

Approaches to welfare provision in the age of super-diversity: looking at health provision in Britain's most diverse city¹.

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Abstract

Commentators have argued that we have entered a new era of migration described by Vertovec (2008: 1025) as a “transformative diversification of diversity”. Multiple variables of difference in the ethnicity, immigration status, rights and entitlements, age and gender profiles and patterns of distribution, of new migrants means that the UK, and many other EU countries, are now home to the most diverse population ever experienced. The onset of super-diversity challenges traditional multi-cultural models to welfare provision originally based upon an understanding of migrants as large and geographically contained clusters of post-colonial migrants. These changes are occurring at a time when migration has become highly politicised, multi-culturalism is being questioned, a shift is underway towards assimilation and welfare provision has become re-racialised (Law 2009). This paper argues that models of welfare provision need to be rethought to take into account the new reality of super-diversity in a way that is affordable, politically acceptable and meets the needs of all. Using data from research undertaken from studies of health service provision in the West Midlands the paper explores the challenges of meeting the needs of new migrants under existing provision, the costs of failing to adapt to super-diversity and the reasons why provision has failed to adapt. The paper concludes by arguing the need for different approaches to provision, and suggesting some new ways forward.

Introduction

Britain has always been a country of migration from the early Roman conquest, subsequent arrivals of Celtic and Pict tribes, Angles and Saxons, to the Post War arrival of New Commonwealth immigrants (Phillimore & Goodson 2008). However the past ten years have seen a shift from post-colonial migration to new migration, as people arrive in the UK from many different countries, with different immigration and employment statuses, ethnicities, rights and entitlements and spatial distributions, as Britain and much of the EU enters an era of super-diversity (Vertovec 2008). While we are unable to know the precise numbers of migrants that have entered the UK in the past ten years, we do know that arrivals to the UK have exceeded departures, the population of Britain is rising largely due to immigration and that immigration is increasing the pressure on services in many areas (Cook 2008; Travers *et al.* 2007).

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Migration is possibly one of the most politicised policy areas in the EU, if not the world (Huysmans 1995; Schierup *et al.* 2006). The last two elections in the UK were fought around the issue of migration with Conservative and Labour parties competing to be the toughest on migrants (Phillimore 2009a). The advent of recession has promoted the call for “*British jobs for British people*” as anti-migrant sentiment increases and the Government are forced to negotiate with workers for the right of economic migrants to work in the UK (BBC 2007). Welfare provision is at the front-line of the debate about, and policy response to, migration. Politicians and the media portray welfare as a major pull factor, attracting migrants for generous benefits and free healthcare (Hubbard 2005), and using this argument to justify a move away from welfare provision for all, to a model of provision for the legitimate and the deserving (Sales 2002; Duvell & Jordan 2002).

Shifts in thinking about the provision of services to meet the needs of new migrants, and indeed established migrant populations, are underway as we move from multiculturalism to social cohesion in a manoeuvre either viewed as step back to assimilation (Schierup *et al.* 2006), or an attempt to retain support for social welfare in the face of a reduction in social solidarity (Banting 2000; Ryner 2000). While the restriction of access to, and rethinking of, models of provision are underway, it is argued that the attempts to offer multicultural provision in response to the needs of established minorities have failed these groups and are unlikely to meet the needs of a super-diverse population (Ahmad & Craig 2003; Law 2009). However little is known about the experiences of new migrants trying to access welfare services. This paper explores the relationship between welfare provision and migration and uses data collected from interviews with new migrants trying to access health services in Birmingham, England’s second city located in the West Midlands region, to look at the ways in which existing models of delivery meet their needs. It considers the challenges of meeting the needs of a super-diverse population and the costs of failing to adapt. The paper concludes by arguing for different approaches to delivery that build on ethnic sensitivity models through the restructuring of power relations.

A new era of migration

Policymakers and academics agree that the EU, and the UK in particular, have over the past ten years, experienced “*a transformative diversification of diversity*” (Vertovec 2008: 1025), now commonly termed super-diversity (Cantle 2008; Schierup *et al.* 2006; Parekh 2008; Law 2009). High economic performance, the need for migrant workers, and increase in asylum seekers due to global conflict and EU accession, all lead to increases in the number and nature of arrivals. These flows and channels have become known as new migration (Vertovec 2008). While diversity once related to relatively discrete, if not homogenous, ethnic “communities” of post-colonial economic migrants and their families, the arrival of hundreds of thousands of migrants from many different countries, mean that the number of ethnic groups living in the UK has proliferated and the growth of smaller groups has “*radically transformed the social landscape in Britain*” (Vertovec 2008: 1028). Furthermore it is now not possible to talk about diversity solely in terms of ethnicity. Other variables including immigration status, different associated rights and entitlements, divergent labour market experiences, gender and age profiles, patterns of spatial distribution mean there is diversity within and between ethnic groups.

The poor quality of migration and ethnicity data does not enable an accurate estimate of the numbers, ethnicities and statuses of migrants living in the UK. IPPR used Labour Force Survey data to estimate that 15.8% of the UK population were immigrants or the descendents of immigrants in 2006 (Sriskandarajah *et al.* 2007). Looking specifically at immigrants some 9.3% of the British population was estimated to be foreign born in 2004, up from 6.9% in

1995 and 8.2% in 2001 (Lemaitre & Thoreau 2006: 13). These figures do not include the 725,000 irregular migrants estimated to be currently living in Britain (IPPR 2009), the 665,000 Accession country migrants who have registered on the Workers Registration Scheme (Pollard *et al.* 2008) or in excess of 100,000 asylum seekers who have arrived in the UK since 2004 (National Statistics 2009) but do include an estimated 1.4 million foreign nationals working in the UK in 2003 (IPPR 2004). These new arrivals join a well established migrant population of 1053411 people of Indian origin, 747285 of Pakistani origin, 283063 Bangladeshi origin and 565876 people of Afro-Caribbean origin (from 2001 census, ESRC 2009). IPPR identify 25 country of birth groups with populations of in excess of 60,000 resident in the UK and explore their immigration status (Sriskandarajah *et al.* 2007). While some groups primarily consist of ex Commonwealth migrants (India, Pakistan, Jamaica), others are predominantly economic migrants (Australia, US, South Africa, Poland) and a further group are predominantly refugees and asylum seekers (Iran, Somalia, Zimbabwe).

The UK's super-diverse population is not stable; the super-diversity of populations varies across the country and continues to change in response to the needs of capital and as a result of global conflict. Many city centre areas operate as "escalator areas" (Travers *et al.* 2007) with new arrivals from a wide range of countries arriving, finding their feet and then moving on after several months or years, whilst rural areas experience the seasonal arrival of new migrants introducing diversity into their previously stable, and predominantly white, populations (Robinson & Reeve 2007). Research commissioned at city level goes some way to indicating the diversity present at least in major cities. London has traditionally been viewed as the most diverse UK city with 29% of residents from ethnic minorities. The super-diversity of London is illustrated by looking at the 64 populations of over 5,000 people who reside there, speaking over 300 different languages (GLA 2005). However more recently it is clear that regional cities such as Birmingham, which houses asylum seekers from 85 different countries (Phillimore *et al.* 2004), are becoming increasingly diverse. Indeed Birmingham is expected to become Britain's first minority majority city in 2020 (Birmingham Chamber of Commerce 2005).

The ability of a multicultural model of welfare provision, designed to meet the needs of Commonwealth migrants, to cope with the sheer complexity of super-diversity, has been questioned (Schierup *et al.* 2006). The nature of super-diversity, particularly the fragmentation of settlement, raises a series of challenges for policymakers. These include how to encourage effective representation without well-established new community organisations to engage in consultation and, most relevant to this paper, how to know who, and where, groups are, in order to identify their needs and ensure effective public service provision. Meeting these challenges has become more difficult with the increasing politicisation of migration and renewed pressures to reduce welfare provision for new migrants, and to move away from multicultural provision generally.

The rise and fall of multicultural provision

Migration has always been politicised but some have argued that the UK entered a period of crisis in 1989 following the collapse of the Soviet Union (Schierup *et al.* 2006) and subsequent arrival of thousands of asylum seekers, undocumented migrants and those arriving for family reunion. Throughout this period an increase in nationalism has been witnessed across Western Europe with the rise of far right political parties such as the BNP in the UK and, critically the incorporation of nationalistic policies into the policies of mainstream parties (Schierup *et al.* 2006). As the new Millennium dawned "*UK politicians and some sections of the media did their best to create a siege mentality*" (Schierup *et al.*

2006: 22) and migrants became “*the most demonised groups of people living in the western world*” (Lewis 2003: 324). While immigration policy continued to be strengthened in order to secure borders and prevent the arrival of unwanted migrants, the UK Government accepted that economic migrants were necessary to provide the flexible labour needed in a post-Fordist economy (Banting 2000). At the same time fears were expressed that increased numbers of migrants placed undue stress upon welfare services, and welfare measures were increasingly used to control migration and marginalise unwanted migrants, particularly undocumented migrants and asylum seekers (Lewis 2003; Bloch 1997; Sales 2002; Home Office 2007).

Migrants’ access to welfare has been problematic throughout the twentieth century. Lewis (2003: 329) points to the 1905 Aliens Act wherein people could be denied entry if they were likely to become a “charge on the rates”. However post war migrants in the UK, although not intended recipients, benefitted from the universality of the Keynesian Welfare State (Ryner 2000). Inclusion of migrants was accepted politically, partly because it was believed that political control of borders would ensure that those without a legitimate place in the labour market would automatically be excluded (Ryder 2000). No attention was paid to the welfare needs of economic migrants (Williams 1989). Inter-racial riots in the 1950s were seen as a problem of migrant numbers, rather than of unequal access to state resources, and little action was taken to address migrants’ welfare needs until the 1970s (Solomos 1998). At this point it became clear that guest workers were not returning to their countries of origin and indeed family reunion had fuelled the development of sizeable and stable ethnic minority communities (Solomos 1998). Emphasis moved from immigration control to considering the future of minorities experiencing discrimination and inequality. Multiculturalism emerged as the dominant approach favoured in the delivery of social policy (Williams 1989).

Multiculturalism focused upon linguistic and cultural pluralism, the celebration of difference, and encouragement of tolerance and respect (Williams 1989). While Conservatives warned multiculturalism was a divisive force, working against the shared values and language required for nationhood, Labour administrations introduced policies that enabled the development of a multicultural society (Solomos 1998). These included Race Relations Act 1976, and the introduction of the Commission for Racial Equality. A combination of local unrest, and lack of national policy to promote equality of access to welfare services, saw local authorities championing equality. The political mobilisation of Black communities in some areas also influenced provision (Solomos 1998). Following decades of marginalisation of minority ethnic health issues, some areas saw the development of ethnically sensitive and specific services particularly around public health, specific health problems, health promotion and the employment of minority staff (Solomos 1998). Multicultural provision did have its critics. Lewis (2000) and Williams (1989) point to the imposition of cultural awareness by white elites creating cultural stereotypes described by Bhavnani (in Lewis 2000: 105) as “*steel bands, saris and samosas*”. Both point to the pathologising of difference as the cause of low achievement rates, rather than a symptom of racism, and lack of power. The development of multicultural models of delivery were said to have prevented the restructuring of welfare to address complex power relations and recognition of an understanding of ethnicity as an interplay of “*personal, collective, structural and political experience and location*” (Lewis 2000: 132).

Through the early 1980s changes were again afoot as Fordist capitalist expansion stagnated and demands to ensure equal access to welfare were repelled. Thatcher changed the local-central relationship seeking to cut expenditure and challenge the role of local government in the delivery of welfare (Butcher 2002). This rolling back of the welfare state was partly in

response to the perceived excess of local government in spending, and to their provision of specialist services aimed at promoting equality of access (Ryner 2000). The gradual shift from local authority provision to pluralist provision, based on a mixed economy of public, private and voluntary sector prevails today. New Labour's emphasis on partnership was said to offer value for money while making services more customer focused and thus offering the prospect of ethnically sensitive provision by the community for the community.

Challenges to multicultural provision

In recent times welfare provision for minority ethnic groups and immigrants has been challenged from two directions. The first is the increased use of welfare as a tool of restrictionism. The second is the move from multiculturalism to community cohesion. Several authors have outlined the use of welfare as a tool of restrictionist migration policy in the UK (Bloch 2000; Sales 2002; Geddes 2000; Lewis 2003). Restrictionism proper emerged in the 1970s with the 1971 Immigration Act stating that migrants had to be ordinarily resident in the UK for five years in order to be eligible for welfare (Williams 1989). Restrictionism has emerged from political concern about both the availability of benefits acting as an incentive attracting migrants to the UK (Geddes 2000; Home Office 2007), although this possibility has largely been discredited by researchers¹ (Robinson & Segrott 2002), and also that the voting public viewed migrants as scroungers (Law 2009). It has subsequently proliferated in the form of "*internal differentiation of migration types (which) means that the relation of immigrants to the welfare state is internally highly differentiated dependent on their legal/residential status and labour market position*" (Ryner 2000: 67).

A whole range of different measures including no recourse to public funds for those joining families in the UK, the call for habitual residence tests, the use of vouchers to support asylum seekers, exclusion of unsuccessful asylum seekers from some secondary health care and HIV treatment, and exclusion of Accession country migrants from some benefits until they have been registered on the Worker Registration Scheme for twelve months, serve as but a few examples. Certainly Law (2009) points to the re-racialisation of welfare, as benefits increasingly have conditions attached to them stating the ineligibility of persons subject to immigration control. In addition the complexity of regulations and eligibility has put service providers under great pressure and led, it is argued, to those unable to prove their status being excluded from services (Mir 2007; Maffia 2008). Restrictionism is said to have culminated in poor welfare outcomes for migrants and immigrants experiencing high levels of unemployment, poor housing conditions, low levels of educational attainment and poor health outcomes as exclusion has become tinged by ethnification (Schierup *et al.* 2006).

Schierup *et al.* (2006) document the shift from thinking of social solidarity as a redistributive welfare state to a socially cohesive workfare state based on obligations and responsibilities, rather than rights. These obligations include being employed, and adopting language and cultural norms. The conditionality of social cohesion enables an incremental approach to integration and citizenship so that different rights are accorded to different residents, according to immigration status, length of stay and ability or willingness to meet obligations (Banting 2000). While the workfare regime is intended to reduce welfare expenditure, social cohesion promotes a move from social citizenship to civic citizenship, wherein long term migrants have civic and political rights but not full nationality; and different categories of migrants have differential access to welfare (Banting 2000). Some commentators have argued that the advent of super-diversity is leading to a situation where social solidarity has been undermined to the point that collective support for the welfare state is under attack, and

rationing immigrants' access to welfare is necessary to reassure taxpayers that their money is being spent on people who deserve their sympathy (Goodhart 2004; Banting 2000).

A further threat to migrant's access to welfare is the ascent of community cohesion in policy thinking around race relations at local and national levels. Cantle's (2002) report of the 2001 riots in northern English towns held the living of "parallel lives", with neighbourhoods and services divided on racial grounds, responsible for political unrest (Cantle 2005; 2008). In the eight years since the riots there has been a paradigm shift in race relations thinking from multiculturalism's celebration and support of cultural difference, to community cohesion's push for shared values. The production of guidance for local authorities outlining that single group funding should only be supported in special circumstances (CLG 2008), whilst challenged, has promoted a move away from provision of ethnically sensitive services (Southall Black Sisters 2008).

The rationing of welfare to immigrants, and move away from culturally specific provision for migrants generally, are compounded in the era of super-diversity by the lack of information about the needs of new arrivals regardless of their migration status (Ahmad & Craig 2003; Law 2009). Yet institutions have a duty to ensure equality of access to their services under the 2000 Race Relations Amendment Act, and new initiatives such as Local Government and Public Involvement in Health Bill also establish the importance of customer involvement in shaping service provision. Little is currently known about the experiences of new migrants seeking to access welfare services in the current policy environment. This paper uses data collected as part of two studies into new migrants' access to health service provision in Birmingham, to explore the experiences of new migrants seeking to access health services, and the challenges of meeting the diverse needs in the existing policy climate. The next section looks at the methods used to collect data.

Methods

Data is taken from two separate studies. The first took place in 2007 and looked at the well-being of refugees living in Birmingham with a particular focus on mental health. The second was undertaken in 2008 and explored the service needs of new arrivals living in the North West of Birmingham. This study included range of new migrants including economic migrants, refugees, asylum seekers, failed asylum seekers and family reunion migrants. Neither study included irregular or undocumented migrants.

Refugee well-being

Leaders from 16 different Refugee Community Organisations (RCOs) were trained in social research and interviewing skills as part of a University accredited course. They were asked to identify a series of refugee respondents from their own communities and to explore a whole range of issues around settlement and well-being using a semi-structured topic guide. Community researchers facilitated contact with respondents who, because many had no contact with community or other organisations, would have been difficult for white, English speaking, University based, researchers to reach. Thus, the impact of language and cultural barriers were minimised whilst rigour and reliability were monitored through one-to-one mentoring and quality control. In total 138 interviews were undertaken to explore refugees' experiences of wellbeing. Some 36.4% of respondents were female. They ranged in age between 17 and 55 and came from 20 different countries of origin including key asylum sending countries of Iran, Afghanistan, Somalia, Sudan, Rwanda, Zimbabwe, Iran and Congo. While the interviews with refugees were undertaken with the general refugee population, the community researchers undertook an additional 17 in-depth case study

interviews with respondents who had experienced a mental health problem in the UK. In addition researchers interviewed 15 community mental health providers to explore existing provision.

New migrants' access to services

This study used a multi-method approach. A brief questionnaire exploring knowledge of, and access to, services was distributed via schools, GP surgeries, libraries, shops and community organisations. In total of 189 questionnaires were returned and all were analysed using SPSS. The questionnaire returns were split equally between male and female respondents (93 of each) with three non responses. Respondents came from over 20 different countries with the largest proportion from Poland (25%), Sudan (11%), Iraq (10%), Somalia (9%) and the Congo (7%) (see Table 1). Two thirds of respondents were aged between 25 and 40, a fifth were under 25 and the remainder over 40.

Table 1: Country of origin

Country	Frequency	Percent	Country	Frequency	Percent
Not known	2	3	Ghana	2	1
Somali	17	9	Cameroon	4	2
Poland	48	25	Portugal	2	1
Eritrea	9	5	Afghanistan	2	1
Rwanda	8	4	Pakistan	3	2
Congo	14	7	British	4	2
Kurdistan	3	2	Other	10	5
Sudan	20	11	Burundi	2	1
Iran	4	2	Zimbabwe	7	4
Iraq	19	10	TOTAL	189	100.0
Liberia	2	1			
Vietnam	4	2			

In addition 97 new migrants attended a total of eight focus groups recruited via community organisations, schools, GP surgeries, and leafleting. The focus groups included Iranian people, Kurdish people, women new arrivals, Francophile Africans, other Africans, Polish families, Somalis and Polish singles. The groups were facilitated by a combination of researchers and interpreters. Finally we interviewed eight community leaders to gather an overview of the experiences and needs of new arrivals living in Birmingham. Three community leaders represented specific communities (Kurdish, Polish and Iranian) and five worked with new migrants more generally. The qualitative data from both studies was analysed using a systematic thematic approach. While the new arrivals study explored access to welfare generally, for brevity this paper will focus upon access to health services as an example of the experiences of new migrants seeking to access welfare provision.

New migrants' access to health provision in Birmingham

The majority of respondents in both studies were able to access a GP with some 13% of survey respondents unregistered, and 10% not knowing how to access GP services. Those without GPs were most likely to be Accession country migrants having been in the UK less than a year, although four were refugees who had been in the UK over five years. Locating and registering with a GP were particularly difficult in areas with large new migrant populations. New migrants were refused access to waiting lists because they were full or they struggled to understand the registration process "*I do not understand the questions even when they are asked to me in Somali*" (Somali woman). Often new migrants registered at a

doctor some distance from their homes, or at the surgery of a friend who could help them register.

While most managed registration, the main problem faced by all new migrants. Regardless of status, was understanding *“the system”*. Respondents struggled to get appointments when they needed them and, not understanding the emergency GP-based system, often used Accident and Emergency services as their main source of medical attention *“you have no option but to go to hospital”* (African woman). A woman respondent described her feelings of panic when she had not known how to get her critically ill child to hospital, while an African community leader said new arrivals *“just suffer inside until someone informs them what is going on”*.

A further problem for new arrivals was their inability to explain their symptoms in terms that a GP could understand within the time they were allotted for an appointment. They felt that GPs dismissed their problems because they did not understand them and were frequently given inappropriate treatment *“my finger was broken and they gave me some pills, just some pills”* (Kurdish man). This was the case for refugees and asylum seekers who experienced mental health problems that related specifically to experiences of persecution, or of the asylum system and discrimination in the UK. Many of the 17 respondents with mental health problems had experienced or witnessed extreme events

“First of all the war I went through, the way people have been killed, the way a body is opened up from the stomach, it is not a story, I have seen it myself. From what I have seen in my country and the way we are treated in this country it is double. I had all those immigration troubles to add to my experience of war. Then I felt mentally ill” (Congolese male)

Most did visit their doctor and request help with symptoms ranging from sleeplessness, listlessness, and inability to concentrate to hallucinations and uncontrollable anger. However in all cases doctors were unable to understand what they were saying and all but three respondents were either sent away *“my doctor said to think positive”* or offered medication

“The only medication I have had so far is paracetamol. I have 800 paracetamol at home. I have never had any treatment. I am not able to do anything, to get a job, to get a good education, I can’t focus” (Ivorian male)

“They do not understand the problem I have, even if I explain to them they give me Panadol. They do not help me at all” (Kenyan male)

“They do not understand me. One thing you will only tell them is that I have a problem I did not sleep during the night. They will prescribe painkillers. They will give you a tablet to help you sleep. In fact those tablets make you lose your appetite” (Congolese male)

Three of these refugees were eventually hospitalised, one for a period of three months. All felt they had experienced breakdowns following the failure of their GPs to provide them with the support they needed. Of the three respondents who had been referred for some kind of psychological counselling none was satisfied with their treatment. One respondent received one hour of treatment and found the impact insignificant. A further respondent was later told

that he was not eligible for mental health care because he was an asylum seeker and another found the counselling technique used inappropriate:

“I had depression. I went to see somebody to do counselling. I went just once because I did not see it helping at all. What the counsellor was concentrating on was my background, whether I had a happy childhood which I thought was irrelevant because I had a very happy childhood, very happy life before I came here and the main problem was here” (Zimbabwean woman)

All 15 service providers stated that there was no specialist mental health provision for migrants in Birmingham although a number of them wanted to receive training to help them offer support to asylum seekers and refugees who had experienced traumatic events. The one specialist service established to address the general and community health needs of asylum seekers was closed shortly after the study was completed because the service offered was not cost effective. Many of the respondents expressed concerns that it was pointless seeking help from the doctor because waiting times were so lengthy:

“The only support available to the people with mental health problem is to send them to the doctor. To get a doctor appointment is a waiting list. It takes 6 weeks before you get one. It takes years (to see a specialist on mental health) and not good services available.” (Kosovan male)

While some refugees had been failed by their GPs, others, women in particular, would not consider visiting white male doctors. Some African respondents had experience extreme sexual violence in their countries of origin and were reluctant to speak with British doctors because of the shame associated with their experiences

“I can not tell him my problem, he is male and he is white. It is a woman’s problem” (Burundian woman)

“The problems of doctors here, they are people from here who do not understand you. And I do not trust them sometimes. I never told them my story because I do not trust them” (Congolese woman)

There was a general view by all respondents that accessing specialist support was too difficult because of a combination of language and cultural problems. Some respondents did not trust professionals with their problems because of the difficulties they had expressing themselves to the medical profession. Interpreters were said to be unreliable in that their attendance was poor, and they were sometimes unable to translate information about symptoms.

Seeking alternatives to the NHS was a common approach adopted by newcomers to get the help they needed, an act that Banting (2000) suggests may represent the rejection of universal services viewed as instruments of assimilation. One respondent said there were migrant doctors practising in the UK, without recognised qualifications, but used as the main source of health care by migrants in their community. Accession country migrants often chose to fly back home for medical treatment and the Somali community leader gave examples of where his community had joined together to raise funds to send a sick friend or relative to other EU countries to get the treatment they needed. Two Iranian refugees sought a specialist Iranian psychologist to provide support for their children. One used his networks to get treatment

from a clinician working within the NHS and paid for a one off session. Another was still looking for a professional:

“We are still trying to find a psychologist. We watch the Iranian psychologist programmes on Iranian channels which are broadcasted (in Farsi) from America. We still got a big problem which has not fully been solved yet and trying to find a solution for that”. (Iranian male)

Accessing and understanding other parts of the health system was difficult. Almost without fail no respondent had access to a dentist. This was said by community leaders to be the norm within new migrant communities. In addition women migrants did not understand the maternity or inoculation systems. Women sometimes presented at hospital in labour having not received any pre-natal care. One women reported *“they forced me to have an HIV test because I was a refugee and said I had to wait a long time because of who I was”* (African woman). Several women had been unable to check compatibility between the inoculation systems in the UK and their country of origin. Polish migrants took their babies back to Poland to be inoculated whilst others proceeded with inoculation worrying about the impact on their child, or left their children un-inoculated.

Discussion

With the majority of respondents accessing GP services within a year of arrival in Birmingham it could be argued that the health needs of new migrants were being met. However closer examination reveals that while there were some differences between different groups of migrants, most were not faring well and the lack of specialist services, language support or information left many without the care or treatment they required. The neglect of new migrants' health needs have serious implications for health services, public health and the migrants themselves. New migrants either ignored a health problem until it became critical, were given treatment that did not address their needs, or used the system in an inappropriate way. All of these failures culminated in additional or unscheduled use of the hospital system, bringing extra pressures and expense when hospital treatment, in most instances, could have been prevented. Furthermore systems such as the inoculations service rely upon significant take up rates within the general population to ensure that public health can be protected. Poor provision of knowledge about the service, and lack of trust about its usage, resulted in failure to inoculate within some new communities which may compromise public health in super-diverse areas. Given new migrants' lack of knowledge of the health system generally it is likely that levels of understanding around other public health issues, such as sexual health and HIV, are also low, problems that are compounded by the exclusion of failed asylum seekers and undocumented migrants from the majority of secondary health care.

While failing to meet new migrant needs presents considerable implications in expenditure and public health terms, the biggest impact is upon migrants themselves and the health outcomes of individuals and families. Without understanding the system, culturally sensitive services, appropriate health education, health promotion and effective language provision, new migrants receive only basic treatment. Minor health problems may worsen until they become chronic; preventing engagement in employment, training and education, a problem already observed in some studies (see Maffia 2008) and impacting on those migrants, and particularly refugees, experiencing mental health problems; some of whom had self-harmed or attempted suicide. The low levels of employment and low incomes of new migrants, with the exception of those who come over as highly skilled workers, has been widely documented

(Bloch 1999; 2000; 2002, Phillimore & Goodson 2008, Aldridge & Waddington 2001; Feeney 2000) so it is particularly worrying that they felt the need to raise funds to seek care overseas or from an unregistered Doctor. Clearly lack of regulation of any underground health service is a concern and further research is needed to explore this issue in greater depth. It is likely that poor health outcomes will combine with poor outcomes from other services such as employment (*ibid*) housing (Phillimore & Goodson 2008; Robinson & Reeve 2006), education (Phillimore & Goodson 2006), and language training (Grover 2007), that were also observed in the two studies discussed in this paper.

It seems, at least in terms of health provision we have returned to the “race-blind” welfare model experienced by new Commonwealth migrants until the 1970s, to address the needs of new-migrants in the era of super-diversity. Multicultural provision may have failed Britain’s minorities (Lewis 2000) but it is not a viable option for new migrants given the political and resource limitations that emerge from the current political and economic climate. Even without these constraints multicultural provision is unlikely to be feasible in areas where migrant populations are extremely diverse, small and/ or scattered (Schierup *et al.* 2006). So how do we ensure the equal access to services that is enshrined in the 2000 Race Relations Amendment Act and promoted in Department of Health strategies for tackling health inequalities while maintaining social solidarity and preventing a retrenchment from the welfare state more generally? The answers lie in a change of thinking around how we contemplate, and organise, provision.

Some ways forward

There are a number of approaches that can be employed to reshape provision in order to adapt to super-diversity. Some of these require few resources whilst others are resource intensive but will offer savings in the longer term. First it is necessary to begin by educating society about the social reality of new migration and super-diversity. It is important we accept our changed status as a country of immigration and appreciate that there are benefits of super-diversity, as well as costs, if we fail to adapt our institutions to meet the needs of all. This new reality of super-diversity needs to be taught at every level from primary to post-graduate. All disciplines need to be encouraged to explore the challenges and opportunities offered by super-diversity. In addition Parekh (2008) argues, that new skills are needed in a multicultural society and, critical in a super-diverse society. He suggests “*sympathetic imagination, tolerance, openness to other ways of life and thought, curiosity and mutual respect*” (2008: 94). Certainly it is important that we do, as a society, develop the skills we need to adapt to, and communicate about, diversity and change. Such changes can be incorporated into our existing education system without the need for significant resources.

There is also a need, as Lewis (2000) argues, to challenge complex power relations. It is clear that we have failed to address issues of representation within existing political systems and governance networks even for existing minorities (Smith & Stephenson 2005), let alone new migrants (Phillimore & Goodson 2009). Many new migrant organisations are insufficiently organised and too preoccupied with defensive, survival focused, activities, to even attempt to influence policy and provision, or participate in consultation (Gameledin-Adhami *et al.* 2002). Yet opportunities to shape services do exist, for example the new Local Involvement Networks, Equality Impact Assessments and Joint Strategic Needs Assessments, have been established to ensure that local people have a voice in shaping health and social care and other services. It is likely a new skills set, even a new profession of super-diversity specialists, needs to be created. Their remit might include changing institutions from within and securing new migrant participation in governance networks such as Local Strategic

Partnerships, as well as in consultations around service provision such as Investing in Health (Department of Health 2008). They would work with new migrants to open up opportunities to shape agendas rather than being the target of them. New ideas about provision and delivery may emerge from inclusion of more diverse decision makers with experience of welfare systems from around the world. Using health services as an example it could be argued that, in our post-Fordist economy with flexible working and women as critical components of the labour market, new models of general health provision could benefit a large proportion of the population. In most areas, we are currently committed to a system of general health provision within GP surgeries within working hours, a system designed when men were the primary wage earners, and women undertook caring activities, in an era of “9 to 5” working. Rethinking this model in a way that takes into account the health needs and experience of new migrants, the system might evolve in some areas along the lines that some new migrants currently use the hospital system: on a walk-in basis, located in A&E departments, and subject to a triage system that filters those who do not need emergency treatment to the most appropriate care. Rethinking and reshaping provision begins with an investment in new skills, and eventually culminates in new approaches to service delivery. These may bring costs associated with restructuring but ultimately reduce the pressures and costs associated with existing system and aids service providers to meet equality targets.

A further consideration is the provision of decent, easy access, low cost or free ESOL (English language) classes. These classes need to meet the practical needs of new migrants through teaching language for communication with service professionals, and an understanding of the system, and move away from the current focus on grammar and citizenship (Grover 2007; Phillimore 2009b). This would be a politically popular move and something that is also sought by new migrants themselves but would require the reversal of the policy introduced in 2007 which withdrew fee remission for most migrants (Phillimore *et al.* 2007). Whilst improving ESOL and making it more affordable would have major cost implications in the short-term, eventually there would be reductions in interpretation and translation costs. Information about how welfare systems work should be available in a much wider range of languages and formats and be available electronically so that it can be printed off by GP surgeries, migrant and community organisations, CABs and others when needed. Others have argued for employing more staff from ethnic minorities (Mir 2007). It is well recognised that new migrant medical, education and welfare professionals struggle to utilise their skills in the UK because of the long-established, expensive and time consuming conversion system (Bloch 2002, Phillimore 2008). This too needs reviewing to develop mechanisms to actively recruit new migrants as welfare professionals, make training fast and relevant, perhaps speeding up access to work through the development of funded internships and new posts, such as auxiliary doctors, for those who are unable to fully re-qualify, yet have much to offer from a new perspective that can help institutions understand and cater for the needs of new communities. Again there are up-front costs associated with establishing these new approaches but the likelihood of longer term savings and improvements in outcomes for new communities.

Conclusion

The experience of the last fifty years have demonstrated that it is not possible to fit new arrivals into our existing systems of welfare provision yet we are in danger now of replicating all the mistakes that were made in the new Commonwealth era of migration. Unless we make changes that enable services to be designed and delivered differently we will continue to fail our existing minorities and ensure the exclusion of new arrivals from both welfare and ultimately wider society. Much has been written about the impacts of such exclusion on the

trajectories of migrant communities (Robinson & Reeve 2007; Rex & Moore 1967) and upon community relations (Robinson & Reeve 2007; Cantle 2005). Precedents do exist to demonstrate that social unrest has often been underpinned by the perceptions, or reality of unequal access to resources (Cantle 2005; Schierup *et al.* 2006). Clearly without some changes to models of welfare delivery we risk missing the opportunities offered by super-diversity while only experiencing the costs of marginalising new migrants at the very beginning of their life in the UK (Phillimore & Goodson 2009).

Concerns expressed about the inevitable erosion of social solidarity with super-diversity, accept the politicisation of migration and demonization of migrants that underpin the rise of restrictionism (Goodhart 2004). Yet these arguments imply that super-diversity is an option, when it is already as permanent as the labour migrations of the 1950s and 1960s. Thus to avoid a shift from our current restrictionist position of welfare chauvinism wherein migrants' access to welfare is tightly rationed, to a position where redistribution is no longer politically supported (Banting 2000), we need changes in attitude and a new way of talking about migration and engaging migrant communities that accept the new reality, and seek practical ways to adapt institutions and thinking. In the current climate there are few signs of any change in thinking around migration, or the use of welfare as mechanism for controlling it. There are indications that new migrants themselves are opting out of some welfare provision in favour of private, communal or even unregistered services possibly undermining further the support for the welfare state, at least in its current form. The anti-migrant political consensus and shift to community cohesion seem set to dominate thinking in UK and EU in the next decade in much the same way as it has the last, and perhaps condemn a whole new wave of migrants to a bleak future.

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ⁱ This study was commissioned by the Home Office to explore the ways in which asylum seekers selected their country of refuge. It found that many asylum seekers had no choice of destination because this was selected by traffickers, while others headed for countries where they had friends or relatives, a post-Colonial relationship or could speak the language