Exploring Potentialities of (Health)Care in Glasgow and Beyond: Negotiations of Social Security Among Czech- and Slovak-Speaking Migrants

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This paper draws on an anthropological perspective on social security to explore the complex ways in which Czech- and Slovak-speaking migrants living in Glasgow negotiated their healthcare concerns and built security in the city and beyond. It is based on 12 months of ethnographic research conducted in 2012 with migrants who moved to Glasgow after 2004. Inquiring into healthcare issues and the resulting insecurities from the migrants' perspective and in their everyday lives, the paper demonstrates how these issues were largely informed by migrants' experiences of 'uncaring care' in Glasgow, rather than due to their lack of knowledge or understanding of the Scottish/UK health system. Furthermore, the findings reveal how these migrants drew on multiple resources and forms of support and care – both locally and transnationally – in order to mitigate and overcome their health problems. At the same time, the analysis also highlights constraints and limitations to the actors' care negotiations, thus going beyond a functional approach to social security, which tends to overlook instances of 'unsuccessful' or unrealised care arrangements. In conclusion, I propose that migrants' care negotiations can be best understood as an ongoing process of exploring potentialities of care by actively and creatively opening up, probing, rearranging and trying out sources of support and care in their efforts to deal with perceived risks and insecurities in their everyday lives.

Keywords: post-accession migration; healthcare; social security; transnational negotiations; limitations

Introduction

In 2004, ten countries[1] joined the EU, and the UK, as one of the few existing EU members that opened their labour markets to the nationals of these new member states, attracted a large number of migrants, especially from the eight Central and Eastern European countries (or so-called A8 states).[2] This post-accession or 'A8

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migration' has attracted significant attention in public discourse as well as among scholars and policy-makers in the UK. Generally, there has been a great deal of negative sentiment in parts of the British media and among the British public about the impact of 'Eastern Europeans' on public services and society. Concerning healthcare, this is well captured in the trope of 'health tourism' in the country's media and public discourse (Bentley, Faulkner and Borland 2015; Bowater 2010; Chapman 2013; Mason and Campbell 2013; Slack 2016). In the UK, the term 'health tourism' has a largely negative connotation and is often used to refer to people who travel to the country with the 'deliberate intention to obtain free healthcare' and who plan to 'take advantage' of the health system or National Health Service (NHS) (Prederi 2013: 61). Although there are various groups of people who could fall under the category of 'health tourists' (including Brits living abroad), the term is closely linked with immigration and, within the context of EU migration, 'Eastern Europeans' are particularly targeted by the media and politicians as 'abusers' of the British health service (Bentley *et al.* 2015; Bowater 2010; Davidson 2017; Slack 2016).

A considerable amount of literature has been responsive to these public concerns. Several (mainly quantitative) studies have focused on the question of whether migrants, including 'A8 migrants', have had a negative or a positive effect on the country's NHS (Giuntella, Nicodemo and Vargas Silva 2015; Hanefeld, Horsfall, Lunt and Smith 2013; Prederi 2013; Vargas Silva and McNeil 2014). At the same time, researchers have also looked at post-accession migrants' own health needs and the challenges they face when accessing health services in the UK. Various studies have, for example, focused on specific health problems encountered by this migrant population – e.g., mental health, smoking, alcohol consumption (Garapich 2010; Goodwin, Polek and Goodwin 2012; Healthwatch Reading 2014; Lakasing and Mirza 2009; Leaman, Rysdale and Webber 2006; Madden, Blikem, Harrison and Timpson 2017; Madden, Harris, Harrison and Timpson 2014; Osipovič 2013; Raphaely and O'Moore 2010; Suffolk City Council 2015) – or discussed concerns around healthcare alongside other problems and challenges – e.g. pertaining to employment, housing and so on (de Lima and Wright 2009; Orchard, Szymanski and Vlahova 2007; Poole and Adamson 2008; Scullion and Morris 2009a, 2009b; Stevenson 2007). With few notable exceptions,[3] however, the findings of this literature have tended to be largely descriptive and policy-orientated, often presenting interview-based and 'snapshot' accounts of healthcare issues among this migrant population that rarely centred on the migrants' own perspective, especially of how they dealt with these problems in their everyday lives and across borders.

This paper attends to this gap in the existing literature. It inquires into healthcare issues and the resulting insecurities from the perspective and in the everyday lives of Czech- and Slovak-speaking migrants living in Glasgow. The paper seeks to understand how these issues were informed by migrants' experiences in the city as well as in their respective countries of origin. Drawing on an anthropological perspective on social security, the paper explores the various ways in which these migrants negotiated their healthcare concerns and sought to build security in Glasgow and beyond. This includes shedding light on the resources, relationships and ideas that these migrants drew on in their attempts to secure themselves and their families against these insecurities, as well as on the limitations of these negotiations.

The article is based on 12 months of ethnographic research with Czech and Slovak nationals who moved to Glasgow after their respective countries joined the EU in 2004. The fieldwork which took place in 2012 explored various insecurities and risks as they were experienced by these post-accession migrants and the ways in which they negotiated these issues in their everyday lives in the city and beyond. Healthcare issues emerged as one central theme for some of my research informants; this paper focuses on this small group of individuals and their experiences of healthcare in Glasgow.

Migrants and healthcare

A major focus of scholarly analysis concerning the nexus of migration and healthcare has been on the impact of migrants on the health systems and public health of the 'host' countries. This includes an extensive amount of research that is preoccupied with migrants' 'health assimilation' in the residence country, which is most notably manifest in the ongoing debates around the presence or absence of the so-called healthy immigrant effect (Constant, Garcia-Muñoz, Neuman and Neuman 2015) – i.e. whether migrants are healthier or not in comparison to the 'host' population (and thus whether or not they pose a risk to the latter). By adopting the interests and perspective of the 'host society', this strand of literature tends to problematise migrants as a potential rupture or strain on the country's health services and, by extension, on society, often neglecting migrants' own experiences and their backgrounds. On the other hand, researchers have also approached the field from a rights-based perspective, looking into migrants' health issues and their use (and underuse) of the health services in the country of residence (Zimmerman, Kiss and Hossain 2011). Studies that follow this approach recognise the specific challenges that migrants experience when accessing healthcare, often drawing attention to the multiple and complex factors – e.g., experience of migration, language and cultural barriers, length of stay, legal status, a lack of understanding of the health system, social exclusion, discrimination and marginalisation – that give rise to these issues (see, e.g. Derose, Escarce and Lurie 2007).

Differently from the aforementioned strand in the literature which has a tendency to restrict the analysis to the context of the 'host' country, an emerging body of research has focused on the ways in which migrants negotiate (access to) healthcare not only within the country of residence but also transnationally (Horton 2013; Horton and Cole 2011; Lee, Kearns and Friesen 2010; Thomas 2010). It has been inspired by a transnational perspective on migration which emerged in the 1990s, when scholars began to take an interest in and to study migrants' lives beyond the places in which they came to live (Basch, Glick Schiller and Szanton Blanc 1994). It further developed in the context of globalising healthcare and what has been described as 'medical tourism' (Kangas 2007; Lunt, Smith, Exworthy, Green, Horsfall and Mannion 2011; Sobo 2009).[4] Studies of migrants' transnational healthcare negotiations have drawn particular attention to the significance of migrants' cultural background in shaping individuals' perception of healthcare and their motivations to seek medical treatment outside their country of residence. In their study of Mexican migrants living in the US, Horton and Cole (2011), for example, use the term 'medical returns' to refer to their respondents who travelled from the US to Mexico for medical treatment. Their research suggests that these migrants accessed healthcare services in their home country due to their preference for a specific 'Mexican medical practice' over that in the US, which their interviewees experienced as impersonal and heavily reliant on medical tests and surgeries. In a similar vein, Lee *et al.*'s (2010) study of South Korean migrants living in New Zealand found that dissatisfaction and frustration with local doctors led many of these migrants to seek medical treatment back in South Korea. For their research participants, the decision to travel to Korea for healthcare was also about receiving treatment in a place that they felt comfortable and familiar with, a place that they associated with 'home'. This included familiar hospital settings, the presence of competent, experienced and trustworthy doctors, familiar surroundings in terms of language, and so on. Thus, the authors argue, by travelling to Korea, migrants were not only seeking 'effective health care but also affective care in which notions of being "in-place", trust and familiarity [were] significant factors in promoting feelings of well-being' (Lee *et al.* 2010: 114).

In this paper, I approach the nexus of migration and healthcare by drawing on an anthropological perspective on 'social security' as proposed by Franz and Kebeet von Benda-Beckmann (1994, 2007). Although originally not specifically formulated in relation to healthcare concerns, their work offers a broader approach for studying the healthcare issues that migrants face and the ways in which they deal with them not in isolation but as part of social security. The von Benda-Beckmanns developed a new perspective on social security

through their critique of the 'institutionalist' concept of social security prominent in Western societies. Drawing on empirical research in developing countries, they questioned the conventional understanding of social security as state-provided support as well as its inherent ethnocentrism, showing, for example, how people draw on multiple resources and relationships which extend beyond institutionalised forms of support in order to deal with insecurities and uncertainties in their lives (von Benda-Beckmann and von Benda-Beckmann 2007). In their reconceptualisation of social security, the term is thus significantly broadened to include not just material support provided by institutions and actors of the state but also informal and immaterial forms of support and care in varied assemblages.

Broadly speaking, social security refers to a plurality of

efforts of individuals, groups of individuals and organisations to overcome insecurities related to their existence, that is, concerning food and water, shelter, care and physical and mental health, education and income, to the extent that the contingencies are not considered a purely individual responsibility, as well as the intended and unintended consequences of these efforts (von Benda-Beckmann and von Benda-Beckmann 2007: 36).

In this sense, the term becomes multireferential in that social security points to both an 'abstractly conceived field of problems, and to the actual social phenomena within this field' (von Benda-Beckmann and von Benda-Beckmann 2007: 6); it denotes the relative state of an individual's or a group's security or insecurity, the social relationships through which securities are built, as well as normative rules or ideas about 'what is a situation of need, who is entitled to receive, and who is obliged to provide goods and services' (2007: 6) to construct social security.

From this broad perspective, (health)care can be considered as part of social security; it refers to resources and relationships that individuals draw on to mitigate and overcome health-related insecurities affecting themselves and their family. This way of conceptualising care, i.e. as a 'dimension of social security' (Read and Thelen 2007: 7), has been adopted and further developed by scholars working in different non-Western contexts such as in post-socialist societies (Kay 2011; Read and Thelen 2007), demonstrating the usefulness of this conception of care in opening up an analytical perspective that enables the examination of care practices and arrangements in a holistic way and in their complexity.

This broader approach to social security can be fruitful here in various ways. Firstly, it enables the studying of migrants' healthcare experiences across formal and informal settings, drawing attention to the diverse set of players and complex relations involved, including state and non-state institutions, family and social networks and public and private resources. Secondly, it facilitates a multi-layered analysis of issues concerning healthcare, taking into account not only care providers and those who receive care but also ideas and histories in which healthcare practices are embedded, both in the context of the 'host society' and that of the migrants' country of origin. Thirdly, the authors' anthropological theorisation of social security necessitates a 'bottom-up' approach, one that does not prioritise the views and perspectives of the institutions and policy-makers or, more generally, of the 'host society', over those of the migrants. Thus, rather than reproducing the 'methodological nationalism' still prevalent in much of mainstream migration research (Glick Schiller and Çağlar 2009; Wimmer and Glick Schiller 2002), their work opens up a conceptual avenue that takes as a starting point the routine, ordinary ways of overcoming problems in migrants' everyday lives that may stretch temporally and spatially well beyond the migrants' present in a specific locality in the country of residence – for example, through transnational linkages.

After describing the methodology of the empirical research on which this paper is based, in the following I draw on this perspective in order to put migrants' experiences and understandings of healthcare issues at the

heart of my analysis and guide my approach to the field of insecurities among Czech- and Slovak-speaking migrants and the ways in which they negotiated these insecurities in their everyday lives in Glasgow and beyond.

Methodology and methods

This paper is based on 12 months of ethnographic research that I conducted in 2012 with Czech- and Slovak-speaking migrants who came to Glasgow after 2004.[5] The study was part of my doctoral research which aimed to gain an in-depth understanding of how these migrants – as both locals and transnational actors – negotiated insecurities and risks in their everyday lives in the city. In order to overcome the problem of 'methodological nationalism' and the 'ethnic lens' (Wimmer and Glick Schiller 2002), I focused on a language-based group consisting of Slovak and Czech speakers including, among them, Roma. Thus, instead of *a priori* pigeonholing these migrants into separate ethnic and/or national groups or 'communities', my research population was constructed across categories of ethnicity, nationality, and culture. This does not mean that ethnic, national and cultural boundaries did not matter; on the contrary, rather than taking them for granted, I empirically inquired into how these boundaries became or were made relevant in the field (Guma 2015). For example, while ethnicity and nationality did not emerge as significant factors regarding my research participants' healthcare issues, I have shown elsewhere how they shaped other insecurities and risks faced by these migrants (Guma 2018).

Importantly, the decision to select Czech- and Slovak-speaking migrants as a research group was informed by the field itself; two small pilot studies that I conducted prior to my research found that these migrants interacted in various ways and on different levels in Glasgow and beyond. For example, I came across several informal groups and gatherings involving Czech and Slovak speakers,[6] such as a Facebook group of 'Czechs and Slovaks in Glasgow' and another one covering Scotland as a whole; I also became aware of shared services and projects involving Slovak and Czech speakers in Glasgow's voluntary sector.

The ethnographic fieldwork involved participant observation at different sites in Glasgow – such as advice centres, drop-ins as well as migrants' informal social gatherings and events – which were frequented by Czech- and Slovak-speaking migrants. My involvement in these different settings over a sustained period of time led to an incremental growth of contacts and to the emergence of new field sites. By way of introduction I got to know other migrants, family members, friends and friends of friends, and I came to participate in events and activities independent of the initial sites and access points. Over the course of 12 months, I came in contact with over 100 migrants who frequented various sites in the city. Among them, 28 individuals became key informants whom I met repeatedly in varying settings throughout the fieldwork period, enabling me to be part of their everyday lives and activities; others I met with less regularly. This paper thus draws on ethnographic data produced throughout 2012 which involved field notes, ethnographic interviews with migrants (in Slovak/Czech and English) and semi-structured interviews with relevant actors and other stakeholders in the field.

As noted, this article is based on a larger study which explored various issues and insecurities as experienced by Czech- and Slovak-speaking migrants living in Glasgow. Here, however, I only discuss healthcare issues.[7] While the study found concerns regarding local healthcare provision in the city to be widespread among these migrants, such concerns developed into significant insecurities only for some individuals within my research sample – nine individuals whose cases I discuss in detail in this paper. This small number of key informants presents a diverse mix regarding aspects such as family status, age, class, employment status, nationality, ethnicity and gender.[8] These key informants were five women and four men aged between 30 and 54 years, living in different parts of Glasgow, and who were single, in a couple, married or widowed (1 person). Three were Czech speakers, while six spoke Slovak. Amongst this group, two informants self-identified as

Roma. In terms of occupation, these individuals held the following jobs: a housekeeper in a hotel, a project worker in the third sector, a freelance interpreter, a factory worker; five people were not in employment. Educational background also varied greatly amongst this group, ranging from those who had finished secondary education, to individuals who had acquired vocational qualifications and those who had completed university or postgraduate degrees. It should be noted that my study did not assess or evaluate the medical conditions of these informants but accepted their understandings and perception of their health problem and its impact on their lives as 'real', in line with the methodological approach adopted here.

Given the small number of research participants, the findings presented here do not claim to be representative of the Czech- and Slovak-speaking migrant population in Glasgow or the UK. Generally, my research aims were not orientated towards producing statistical generalisations of the risks and insecurities experienced by this group of migrants. As noted, the study aimed at providing an in-depth understanding of these issues from the migrants' perspective in their complexity and as and how they unfolded over time. Following Creswell (2003: 125–128), I employed a theoretical sampling technique which aimed to develop theoretically generalisable concepts through an intensive, interpretive engagement with the empirical data. Thus, the strength of this paper lies in offering an empirically grounded, ethnographically rich and theoretically informed account of the ways in which my research informants dealt with healthcare issues and built security in their everyday lives 'here and there'.

Uncaring care

Irena Herčeková,[9] her partner Stefan Materák and their baby boy had just returned from a two-week holiday in Slovakia when I met them at their home in north Glasgow in early October to catch up. As well as seeing their family, relatives and friends, this time they had also taken their one-year old boy to a paediatrician in their home town, and they told me about the professional manner in which the health check had been conducted in Slovakia. Among other examinations, the paediatrician had also carried out a blood test and 'told us straight away what the problem was', enthused Ms Herčeková. This account and the enthusiasm with which it was presented to me have to be understood in the context of several previous conversations around their worries about illness and issues of healthcare in Glasgow. Their baby, who seemed to suffer from abdominal pain, had caused the couple great concern for several months, and they had wanted to find out what was causing it, but also, more generally, to check his health with a specialist. Ms Herčeková had consulted her local GP (General Practitioner) in Glasgow several times but to her frustration, the latter had not, she felt, addressed their concerns. On one occasion, she told me, she had even taken the baby's soiled nappy with her and showed it to the GP in an attempt to get the doctor to take this issue more seriously. However, this desperate attempt was of little avail. On the contrary, as Ms Herčeková reported, bringing the nappy along with her rather 'shocked' the doctor, who asked her disparagingly: 'Oh, is that what you do when you are in Slovakia!?'. For Ms Herčeková, this remark only added to her frustration, which was mixed with feelings of being discriminated against. 'It wasn't enough that I was worried about my son, but the doctor was also making jokes about my country', said the 32-year old with bitter disappointment. It was 'little situations like these' that had left the couple worried about the prospect of raising a child in this country, and this was further exacerbated when their baby boy seemed unwell.

The couple's dissatisfaction with the local health services and their worries were further reinforced by previous experiences of these services. Stefan Materák, for example, recalled a visit to his doctor when he was suffering from a chest infection. During the visit, he explained, he found it surprising that the doctor did not use the stethoscope but, after listening to his account, told him that his illness might be stress-related and that, if the pain continued, he should take painkillers. The doctor's swift diagnosis angered Mr Materák because

'I didn't feel like I was under stress. But to be honest, that he didn't examine me, that he didn't seem to be interested, that stressed me out'. In the end, he continued, 'I had to force him to use the stethoscope, and that is why I'm so angry with healthcare here'.

Feelings of frustration and concerns about local healthcare provision, especially by GPs, were widely shared by my key research informants as well as the other migrants whom I encountered during my fieldwork. Overall, GPs were described as impersonal, 'cold' and not trustworthy, and as having little interest in the individual patient but being more concerned about following a standard procedure. A widespread complaint about GPs in Glasgow referred to what these migrants perceived as doctors routinely prescribing painkillers as a panacea for all illnesses: 'All they do is give you paracetamol and say goodbye', was how the Šimkos, a Czech couple in their early fifties, summed it up.[10] Similar criticism also came from Eva Mešková, a 30-year-old Roma informant, who told me the story of her husband, who went to see his local GP after he had injured his back at work. But the doctor 'gave him only paracetamol', she stated looking perplexed. 'He didn't give him an injection or anything, but paracetamol!?'. Nevertheless, such concerns did not always have a significant impact on people's everyday lives and mid- or long-term plans. However, for some key research informants, like the Šimkos, Mrs Mešková's family and the Slovak couple introduced above, they emerged as major insecurities which they actively sought to address. In the following, I focus on their experiences.

The negative perceptions of local health services seemed to be informed by the informants' past experiences and familiarity with healthcare services in their countries of origin. This was evident in the various 'comparing and contrasting' assessments of healthcare that they made between Scotland and Slovakia and the Czech Republic respectively, pointing to a 'dual frame of reference' being at play.[11] For instance, the lack of 'proper examinations' by local GPs was a common theme which was juxtaposed to the more thorough checks that doctors would routinely carry out in Slovakia or the Czech Republic, such as measuring a patient's temperature and blood pressure, undertaking blood tests, palpating a painful body part and so on. This was exemplified by Mr Materák's complaint above, who felt he had to urge his GP to physically examine him rather than just rely on his verbal account. Other research participants emphasised the difference in the ways in which particular treatments were administered in Glasgow in comparison to treatment methods in their country of origin. The prescription of the painkiller paracetamol was contrasted with remedies treating the causes of ill health such as the antibiotics which doctors would 'normally' prescribe to patients in their countries of origin. This is reminiscent of Lindenmeyer, Redwood, Griffith, Ahmed and Phillimore's (2016) study on antibiotic use among recently arrived migrants in the UK which reported similar contrasts among their research participants, who felt frustrated with the doctors prescribing them paracetamol instead of antibiotics. In their research they note how these migrants perceived paracetamol as being a 'weak' or 'ineffective' form of medication, as opposed to antibiotics, which were seen as 'effective' and 'strong', perceptions which, the authors point out, reflected migrants' cultural background and experiences of healthcare in their home countries (Lindenmeyer *et al*. 2016: 805–806).

Specific expectations towards healthcare in line with my informants' cultural understandings of health and illness seemed to underpin their perceptions. Historically, in socialist Czechoslovakia, for example, a 'modernist' or scientific and rational approach to healthcare had been promoted, focusing on physical and biological care and relegating emotional care to the realm of family and kinship relations (Read 2007: 204–208). While ideas and ideologies around medical care provision have started to change post-1989, some of the older values appeared to still shape medical culture in the Czech Republic (Read 2007: 216) and Slovakia and might have contributed to my informants' complaints about the lack of examinations and medical tests by their 'unprofessional', 'unskilled' and 'cold' GPs in Scotland. In other words, compared to the rather 'more physical' practice of healthcare in their countries of origin, my research participants perceived GP services in Glasgow as 'uncaring'.

To some extent, my informants' everyday comparisons also reflect differences in the organisation of insti-tutionalised healthcare between Scotland and Slovakia and the Czech Republic. Take, for example, the com-mon complaint about GPs acting as 'gatekeepers', making it very difficult for patients to be seen by 'specialists' in Glasgow, as the above case of Ms Herčeková exemplified. The healthcare system in Scotland / the UK consists of two key components: GPs who provide primary care (and thus are the first point of contact for patients) and hospitals that provide specialist or secondary care (Robson 2011). The key arrangement in this system is that it is GPs, as primary service providers, who refer patients to further services such as specialist examinations and surgeries in hospital if they (the GPs) deem it necessary. In Slovakia and the Czech Republic, on the other hand, there is no such rigid differentiation, as hospitals and/or polyclinics provide both primary and secondary care (Bryndová, Pavloková, Roubal, Rokosová aand Gaskins 2009; Szalay, Pažitný, Szalayová, Frisová, Morvay, Petrovic and Ginneken 2011). This means that patients are able to access specialists such as paediatricians, gynaecologists and physiotherapists directly, without the need for a doctor's referral.

At the same time, even when access to specialist care was readily granted, experiences of it varied. Marta Černáková, for example, a 39-year-old research informant, spoke positively about the emergency care she received following an accident on a hiking trip in Scotland which left her with a broken leg and out of work for six months. While she was full of praise for the ambulance staff and hospital surgeons who operated on her, she described the post-surgery physiotherapy treatment that she received as inadequate and disappointing: 'Back home they do physio every second or third day… for an hour or so, different exercises. Here, the whole treatment is for about 10 minutes. I have got an exercise sheet with some exercises [to] do at home, I wasn't sure because should I push more, rest more.' While Ms Černáková's account was once again constructed with reference to her experiences of healthcare in Slovakia against which the physiotherapy in Glasgow compared unfavourably, Ms Herčeková experienced maternity services in Glasgow as exceeding her expectations. She was very satisfied with the hospital care that she received when she gave birth to her son the previous year. In particular, she liked the patient-centred approach that placed importance on the birth plan that she was allowed to draw up. She found this approach to be more relaxed and natural, in contrast to the rather 'pushy' doctors in Slovakia. This led her to draw a clear line between what she perceived as the bad quality of primary care on the one hand and the good hospital service or secondary care in Glasgow on the other: 'Here, health profes-sionals [at the hospital] are good but not the GPs'. These accounts show that my research informants distin-guished not only between but also within national healthcare systems, thus pointing to more nuanced perceptions of healthcare services beyond a monolithic commendation or rejection of different national healthcare cultures. Importantly, previous experience of healthcare services in the country of origin did not serve as a standard which automatically devalued any deviation in the way care was provided in Glasgow. Rather, as Ms Herčeková's evaluation of maternity services in Glasgow illustrates, such perceptions were also open to change.

In other words, a health issue engendered insecurity in the daily life of my key informants whenever they felt that the health problem was not being resolved and that they were not 'receiving care'. Especially with regard to primary care services in Glasgow, they felt they were merely 'processed' rather than 'cared for'. Thus, while their past experiences and cultural understandings formed in their countries of origin played a role, incidents and encounters with local GP services and health professionals in Glasgow did not just evoke feelings of bewilderment among the research informants; being prescribed the 'wrong' medicine, not getting 'properly' examined or receiving derogatory remarks about one's country of origin, all gave rise to a sense that their health was not taken seriously, that they were, as the Šimkos put it, 'not being looked after'. In this sense, their experiences of local healthcare in Glasgow were not shaped by a lack of understanding of the Scottish healthcare system but were, rather, underpinned by what I call a notion of 'uncaring care'. Here, care referred not only to the medical practices administered by GPs or other health professionals meant to (perform) care by

profession but also to the quality of the relationship between migrant patients and medical staff. These different 'constructions of care' (Read 2007) mean that, from these migrants' point of view, the availability and accessibility of healthcare through the NHS in Glasgow did not automatically translate into 'receiving care'.

Negotiating social security 'here and there'

Faced with these health-related insecurities, my informants employed various ways to deal with these issues. Focusing on the multiple resources and forms of support that these migrants drew on to negotiate social security for themselves and their families, my analysis showed that some did so transnationally, as they considered and/or used health services in their home countries. This was the case, as noted above, with the Materáks, the Slovak couple who took their baby son to a paediatrician in Slovakia. This involved mobilising support through their social networks; for example, family and friends in their home town provided them with accommodation during their stay as well as advice and recommendations of a 'good' and trustworthy doctor. Although they had to pay for this medical service privately, having their baby 'properly examined' by a specialist and gaining a picture of his overall health was a relief for the couple, as it brought a long phase of insecurity to an end. In fact, theirs was a rather long-term strategy; after this experience they planned to take their boy for further routine medical checks whenever they visited Slovakia, usually twice a year. To this end, they registered their son with the paediatrician in Slovakia in addition to the GP in Glasgow.

Combining visits home with medical treatment was also the way in which Marta Černáková mitigated her concerns about the long-term recovery from her accident which resulted in a broken leg. During one of her trips home, she had her leg checked by doctors in Slovakia who, she said, confirmed that 'they really did a good job' in Glasgow. Furthermore, Ms Černáková described how, during the long period of convalescence in Glasgow which she mostly spent confined to her flat, regular Skype calls with her mother in Slovakia offered her much-needed emotional support. At the same time, she was also very grateful to friends and colleagues in Glasgow for their visits and the practical help that they offered, such as bringing her food, doing shopping for her, etc.

In the case of Mrs Mešková, whom I briefly mentioned above, and her family (husband and two children), healthcare abroad was sought *ad hoc* and under difficult circumstances. The Meškos left for Slovakia a few days after their GP had told her husband that his back injury was not serious and had prescribed him paracetamol to cope with the pain. The decision to seek medical treatment in Slovakia was not taken lightly. The Meškos' finances were already stretched to the limit (Mrs Mešková was unemployed at the time, whereas her husband was participating in an unpaid work scheme when the accident occurred), so they were very worried about the costs for their flights to and healthcare in Slovakia, especially given the last-minute arrangements. Nevertheless, dissatisfied and mistrustful of the GP's (failure, in their view, to make a) diagnosis, the couple managed, over the course of several days, to raise money from relatives and friends living in Glasgow to buy flight tickets and leave for Slovakia. For the Meškos, dealing with an imminent health issue was thus facilitated by a collective effort involving their local family and friendship network in Glasgow. It was by drawing on this informal support network that they were able to raise enough money to travel abroad and have Mr Meško's back 'properly' checked. However, this came at a high risk. As the family had managed to borrow just enough money to purchase one-way tickets to Slovakia, Mrs Mešková was worried that they might not be able to return to Glasgow, which would again involve a collective effort, only this time in Slovakia. If they did eventually get back to Glasgow, they would have to pay back the several hundred pounds that they had borrowed.

At first sight, my informants' actions to consider or seek care abroad may be read as a matter of consumer choice, as part of the free movement of EU citizens and the globalisation of medical services. From this per-

spective, my informants could be framed as 'medical tourists' or 'medical travellers' who, free from immigration controls and with readily available transport links between Scotland and Central European countries, chose to access medical care in these locations. This would place them among the rising number of people who utilise medical services abroad, a growing phenomenon which I described earlier. Yet, clearly, the experiences of my research participants do not sit easily with such a description. Cost-effectiveness was not the rationale for accessing healthcare in the Czech Republic or Slovakia; on the contrary, instead of relying on free NHS healthcare services in Glasgow, they had to pay privately for treatment abroad (in addition to further expenditure for flights etc.) as I indicated above.

To some extent, my participants' transnational arrangements can be seen as migrants' 'medical returns', in line with Horton and Cole's (2011) definition mentioned earlier, since their decisions to travel abroad to seek medical care were informed by their past experiences and familiarity with healthcare services 'back home'. In line with a 'dual frame of reference' perspective, both theirs and Lee *et al.*'s (2010) study emphasised the significance of migrants' cultural backgrounds, showing how their informants accessed medical care in their home countries because they felt better cared for in a medical environment which was familiar to them, both with regard to broader cultural aspects (such as language and ideas about the body) and medical practices. However, whereas Lee *et al.*'s (2010) study highlighted the relevance of 'home' and 'homeland' in migrants' choices regarding healthcare, notions of 'home' were not invoked in my informants' accounts of their decisions to use healthcare services in their countries of origin. My analysis showed that, even though cultural preferences informed their perceptions of healthcare to some extent, my participants formed a more nuanced understanding of healthcare services and the differences between them in the two countries than the notion of 'cultural background' seems to imply. Based on their ongoing experiences with healthcare providers in Glasgow, these perceptions were also open to change (see also Osipovič 2013).

Importantly, as the literature on migrants' medical returns focuses on those who have used medical services abroad, it often neglects the experiences of migrants who did not or could not seek healthcare in their countries of origin (or elsewhere) or where such attempts were unsuccessful. The case of Pavel Hubar provides an example of the latter. Mr Hubar, a 48-year-old divorcee from the Czech Republic, suffered an accident while at work four years earlier when he fell from a height and injured his back. The accident had a huge impact on his life and wellbeing. After the accident, he found it difficult to gain suitable employment and only managed to find work for a few months in between. Increasingly, the back pain intensified and he was frustrated with the doctors who, he said, kept prescribing him various strong painkillers to help cope with the pain but did not operate on him or 'do something about it'. Scared at the thought of ending up in a wheelchair, he was keen to go to the Czech Republic to get medical treatment but had given up on the idea as he lacked the necessary financial resources. By 2012, he could only walk with the aid of a cane and increasingly needed everyday care and support. However, his legal status as an 'A8 migrant' had hindered his access to social care provision.[12] This is why Mr Hubar asked his adult daughter to come from the Czech Republic and join him in Glasgow. This was a long-term family plan that was supposed to benefit both him and his daughter. Moving to Scotland would be an opportunity for her and her two children to escape their difficult economic situation back in the Czech Republic and 'start a new life' in Glasgow, while providing emotional and practical support to Mr Hubar. However, things did not go according to plan. His daughter was unable to find employment when she arrived in Glasgow, while Mr Hubar was himself in a precarious situation and could not help financially. Eventually, three months after their arrival she and her children were forced to return to the Czech Republic.

Interestingly, Mr Hubar's case shows that efforts to negotiate healthcare issues transnationally could also involve movements in the other direction: not just migrants going abroad for healthcare but also attempts to draw on the support of a family member by having them join them at the migrant's place of residence. Furthermore, excluded from state-provided support and unable to access healthcare abroad or to bring a family

carer to Glasgow, Mr Hubar often relied on help from individuals in the city (e.g., interpreters, local shop owners) who would invite him for a coffee, give him advice and help him renovate his flat, etc. Various local organisations were also important sources of (formal) support for Mr Hubar, not only in terms of offering support in the Czech language (e.g., regarding housing, health or welfare) but also as places he visited to share his concerns and socialise. His case thus emphasises once again how migrants (try to) draw on a multitude of forms of care and support locally as well as transnationally in their efforts to build security in their daily lives; however, it also points to the fact that the varying sources of care do not easily substitute each other and do not lead to the same degree or kind of security.

In addition, the Šimkos, the middle-aged couple briefly mentioned above, provide an example of cases where the individuals' social marginalisation left them with hardly any forms of support and, thus, with few options to negotiate their health-related insecurities. Throughout the fieldwork period, the couple spoke repeatedly and at great length about their struggles with severe pain in their joints and limbs and how much it affected their daily life. However, to their frustration, they had not received a clear diagnosis in Glasgow. They dreamed of undergoing 'proper' health checks in the Czech Republic but could not afford to travel to their home town to do so. They faced financial difficulties and were struggling to make ends meet since they lost their factory jobs five years earlier. In addition, they could not secure help from Mrs Šimková's sister who, although living in Glasgow, suffered from health problems herself. This led to feelings of vulnerability which came to the fore in expressions such as 'We're just guinea pigs for them (the doctors in Glasgow)'; from the couple's perspective, local health professionals were not caring for them but 'experimenting' with them. The reference to 'guinea pigs' also hints at feelings of being trapped and isolated, feelings which were sometimes vented in sudden outbursts: 'I did not come here to die. And since I have worked here and I have paid [National] Insurance [contributions] and I have done everything right, I believe that they have to look after us a little'.

As the cases of the Šimkos and Mr Hubar show, drawing on healthcare resources abroad was not always a realisable option; for some, it remained out of reach while, for others like the Meškos, it was only achieved at great (emotional, social, financial) cost. My findings, thus, differ from Lee *et al.*'s (2010) and Horton and Cole's (2011) findings also in emphasising, firstly, that the phenomenon of medical returns among migrants was not equally available to all; secondly, that seeking healthcare abroad was only one way of dealing with healthcare concerns; and, thirdly, that transnational negotiations were often interconnected with or even dependent on migrants' efforts to resolve these issues locally.

A qualitatively different trajectory emerged in the case of one of my key informants, which is included here to adequately represent the spectrum of ways in which these migrants dealt with healthcare-related insecurity. Miroslava Třpková, a 39-year-old informant from Slovakia, suffered from an ongoing health condition that caused inflammation in her legs, feet and hands, impacting significantly on her physical and mental wellbeing. The illness appeared irregularly but, when it did, it had a devastating effect on her daily life: 'I found myself in a situation that I could not walk, you can imagine [the] pain. I felt hopeless and, due to the fact that I stayed alone, I do not have anybody to help me. I could not go to chemist to buy any painkillers, I literally could not move'. Ms Třpková became increasingly concerned about her continuing illness and, as in the cases discussed above, with her experiences of 'uncaring care' in Glasgow. Unlike the other participants, however, she did not want to go to Slovakia to get 'proper' treatment. She believed in the importance of alternative forms of medicines and treatments, practices which, she said, were not encouraged or promoted by the 'modernist' mainstream healthcare system in Slovakia. It is in this context that Ms Třpková embarked on a journey of self-care which included maintaining a strict diet and reading 'all kinds of books about therapy, body, mind' to learn more about her condition and find ways to treat herself. This ultimately led her to study for a complementary healthcare degree at a Scottish university, which she completed after my fieldwork period came to an end. She currently works as a professional therapist in Glasgow.

Conclusion

This article has inquired into healthcare issues as experienced by Slovak- and Czech-speaking migrants living in Glasgow and examined the complex ways in which they dealt with these healthcare concerns and negotiated their social security in Glasgow and across borders. Placing the perspective and everyday experiences of a small number of informants at the centre of my analysis, I showed that experiences of 'uncaring care' in Glasgow gave rise to significant insecurities for those left to deal with unresolved health problems. Based on an extended notion of social security proposed by the von Benda-Beckmanns, I then considered what formal/informal and material/immaterial forms of support and care they drew on to mitigate and overcome these insecurities.

What emerged from the empirical data was that my research informants sought or relied on multiple resources and forms of care, including formal medical care and informal (self-)care, emotional and practical support as well as financial and social resources, often bringing these into play both locally and transnationally. My analysis found that some informants accessed formal healthcare services abroad, often in addition to their use of services available in Glasgow. At the same time, it pointed to the fact that 'medical returns' to their countries of origin were not equally available to all migrants concerned; some informants could achieve medical travel only with great difficulties while, for some informants, this option could not be realised at all. The financial costs of specific solutions (e.g. paying for private healthcare in Slovakia or the Czech Republic or the costs of accommodating a family member in Glasgow) were certainly an issue for most of my informants. However, their economic capital alone did not determine the different trajectories. For example, the case of the Meškos showed that, despite their lack of financial resources, their social capital enabled them to seek healthcare abroad. More generally, across the cases I found that concrete negotiations of healthcare concerns were dependent on the various resources available (cf. Kay 2011); this, in turn, could lead to multiple exclusions for those economically and socially marginalised, as we have seen in the cases of the Šimkos and Mr Hubar.

Thus, while my informants' EU citizenship and freedom of movement[13] between Slovakia, the Czech Republic and the UK enabled them to hypothetically draw on a relatively wide range of options, my analysis highlighted the uneven nature of possible care arrangements. In this sense, the paper did not stop with a celebratory image (Favell 2009; Morokvasic 2004) of post-accession/EU migrants' ability to negotiate care transnationally. Rather, from the research informants' perspective, prioritising and trade-offs between the various options and risks were important elements in their negotiations of social security, sometimes even putting their life in Glasgow at stake, in their efforts to contain or mitigate a health problem that was considered as severe or urgent (see, for example, the Meškos' case). This was also exemplified by the Materáks who, although both had negative experiences of GPs in Glasgow, prioritised their son's health issue and only sought medical care abroad for him, not so for themselves. Connected to this aspect is the finding that not all available resources and options are drawn on – emotions and ideas, for example, around what constitutes 'good healthcare' or makes a 'good doctor' were important elements in care considerations. This was most evident in the informants' readiness to pay for healthcare services abroad (rather than rely on free NHS services in Glasgow), which somewhat belies the common trope of these migrants as 'health tourists'. The significance of ideas about the body and health/illness was also manifest in Ms Třpková's case, whose strong convictions favouring alternative therapies shaped her healthcare negotiation.

My emphasis on understanding healthcare negotiations as ongoing processes which span instances of 'successful' care arrangements as well as situations and periods when the actors in my field were unable to realise certain options or where the outcome was still uncertain, somewhat complicates the functional approach to social security suggested by the von Benda-Beckmanns (1994, 2007). Their approach is functional 'because,

instead of looking primarily at institutions normatively or symbolically designed for social security, it also considers relationships and institutions that are not primarily designed for it, but that take on a function for social security' (2007: 6). While this conceptualisation proved useful here for opening up the analysis to a whole array of different practices and levels as relevant resources for dealing with health-related insecurities, it strongly favours an *ex post* perspective focused on the outcome. I argue that we need to go beyond such a functional approach so as not to lose sight of unsuccessful attempts at drawing on / offering specific resources or relationships to build security. This way, we can make visible not only a multitude of sources of support and care but also assess their constraints and limitations. In this sense, I argue that my research informants' negotiations of social security can be best understood as an ongoing process of exploring potentialities of care. With this concept, I suggest that the research participants actively and creatively opened up, probed, re-evaluated, rearranged and tried out sources of support and care in their efforts to manage and/or overcome perceived risks and insecurities. From the perspective of their unfolding everyday lives, this ongoing process also involved 'making-do' with certain situations, which reminds us that the negotiation of insecurities is not about reaching a fixed state of security but an elemental feature of living life and making sense of it in the face of ever changing uncertainties.

With its capacity to include various forms of support and assistance, its emphasis on individual agency and everyday practices as well as on structural limitations and opportunities, the notion of 'exploring of potentialities of care' offers a fresh perspective that might be usefully employed in future research related to healthcare. It also contributes to recent and emerging research in the field that is calling for more creative and alternative conceptual approaches to the study of migrants' (and non-migrants') health-seeking behaviour in an increasingly changing and interconnected world (Phillimore, Humphries, Klaas and Knecht 2016).

Notes

[1] These were Poland, the Czech Republic, Slovakia, Hungary, Estonia, Latvia, Lithuania, Slovenia, Malta and Cyprus.

[2] Statistical analyses have estimated that, between 2004 and 2010, more than one million people went to the UK from these countries (McCollum, Cook, Chiroro, Platts, MacLeod and Findlay 2012: i). The term 'A8' or 'accession 8' refers to the eight countries that acceded the EU in 2004; I use scare quotes for the expressions 'A8 migrants' and 'A8 migration' to problematise their homogenising and essentialising tendencies with regard to individuals coming from these countries and their movements.

[3] For example, Osipovič's (2013) research has highlighted the complexity and interdependence of various factors influencing healthcare issues amongst Polish migrants in London and their actions to seek medical care abroad.

[4] Although it initially emerged with reference to the one-directional flow of often wealthy people in search of cost-effective care, 'medical tourism' has increasingly become a global phenomenon and highly profitable industry, with people moving for varying reasons, in various directions and between different countries around the world, to seek healthcare. Hence, Kangas (2007) suggests replacing the term 'medical tourism' with 'medical travel' in order to adequately capture the diverse experiences and contexts of people seeking transnational healthcare. Also, 'medical tourism' differs from 'health tourism'; while both relate to the practice of travelling abroad for medical treatment, as noted above, 'health tourism' has a negative association in the context of the UK.

[5] Between 2004 and 2011, Glasgow is estimated to have received the second-largest number of migrants from the so-called A8 countries in Scotland (McCollum *et al*. 2012: 15), with Polish, Slovak and Czech nationals (in that order) constituting the three biggest groups.

[6] Czech and Slovak are 'mutually intelligible' West Slavic languages, and the communication between Czechs and Slovaks can be characterised as a sort of 'passive bilingualism' (Nábělková 2007: 55–56). The two languages are closely related in terms of vocabulary, phonetics and grammar, so that speakers of one of the languages can generally understand a speaker of the other language without ever having learnt the latter. Indeed, as I also found during my fieldwork, Czech and Slovak speakers communicated with and understood each other in a very natural way.

[7] Among the issues which I explored were employment insecurities, problems arising from welfare 'cancellations' and the risk of children being taken away by social services, etc. (Guma 2015).

[8] In line with the significance of range in ethnographic (and generally in qualitative) research, I consciously aimed at recruiting a diverse population in my study and sought to emphasise and explore the heterogeneity within this group of migrants to avoid crude generalisations.

[9] All research participants have been anonymised; I chose to use randomly selected full Slovak and Czech names to capture the authenticity of the field and be respectful towards the informants.

[10] Concerns around the 'paracetamol issue' have been widely documented by various studies, be they on Eastern European migrants (e.g., Goodwin et al. 2012; Madden et al 2017) or other migrant groups living in the UK ((Lindenmeyer et al. 2016). For example, in Goodwin et al.'s (2012: 162) study, their Polish respondents referred to GPs as 'the paracetamol force' while, in a small qualitative research on Polish migrants conducted by Healthwatch Reading (2014: 8) their participants dubbed the local GP practice as 'the paracetamol service'.

[11] Suárez-Orozco and Suárez-Orozco (1994: 130) define a 'dual frame of reference' as an orientation whereby migrants 'are constantly comparing and contrasting their current lot in the host society against their previous experiences and expectations in the country of origin'.

[12] The accident happened during the time when citizens of the Czech Republic and Slovakia (and members of other European countries that joined the EU in 2004) were subject to restrictions that the UK government put in place as part of transitional measures for these nationals. These measures required post-accession nationals to work continuously for 12 months in order to be entitled to social security benefits, a condition which Mr Hubar could not meet as he suffered the accident on the eleventh month of his full-time employment in a cash-and-carry company.

[13] Following the 2016 EU referendum and the resulting Brexit vote, currently in the UK there is a great deal of uncertainty surrounding the rights of EU nationals and the freedom associated with EU citizenship.

Funding

Conflict of interest statement

No potential conflict of interest was reported by the author.

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