Germany (63%) and Portugal (56%). The UK was most diverse with respondents from 22 different countries followed by Germany (17), Portugal (16) and Sweden (14). Europe was the largest country of origin (46% of those born overseas), followed by Asia (26%), Africa (21%) and the Americas (7%). The faith profiles of respondents differed across the case study countries. Christian was most frequent (42.5%) followed by Muslim (26%) and atheist (12.5%) The majority of respondents reported ability to speak the local language fluently (30%) or reporting that it was their mother tongue (35%) while only 3% could not speak the language at

all. Of those born overseas only 16% had arrived in the five years prior to interviewing.

Respondents were asked to describe a health concern, which they had sought to address since moving to the neighbourhood and the actions taken to address that concern where possible in chronological order. They were asked to describe all resources used whether within or beyond the neighbourhood. Each research team received ethical approval from their respective ethics committees. All respondents were given oral and written information about the project, including the option to withdraw up to 28 days after the interview and then asked to sign a consent form. All data were anonymised. Interviews were undertaken in multiple languages working in the chosen language of respondents and then transcribed in full.

Third, some 80 interviews were undertaken with healthcare providers identified in the resident interviews and ethnographic work. Providers included those offering primary and secondary healthcare, alternative / complementary care, faith groups, mental health services, community-based care and specialist services for forced migrants. For both qualitative phases an analytical framework was designed collaboratively by researchers from each of the four countries. Data were coded collectively using a systematic thematic analysis approach (Guest et al., 2012) 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 interpretative thematic analysis. A shared codebook was devised between teams in the four countries using MAXQDA software. The project lead (Author x) checked inter-coder reliability across sites.

4. Results and analysis

Whilst individuals' healthcare-seeking practices vary according to the nature of their health concern(s), as well as their dispositions, identities, previous experiences etc., they were also shaped by the context and composition of neighbourhoods. Figure 2 draws together the key points emerging from the research to highlight the different features of superdiverse areas shaping access to health services.

4.1 Physical domain and rules of uncertainty and responsibility

With regards to the 'physical' domain and the physical environment of superdiverse neighbourhoods, residents generally highlighted physical proximity to healthcare resources – and especially public healthcare – as being unproblematic. Many discussed how they used the local health centre / local Doctor or went straight to emergency services based upon the severity of their condition and/or waiting times at the local health centre. As stated by one respondent: *"I mean you go directly to the Vårdcentral (Community Health Centre) Right? Have I missed something?"* (Swedish-born woman, 57, Sweden). Indeed, many (but not all) superdiverse environments provided a range of healthcare resources, especially in areas with a long history of population diversity.

Moreover, respondents reported that some Community Pharmacies offered home-based provision and mobile nursing care services was also referred to in several neighbourhoods.

Rather than 'proximity', the more fundamental challenge in shaping access to health services related to 'uncertainty' (see Figure 2), particularly for more recently arrived respondents who encountered the 'newness' and 'novelty' of the neighbourhood environment. A number of interviewees noted they had little knowledge of services available locally and the 'suitability' such services to address their needs:

"...it is difficult to find the right place to seek help for my health issue. If I were in China, I know exactly where to turn to, I would just go..." (Chinese-born woman, 64, UK).

Arguably, whilst such experiences may apply to migrants who have moved through different residential settings, the key point is that the persistent presence of new individuals as an inherent feature of superdiverse neighbourhoods means that issues of uncertainty were amplified. As such, interviewees highlighted that they were uncertain of which health resources were available and where – as well as their suitability – given the continually evolving nature of service provision and resource availability in the area. This was particularly evident in terms of informal provision, which could emerge quickly in response to demands from new populations and then promptly disappear as individuals moved on and demand fell. A number of interviewees also highlighted their inability to connect with services in the neighbourhood because they perceived that appropriate local resources had not yet developed or been adapted to meet their specific need.

Related to uncertainty were issues of 'responsibility'. For example, some migrant respondents in the UK and Portugal stated they only wished to see a doctor of their own gender. Indeed, particular challenges were noted in encouraging newly arrived migrants from sub-Saharan Africa to access maternity services in Portugal because they feared being examined by male doctors. In Germany, a number of migrant respondents discussed the stigma associated with using mental health services, which for them acted as a barrier to access. Once again, such issues were amplified by the superdiversity of the neighbourhoods. For example, many individuals did not share a common approach to accessing healthcare, raising challenges for professionals in responding to novel and rarely encountered cultural and linguistic features. In addition, in terms of sensitive topics such as mental health, the social networks available to those newly arrived were limited given the lack of a critical mass of individuals with similar characteristics, needs, and / or dispositions), contributing to exclusion and isolation (also see Section 4.4).

Linguistic diversity, time and trust intersected with uncertainty and responsibility in shaping access to healthcare. For example, in Portugal and Germany, many migrant residents were compelled to bring their own interpreters, in order to communicate with a doctor, and stated that they were

often viewed as problematic because they could not use the local language. The challenge of linguistic diversity in accessing services has been previously documented in other contexts (see Norredam et al., 2011). However, the proliferation of languages spoken in superdiverse neighbourhoods was identified as being particularly problematic for healthcare providers: *“There are much more people who actually need your help, but don’t come because of well...the language, (but) we just don’t...have time to engage”* (Psychiatrist, Gropeligen, Germany).

Temporal issues were also of relevance given the wide variation in working hours of respondents, reflecting the demographic complexity and varying socio-economic statuses of superdiverse neighbourhoods – *“Chinese patients only do the treatment after they have finished their work later in the evening....”* (Alternative Medicine Doctor, Mouraria, Portugal). Yet ‘out of office hours’ provision in such neighbourhoods – particularly in Sweden and Portugal - was accessible only to the wealthy or those who had private health insurance, who could access (private) health provision on their own terms (also see affordability discussion).

Finally, a further influence on access to healthcare related to the importance of trust, and with a number of migrant and non-migrant interviewees noting they did not use public health services due to a lack of trust. Whilst the importance of trust has been recorded in a range of different residential contexts, in respect of superdiverse neighbourhoods there was a broad range of ‘relational proximities’ to healthcare support evident – for example, from interviewees’ previous country, city or neighbourhood. As such, challenges of building trusting relationships between health professionals and individuals with infrequently encountered cultures / languages was evident. There were examples of individuals going ‘back home’ for treatment and sourcing medication (including ‘alternative’ medication). Thus ‘relational proximity’ to healthcare support was often as important as physical proximity in these superdiverse contexts.

4.2 Economic domain and the rule of affordability

Turning to the social environment and the ‘economic’ domain of superdiverse neighbourhoods, we have illustrated in Table 1 how some of the case study neighbourhoods were deprived. Poverty is often a defining feature of superdiverse neighbourhoods. Crucially, in the context of neighbourhood superdiversity, this intersects with the variety of rights and entitlements (institutional domain – see Section 4.3) for some residents. Consequently, although Bernard et al. (2007) reported how issues such as ‘availability’, ‘accessibility’ and ‘affordability’ are all important in respect of the ‘rule of prices’, in the superdiverse neighbourhoods included in our study, it was apparent that (a rule of) ‘affordability’ was a key driver impacting on access to health-relevant resources.

Indeed, many individuals could not afford healthcare or medication. While this is often true of poor neighbourhoods, it was apparent that such issues were more widely spread across a broader range of individuals, due to the intersection of

poverty and the varying rights and entitlements of individuals in superdiverse neighbourhoods. Challenges of affordability were particularly evident for elderly residents with low / no pensions, asylum seekers, refugees and poorer migrants who lacked rights and/or resources. An asylum seeker noted that dental care was costly in Sweden and that his municipality would not meet the costs of the bridge he needed. However, poorer migrants with Swedish residency and non-migrants living in the case study neighbourhoods also remarked on the prohibitive cost of dental care. In Portugal, an undocumented migrant with high cholesterol levels was unable to afford medication: *“I’m not making money.....that’s why I couldn’t go (to the doctor)”* (Indian-born man (undocumented migrant), 32, Sweden), whilst a Portuguese-born woman could not afford to pay for a cataract operation: *“If I had enough I would run to the doctor and get my cataract treated but there is no money to pay a cataract clinic, it costs around 3,000 euros* (Portuguese-born woman, 63).

In some case study neighbourhoods people became reliant on support from charitable organisations and voluntary sector organisations, which had arisen in response to (and reflective of) the rise of superdiversity (Padilla, 2008; Authors, 2018); in other neighbourhoods individuals combined such support with emergency state provision.

“When people are in an illegal situation they already have some kind of economic issue and when they have to pay 38 euros for a consultation in the Health Center they just end up not going. We tell them that they can go to the Emergency service of the local hospital...and if they really can't pay, they'll just have a debt to the hospital. They have the right to be seen, always” (Nurse, Doctors of the World (Non-Governmental Organisation (NGO), Portugal).

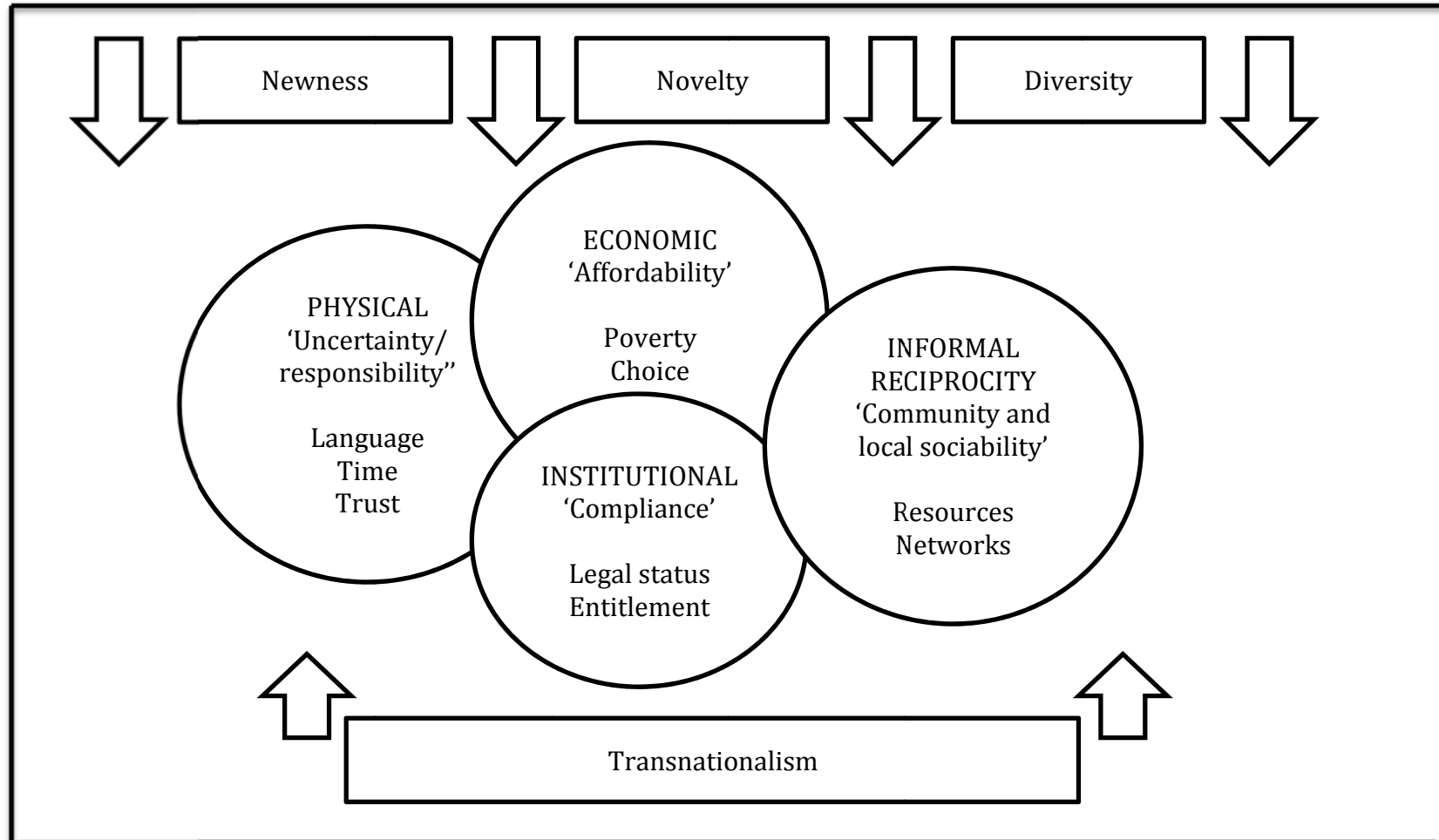
Interesting variations in healthcare-seeking were reported in the superdiverse neighbourhoods because of challenges associated with affordability. In Portugal, emergency services were free and primary care services attracted a charge, so undocumented migrants often went straight to emergency if they could not address their health concern in other ways. In Germany, where health insurance is mandatory, either through statutory (not-for-profit) health insurance providers or private health insurance providers, the prevalence of poverty for many migrants residing in superdiverse neighbourhoods was compounded by a lack of residence permit that made it almost impossible to purchase health insurance and thus access healthcare. Even where individuals had a residence permit and insurance, problems were often compounded through providers (and particularly community pharmacies) restricting access to the more costly medication, which was perceived by some migrants as discrimination: *“I’ve been told certain medicine is only for Germans”* (Sri Lankan-born man, 76, Germany). Hence poverty, legal status and perceived discrimination come together in different ways and at different times in the context of neighbourhood superdiversity, to impinge on affordability and access to health resources. Indeed, in contrast to findings by Duckett (2015) which focused on how pharmacies in “hyper-diverse” communities responded rapidly to changing populations in terms of the nature of provision, our research highlighted the

opposite. As such, certain treatments or services were said to be less prevalent in superdiverse neighbourhoods compared to elsewhere:

“Over there at XX pharmacy, they have a completely different clientele. There, a lot of value is placed on homeopathy and on alternative medicine, I don’t need to put it up here, because it’s not asked for here” (Pharmacist, Neustadt, Germany).

Individuals who could not afford to purchase medicine or incur other ‘out of pocket’ expenses either relied on their doctor to prescribe medication (where eligible) or sought resources from charitable / welfare organisations or transnationally. Transnational health seeking was considered a necessity by some interviewees given the intersection of affordability with issues of uncertainty and responsibility reported in Section 4.1, as well as restricted rights and entitlement: *“I went back to Spain to get physiotherapy as it was cheaper and widely available”* (Spanish-born man, 28, UK).

Figure 2: Superdiverse neighbourhood domains and rules of access



4.3 Institutional domain and the rule of compliance

The 'institutional' neighbourhood domain is particularly important in a superdiverse context given the role of institutions in shaping rights of access to healthcare according to legal status. The diversity of populations present - including migrants and non-migrants - means that individuals' rights and entitlements to healthcare are highly variable.

Newcomers frequently arrived in our case study neighbourhoods from abroad lacking knowledge about how to access care and then moved away quickly. This mobility and associated newness presented challenges to providers in terms of their ability to support access to provision and build trust with residents (Authors, 2011; 2015a). Importantly, new arrivals often had differing expectations and preferences to those resident longer: *"they've (new migrants) got certain preconceived ideas about healthcare, and preconceived ideas about medications"* (Pharmacist, Edgbaston, UK). This highlights the importance of a 'rule of compliance' - rather than simply 'rights' *per se* (see Bernard et al., 2007) - in respect of individuals' ability to adhere to prescribed medication or treatments.

In essence, those who were eligible to access treatment often engaged in transnational health seeking due to difficulties in understanding prescribed treatments - sometimes because of language barriers but also because they did not understand the healthcare system. Such influences on transnational health-seeking acted over and above those of affordability and uncertainty. Provider interviewees noted how some individuals went abroad to secure medical advice or medication from elsewhere. However, during this process it was argued that they either received treatment deemed 'inappropriate', found that the costs of engaging in transnational practices were more significant than first envisaged, or stopped following the treatment that the providers had prescribed to them - as such, a lack of compliance. Eventually they returned to the superdiverse neighbourhood with their condition deteriorating and requiring 'corrective' treatment:

"I get a lot of Eastern Europeans who start their treatment abroad in their own countries because a) they can speak the language; and b) because they think it will be cheaper to get treatment back at home.....but they often find it's very expensive and inconvenient to keep going back every six or eight weeks. And as a consequence they then seek treatment from me and I have to maybe undo some of the work that's been done, to correct it" (Orthodontist / Dentist, Edgbaston, UK).

Non-compliance with prescribed treatments could prompt further rounds of transnational healthcare-seeking as their condition deteriorated, and they searched for alternative medication to address their health problems. Compliance issues were also evident for those whose legal status acted as a barrier to healthcare, such as some migrant, refugee and asylum seekers. For example, in Germany a Nigerian woman highlighted how she had little option but to use medication prescribed elsewhere - either 'back home' or from other

informal sources of support in Germany - prior to securing a residence permit (and which subsequently allowed her to secure health insurance). With her permit and insurance policy, she had been prescribed medication from a local Doctor. However, she had not always followed such treatment given that she perceived that this conflicted with previous advice / medication received from back home or from informal providers.

Other attempts to overcome eligibility restrictions for those who had limited access to state services or who lacked health insurance included greater use of local pharmacies for medical advice in order to access 'cheap support' (see Duckett, 2015). Nevertheless, some provider interviewees questioned the extent to which individuals were following and complying with prescribed treatment by pharmacists. Whilst it has been reported elsewhere that migrants are often unclear about their eligibility to healthcare (Authors, 2014) in all four countries it was evident that some providers were also unsure: *"There was an attendant in the healthcare centre who said that I was an illegal here, I told him that I was an Italian and I have a document of EU, and he did not even know what document it was"* (Italian-born woman, 31, Portugal).

Such confusion had a number of 'compliance' effects. On the one hand, it impinged on providers' ability to engage with, as well as manage, expectations of access to state-sponsored health services for undocumented migrants, refugees and asylum seekers; on the other, some resident respondents perceived that regardless of their citizenship they were not prioritised by clinicians if they spoke with a foreign accent:

"I think that there is a difference as to how you would be treated if you are an immigrant and if you are Swedish. The person you speak on the phone would decide whether or not to admit you and if you were Swedish you would probably be admitted" (Somalian-born woman, 64, Sweden).

Immigration status also impinged on provider-patient relations and the extent to which individuals were able to follow and comply with treatments prescribed. For example, in the UK we heard that asylum seekers struggled to attend follow-up medical appointments because they were dispersed by the state to accommodation long distances from their doctor.

4.4 Informal reciprocity domain and rules of community and local sociability

With reference to informal reciprocity, Bernard et al. (2007) identify two domains of the neighbourhood being of importance in shaping access to healthcare – the 'community organisational domain' (involving the commitment of individuals to more formal collective entities in the form of community organisations), and the 'local sociability' domain (for example, neighbourhood-based networks of social links, and the use of information, social support and informal networks). Both are important in superdiverse neighbourhoods in shaping healthcare access, and are distinctive in terms of the extent to which they may reflect neighbourhood superdiversity. Nevertheless, the ability to draw upon such resources to address a health concern can vary considerably in a

superdiverse context – for example, according to individual’s local networks, family context; socio-economic resources; linguistic capabilities, length of residence in the neighbourhood and ethnic or national background. Ability may also vary according to broader political-economic influences shaping the ‘landscape of care’ (Milligan and Wiles, 2010).

Regarding the community organizational domain, individuals who were more place-bound – elderly residents with restricted mobility or limited activity spaces – as well as those experiencing poverty, were heavily reliant on local community organisations. Such help took various forms – for example, the opportunity to discuss health problems; seek further information, advice and guidance, overcome language barriers and access different forms of medication. In Portugal, Santa Casa da Misericórdia-Lisboa (SCML) - provided social and health support to vulnerable (including older) people:

“When for example a child was sick one week ago, we called to know how the child is, to know if it’s doing better. We show them that we care and that we call them because we are worried...some people are surprised when we call to know how they are. They have been lonely for so long that they don’t know what it means anymore when someone cares. For them it is a very comforting thing” (Nurse, SCML, Portugal).

Other community-based organisations across all case study areas – and reflecting a neo-liberal drive towards welfare pluralism - also sought to provide healthcare services to a range of vulnerable groups such as substance abusers, sex workers and irregular migrants *“they made some kind of letter saying that based on some article I am eligible to get the access to get the treatment”* (Cape Verdean-born man (undocumented migrant), 24, Portugal).

Equally, local sociability was evident with individuals highlighting how they drew upon a variety of different local networks – and reflective of superdiversity - in the neighbourhood to secure support:

“I think it’s beautiful that Africans give us very good medicines, such as herbs, spices....they are also immigrants..... when I arrived, it was them who gave me the medicine or told me the shops where I could go” (Mexican-born man, 26, Portugal).

Once again, older respondents, who were sometimes housebound, relied heavily on local sociability: *“What has helped me are these (local) ladies....they have helped me with my health.....they go with me to the doctor, to the hospital”* (Portuguese-born woman, 86, Portugal).

In addition, recently arrived migrant interviewees described the assistance they received from people in their local networks to overcome language barriers and access information about different healthcare services in and beyond the neighbourhood. For example, the parents of a visually impaired Syrian girl relied on local sociability to help raise money to pay for therapy.

Other migrants described family members and friends (in and beyond the local area) as ‘enablers’ to secure support for addressing a health concern. For example, two Bulgarian migrants in Germany had statutory health insurance but asked for medication to be sent from Bulgaria because they struggled to communicate with their doctor and were relying instead on friends and family ‘back home’. In Sweden, a man who had sought asylum in another European country was (incorrectly) denied urgent treatment for a hand injury. He mobilized financial and practical support from friends (in the neighbourhood and abroad) to pay for surgery undertaken privately in Turkey. Thus we can see different forms of both practical and emotional support being provided as a form of ‘care’ in the case study neighbourhoods (see Milligan and Wiles, 2010), and with the nature of support being strongly shaped by the diversity of local residents in each neighbourhood.

Providers also exhibited forms of local sociability in terms of working informally with each other to provide support to those whose with restricted entitlements to health services (Author et al., 2018): *“when we need a blood sample, we send it to a neighbouring practice where it is done free of charge.....we are a small – what you may say – illegal – network”* (Doctor, Gropelingen, Germany).

However, on a more cautionary note, the ability to draw on different forms of informal reciprocity in the context of superdiverse neighbourhoods was uneven. For example, newer migrants tended to rely more heavily on networks in their country of origin whilst non-migrants appeared less likely to rely on informal networks and local sociability in securing advice or medical support given their access to formal health services. Furthermore, community organisations or local networks were often based around a particular ethnic, national or religious group, confirming Padilla’s (2008) arguments that many charity and faith based organizations offer services based on religious (or other) beliefs, which can serve to exclude others. Linguistic diversity also restricted local sociability for those unable to communicate in different languages.

5. Conclusion

This paper is both original and significant in its illustration of the ways in which the different features of superdiverse neighbourhoods influence local residents’ access to healthcare. In particular, we have highlighted how the importance of a number of new rules of access – namely those concerned with uncertainty and responsibility, affordability, compliance, transnationalism and levels (and different forms) of community and local sociability shape access to healthcare across a number of intersecting domains in the case study neighbourhoods. It is apparent that a number of defining features of superdiverse neighbourhoods, namely the newness, novelty and diversity of populations also frame the domains and rules of access of relevance to such places.

The paper has also highlighted the contingency and relationality of superdiverse neighbourhoods. It is clear that whilst a focus on health seeking in superdiverse areas is spatially focused, it is not necessarily spatially constrained. The lack of spatial constraints is important – ‘within’ the neighbourhood the prevalence of

poverty for many individuals intersected with issues such as rights and entitlements in shaping healthcare access. In turn, this meant that some had little option but to look to networks within and beyond the neighbourhood for support, with migrants in particular highlighting the importance of local and transnational networks.

To conclude, in the context of our superdiverse neighbourhoods, the neighbourhood domains identified by Bernard et al. (2007) as shaping access to healthcare services remain of pertinence. However, the 'rules of access' to healthcare resources in each of the neighbourhood domains are different. Further empirical research is required in different superdiverse neighbourhoods: a limitation of the study is that it includes only eight neighbourhoods in four countries. A larger number of neighbourhoods in different settings and countries would allow generalisations to be tested. Equally, the significance of different welfare regime types on shaping local experiences could be explored further. In addition, whilst maximum diversity sampling was adopted, the inclusion of marginalised groups such as asylum seekers and refugees was a major challenge. Hence further work is required to explore the respective importance of neighbourhood domains and rules of access in shaping access for such groups in different contexts of superdiversity. Such work will provide further insights into the ways in which the different types of healthcare services available in superdiverse areas are responsive to the needs of increasingly diverse populations.

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