

The Role of Welfare State Characteristics for Health and Inequalities in Health from a Cross-National Perspective: A Critical Research Synthesis

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Table 1: Reviewed studies on the role of welfare state characteristics for health and inequalities in health (unsystematic review)

Authors (year)	Research aim	Data basis	Method	Outcome	Independent variables	Main findings
<i>Reviewed studies from Chapter 2: Public health and the “three worlds of welfare”</i>						
Beckfield et al. (2009)	Review studies that conduct within- and between-country comparisons of health inequality in relation to political systems, political economy, and changes in politics and policies	45 studies	Systematic review	n/a	n/a	<ul style="list-style-type: none"> The transition to a capitalist economy and neoliberal restructuring probably increases inequality in health. Welfare states are inconsistently related to inequality in health. Political incorporation of subordinated racial/ethnic, indigenous, and gender groups helps reduce inequality in health.
Bergqvist et al. (2013)	Review studies on welfare state, health and health inequalities according to their principal method for characterizing the welfare state; as regime types, as welfare institutions or as social spending	54 studies	Analytical review	n/a	n/a	<ul style="list-style-type: none"> Findings using the regime types are diverse and contradictory. Social spending and more generous social rights line up with lower mortality, better health and, probably, smaller health inequalities.
Brennestuhl et al. (2012)	Review studies that use a welfare regime typology to compare population health and social inequalities in health across regime types	33 studies	Systematic review	n/a	n/a	<ul style="list-style-type: none"> Social democratic regimes show better health than other regimes when using mortality measures and specific policy instruments in analytical models. Little support that inequality in health is smaller in social democratic regimes than in other regime types

Muntaner et al. (2011)	Review studies that address identifying the political origins and traditions of population health and health inequalities	73 studies	Systematic review	n/a	n/a	<ul style="list-style-type: none"> • Left and egalitarian political traditions are related to better population health. • Advanced and liberal democracies are related with better population health. • Social democratic regimes are associated with better population health, but inconsistently related to inequality in health. • Globalization defined as dependency indicators such as trade, foreign investment, and national debt is negatively related to population health.
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Reviewed studies from Chapter 3: Going beyond the regime typology – the institutional approach

Aitken et al. (2015)	Review of studies that examine the association between paid maternity leave and maternal health	7 studies	Systematic review	n/a	n/a	<ul style="list-style-type: none"> • Results suggested that paid maternity leave provided maternal health benefits depending on the length of leave.
Hamad & Rehkopf (2016)	Examining the impact of the Earned Income Tax Credit on child development	<u>Individual level:</u> NLSY USA 1986-2000	MR; IV	BPI; HOME	EITC payment	<ul style="list-style-type: none"> • Results from MR suggested a positive association of EITC payment with BPI, but no association with HOME. • Results from IV analyses suggested a positive effect of EITC payment on BPI and HOME
Strully et al. (2010)	Examining the association between prenatal poverty and birth weight, and the impact of the introduction of the Earned Income Tax Credit on maternal/child health	<u>Individual level:</u> NDF CPS USA 1980-2002	DID	Birth weight; Labor market participation; Logged wages; Maternal smoking	State providing EITC	<ul style="list-style-type: none"> • Introduction of EITC is associated with increased birth weight, maternal employment and earnings as well as reductions in smoking during pregnancy.
Larrimore (2011)	Examining whether increases in income improve the health of the low-income population	<u>Individual level:</u> US SIPP CPS	IV	SRH; functional limitations	EITC payment	<ul style="list-style-type: none"> • Increased EITC generally had no statistically-significant effect on functional limitations, and the effect was weakly significant on SRH.

		USA 1992-2005				
		<u>Individual level:</u>				
		SoFIE				
Pega et al. (2016)	Examining the association between New Zealand's Family Tax Credit and self-rated health		MSM	SRH	FTC payment in years	<ul style="list-style-type: none"> A small, but clinically not meaningful, association between years of FTC payment and SRH
		New Zealand 2002-2009				
		<u>Individual level:</u>				
		SoFIE				
Pega et al. (2014)	Examining the effect of New Zealand's Family Tax Credit on self-rated health		FE	SRH	FTC status	<ul style="list-style-type: none"> Becoming eligible for FTC was associated with a small, statistically-insignificant change in SRH.
		New Zealand 2002-2009				
		<u>Individual level:</u>				
		SoFIE				
Pega et al. (2013)	Examining the effect of becoming eligible for IWTC or an increase in the amount of income from IWTC on SRH		FE	SRH	Eligibility for IWTC; Dollar amount of IWTC	<ul style="list-style-type: none"> Becoming eligible for IWTC or a \$1000 increase in the IWTC amount was not associated with any detectable change in SRH in adults.
		New Zealand 2002-2009				
		<u>Neighborhood level:</u>				
		Federal statistics				
				Low birth weight;		
				Pediatric asthma hospitalization;		
				Prenatal care		
Wicks-Lim & Arno (2017)	Examining child health outcomes in 90 low- and middle-income neighborhoods before and after the expansion of the New York State and New York City EITC policy	USA (NYC) 1997-2010	DID		State and local EITC rate	<ul style="list-style-type: none"> State and local EITC benefits improves only low birth weight rates

Norström & Palme (2010)	Examining the impact of changes in pension rights on old-age mortality	<u>Country level:</u>	ARIMA	Old-age excess mortality	Total Pension; Basic security; Income security	<ul style="list-style-type: none"> • Increase in GDP per capita is associated with decreased old-age excess mortality. • Basic [word missing?] but not income security is associated with decreased old-age excess mortality.
		WHO MDB HMD SCIP MPD				
		18 countries 1950-2000				
Esser & Palme (2010)	Examining the importance of public pensions for self-reported health and well-being among retired persons	<u>Country level:</u>	MLA	SRH; Subjective well-being	Total pension; Basic security; Income security	<ul style="list-style-type: none"> • Better health is found in countries with more generous pensions • Women's health & high basic security of the pension system appear to be particularly important.
		SCIP <u>Individual level:</u> ESS				
		13 countries 2003-2005				
Farrants (2017)	Examining whether cuts in pensions and unemployment insurance are associated with increasing inequalities in health	<u>Individual level:</u> ULF & HSE	PLR	SRH	Net replacement rate for the unemployed and retired	<ul style="list-style-type: none"> • Cuts in pensions and unemployment benefits had a stronger association with inequalities in health in Sweden than in England. • Cuts in unemployment insurance had a stronger association with health inequality than cuts in pensions.
		Sweden/ UK 1991-2011				
Reeves et al. (2017)	Examining whether greater public pension entitlement reduced unmet medical need in older persons during the Great Recession	<u>Country level:</u>	CLFE	Unmet medical need	Public pension entitlement	<ul style="list-style-type: none"> • Greater public pension entitlement is associated with reduced unmet medical need. • Association of public pension [entitlement?] with reduced unmet medical need is only observed in countries with high levels of out-of-pocket expenditure. • Association of public pension entitlement with unmet medical need is greatest among the poorest income group.
		CWED Eurostat				

		16 countries 2004-2010				
		<u>State level:</u> ETA				
Cylus et al. (2015)	Examining the impact of unemployment benefit programs on the health of the unemployed	<u>Individual level:</u> PSID	OLS; FE	SRH	Maximum allowable unemployment benefit level	<ul style="list-style-type: none"> Generous state unemployment benefits were associated with lower inequalities in SRH by employment status only for men.
		USA 1985-2008				
O'Campo et al. (2015)	Examining whether, why and how unemployment insurance policies increase or reduce poverty and improve or harm psychological health	33 articles	Realist Review	n/a	n/a	<ul style="list-style-type: none"> Poverty and psychological distress, among the unemployed and even the employed, are beneficially impacted by generosity of unemployment insurance in terms of eligibility, duration and wage replacement levels.
		<u>Country level:</u> CWED				
Vahid Shahidi et al. (2016)	Examining whether differences in the generosity of social protection policies and in public attitudes towards those policies explains why unemployment-related health inequalities are more pronounced in some societies than in others.	<u>Individual level:</u> ESS	MLA	SRH	Unemployment insurance replacement rates; Public support for the welfare state	<ul style="list-style-type: none"> More generous levels of social protection and more favorable public attitudes towards the welfare state are associated with narrower inequalities in self-reported health between the unemployed and the employed.
		23 countries 2012				
		<u>Country level:</u> OECD Health data				
Or et al. (2008)	Examining the impact of health system characteristics on social inequities in health care use in Europe	WHO data base <u>Individual level:</u>	MLA	Generalist and specialist visits by educational attainment	Doctor availability; Physician remuneration; Referral system, financing	<ul style="list-style-type: none"> Individuals with a higher level of education have a higher probability of consulting a specialist in all countries. Degree of social inequities in specialist use is smaller in countries with a tax-based National Health system and in countries where doctors play a "gatekeeper" role. Social inequalities in use of GPs and

		Eurothine			system	specialists are stronger in countries where out-of-pocket payments are higher and the level of public health resources is lower than in other countries.
		13 countries				
		1998-2004				
		<u>Individual level:</u>				
Jones et al. (2006)	Examining the impact of private health insurance coverage on the use of specialist visits in four European countries which allow supplementary coverage	ECHP	PM; PSM; RB PM	Specialist visits	Private insurance coverage	<ul style="list-style-type: none"> The ability of having private insurance increases with income and, to some extent, with better health. Having private insurance increases the probability of seeing a specialist.
		4 countries				
		1994-1997				
Huber & Mielck (2010)	Review of studies that examined differences in morbidity and healthcare between insured by statutory health insurance and insured by private health insurance	18 Studies	Systematic Review	n/a	n/a	<ul style="list-style-type: none"> Persons with statutory health insurance are often less healthy than those with private health insurance, go to primary care physicians more often, and are more often disadvantaged with regard to new, innovative drugs, organ transplantations, financial burden due to co-payments, waiting times, and communication between patient and physician.
		<u>Individual level:</u>				
		Prospective cohort study				
Klein et al. (2016)	Examining the associations between socioeconomic status and health-related quality of life and the explanatory contribution of disease, patient and healthcare factors among patients with prostate cancer		GEE	HRQOL by SES	Disease; Patient; Health Care	<ul style="list-style-type: none"> Patients with lower income, education or occupational status reported a lower quality of life. Patient factors (comorbidity and psychosocial factors such as coping strategies and social support) and in some instances healthcare factors (barriers of access, healthcare use, quality of information) tend to contribute to social inequalities in HRQOL rather than those that are disease related (tumor stage, Gleason grade, surgical margin status).
		Germany				

		2013/14					
		<i>Individual level:</i>					
Banks et al. (2006)	Examining the relative health status of older individuals in England and the United States, especially how their health status varies by important indicators of socioeconomic position	HRS ELSA NHANES HSE	OLS	Self-reported health outcomes; Risk factors; Biological health outcomes	SES		<ul style="list-style-type: none"> The US population in late middle age is less healthy than the equivalent British population for diabetes, hypertension, heart disease, myocardial infarction, stroke, lung disease, and cancer. Country-based differences are not solely driven by the bottom of the SES distribution. Major social inequalities in health outcomes even after controlling for a set of risk behaviors.
		England & USA 2002					
Lorenc et al. (2013)	Examining evidence from systematic reviews in order to provide preliminary indications as to which types of interventions are more likely to produce inequalities, and which have the potential to reduce inequalities	12 reviews	Systematic reviews of reviews	n/a	n/a		<ul style="list-style-type: none"> Downstream interventions do not appear to reduce inequalities, and may indeed increase them, such as mass media campaigns against smoking or workplace smoking bans. Upstream interventions have the potential to reduce inequalities such as structural workplace interventions, resource provision interventions and tobacco pricing.
McGill et al. (2015)	Systematic review of interventions to promote healthy eating to identify whether impacts differ by socioeconomic status	36 studies	Systematic review	n/a	n/a		<ul style="list-style-type: none"> Price interventions were most effective in groups with lower socioeconomic status, and reduced inequalities. Interventions that combined taxes and subsidies consistently decreased inequalities. Person-specific interventions appear likely to widen inequalities with a greater impact with increasing socioeconomic status such as dietary counseling.

Beauchamp et al. (2014)	Systematic review of interventions for obesity prevention that evaluated a change in adiposity according to socioeconomic status and to determine the effectiveness of these interventions across different socioeconomic groups	14 studies	Systematic review	n/a	n/a	<ul style="list-style-type: none"> Interventions shown to be ineffective in lower socioeconomic groups were primarily based on information provision directed at individual behavior change. Interventions shown to be effective in lower socioeconomic participants primarily included community-based strategies or policies aimed at structural changes to the environment.
Hill et al. (2013)	Systematic review of interventions on socioeconomic inequalities in smoking	77 studies + 7 reviews	Systematic review	n/a	n/a	<ul style="list-style-type: none"> Increased tobacco price is the only tobacco control intervention shown to be effective in lower socioeconomic groups. Mainstream non-targeted smoking cessation programs appear to increase social inequalities in smoking due to their greater effectiveness among high-SES smokers.

Reviewed studies from Chapter 5: Methodological considerations in research into the role of welfare state characteristics for health and inequalities in health

Navarron & Shi (2001)	Examining the importance of political parties and policies in determining the level of equalities/inequalities in a society, the extent of the welfare state, the employment/unemployment rate, and the level of population health	<u>Country level:</u>	Descriptive statistics	IMR	WSR	<ul style="list-style-type: none"> Labor movements and the social democratic parties that have governed as a majority for long periods since World War II have generally been the most committed to redistributive policies, contributing to better health indicators such as lower infant mortality rates.
		OECD Other studies				
Navarro et al. (2003)	Examining the impact of political variables on redistributive policies on the labor market and in the welfare state; the income inequalities; and health indicators	<u>Country level:</u>	MR	IMR; Life expectancy	Time of government by political party WSR	<ul style="list-style-type: none"> Political parties more committed to redistributive policies, such as social democratic parties, and are the most successful in reducing inequalities and improving infant mortality, whereas less evidence exists with regard to life expectancy.
		OECD Other studies				
Bambra (2006)	Examining whether a relationship exists between labor market decommodification and health status, and whether labor market decommodification varies between welfare states	<u>Country level:</u>	Bivariate statistics	IMR	Labor market decommodification	<ul style="list-style-type: none"> The results indicate that IMR varies significantly across welfare states. The results have gone some way towards confirming a moderate-strength negative correlation between IMRs and decommodification.

		<u>Country level:</u>				
Regidor et al. (2011)	Examining infant mortality since the late 19th century in wealthy countries to determine whether the magnitude and trend in infant mortality according to welfare regime reflect the different times at which the transition in infant mortality took place in these countries	OECD HMD	GEE	IMR	WSR; Health expenditure; Income inequality	<ul style="list-style-type: none"> The social democratic and Scandinavian countries, and those with the earliest transition in infant mortality, had the lowest infant mortality rates until the early 21st century. Relation between health expenditure and infant mortality varied depending on the time period in which the analysis was made, and increased income inequality was associated with higher infant mortality.
		17 countries 1980-2005				
		<u>Individual level:</u>				
Zambon et al. (2006)	Examining whether different types of welfare states mediate the effect of socioeconomic position on adolescents' health	HBSC	PLR	SRH; Well-being; Symptom load; Health behaviors	WSR; FAS	<ul style="list-style-type: none"> Social democratic and conservative welfare regimes rank lowest in the strength of association between low FAS and poor health, followed by liberal and other regime types. Mediterranean welfare regimes have mixed results.
		33 countries 2001/02				
		<u>Individual level:</u>				
Eikemo et al. (2008a)	Examining whether the magnitude of income-related health inequalities varies between welfare regimes	ESS	PLR	SRH; Limiting longstanding illness	WSR; Income	<ul style="list-style-type: none"> The Anglo-Saxon welfare states had the largest income-related health inequalities for both men and women, while countries with Bismarckian welfare states tended to demonstrate the smallest. Scandinavian countries only seemed to hold an intermediate position.
		23 countries 2002 & 2004				
		<u>Individual level:</u>				
Eikemo et al. (2008b)	Examining whether the magnitude of educational health inequalities varies between European countries with different welfare regimes	ESS	PLR; ANOVA	SRH; Limiting longstanding illness	WSR; Education	<ul style="list-style-type: none"> South European welfare regimes had the largest health inequalities, while countries with Bismarckian welfare regimes tended to demonstrate the smallest. The Scandinavian welfare regimes were placed less favorably than the Anglo-

		23 countries 2002 & 2004				Saxon and Eastern European.
Eikemo et al. (2008c)	Examining which welfare state regime characteristics explained the proportional variation of self-perceived health between European countries	<u>Individual level:</u> ESS	MLA	SRH	WSR	<ul style="list-style-type: none"> • 10% of the variation in health was associated with national welfare state characteristics. • People in countries with Scandinavian and Anglo-Saxon welfare regimes were observed to have better self-perceived general health in comparison to Southern and Eastern European welfare regimes.
Bambra et al. (2009)	Examining the relationship between gender and self-assessed health (SAH), and the extent to which this varies by socioeconomic position in different European welfare state regimes	<u>Individual level:</u> Eurothine	LR	SRH	WSR	<ul style="list-style-type: none"> • There was no consistent welfare state regime patterning for gender differences in SRH by socioeconomic position. • Women in the Social Democratic and Southern welfare states were more likely to report worse SRH than men. There were no gender differences in SRH in Corporatist countries.
Bambra et al. (2010)	Examining whether educational inequalities in self-reported health will vary by welfare state experience both temporally, in terms of the different phases of welfare state development, and spatially, in terms of welfare state regime type	<u>Individual level:</u> ESS	LR	SRH; Limiting longstanding illness	WSR; Education	<ul style="list-style-type: none"> • Age-related differences in the magnitude of health inequalities varied by welfare state regime. • Although patterns of educational inequalities in health varied by age among welfare state regimes, they were not smallest for the Scandinavian regime or among the older Scandinavian cohorts. • The Bismarckian and Southern regimes had smaller educational inequalities in health.
		13 countries 1998-2004				
		17 countries 2002, 2004 & 2006				

Guarnizo-Herreño et al. (2013)	Examining socioeconomic inequalities in adults' oral health in five European welfare-state regimes	<u>Individual level:</u> Eurobarometer	LR	No functional dentition; Edentulousness	WSR; SES	<ul style="list-style-type: none"> The Scandinavian regime showed the lowest prevalence rates of the two oral health measures, while the Eastern regime showed the highest. Inequalities in no functional dentition were largest in the Scandinavian welfare regime as well as for edentulousness by occupation and education.
Alvarez-Galvez et al. (2014)	Examining the effect of different measures of socioeconomic status on self-rated health throughout European welfare state regimes during the period 2002–2008	<u>Individual level:</u> ESS 29 countries 2002-2008	OLR	SRH	WSR; SES	<ul style="list-style-type: none"> Self-perceived health of people living in social democratic and liberal welfare state regimes is observed to be less affected by SES determinants in comparison to Southern and Eastern European regions.
Guarnizo-Herreño et al. (2014)	Examining socioeconomic inequalities in oral impacts on daily life among 21 European countries with different welfare state regimes	<u>Individual level:</u> Eurobarometer 31 countries 2009	LR	No functional dentition; Edentulousness	WSR; SES	<ul style="list-style-type: none"> Educational inequalities in the form of social gradients were observed in all welfare regimes. The Scandinavian and Southern welfare regimes also showed gradients for all SES measures. Absolute educational inequalities were greatest in the Anglo-Saxon welfare regime and smallest in the Bismarckian one.
Bambra und Eikemo (2009)	Examining whether the relationship between unemployment and self-rated health varies between welfare states with differing levels of social protection for the unemployed	<u>Individual level:</u> ESS	PLR	SRH; longstanding illness	WSR; Unemployment	<ul style="list-style-type: none"> The negative relationship between unemployment and health is consistent across Europe, but varies by welfare state regime, suggesting that levels of social protection may indeed have a moderating influence. The study shows that relative inequalities are largest in the Anglo-

		23 countries 2002 & 2004				Saxon, Bismarckian (men only), and Scandinavian (women only) regimes, and smallest in the Southern and Eastern regimes (women only).
Dragano et al. (2011)	Examining quality of work according to type of welfare regime and examining differences in the size of effects of quality of work on workers' health according to type of welfare regime	<u>Individual level:</u> SHARE ELSA	MLA	Depressive symptoms	WSR; Stressful psychosocial work environment	<ul style="list-style-type: none"> The effect of work-related stress on health (depressive symptoms) is less pronounced in older workers living in countries with social protection-oriented welfare regimes, compared with those living in more liberal welfare states.
		12 countries 2004 & 2006				
		<u>Individual level:</u> HBSC				
Richter et al. (2012)	Examining whether different welfare regimes are associated with health and health inequalities among adolescents		MLA	SRH	WSR; FAS; Parental occupation	<ul style="list-style-type: none"> Results show that between 4 and 7 per cent of the variation in both health outcomes is attributable to differences between countries. Adolescents in the Southern regime showed lower odds ratios of fair/poor SRH, while for two or more health complaints higher odds ratios were found for students in the Eastern and Southern regimes. No clear regime-specific pattern for young people was found.
		32 countries 2006				
		<u>Individual level:</u> EU-SILC	MLA	Longstanding illness	WSR; Education	<ul style="list-style-type: none"> For men, absolute and relative social inequalities in sickness were lowest in the Southern regime. For women, inequalities were lowest in the Scandinavian regime.

Witvliet et al. (2014)	Examining the differences in the prevalence of disability between welfare regimes worldwide by individual socioeconomic position	26 countries <u>Individual level:</u> World Health Survey	MLA	Self-reported disability	WSR; Education	<ul style="list-style-type: none"> • State-organized regimes of Europe and the productivist regime of East Asia seem to contain protecting features against disability for all citizens, and especially for the most vulnerable. • Apart from the productivist regime of East Asia, the low educated and the unemployed seem to bear the greatest health burden within more insecure regimes.
Chung et al. (2013)	Examining inequalities in depression across a wide range of welfare regimes and examining possible cross-level interactions between gender and welfare state regimes	46 countries 2002-2005 <u>Individual level:</u> World Health Survey	MLA	Depression	WSR; Gender	<ul style="list-style-type: none"> • Latin Americans, Eastern Europeans, and Southeast Asians were found to have lower odds of experiencing depression compared to people in the Southern/ex-dictatorship regimes. • Compared to Southern/ ex-dictatorship males, males in Southeast Asian and Eastern European countries fared significantly better, as did Southeast Asian females. • Mental health disadvantages were observed among females from liberal and Southern regimes.
van de Velde et al. (2014)	Examining whether health inequalities exist between lone and cohabiting mothers across Europe, and how these may differ by welfare regime	26 countries 2002-2005 <u>Individual level:</u> ESS	MLA	SRH; Longstanding illness; Depressive feelings	WSR; Lone motherhood	<ul style="list-style-type: none"> • Lone mothers are at greater risk of poor health than cohabiting mothers. • Inequalities by marital status are most pronounced in the Anglo-Saxon regime for self-rated general health and limiting long-standing illness, while for depressive feelings it is most pronounced in the Bismarckian welfare regime. • Risk difference is smallest in the Central Eastern European regimes, but both lone and cohabiting mothers also reported the highest levels of poor health

						compared with the other regimes.
		27 countries				
		2002 & 2004				
		<u>Individual level:</u>				
		SHARE				
Niedzwiedz et al. (2014a)	Examining the magnitude of socioeconomic inequality in the quality of life of Europeans in early old age and the influence of the welfare regime type on these relationships		MLA	CASP-12	WSR; Education; Occupation; Wealth; Income	<ul style="list-style-type: none"> Socioeconomic inequalities in the quality of life of individuals in early old age were identified in all welfare states, but not using all measures of socioeconomic position. For most socioeconomic position measures, narrower inequalities in quality of life were found in Scandinavian and Bismarckian countries, and these also displayed the highest levels of quality of life.
		13 countries				
		2006/07 & 2008/09				
		<u>Individual level:</u>				
		SHARE				
Niedzwiedz et al. (2014b)	Examining the magnitude of socioeconomic inequalities in life satisfaction among individuals in early old age and the influence of the welfare state regime on the associations		MLA	Life satisfaction	WSR; Life course socioeconomic position	<ul style="list-style-type: none"> Socioeconomic inequalities in life satisfaction were present in all welfare regimes. Educational inequalities in life satisfaction were narrowest in Scandinavian and Bismarckian regimes among both genders. Post-Communist and Southern countries experienced both lower life satisfaction and larger socioeconomic inequalities in life satisfaction.
		13 countries				
		2006/07 & 2008/09				
		<u>Individual level:</u>				
		SHARE				
Niedzwiedz et al. (2015)	Examining the extent to which current financial distress explains the relationship between life-course socioeconomic position and well-being in Southern, Scandinavian, post-Communist, and Bismarckian welfare regimes		MLA	CASP-12; Life satisfaction	WSR; Life course socioeconomic position	<ul style="list-style-type: none"> Life-course socioeconomic advantage was related to higher well-being. The weakest associations were found among Scandinavian countries. Financial distress was associated with lower well-being, and attenuated the relationship between life-course socioeconomic position and well-being in all regimes.

		13 countries					
		2006/07 & 2008/09					
		<u>Individual level:</u>					
		ESS					
Moortel et al. (2015)	Examining the association of mental well-being and NMSC among employees in Europe, examining whether the relation between NMSC and mental well-being is the same in women compared to men within each welfare regime, examining the role of the gender division of labor within each welfare regime		PR	WHO Well-being Index	WSR; Neo-Marxian Social Class; Gender division of labor; Job quality	<ul style="list-style-type: none"> For women, class differences in mental well-being are found in State corporatist/family support and Southern welfare regimes. For men, class differences in mental well-being are found in all but basic security/market-oriented welfare regimes. Gender inequalities in mental well-being are more marked and widespread in basic security/market-oriented welfare regimes. 	
		21 countries					
		2010					
		<u>Individual level:</u>					
		HBSC					
Rathmann et al. (2015)	Examining whether macro-level determinants are associated with health and socioeconomic inequalities in young people's health		MLA	Psychosomatic health complaint	WSR; FAS	<ul style="list-style-type: none"> Results showed that adolescents living in liberal-regime countries reported significantly more health complaints. No differences between welfare regimes in the association between FAS and psychosomatic health complaints 	
		27 countries					
		2006					
		<u>Individual level:</u>					
		ESS					
Alvarez-Galvez (2016)	Examining alternative interrelationships between SES and health in different welfare state regimes, and using this information to develop new hypotheses and a better theoretical understanding		BN	SRH	WSR; Income; Occupation; Education; Insider	<ul style="list-style-type: none"> The linkage between SES and health depends on welfare state regimes. Income seems to be the main determinant of health in the liberal welfare state regime, whereas occupational status is the main determinant of individuals' state of health in Social-Democratic welfare state regimes. In Southern countries educational inequalities seem to be an evident determinant of health outcomes. 	

		29 countries							
		2002-2008							
		<u>Individual level:</u>							
Leão et al. (2018)	Examining how educational inequalities in self-reported health have evolved in different European countries and welfare state regimes over the last decade	EU-SILC	PLR	SRH	WSR; Education				<ul style="list-style-type: none"> Anglo-Saxon countries experienced the largest increase in absolute inequalities, followed by Bismarkian countries, while these inequalities decreased in post-Communist countries. Post-Communist countries also experienced a widening in relative inequalities.
		29 countries							
		2002-2008							
		<u>Individual level:</u>							
		SHARE							
Romaniuk (2014)	Examining differences between the subjective and objective health measures in a welfare state regime perspective		MLA	SRH; Handgrip strength	WSR; SES				<ul style="list-style-type: none"> Type of welfare regime helps to explain the variations in subjective health between countries, as well as the differences between individuals. WSR does not explain the differences in objective health when analyzing all socioeconomic groups collectively. The health of those who are least well-off in all of the analyzed welfare regimes was found to be similar.
		16 countries							
		2012							

Abbreviations in data basis:

NLSY: US National Longitudinal Survey of Youth; NDF: Natality Detail File; CPS: Current Population Surveys; SIPP: Survey of Income and Program Participation; SoFIE: Survey of Family, Income and Employment; WHO MDB: WHO Mortality Data Base; HMD: Human Mortality Database; SCIP: Social Citizenship Indicator Program; MPD: Maddison Project Database; CWED: Comparative Welfare Entitlements Dataset; ESS: European Social Survey; ULF: Swedish Living Conditions Survey; HSE: Health Survey for England; PSID: Panel Study of Income Dynamics; ETA: US Department of Labor Employment and Training Administration; PACO: Household Panel Comparability Project; HRS: Health and Retirement Study; ELSA: English Longitudinal Study of Aging; NHANES: National Health and Nutrition Examination Survey; AIHW: Australian Institute of Health and Welfare health expenditure database; HBSC: Health Behavior in School-aged Children survey; SHARE: Survey of Health, Ageing and Retirement in Europe; EU-SILC: European Union Statistics on Income and Living Conditions

Abbreviations in method:

MR: Multivariate Regression; IV: Instrument Variable Approach; DID: Difference in Difference; MSM: Marginal Structural Modeling; FE: Fixed Effect Regression; ARIMA: Autoregressive Integrated Moving Average; MLA: Multi Level Analysis; PLR: Pooled Linear/Logistic Regression; CLFE: Country-Level Fixed-Effects Regression Model; OLS RE: Ordinary Least Square with Random Effects; GLM: Generalized Linear Model; LR: Logistic Regression; PM: Probit Model; PSM: Propensity Score Matching; RB PM: Recursive Bivariate Probit Model; PTSA:

Pooled Time-Series Analysis; ANOVA: Analysis of Variance; OLR: Ordered Logistic Regression; PR: Poisson Regression; BN: Bayesian Network Modeling

Abbreviations in Outcome:

BPI: Behavioral Problems Index; HOME, Home: Observation Measurement of the Environment; SRH: self-reported health; IMR: Infant Mortality Rate; CD: Chronic Diseases; CASP-12: control, autonomy, self-realization and pleasure

Abbreviations in independent variables:

EITC: Earned Income Tax Credit; FTC: New Zealand's Family Tax Credit; IWTC: In-Work-Tax Credit; SES: Socioeconomic Status; FAS: Family Affluence Scale; WSR: Welfare State Regimes