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Welfare State Regimes: a Literature Review

Arshad Isakjee

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Abstract

This literature review seeks to position the UPWEB research project in relation to discourses on welfare regimes. The UPWEB project is exploring the workings of healthcare in four European states with different types of welfare governance. Any comparison between these case-studies depends on an analysis of welfare regimes themselves, their construction, their validity and applicability.

About the author

Dr Arshad Isakjee is Lecturer at the University of Liverpool, and, formerly, Research Fellow at IRiS.

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Introduction

This literature review seeks to position the UPWEB research project in relation to discourses on welfare regimes. The UPWEB project is exploring the workings of healthcare in four European states with different types of welfare governance. Any comparison between these case-studies depends on an analysis of welfare regimes themselves, their construction, their validity and applicability.

Following the publication of Esping-Andersen's seminal work *The Three Worlds of Welfare Capitalism* (1990), comparative research into the organisation, construction and operation of welfare states blossomed. By suggesting that welfare regimes across diverse socio-economic states could be classified within and around three categories, Esping-Andersen's approach enabled researchers to analyse the real world effects of 'ideal type' systems of welfare. Debates continue as to whether the tripartite or more contemporary complex typologies offer valuable comparative insights into welfare regime construction. Regardless, the typologies remain a popular, and indeed a simple dimension through which comparative social policy research takes place. Welfare Regimes are also considered by proponents to be important determinants of health, due to the extent to which they mediate provision and resources (Eikemo et al 2008)

This short literature review firstly outlines the original framework proposed by Andersen and its various developments over the past 25 years. It critically examines the value of regime models, based upon empirical research which has been used to both underpin and undermine Esping-Andersen's ideal types. The review then summarises the outcomes of studies which draw conclusions around health outcomes in the context of varying welfare regimes. The review concludes by outlining pioneering work in which regime models are being used to compare outcomes for diverse populations.

The Three Worlds of Welfare Capitalism and beyond

Welfare states are rarely constructed during sudden or radical revolutions, but rather through slower social and political evolutions. Democratic capitalist societies tend to utilise state-led welfare provision in addition to any market-led, civil-society produced or family-centred models of provision and care (Arts and Gelissen 2002: 139). Prior to Esping-Andersen's contribution, Titmuss (1963, 1987) had categorised welfare states as 'residual' or 'institutional', the former referring to systems in place as a safety-net in the event of market failure, the latter existing as a more comprehensive institutional system, often based on notions of social rights. Esping-Andersen's work utilised deductive techniques applied to the social policy history of 18 OECD states, to arrive at Weberian ideal-type typologies of welfare. He identified three distinct ways in which this state provision could be categorised:

- (i) 'Liberal' regimes of welfare would tend towards lower levels of state intervention, leaving market-forces to establish a level of social security, to which the state made

modest reallocations. Examples of such systems include the United States, The United Kingdom and Australia.

- (ii) Conservative or 'conservative-corporatist' regimes such as Italy, France and Germany would provide relatively more generous benefits based upon principles of insurance contributions.
- (iii) Social-democratic regimes would exist at the most interventionist end of the spectrum, guaranteeing universal benefits at more generous levels. Scandinavian states of Sweden, Norway and Denmark are oft-cited examples of social-democratic welfare regimes.

The contribution of Esping-Andersen goes beyond the mere construction of a typology to seek to explain how and why welfare regimes are formed. In so-doing, he makes claims which run counter to previous assumptions about the causes and impacts of welfare state growth. Whereas it is assumed by some that welfare state retrenchment can be strongly linked with tax revolts and backlashes against the welfare states which appear when tax and spending become too great, Esping-Andersen suggests the opposite is in fact true – that anti-welfare state sentiment is actually very weak where spending is highest. This argument is explained by the complexity of welfare-state regimes - which goes beyond simple dichotomies of 'more' or 'less' welfare. Instead, the systems themselves result from historical reforms and political movements; moreover, they contribute decisively to the construction of social categories institutionalising a set of class preferences and modes of political behaviour (Esping-Andersen 1990: 32).

There have been a number of critiques of Esping-Andersen's work, and by implication the comparative studies of welfare regimes which utilise such typologies. First the sample of countries used has been argued to be too narrow to provide an adequately robust model. Very soon after the publication of the Esping-Andersen model, Leibfried (1993) and Ferrera (1993) suggested that Mediterranean states (which did not feature in Esping-Andersen's qualitative analysis) should constitute a separate regime, with limited social security, based in part on clientelism and a decidedly traditional family or community orientated focus. Crucially for the UPWEB project, this includes Portugal, as well as Greece and Spain. Subsequently Jones (1993) and Goodman and Peng (1996) argued that East Asian welfare states also represented unique regimes. Aspalter (2006) and Walker and Wong (2005) in particular have suggested that Confucian models of the welfare state in Japan, and possibly South Korea, Taiwan and Singapore combine elements of all three types of welfare regimes: relatively low levels of state intervention and welfare, but with socially grounded obligations on immediate family members and strong advocacy and investment in education and emphasis on work ethic.

As Ebbinghaus (2012) also points out, the publication of Esping-Andersen's treatise coincided with the break-up of the Soviet Union, and Central Eastern European states and their post-socialist transitions are also not represented well by the tripartite model. Intriguingly, in returning to his analysis a decade later, Esping-Andersen (1999) actually reduced the number of case study states from 18 to

16, including Spain but excluding potential hybrid cases such as Belgium, Ireland, Switzerland, post-Soviet states, EU-accession countries and Asian tiger economies (Ebbinghaus 2012).

As theories of welfare regimes developed, Hall and Soskice (2001) proposed an altogether alternative distinction between types of capitalist economies. Their dualist model is based upon the ways in which firms organise their structures and processes in relation to market mechanisms. The resulting typology is a state being classified as either a liberal market economy (LME) or alternatively a coordinate market economy (CME). For Hall and Soskice (ibid), the categorisation can be developed along five spheres:

- (i) Industrial relations – the ways in which companies manage their workers, trade union relationships, conduct wage bargaining
- (ii) Vocational training and education – whether or not workers have generalised skills across sectors (LME) or if skills tend to be sector-specific (CME)
- (iii) Corporate governance – CMEs rely on patient capital, LMEs on public information and short-term returns on investments through stock-markets
- (iv) Inter-Firm Relations – The extent to which inter-firm relationships are defined by co-operation (CMEs) or competition (LMEs).
- (v) Employee Relations – the extent to which management and employees reach major decisions collaboratively (CMEs) or through more hierarchical or adversarial relationships (LMEs)

The Varieties of Capitalism model may be binary, but countries can be considered ‘hybrid’, though these hybrid states suggested to be around the Mediterranean were not used for the analysis. In contrast to this simplified categorisation, Amable (2005) developed a model with five theoretically founded ideal-types: market-based economies (UK), social democratic economies (Sweden), Asian capitalism, continental European capitalism (Germany) and South European capitalism (Portugal). In situating real-world states into this model, Amable considered five variables: product markets, labour markets, financial systems, social protection and education systems. Note once more that despite the development of in-depth statistical frameworks, the dynamics of health systems were not investigated as an influencing factor of regime categorisation. Under ‘social protection’ in Amable’s model, indices are based upon tax and expenditure details such as the contributions to income taxes, social security taxes, employer contributions as well as taxation on goods and services more generally.

Secondly, welfare regime methodologies have been criticised for failing to consider healthcare and other social policies. In general, taxation and spending in its various forms are used as proxies for regime type. Scholars thus criticise the lack of consideration of the full range of social services within

the methods used by regime analysts. Neither Esping-Andersen, nor his contemporaries Castles and Mitchell (1993), Ferrera (1996), Korpi and Plame (1998) have considered the specific dynamics of healthcare provision in identifying types of welfare regimes. In most models, cash benefits were used as indicators of regime type, whereas healthcare (which accounts for by far the largest proportion of welfare-state spend), education systems and social care provisions were all omitted.

Bambra (2005) sought to address this shortcoming through the development of a healthcare decommodification index which sought to quantify the extent to which healthcare access was influenced by or dependent upon an individual's market position. Bringing healthcare into the analyses, states such as the UK, generally considered a good example of a liberal welfare regime and one which shows low decommodification in its labour market, instead shows high decommodification in its healthcare system. High decommodification in such a sense represents a more universalist and redistributive system than would be expected of a liberal welfare regime, at least in this sector.

Thirdly, welfare regime analysis also tends to be gender-blind, with little critical consideration of the role of women in the provision of welfare, or taking account of gender division as its own distinct form of social stratification (Bambra 2007a, Korpi 2000). Whilst Bambra (2004, 2007a) has addressed this issue theoretically and attempted to draw out the levels of autonomy given to women within welfare regimes, there has been no exploration of defamilisation and health or gender and health by welfare regime type (Bambra 2007b). A final critique of welfare regime approaches concerns the lack of consideration given to the localised nature of healthcare access. As Davis (2001) noted in his study of healthcare in Bangladesh, funding can be regulated through local institutions and NGOs in developing world contexts.

Nonetheless, models of welfare states deliver fairly consistent results in terms of the typologies they assign to various states. This is true for the countries represented in the UPWEB study. Sweden for instance is considered a 'social democratic' welfare regime in studies by Esping Andersen (1990, 1999), Leibfried (1992), Castles and Mitchell (1993), Ferrera (1996), Bonoli (1997), Korpi and Palme (1998), Pitruzello (1999), Korpi (2000) and Bambra. Similarly, Germany in all these models is considered 'conservative'. All the aforementioned studies class the UK as a 'liberal' regime, with the exception of Bambra (2004), who classes the UK as 'conservative' as part of a tripartite model, and Castles and Mitchell (1993) who assign a fourth category of 'Radical' welfare states, within which the UK finds itself with Australia and New Zealand. Portugal is only classified in three of the models, but Leibfried (1992), Ferrera (1996) and Bonoli (1997) all assign it a 'Mediterranean, or 'Latin rim' - in each model alongside Greece, Italy and Spain.

Welfare Regimes, Gender and Race

As previously discussed, a key criticism of Welfare Regime approaches has been the lack of reflection about gender issues. In practice, it can be argued that families and voluntary sectors make significant contributions towards welfare provisions. Women can be affected disproportionately if assumptions are made about a gender-neutral system of welfare. Similarly, the experiences of ethnic minority groups within welfare regimes has not been wholly considered; access and quality of care may be differential between majority and minority ethnic populations.

Wilson (1977) in an early feminist analysis of the British welfare state argued that it was predicated upon women being home-makers and care-givers. Historically, women and family networks have played a crucial role in providing welfare support (Oakley 1976, Kolberg 1991, Taylor-Gooby 1991). Wage inequalities frequently operate to the detriment of women and the unpaid work done by women in caregiving roles is rarely considered. Similarly, access to welfare can vary between genders with women in particular denied access to welfare funds if they cannot meet job-seeking-related or insurance-contribution requirements. These requirements in relation to job-search activity, though seemingly gender-neutral, do not consider that women may be relatively socially constrained in terms of time due to patriarchal societal pressures to deliver unpaid work within the home. Therefore, the use of (de)commodification data in the construction of regime theories is inherently gendered (Lewis 1997: 162). Lewis (ibid) lists some responses to these shortcomings, including work by Bradshaw et al (1993, cited in Lewis 1997) which seeks to draw out the ways in which social security payments would benefit children and lone mothers. In this model the UK's welfare system increased in its 'generosity' (ibid; 165-166). And yet, as Brush (2002) argues, welfare state theorists, including Esping-Andersen (1999b) himself, retain largely distant arguments made regarding gender neutrality.

Brush (2002) is highly critical of this oversight, pointing out that contrary to a masculinist perspective of welfare regimes, the provision of welfare goes beyond state-sanctioned individualised provision. Yet even beyond familial provision (the burdens of which fall unevenly on men and women), organisations of mutual support, solidarity, volunteer organisations and informal networks all provide various forms of protection. Brush also argues that welfare extends beyond mere 'provision'; civil society and associated social capital provides an added layer of protection for those who can attain it (Brush 2002: 169). The unevenness of some of these resources makes them difficult to quantify. Yet from a health perspective they are particularly pertinent, as health inequalities cannot be addressed through equalised provision, but instead have been argued to be a product of societal inequalities (Bartley 2004) or social determinants.

Korpi (2000) produced one of the first comprehensive studies of regime variations while Clare Bambra has been at the forefront of efforts to employ methodologies in welfare regime research which take account of gender. Based on economic data between 1985-90, Korpi's model showed some correlations with existing typologies; notably Sweden, Denmark, Finland and Norway were shown to have low gender inequalities, the UK and US showed medium gender inequality and Germany, Italy, Belgium, the Netherlands and Australia were shown to have high gender inequalities (ibid: 168). But if we start looking specifically at health inequalities, whilst women have a higher life expectancy than men in economically developed countries, women actually report higher morbidity and limiting illness as part of self-assessed health (Bambra et al. 2009). Whilst such inequalities have in the past been explained by biological and psychological factors, Bambra et al (ibid) point to the welfare regimes as influencers of women's self-reported health. Through welfare regime analysis Bambra et al (2009) find that women are moderately more likely to report poor health in social democratic countries and highly likely to report poor health in Southern European or Mediterranean countries, including Portugal, Italy and Spain (ibid: 39). Corporatist countries of Belgium, France and Germany as Corporatist regimes show no gender differences in self-assessed health. The poor equality outcomes in healthcare for women are thought to be linked to welfare-patriarchy, a higher proportion of women in work (and potentially experiencing the burden of dual roles) and gender discrimination and disadvantage in the workplace (ibid; 40).

Van der Velde et al (2010) conducted a study across welfare regimes of depression (as an indicator of poor mental health), by gender. In this study the gender gap for depression is higher among Southern European countries. Portugal was found to have had the largest gender gap in terms of depression. The authors note that more recently, Portugal and other Southern countries have seen a rapid expansion in women's employment, with men's behaviour in this period changing relatively little (ibid: 311). The challenges of balancing increased labour-market involvement with traditional domestic responsibilities and little support could explain these findings. In addition, Belgium, Sweden and France also were shown to have significant gender gaps for depression, and Van der Velde et al (2010) called for increased research into the pressures of balancing parenthood and employment.

In relation to race and ethnicity it is also arguable that taking the holistic nation-state approach to assessing welfare regimes, intra-national disparities and discriminations can be obscured. However, regime theory is fundamentally concerned with decommodification and distribution of resources and the social stratification that results from the organisation of the state. In order to meaningfully integrate race and ethnicity into a quantitative model for welfare regime analysis, one would have to reassess the groupings of welfare regimes themselves. Liberal regimes, such as for instance, the UK and US, may indeed share similar decommodification rates and be part of the same grouping in Regime models. However, outcomes for minorities within those two states would be based more around citizenship models (typically described as integrationist or multicultural) which vary hugely between both countries as well the implementation of equality policies. Similarly, so-called 'conservative/corporatist' states such as Belgium, France and Germany would have very different methods for inclusion of ethnic groups, which are more likely to explain disparities of access to health or welfare services - rather than regime theory as we know it. Sainsbury (2006) makes some headway in investigating specifically the social rights of immigrants in developed countries in relation to welfare. Sainsbury's research compares three countries (including two being used as Case Studies for the UPWEB project): the USA, Sweden and Germany. These countries' immigration regimes are categorised as Inclusionary (USA), Exclusionary (Germany) and Inclusive (Sweden), and it is posited that these in turn affect the social rights of immigrants. For example, due to immigrants not having made long-term contributions to welfare systems, the German welfare system can produce greater inequalities than the Swedish system. This is because migrants who have not contributed to the system over a period of time, receive less in welfare resources from the state. Ultimately these cleavages in social policy mean that one cannot make broad conclusions about the redistributive effect of welfare policies, without also considering the impact that immigration regimes have on a section of the population.

Beyond the immigrant demographic, there is indeed a body of literature focusing upon the relationship between race and ethnicity and health independently of Welfare regime categorisation, and these are further explored in another working paper in this series (Bradby and Brand 2016).

The Positioning of Welfare Regimes in Relation to Healthcare and Health Outcomes

Despite increases in economic prosperity which arguably have been uneven, the differences in mortality and morbidity between citizens has persisted (Mackenbach 2012). Whilst inter-state disparities in health outcomes would indicate the extent of inequality, contemporary epidemiological research also seeks to draw comparisons between state systems in relation to healthcare. The

connection between welfare regime type and health has been pioneered by Bambra (2006, 2007) together with other co-investigators.

Bambra (2006) conducted a study comparing infant mortality rates between 18 countries in two years; 1980 and 1998 (See table 1). Using Esping Andersen's 'Three Worlds' model, Bambra found significant correlations between regime type and healthcare outcome. Liberal regimes showed low rates of decommodification (indicating lower levels of wealth redistribution) and higher infant mortality rates. Social Democratic regimes showed higher rates of decommodification (high levels of redistribution) together with low rates of infant mortality. Conservative regimes contained median figures for both decommodification and infant mortality. Indeed, decommodification in the past has proven to be linked with other established social indicators such as income and class. Bambra (ibid) stresses that such a relationship does not necessarily imply a causal relationship.

Navarro et al (2006) conducted a study using a different methodology to Bambra. Their research compared how policies over a 50-year period in 'social democratic' regimes (Norway, Sweden, Denmark, Finland, and Austria) and 'Christian-democratic' or 'conservative' regimes (Italy, Netherlands, West Germany, Belgium, France) impacted life expectancy and infant mortality rates over that period. The study made these classifications based upon labour market statistics and health expenditure, and concluded that redistributive policies are positively associated with health outcomes, raising life expectancy and reducing infant mortality (ibid). A similar study analysing data across a 39-year period by Chung and Muntaner (2007) showed that social democratic states (Sweden, Denmark, Norway, Finland) showed better health status compared with other countries in the study, both before and after neo-liberal reforms in the early 1980s.

Dahl et al (2006) and Coburn (2004) have also found infant mortality rates varying significantly between regime types. Contradicting these findings, Karim et al (2010) failed to find a link to infant mortality although controlling for GDP, found that 47% of the variance in life expectancy could be explained by welfare regime type. This last study also included East Asian welfare state types as part of its analysis – and in doing so raised further questions. East Asian welfare states bucked the trend of linkage between welfare spending and health outcomes. In East Asian welfare regimes, state spending remained low (low decommodification), yet life expectancy was unusually high. These findings suggest that other social and cultural public health factors might be playing a part, such as rates of smoking, drinking, and the specificities of East Asian diets (ibid: 51). Nonetheless, as Baum and Fisher (2014) contend, behavioural change is not necessarily a silver bullet in reducing health inequality; social determinants of health themselves influence 'unhealthy' behaviours.

Another intersection between the effect of welfare regime type and culture may be found in studies of obesity. Offer et al (2010) found that the 'shock' impact of fast food would work more strongly in market-liberal countries compared to other regimes. The relationship discovered from this study was strong, and posed the question about the origin of particular welfare systems; indeed there must be an extent to which national cultures have influenced the ways in which welfare regimes have developed. In these studies, economic security and insecurity at work is also found to be correlated with obesity; market economies tend to have greater levels of job insecurity and lower levels of economic security.

Finally, it is worth noting that Eikemo et al (2008) conducted a study to investigate whether *self-perceived* health could be shown to be determined by welfare regime type. However, in their study

they found that only 10% of the variation of self-perceived health could be explained by regime-type. Once more, pointing to the limitations of regime types when scaling down findings, Guarnizo-Herreno et al (2013) found that oral health inequalities existed throughout all welfare regimes, and were no smaller in Scandinavian (socio-democratic) regimes compared with others.

Table 1 IMRs¹ and decommodification scores² in the 'three worlds of welfare', 1980 and 1998

	Infant mortality rate ³ (deaths per 1000 live births)		Decommodification score	
	1980	1998	1980	1998
Liberal	12.3	6.7	18.8	17.4
Australia	10.7	5	13	13.5
Canada	10.4	5.3	22	27.9
Ireland	11.1	5.9	22.3	22.1
New Zealand	13	5.4	17.1	11.5
UK	12.1	5.7	23.4	15.4
USA	12.6	7.2	13.8	14
Conservative	10.5	4.5	29	28.2
Austria	14.3	4.9	31.1	31.1
Belgium	12.1	5.6	32.4	31.9
France	10	4.6	27.5	31.5
Germany	12.6	4.7	27.7	27.7
Italy	14.6	5.4	24.1	27.6
Japan	7.5	3.6	27.1	18.3
Netherlands	8.6	5.2	32.4	28
Switzerland	9.1	4.8	29.8	29.7
Social democratic	7.6	4.0	36.2	33.1
Denmark	8.4	4.7	38.1	29
Finland	7.6	4.2	29.2	34.6
Norway	8.1	3.9	38.3	34
Sweden	6.9	3.5	39.1	34.7

Notes: ¹ OECD (2003).

² Esping-Andersen (1990), Bambra (2004b, 2005b).

³ Regime rates are population weighted.

Towards Local Welfare Systems?

One of the recent critiques of traditional welfare regime theory is that it takes no account of local differentials in relation to decommodification and social stratification. These critiques tend towards the post-structural, emphasising the multifaceted and hybrid nature of lived social life (Anheier and Krlev 2014). Some of these critiques emphasise for instance that local contexts can involve multiple actors delivering services, from a range of formal and informal actors (Minigione and Oberti 2003). As a result of these specificities, provision of welfare is necessarily unequal over space rather than uniform across states. These arguments are not new: even in those states renowned for welfare uniformity such as the UK, the delivery agents of welfare (when it is not in the form of pure economic capital) has always been prone to vary depending on a range of social and spatial factors. In other contexts, a lack of state incentives for medical professionals to set up services in particular areas may also result in uneven health access.

The arguments for focussing more on localised welfare systems is pertinent in some contexts. This is especially the case in states where health spending is locally funded through federal systems of government, as in such scenarios, variation is likely to be at its greatest. In other ways welfare localisation can be impacted by uneven provision distributed through central government. It may also be the case that despite theoretical equality of provision in terms of state finance, specific area needs may not be taken into account, and areas with vulnerable or highly diverse populations may be at a subsequent disadvantage. Andreotti et al (2012: 1935) expand on this theme by giving examples of factors which shape variation including migration status, age and ethnic minorities and gender – all of which may be regulators of health need, if not health access

However, there is a danger too of overplaying local governance issues and their influence on health disparities. A wealth of literature exists that connects socio-economic disadvantage with poor health, but the mechanisms through which this relationship forms are manifold, and often dependent on broader environmental, employment and lifestyle factors in addition to issues of healthcare access and resource. Welfare regime analysis is by its inherent nature interested in the economics of redistribution, and the way this impacts social stratification. Thus the traditional quantitative analyses which underpin regime construction and comparison do not lend themselves well to understanding the complex variations and hybridities that occur at local settings. Literatures that connect up health and (local) space in this way are explored outside the context of welfare regimes can be found in another paper in this series (Pemberton and Humphris 2016).

Superdiversity and Welfare Regimes: A Reflection

Of the most pertinent reflections on the set of literatures around welfare regimes, is that studies are predicated on systemic and holistic visions of welfare states. Yet, drawing on de Certeau (1984), if welfare states are holistic state-wide strategies, they have to then be negotiated by citizens (and non-citizens) with their agency. In this way, service users develop approaches and tactics to reap the benefits of provision. In some instances, their tactics may not involve using the system as it was designed, in order to get past systemic barriers to healthcare.

Areas with superdiverse populations are comprised of high concentrations of new migrants and long-established minorities as well as native residents. Each separate group from different origin states (including states without statutory provision of healthcare), may have developed similarly diverse and varied tactics to getting healthcare needs met. Origin states may have greater or less emphasis on dependence on familial networks, communities – tactics developed within origin countries could be rendered less useful within the regimes of host countries, but alternatively may have increased the resilience and breadth of support that migrants have access to. Additionally other characteristics such as levels of education, length of time in residence in countries of migration, language ability and extent of transnational connections may all shape the tactics adopted by superdiverse residents.

The UPWEB project would ideally provide empirical evidence as to the extent to which experience of regimes in origin countries are influencing behaviour in host countries. Such knowledge would require research methods capable of capturing the behavioural changes of migrant interviewees and respondents over time, in the country of migration. Focussed data around the process of adaptation from one system to another would offer useful insights. A further debate to be instigated would be the familiar one around the extent to which providers of health-related services at a local level

should focus on providing a breadth of access catering to the behaviours and understandings of diverse populations – or instead, focussing on integrating new residents and citizens within a more singular framework of healthcare provision.

However, to connect up structure and agency in this way is very challenging. As Andreotti et al (2012) and Davis (2001) suggest, little emphasis is placed upon local scale in regime theory. It may be the case that the very nature of regime theory with its macro-economic analytical tools and its international outlook does not provide the basis on which in-depth local analyses may be constructed. Although health *outcomes* may vary in UPWEB case-study countries, evidence of differentiated *provision and access* in neighbourhoods within the same country would be valuable. The UPWEB project would therefore give us an idea of how local factors, individual identities and capacities may shape unequal access to healthcare in superdiverse neighbourhoods. Despite the scope for critiquing regime theory or making international comparisons being more limited, the localised scale of the research project provides a fertile ground for a richer case-study-based analysis of the interaction of health-provision on more local scales.

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