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Bricolage as conceptual tool for understanding access to healthcare in superdiverse populations *Social Theory and Health*

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Abstract

This paper applies, for the first time, the concept of bricolage to understand the experiences of superdiverse urban populations and their practices of improvisation in accessing health services across healthcare ecosystems. By using the concept of healthcare bricolage and an ecosystem approach, we render visible the agency of individuals as they creatively mobilise, utilise and re-use resources in the face of constraints on access to healthcare services. Such resources include multiple knowledges, ideas, materials, and networks. The concept of bricolage is particularly useful given that superdiverse populations are by definition heterogeneous, multilingual and transnational, and frequently in localities characterised as ‘resource-poor’, in which bricolage may be necessary to overcome such constraints, and where mainstream healthcare providers have limited understanding of the challenges that populations experience in accessing services. The ‘politics of bricolage’ as neoliberal strategies of self-empowerment legitimizing the withdrawal of the welfare state are critically discussed. Conflicting aspects of bricolage are made explicit in setting out tactics of relevance to researching the practices of bricolage.

Keywords: Bricolage, healthcare, right to health, service users, superdiversity

1. Introduction

This paper introduces the original concept of healthcare bricolage and shows how it can be used to enable understanding of the processes and resources employed to access healthcare in demographically diverse areas. The numbers of migrants arriving in Europe, have increased significantly in past decades, most recently typified by the so-called migration crisis. While there has been an increase in the *scale* of migration, other factors mark a shift in the *nature* of migration and its effects at local and national levels. Across the European Union old migration trends based on long-standing post-colonial relationships and/or bi-lateral labour agreements have been added to by new arrivals from many different countries without any prior relationship. These new demographic patterns, intertwined with shifting immigration policies have resulted in superdiverse urban settings (see Vertovec 2007) containing people from many different countries forming less of a critical mass than the concentrated ethnic groups of old migration. Such populations exhibit what Vertovec (2007) described as “the diversification of diversity” with residents having different origin, migration and employment statuses, cultures, rights and entitlements and spatial distributions.

Thus, superdiversity goes beyond and enriches influential intersectional approaches to diversity by highlighting economic, legal, educational and political drivers of diversification. The concept of superdiversity has been criticized as simplistically representing no more than an amplification of multiculturalism (i.e. ‘more countries of origin’). Others have also argued that superdiversity may conceal structural forms of inequality through individualizing explanations for inequality, discrimination and labour market exploitation (Raco et al., 2014). Nevertheless, the term has been widely accepted as, at the very least, overcoming the limitations of ethnic categorisations (Phillimore et al 2015). Superdiversity is used herein to signify a high degree of population complexity comprising people from many places, of multiple immigration statuses, ages, education levels, faiths and so on, and which does not easily lend itself to ethnic or country of origin classifications (Cuthill 2017).

Many urban areas now have multi-layered populations accommodating both old and new immigrants with fast changing profiles from multiple countries of origin, as well as long-standing non-migrant populations (Pemberton and Phillimore, 2018). Consequently, there is often no critical mass to justify the provision of tailored services in a specific language, to offer support to access services to particular groups or to enable health professionals to develop specific knowledge to meet people’s needs effectively (Phillimore, 2011). Newcomers and service providers frequently encounter ‘novelty’ (i.e. surprising ways of organising, navigating and doing health) (Phillimore, 2015) which makes adapting services to meet the needs of complex populations a challenge. This is particularly the case for healthcare provision, which, even before the advent of superdiversity, has consistently failed to resolve inequalities of outcome and inequity of access for areas with high concentrations of migrants (Hernandez-Plaza et al. 2014).

In some parts of Europe, contentious claims have been made that migrants are motivated by health tourism, strategically seeking out publicly provided health services (Wadsworth, 2012a), or that they over-use accident and emergency provision (Scheppers et al., 2006), pushing health services to breaking point (Kressin and Groeneveld, 2015). These claims rely on stereotypes or victim-blaming and are not empirically supported. Migrants may use health services less than the general population (Wadsworth, 2012b) and besides being a human right, healthcare provision for migrants offers financial and public health advantages (Steele et al., 2014). In addition, newcomers utilise a wide range of resources (including knowledge of various healing systems and transnational networks), accessing them from many places (Migge and Gilmartin, 2011), thus, not relying solely on state-provided care.

Notwithstanding studies of how migrants and their descendants use parallel and/or charity-based systems, there is a lack of knowledge about the common practices used to access multiple health resources, covering biomedical and alternative or traditional, online, secular and religious, local and trans-local services simultaneously across different settings. Such knowledge is important, valid and is needed to address how health provision can meet the needs of new populations and reduce enduring inequities in access.

This paper offers the concept of bricolage as a heuristic device not only capable of making visible the variety of barriers, limits and constraints people face in accessing services but also the experiences, practices and tactics of heterogeneous actors in assembling resources and improvising structured processes when seeking to address their health concerns

Section Two provides a review of the existing literature around diversity and healthcare access. Section Three explores the concept of bricolage and its application to researching access to healthcare services. Section Four draws on two vignettes compiled from interviews and ethnographic observations to illustrate how - in the face of constraints - respondents combine multiple resources to address health concerns in ways that are highly resourceful and show great agency. Because the nature of existing welfare systems shapes the reach of bricolage, Section five focuses on an emergent 'politics of bricolage', assessing the extent that such practices may be perceived as innovative and valuable, without legitimizing the withdrawal of statutory provision. In conclusion, Section Six outlines the risks and opportunities of using the concept of bricolage.

2. Diversity and access to healthcare

This section considers how diversity has been treated in relation to access to healthcare, emphasizing the limitations of our understanding of its challenges. Discussions of ethnicity, migration and public health began to appear in the 1980s (Rathwell and Phillips, 1986), but critical accounts of the implications of diversity in healthcare were slow to emerge (Ahmed and Bradby 2007) evolving

from cultural competence and migrant friendly policies to responsiveness to diversity and cultural safety.

The development of National Health systems in post-World War II Europe saw universal provision re-designing the social contract between the State and residents, through two main models: National Health Services or insurance-based health services. Healthcare provision was broadly conceived at the level of the national population, despite migrant labour being central to delivery of such provision (Raghuram et al., 2011). During the second half of the twentieth century, systems of provision routinely ignored the needs of migrants assuming they would either 'go home' or become assimilated. However, the increasing mobility of people, capital, technology and information has made the idea of a local community of stable patients and providers, who share common ideas about healthcare untenable.

Originally, public health interest in immigrants centred on infectious and tropical disease and their implications for native populations. This focus was superseded by research on chronic disease although with the emphasis remaining on how minorities differed from the general population. Epidemiological comparisons of the relative risks of different populations in terms of morbidity, mortality or health behaviour outlined excess pathology, or harmful behaviour among migrants. In the UK, Black et al. (1982) documented socioeconomic inequalities in mortality and morbidity, highlighting that country of birth had an independent effect on outcomes. Later, ethnic group categories mapped inequalities in healthcare access between ethnic groups, independently of the effects of socioeconomic class (Nazroo, 2001; Mindell et al., 2008).

While ethnicity intended to conceptualise the dynamism of cultural, religious and linguistic variation beyond racialised categories (Bradby, 1995), its use in routine datasets arguably necessitated reductionist groupings. Elsewhere in Europe some countries prohibit the use of ethnic categories (i.e. Portugal and Sweden), while proxies include migrant status, 'migrant background' (grand-parents/parents born abroad) and country of birth. The lack of a coordinated system across the EU to record the health outcomes of populations with a migrant background (Ingleby, 2009) combined with different definitions of migrants and minorities across the supra-national region (Helberg-Proctor et al., 2016) have hindered cross-national research.

Our contention is that ethno-national group classifications all have some limitations in terms of their ability to capture emergent demographic complexity (Bradby, 2003; 2012). Regardless of the validity of categorisations, their functionality in the context of the 'superdiversity' is questionable given the challenges faced by increasingly mobile, fragmented and complex populations in accessing healthcare.

Research exploring healthcare amongst diverse groups has also tended to focus upon service provision by sector including the role of the state (van Houtum and Pijpers, 2007); the third (Crampton et al., 2001) and private sectors (Green et al., 2005); on good practices (Padilla et al., 2009) and the patient/clinician health

encounter (Shim 2010). The influence of ethnicity and culture (Clark and Drinkwater, 2007) rather than migration status (Jayaweera, 2010) is often highlighted with little attention paid to informal services (Krause, 2008), internet provision (Gundersen, 2011) and transnational strategies (Bell et al., 2015).

Responses to addressing migrant and minorities healthcare needs have diverged across Europe. A multicultural approach to service provision in the UK and the Netherlands was based on partnerships with minority ethnic voluntary organizations, expected to address migrants' 'special needs'. Special needs were attributed to groups' cultural or linguistic difference, providing a rationale for why they could not be met by existing services (Rex, 1991). Across the Global North a variety of approaches have been adopted by providers focusing upon healthcare settings with high proportions of migrants. These include: increasing the proportion of professional and support staff from migrant backgrounds (Bischoff et al. 2006); increasing the cultural competence of professionals (Balcazar et al. 2010); outreach services in diverse areas (Mladovsky et al. 2012); cultural mediators to help newcomers into the mainstream services (Lizana 2012); and neighbourhood hubs offering multiple services in one location (Duckett 2013). Provision is patchy (Rechel et al. 2013) and often constructs migrant and minority health needs as 'special', requiring temporary intervention (rather than wholesale reform) to help migrants fit into existing services. Evidence that universal services fail to offer equal access for all (Westin et al 2004) has not resulted in adaptation of those services.

The provision of separate services has, with some notable exceptions, reinforced a model of migrant or minority pathology, blaming individuals for their own poor health outcomes (Rocheron, 1988). Migrants' efforts to access healthcare have frequently been represented as problematic, with access to alternative providers (e.g. Hakims, herbalists) viewed as deviant, and blamed for migrants' health problems. Emphasis on migrants' behaviours avoids consideration of the structural underpinnings of inequality such as racism and discrimination. Furthermore, a 'politics of austerity' in many EU countries has emphasised individual responsibility for healthcare access, reducing special measures while systems continue unchanged albeit with less resources.

In summary, approaches targeting specific groups may have been practical for old or post-colonial migration when a critical mass of individuals arrived from a few countries. However, the advent of superdiversity, transnationalism and the spread of new communication technologies have rendered such approaches increasingly impractical, as individuals are likely to use multiple health resources from multiple places to respond to their health concerns. The idea of 'bricolage' helps us to describe such practices.

3. Bricolage, superdiversity and access to healthcare

The concept of bricolage has been widely used but is yet to be applied in relation to diversity, transnationalism and healthcare access. Bricolage has described patterns of thought and practice (Levi-Strauss, 1962), discourse (Derrida, 1967),

intra-individual processes, institutional change and broader social and economic transformation in society (Andersen 2008). Bricolage has been applied to highly contingent and evolving specific logics or politics of social practice (Deleuze and Guattari, 1987) that inventively make use of available resources (De Certeau, 1984), deploying both knowledge and resources to reduce uncertainty. Bricolage practices exploit opportunity (Vanevenhoven et al., 2011) or mobilise resources through embodied agency (Deleuze and Guattari, 1972).

Bricolage is frequently a response to scarce resources (Halme et al., 2012) and a way of overcoming challenges, turning them into opportunities, through mobilising, mixing, re-assembling and re-using resources to 'make do'. 'Making do' resonates with enduring concerns about a lack of appropriate and approachable healthcare resources for migrants (Baker and Nelson, 2005). But bricolage could potentially be used in situations where there are ample resources. In resource rich environments bricolage can be an innovative and creative alternative or addition to mainstream approaches resulting in better performance or outcomes (Burgers et al., 2014). Bricolage involves creativity and innovation utilizing 'at-hand' resources, and combining or re-combining them to meet particular challenges. For the purpose of this paper we invoke 'healthcare bricolage' as a creative mobilisation, use and re-use, of wide-ranging resources, including multiple knowledges, ideas, materials and networks in order to address particular health concerns.

Areas accommodating superdiverse populations may be resource-poor and necessitate bricolage to overcome challenges of access to healthcare (Phillimore, 2011; 2015). Conversely, the co-existence of different belief systems, educational and cultural backgrounds, languages, networks and institutional awareness may widen the range of resources available for mixing, re-making, combining and re-imagining. A combination of local, regional and transnational resources may be harnessed to find creative alternatives or additions to existing approaches to meeting health concerns. Thus, there is a spatial dimension to bricolage, it can be multi-scalar, shaped by the differential 'healthscapes' (Vallée et al., 2010) ranging from the local to the transnational.

Bricolage may also be used to identify new solutions to enduring health problems and so of particular importance under service constraints driven by austerity, restrictionism and individual responsabilisation. The neo-liberal emphasis on competition and choice, and the notion that people should be empowered to help themselves may further drive the need to bricolage. Increasing challenges that some individuals face in accessing and mobilising resources in different types of healthscape, comprised of public and private provision, through a variety of social processes need to be recognised (Mitchell, 1995). Rights of access to particular resources and services for healthcare bricolage are variable and can be regulated by service providers within and beyond areas accommodating superdiverse populations.

Thus, healthcare bricolage might encapsulate actions which involve individuals undertaking practices to augment existing provision, as an alternative to existing provision, or as a necessity go beyond existing provision (Phillimore et al., 2018).

All such approaches may be contextualised by issues of access to healthcare services associated with migration status. Importantly, bricolage offers considerable potential to bring innovation to health systems largely designed around the principle of universalism and (imagined) homogenous populations. Applied in transnational contexts linked to migration, bricolage has the analytic potential to make visible how resources from across the world get connected to solve health problems, highlighting agency in healthcare seeking.

Bricolage could thus be conceived of as a tactic whereby individuals make the most of all available resources as part of a broader strategy for accessing healthcare. Although bricolage has not been deployed as a concept in healthcare research, 'everyday tinkering' describes how people adjust healthcare professionals' recommendations in the face of choice (Guell, 2012). Tinkering and improvising (Livingston, 2012) are dimensions of 'doing' bricolage, but in superdiverse populations, bricolage may involve prioritising certain approaches to address health concerns, especially in the context of resource constraints. For example, a lack of knowledge and/or ability to access public healthcare services may mean a greater focus on 'making do'. On the other hand, if individuals have access to public healthcare services, alternative or transnational resources may be mixed in, rather than substituted.

4. Healthcare bricolage in action

The paper draws on data from the UPWEB project which developed the concept of bricolage to understand the ways in which healthcare was accessed by residents of two superdiverse neighbourhoods in four European cities: Birmingham, Bremen, Lisbon and Uppsala, each located in countries with different health, welfare and migration regimes (Sainsbury, 2006) (see Table 1). The project used multiple methods including interviews with residents and providers and a survey. The neighbourhoods presented different patterns of superdiversity. Extended details of neighbourhoods and methods are available elsewhere (Phillimore et al., 2015). The project received ethical approval from the relevant committees in each study location¹.

Healthcare bricolage is illustrated using vignettes constructed from interviews with two residents selected from around 40 interviews in each city (see Annex). Interviews were conducted by trained community researchers, who were recruited due to their polyvalent skills: multi-lingual abilities, knowledge of local networks and NGOs. Each team trained community researchers using an adapted version of an accredited training model developed by the UK team (Phillimore et al., 2015).

¹ Authorisation code for Project Lead ERN_14-1111B

Table 1: Characteristics of the comparison countries and neighbourhoods²

	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.
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.

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

		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.
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The community researchers were paired with academic researchers and together identified interviewees via their networks, local organisations, snow-ball sampling through street mapping and interaction with locals. Maximum variation sampling was used to ensure heterogeneity in the composition of the sample in each country in terms of origin, age, gender, education levels, income, ethnic and linguistic backgrounds. This is a form of comparison-focused sampling that selects cases to compare and contrast to identify factors explaining similarities and differences (Patton 1990). The shared aspects that emerged, despite the many intersecting axes of difference, hold increased authenticity and validity because they are not the result of sampling by pre-determined characteristics in a pre-defined informant group.

Residents were interviewed at the place, and in the language, of their choice. Interviewees and interviewers signed consent forms which emphasised the option to withdraw from the interview at any time. Names used in this paper are pseudonyms. Interviews with residents asked them to recall a recent health concern and to describe all actions taken from the emergence of symptoms until some resolution was reached. Prompts such as “did you do anything else?” were used to support recall of the range of actions. All interviews were digitally recorded, transcribed and translated where necessary. Data were coded collectively using a systematic thematic analysis approach (Guest 2011) to identify the key issues and moments 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 (Phillimore) checked inter-coder reliability across sites.

The vignettes for this paper were selected because they demonstrated different approaches to mixing, combining and re-using multiple resources to address a health concern and represent the practices we define as healthcare bricolage. We do not claim these vignettes are illustrative of all healthcare bricolage. Indeed bricolage is inherently variable so each case is unique and not every respondent, whether migrant or non-migrant, bricolages³.

Isabela

Isabela, 33, a university graduate from Brazil, had been Portugal for two years. She lived in Lisbon and was unemployed at the time of the interview. From childhood she had adopted a healthy lifestyle learning from her mother, a nutritionist. Isabela held an Italian passport, entitling her to access health

³ This paper is not intended to report on the frequency of bricolage (to be reported elsewhere) but we note that over 50% of interview respondents reported some form of bricolage

services as an EU citizen. With Portuguese as her mother-tongue, communication was not problematic but she did not fully understand how the public healthcare system worked.

Since arriving in Portugal Isabela had developed alopecia (hair loss). Hoping it would resolve itself, she waited two months before attending the health centre where her registration was delayed because her right to access services was not recognised. Eventually she gained access through the support of a non-governmental organisation (NGO) only to find that the doctor offered no treatment.

Following discussions with her yoga teacher, Isabela realised her hair loss was due to alopecia. On the advice of a friend, she paid for a consultation with a doctor in a private hospital. The consultation proved disappointing as no further investigations were offered. She was prescribed a sedative but, following internet research, only took 25% of the prescribed dose, since she was unclear how the medication would resolve her hair loss and concerned it would make her sleepy. Subsequently, her yoga teacher suggested Chinese medicine. At the same time, she took special vitamins manufactured by her mother in Brazil and imported by a friend.

Isabel's superdiverse neighbourhood offered various alternative and traditional therapies including acupuncture. Isabela used her credits with the local time bankⁱ to get discounted treatment. After weekly acupuncture treatments combined with vitamins, she felt that there was some improvement. She returned to Brazil and visited a trichologist, gaining a formal diagnosis and an understanding that the condition could be managed but not cured. Back in Lisbon she employed a combination of alternative and traditional medicines to manage the psychological state underpinning the hair-loss. She imported medication purchased from her Brazilian trichologist because her Portuguese doctor would not prescribe it.

Isabela's story reveals a series of constraints and opportunities in response to which she acted creatively to construct a highly individualised answer to problems of access, diagnosis and treatment. Isabela felt that public and private healthcare providers dismissed her concerns as superfluous, leaving her without a diagnosis or treatment options beyond sedatives. Isabela mobilised NGO support to facilitate access to public healthcare and a range of supporters to get access to traditional and alternative therapies. Through working with others and deploying her accumulated financial and exchange resources, she took control of her condition. Isabela called upon transnational connections and knowledge of different healing systems to secure diagnosis, medication and treatment. She was creative and methodical, recording her treatments and their effects in a diary. She was also critical, conducting internet-based research and developing a set of expectations as to how she should be treated. Living in a superdiverse neighbourhood enabled Isabela to utilise alternative healthcare, at an affordable price, which together with advice, allowed her to manage her condition. Far from being a passive patient, misusing or overusing the Portuguese medical system, as migrants are sometimes portrayed, she adopted multiple and carefully co-

ordinated approaches. She consciously bricolaged networks, knowledge, local and transnational resources and alternative therapies and eventually ceased to engage with the public healthcare system.

Akram

Akram, 27, had lived in Sweden for two years on a temporary residence permit granted by the European country where he first claimed asylum. Having cut his hand, Akram went to the local emergency clinic, accompanied by a friend, where his wound was stitched. Realising that there was nerve damage to the hand, a nurse referred him to a doctor, who then refused to operate because Akram's EU Health Card had expired.

Akram had little knowledge of the Swedish health system and neither he nor his friends were aware that he could have claimed treatment for the nerve damage, on the basis that any delayⁱⁱ would damage his hand's functioning. Akram was initially told he must pay for hospital treatment but even after a friend agreed to cover the cost, Akram was refused treatment in Sweden. He was sent away to seek treatment in the country where he had initially sought asylum and which had granted him temporary residency. Without access to social support in that country of asylum, Akram asked a friend in Sweden to lend him 4,200 Euros to access treatment in Turkey.

Akram had other disruptive problems for which he neither sought treatment nor mobilised resources. He reported dental pain that sometimes prevented him from sleeping and a periodic cramping stomach pain, only eased by vomiting. He self-treated pain with chamomile tea and over-the-counter painkillers. Akram avoided social contact where possible and listened to Arabic music to soothe the sadness and loss underpinning his distress.

Akram's story highlights multiple constraints to accessing healthcare, including (inappropriate) denial of access to public healthcare, a restriction of services, a lack of financial resources to secure treatment and insufficient knowledge of rights and entitlements to be able to negotiate access. Akram experienced high levels of psychological stress preventing him from accessing support. Nonetheless to address his injured hand, Akram mobilized his networks in both Sweden and Turkey and availed himself of another country's services. With regard to his other problems, Akram's ability to withstand psychic and somatic suffering, either until his symptoms improved or until his residency status changed, rather than mobilizing support, suggests a set of priorities where the costs and benefits of short and long-term actions were weighed up. He employed teas, painkillers and music to manage his disruptive chronic conditions. His pattern of bricolage had, at its heart, a personal set of priorities regarding what could be borne and what could not, grounded in his knowledge of available resources and indicative of a desire not to overtax his social networks. This contrasts with professional-centred priority-setting, in which clinical judgments about need dominate decision-making processes.

6. Discussion: Towards a Politics of Bricolage?

Both vignettes draw attention to a range of constraints to accessing healthcare in systems constructed as universal. Isabela and Akram required help to access public healthcare and whilst Isabela eventually gained access, neither was able to address their health concern within that system. Both bricolaged solutions beyond the public health system. Their ability to bricolage was mediated by their capacity to be mobile, the extent of their networks, their financial resources, access to navigators and the proximity of alternative healthcare resources. A combination of Isabela's education, networks and financial resources enabled her to systematically assess the effectiveness of her actions. Akram, on the other hand, had fewer resources and less support. He deployed the limited support to prioritise treatment for his hand, then relied his own resilience to withstand chronic pain and psychological distress. Neither respondents actively chose to bricolage. They did not seek spiritual or traditional solutions for comfort or for cultural reasons; on the contrary, they were compelled to use such resources to secure diagnoses and/or to manage their conditions. They employed different degrees of agency and creativity in order to resolve or at least manage their health concerns.

The heuristic of healthcare bricolage enabled us to make visible the activities, processes and relations our respondents used to address health concerns which would have remained hidden in an analysis focussed on interactions within formal healthcare. Focusing on the process and actions of bricolage enabled us to show how Isabela and Akram under-utilised public healthcare and instead bricolaged their own solutions. Far from accepting service providers' dismissal, we describe an emergent 'politics of bricolage' emphasizing the agency, resources, knowledge and networks underpinning our respondents' ability to shape, re-shape and/or transform existing structures of healthcare provision. This politics of bricolage can highlight where change is needed from a policy perspective.

A bricolage lens reveals the uneven distribution of resources and access within and across populations. Our case studies showed the importance of local opportunity structures alongside the ability to generate contact and interaction(s) with different communities based around shared identities, understandings (of particular health problems) and practices. Bricolage may also be symbolic, reflected in patterns of thought, discourse and orientation that interact with material practices. Arguably, a key task in securing more progressive forms of healthcare provision is making bricolage processes visible, to develop more equal possibilities for accessing, mobilising and re-shaping resources within healthspaces.

The concept of bricolage has the potential to move us beyond neoliberal strategies of self-empowerment which over-emphasise the utility-maximising rational, private individual or homogenous group operating at the 'will of the market'. Bricolage emphasises individual and collective agency, mediation, mobilization and experimentation and innovation (Clarke and Cochrane, 2013:16) as well as the 'logics of care' (Mol, 2008) enacted in health services and in informal and private social networks. Bricolage can help secure innovation

and flexibility in the inter-relationships between service-providers and service-users, navigating between entangled 'logics of choice' and 'logics of care' (Mol, 2008). The ability to 'do bricolage' varies according to people's characteristics, backgrounds and, crucially, local opportunity structures.

While bricolage could form a 'perverse alignment' with neo-liberal strategies of self-empowerment in that both concepts involve a pro-active society (Dagnino 2007:355), we emphasize the importance of attending to market forces, and mediation, innovation and resistance. Dagnino argues that bricolage may be conflated with or appropriated within neo-liberal logics. Based on our tentative findings we argue that the politics of healthcare bricolage are central to demonstrating tactics for grasping the innovative and valuable practices that people engage in when trying to address their health concerns. In the absence of these politics, a focus on bricolage risks legitimizing or justifying the withdrawal of the welfare state. To make this conflict explicit we propose three tactics relevant to researching the practices of bricolage: critical contextualisation; revealing 'the hidden'; and the right to health.

First, research on bricolage requires a critical contextualization of broader forms of government, migration regimes, and – where relevant - neoliberal transformations. For example, in neo-liberal contexts, bricolage is associated with (to some extent) marginalized subjects in precarious situations and environments of scarcity. In both Portugal and Sweden, which have experienced neoliberal reforms to differing degrees, the vignettes show that although both public and alternative healthcare was available, access to, and the approachability of, service providers were problematic at different stages, and necessitated different tactics of bricolage, including at the transnational level. Consequently, it is possible to illustrate the ways that people insert themselves into the cracks that neo-liberal health policies create in terms of availability, approachability and accessibility. Bricolage can help to make visible conditions and contexts of advocacy and the qualities of situations in which individuals, networks or collectives can re-work the 'spaces of power' through which such activities can be pursued (Newman 2012). Such an approach should also attend to the country-specific historical and emergent withdrawal of the welfare state (often termed 'reform') to reflect the broader politics of healthcare provision, welfare and immigration.

Second, research on bricolage requires a focus on 'the hidden', including the processes by which individuals assemble a mix of resources in attempting to address their health concerns. Bricolage reveals critical practices in accessing healthcare, making visible acts and logics of resistance. Our vignettes show that the withdrawal of public healthcare produces neither passive subjects nor autonomous patient-consumers, as evident in Isabela's actions in and beyond the Lisbon neighbourhood, and, partially, in respect of Akram's prioritisation of the need to regain his manual dexterity through travel to access treatment, despite its cost. Bricolage can be researched as the politics of tactical/experimental transformation, which creates new and alternative forms of access to information, involving empowerment and knowledge-sharing. In this respect,

the notion of 'pre-figurative' behaviours may be useful (Jordan, 1987) to identify emergent bricolage types of bricolage.

Third, research on bricolage must begin by focussing on the right to health (see UNHCR 1976), regardless of resources, legal status, gender, ethnicity etc. Acknowledging health and access to healthcare as a basic right for all problematizes the privatization of healthcare. A critique of paternalistic approaches to marginalized and/or deprived groups allows the value of bricolage as resistance to emerge as part of a practical claim to the right of health. Implicit in the vignettes is that who you are, where you live and the nature of the welfare and immigration regimes to which you are subject, shape particular tactics of bricolage (Cummins et al., 2007). Indeed, questions about residency rights and eligibility to access services within (and beyond) the neighbourhood were apparent in shaping Isabela's and Akram's tactics.

7. Conclusion

This paper presents the original concept of bricolage illustrating its potential and versatility to better understand the ways in which superdiverse populations address their health concerns. We show how bricolage practices are not just creative processes in which various outcomes are possible; they are situated in social life and shaped by local routines, traditions and resource availability.

The concept has strengths and weaknesses. Viewing bricolage as a tactic whereby people creatively utilise available resources reveals agency and avoids pathologisation. Focussing on superdiverse neighbourhoods, often associated with resource scarcity and inaccessible services, highlights opportunity, rather than deficit, visualises resources such as multiple health knowledges and transnational connections that are sometimes overlooked, exoticized or problematised. Using the lens of bricolage offers insight into possible new ways of improving access to public healthcare, informing the design of adequate policies to meet the needs of increasingly complex populations. Yet the concept of bricolage could be used to reinforce neo-liberal ideas around self-help and responsabilisation and to provide further justification for the withdrawal of the welfare state. The concept does not allow the measurement of health outcomes mitigating against assessments of effectiveness vis-a-vis other approaches.

In introducing the concept of bricolage, we suggesting how it may be used. In other papers we show that bricolage takes place across different health systems, as well as within such systems – and is shaped and informed by service users and providers (Phillimore *et al.* 2018). Elsewhere, we demonstrate how healthcare providers bricolage when trying to meet complex health needs in superdiverse neighbourhoods (Phillimore et al forthcoming). Additional research is needed to further develop the notion of healthcare bricolage in different settings, for example where there is less diversity, no public healthcare system or where resources are plentiful. Such work will enable further theorisation and the outlining of basic parameters for identifying bricolage and its limits. Furthermore, the nature of successful bricolage needs to be identified

and the unintended and potentially negative consequences of bricolage evaluated. Finally, there is a need to consider the importance of symbolic or ideational resources as part of bricolage processes, as well as exploring the different approaches to bricolage in different contexts for different people.

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ⁱ A network for exchanging services without direct cash payment.

ⁱⁱ 'vård som inte kan anstå' or 'care that cannot wait' must be given to asylum seekers