

Policies to reduce health inequalities in families with children

Document analysis in four European countries

By

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Working document from GRADIENT project, Work Package 5 (Tackling the Gradient: Applying Public Health Policies to Effectively Reduce Health Inequalities amongst Families and Children)

Foreword

INTRODUCTION

Health inequalities are regarded as one of the most important public health challenges in the EU. However, we do not have sufficient knowledge of which actions are effective to level up the gradient in health inequalities. The EU funded project “Tackling the Gradient: Applying Public Health Policies to Effectively Reduce Health Inequalities amongst Families and Children” (GRADIENT) aims to address this knowledge gap, to ensure that political momentum is maintained and that operational strategies can be developed to make progress on this issue. The focus of the research project is on families and children, since the greatest impact on reducing the health gradient can be achieved through early life policy interventions and by creating equal opportunities during childhood and adolescence (www.health-gradient.eu).

One of the aims of the GRADIENT project is to analyse and compare the impact of general policies for families and children, and also policies targeted at ‘at risk’ families and children. Work package 5 (WP5) is a case study, comparing policies in four countries. The objectives of the case study are:

- To map general national policies for families and children and national policies targeted at “at risk” families and children in selected countries
- To compare policies in different countries, representing different welfare state regimes
- To explore how different types of policies work together to protect families and children from falling into poverty and ill-health
- To investigate what anticipated impacts the different types of policies have in terms of reducing social inequalities and the social gradient

The four European countries participating in the case study are England, The Netherlands, Slovenia and Sweden.

As a basis for the project, a literature study was undertaken. The aim of the study was to increase the knowledge of how national policies influence the social conditions for families

with children, based on published research. The results from the literature study will be used as the analytical framework and point of departure of this document study.

THEORETICAL BASIS

Applying a gradient perspective to study social inequalities in health implies that welfare policies in many areas are relevant for the distribution of social inequalities in health. Social inequalities shape a pattern of a gradient through populations. It is not only the poorest who stand out as having a worse health than the average. The wealthiest have better health than the second wealthiest, who have better health than the third wealthiest etc. Social inequalities in health are therefore an issue concerning the whole population (Graham 2000, 2002; Marmot 2007; Bambra, Fox, Scott-Samuel 2005).

In the process of bringing research into policy, health determinants and health inequality determinants can become conflated. Therefore it is important to make a distinction between social health determinants and social determinants of health inequalities. Policies to achieve improved health aim at improving population health through a focus on the health determinants, while policies to promote health equity address the unequal distribution of these determinants between advantaged and disadvantaged groups. Governments committed to improving health and reducing health inequalities need to address the effect on the population as a whole. In addition, they must attend to the differing consequences of their policies for groups with unequal access to the determinants of good health (Graham 2000, 2002; Marmot 2007; Bambra, Fox, Scott-Samuel 2005).

Governments address the issue of health inequalities differently. The policies chosen will have strong political implications on the results achieved. Policies aimed at marginalised groups may improve the situation for these groups, but the gradient will not change. Policies aimed at the whole population will also be necessary in order to reduce the social gradient in health. This will demand structural measures, and is therefore also a highly political issue.

Based on the final selection of literature and the research questions outlined above, the literature study from WP5 included the following themes (<http://forum.health-gradient.eu/viewtopic.php?f=14&t=98>):

Health inequalities: Politics behind policies

Social inequalities may be defined as a “wicked” problem (Rittel & Webber 1973). Searching for scientific bases for the confrontation of problems of social policy is bound to fail, because of the nature of these problems. They are “wicked problems” whereas science has been developed to deal with “tame” problems. Policy problems cannot be definitively described. Moreover, there is no objective definition of equity; policies that respond to social problems cannot be meaningfully correct or false; and there are no objective ‘optimal solutions’ to social problems. Social inequalities in health are a highly political issue. Leftist or social democratic parties will traditionally have a policy reduce social inequalities in the population, and consider the differences inequitable, while right wing parties might consider the differences as “natural” and use a different language, for instance by calling them disparities instead of inequities (Navarro and Shi 2001, Navarro et al. 2003).

Do different welfare states matter?

One of the research questions to be answered by the GRADIENT WP5 project is whether different welfare states secure the living conditions for families and children differently. What are the characteristics of different welfare state types? Is it possible to state that one type of welfare state is better than the other?

The terms ‘welfare state’ and ‘welfare state policies’ have different meanings in different political systems (Esping-Andersen1990). Esping-Andersen classifies, not welfare states, but welfare regimes, according to three types: liberal, corporatist/traditional and social-democratic, each having particular characteristics. In the liberal welfare regime, market forces play a dominant role and the state encourages the market to flourish, either passively, by guaranteeing a minimum of regulation, or actively, by subsidizing private welfare

schemes. Public transfers are means-tested and only modest universal benefits and social insurance plans exist. Examples of this type of welfare regime are the UK, the USA, Canada and Australia.

In the corporatist/ traditional welfare regime, the market does not play a predominant role with regard to protecting the health of the population. The ideas of social rights and encompassing social security networks hold a high degree of legitimacy. Their basis is built on conservative grounds, and the upholding of 'traditional' family values. The social security systems are traditionally built on the male bread-winner; they are strongly attached to the labour market, and hence mostly exclude women not employed outside the home. Among corporatist regimes are France, Germany and Italy.

The 'social democratic' regime is characterised by its emphasis on solidarity and universalism, and the redistribution of resources among social groups, mainly through a progressive tax system and entitlements to vulnerable groups. This is a system of emancipation, not only from the market, but also of the family. The result is a welfare regime with direct transfers to children and one which takes direct responsibility for the care of children, providing the conditions for women with families to engage in paid work. Women are encouraged to work and the welfare state is dependent on female participation in the labour market. The Scandinavian countries are usually cited as exemplars of the social democratic welfare regime.

The literature on welfare regimes is somewhat ambiguous concerning the impact of welfare regimes and different welfare state arrangements on health inequalities (Bambra 2007, 2009; Lundberg et al. 2008). Still, it seems meaningful to use welfare regimes as an analytical category. However, the analysis could be performed from an open-minded, empirical approach rather than using strict categories at the outset.

Comprehensive strategies/intersectoral collaboration

What policy measures are necessary in order to reduce social inequalities in health? The authors seem to agree that what works would include the following points (Östergren, Meyer and Barnekov, 2007; Frazer and Marlier 2007; Lundberg 2009):

- Increasing quality of life and reducing social inequalities among children will demand resources. Countries need to spend more resources on children and families to reduce inequalities.
- In order to reduce social inequalities among children and families it is necessary with comprehensive, intersectoral action.
- It is also necessary that comprehensive, intersectoral policies must be combined with targeted measures aimed at disadvantaged and vulnerable children and families.
- Macro policies, in terms of general universal and generous welfare policies will provide a security net and promote the health of children and families.

The gradient perspective implies that welfare policies in many areas are relevant for the distribution of social inequalities in health. There is an overall recognition that policies developed in other sectors than health play an important role for the public health of the population. Policies to keep children and families out of poverty and ill-health seem to be: Labour market policies, Cash benefits, childcare, access to education, participation in culture, sport and recreation, access to decent housing and safe neighbourhoods, access to health care and access to social services.

Methods: Document analysis

In comparing different countries, it is vital to have an understanding of the institutional contexts of the countries studied and it is also necessary to classify institutional differences across countries. Vining and Weimer (1999) outline two different types of comparative studies, the study of institutional design itself (first order policy instruments) and the policy instruments used as mechanisms of the institutional design (second order policy instruments). Within political science, the traditions could be divided in studies focussing on

policy design including the content of the policy and a second tradition, studying the implementation of policies. The present study has its focus on the design of the policies. Esping-Andersen's classification has been chosen to capture the different institutional contexts in the countries studied. The use of this framework has an exploratory aim, as it intends to explore whether the framework is useful in studying this particular policy field. England represents the liberal welfare regime, Netherlands the conservative/traditional regime, and Sweden the social-democratic regime. The former Eastern European communist countries were not included in Esping-Andersen's categorisation. It would therefore be interesting to study the development in these countries, and Slovenia is chosen as an example of this category.

Document analysis is a research strategy within qualitative methods. Documents may be used in combination with other methods but can also be used as a method in its own right (Yin 1989; Denscombe 1998; Flick 2009).

When using documents as a data source, it is important to study them in their context and to understand the purpose of the documents. Also in document studies it is important to critically assess the authenticity, credibility, representativity and meaning of the documents (Flick 2009). In this project authoritative political documents like government white papers and government action plans are the data sources. Political documents are usually meeting the criteria of authenticity and credibility as they are expressions of formulated government policies. Representativity in this context is linked to the question whether the document is typical or atypical. In all the four countries we have access to several documents and in these countries the policies presented are typical of documents produced at the same time. The issue of meaning will be essential in the analysis. It concerns the explicit and implicit values of the policies presented and it is closely linked to the explicit analytical tools chosen for the study.

There are limitations to using political documents as a sole source of data, as they may provide a very specific approach to a political process. They state what a government intends to do, and can be accused of presenting wishes and vague plans rather than solid

results. And truly, most research show that in many policies, there is a discrepancy between intentions and implemented results (Mackenbach et al. 2007). Still, policy documents serve as valuable data sources as they are produced by governments and have credibility and authority. Last but not least, they serve as guiding principles and tools for government action and will thus reflect government ideology and intentions regarding the choice of policy instruments to deal with policies regarding health inequalities.

The Procedure for selecting the documents was the following: The National websites were searched for documents, in the three countries that do not have English as their native language we searched for documents published in English. An exception to this is Sweden, since the principal researcher understands Swedish. We started the searches at the websites of National ministries, looking for the institutions responsible for policies regarding families and children and policies regarding health inequalities. All countries had well updated websites, with all the most important documents translated to English. We basically selected documents that described government policies (Government White Papers i.a) and actions plans or other documents that outlined strategies to follow up the government policies. Some of the documents also included evaluation of former policies. The chosen documents were sent to the National partners for them to validate the choice of documents and supply the selection. They were also asked to control if there were important documents that only had been published in the native language.

The documents were analyzed using the analytical framework outlined above, based on the following questions:

- Is the social gradient addressed in any of the documents?
- Who are responsible for policies to reduce social inequalities among children and families? What strategies are chosen are these comprehensive/intersectoral strategies? Do these issues hold a high priority on the National agendas?
- Did the documents reflect that policies to reduce health inequalities could be a wicked issue, and if they did, how was this reflected?
- Did the policies outlined in the documents reflect different welfare regimes, and how was this reflected?

Findings

England

The following English documents were included in the analysis, however, the main emphasis of the analysis is on documents where children and families are the target group.

Child Poverty Review 2004 (HM Treasury)

Every Child Matters: Change for Children. HM Government 2004

Summary of the Children's Act 2004 (In every child matters)

Tackling Health Inequalities A Programme for Action. Department of Health. 2003

Tackling Health Inequalities: 2007 Status Report on the Programme for Action. Department of Health

Health Inequalities: Progress and Next Steps. Department of Health June 2008

The Government's Response to the Health Select Committee Report on Health Inequalities Presented to Parliament by the Secretary of State for Health by Command of Her Majesty May 2009

Inequalities Act 2010

Tackling Health Inequalities: 10 Years On – A review of developments in tackling health inequalities in England over the last 10 years . Department of Health May 2009

Fair Society, Healthy Lives. The Marmot Review, 2009. Strategic Review of Health Inequalities in England post 2010.

Child Poverty Review 2004 (HM Treasury)

In the mid to late 1990s, the UK suffered higher child poverty than nearly all other industrialised nations. Over a period of 20 years, the proportion of children in relative low income households had more than doubled. The Government therefore set an ambitious long-term goal to halve child poverty by 2010 and eradicate it by 2020. As a first step, the Government sought to reduce the number of children in low-income households by at least a quarter by 2004-05.

The Government increased financial support for children through tax credits, Child

Benefit and other benefits by 72 per cent. As a result, combined with its success in helping parents into work, the previous trend toward increasing levels of child poverty was reversed. Between 1998-99 and 2002-03, the number of children in relative low-income households fell by around 500 000.

But child poverty is about more than just income. The Government's strategy for tackling child poverty also involved ensuring work for those who can and support for those who cannot; supporting parents in their parenting role; and delivering high quality public services.

In the Budget 2003 the Chancellor announced the child poverty review, which examined both the welfare reform and public service changes necessary to advance towards the long-term goal of halving and eradicating child poverty. The child poverty review outlined the need for continued collaboration between central and local government and the voluntary and community sector. The Government also established a 'child poverty accord' between the Local Government Association and central government, which aimed at supporting further co-ordination.

Every Child Matters: Change for Children. HM Government 2004 (England) Department for Children, Schools and Families

The Government published Every child matters: The next steps, and passed the Children Act 2004. "Every child matters: Change for children" was published in November 2004 and a website was launched soon afterwards. (<http://www.dcsf.gov.uk/everychildmatters/>).

The Children Act 2004 provided the legislative foundation for whole-system reform to support this long-term and ambitious programme. It outlined new statutory duties and clarifies accountabilities for children's services. It was underlined that legislation must be part of a wider process of change. Every Child Matters: Change for Children set out the national framework for local change programmes to build services around the needs of children and young people. The document set out what action needed to be taken locally and how Government would work with and support Local Authorities and their partners.

The Children Act 2004

The Act was “the legislative spine on which the government wants to build the reforms of children’s services”. It established for England:

1. a Children’s Commissioner to champion the views and interests of children and young people;
2. a duty on Local Authorities to make arrangements to promote co-operation between agencies and other appropriate bodies (such as voluntary and community organisations) in order to improve children’s well-being, and a duty on key partners to take part in the co-operation arrangements;
3. a duty on key agencies to safeguard and promote the welfare of children;
4. a duty on Local Authorities to set up Local Safeguarding Children Boards and on key partners to take part;
5. provision for indexes or databases containing basic information about children and young people to enable better sharing of information;
6. a requirement for a single Children and Young People’s Plan to be drawn up by each Local Authority;
7. a requirement on Local Authorities to appoint a Director of Children’s Services and designate a Lead Member;
8. the creation of an integrated inspection framework and the conduct of Joint Area Reviews to assess local areas’ progress in improving outcomes; and provisions relating to foster care, private fostering and the education of children in care.

Tackling Health Inequalities A Programme for Action. Department of Health. 2003

In 2003, an action programme was launched to tackle social inequalities in health. The programme aimed to reduce health inequalities between different geographical areas, genders, ethnic communities and social and economic groups, and to tackle the underlying causes of health inequalities. The wider determinants of health inequalities were in focus, such as poverty, poor educational outcomes, unemployment and poor housing. However, the main aim of the plan was to improve the health of the poorest, and there was no focus on the social gradient. Even though there was a focus on the social determinants of health,

no connection was made to the broader aims of social and welfare policies and to the distribution of welfare between social groups.

Health Inequalities: Progress and Next Steps. Department of Health June 2008

This policy document served two purposes. Firstly it set out progress on the current health inequalities strategy, focused around the PSA targets. Secondly action to two timescales: redoubling efforts to deliver the 2010 targets; and the process of developing ambitions, structures and systems for beyond 2010.

Tackling Health Inequalities: 10 Years On – A review of developments in tackling health inequalities in England over the last 10 years. Department of Health 2009

This report reviewed developments in health inequalities over the last 10 years – from November 1998 when the Acheson report on health inequalities was published to November 2008 when the post-2010 strategic review of health inequalities was announced. It covers developments against the wider, social determinants of health and the role of the NHS. It provided an assessment of developments against the Acheson report, a review of key data developments against a wide range of social, economic, health and environmental indicators, and it considers lessons learned and future challenges

The three reports sum up the policies and actions that have been implemented in the UK since 1998. The report outlines the general policies, where families and children hold a high priority.

Fair Society, Healthy Lives. The Marmot Review . Strategic Review of Health Inequalities in England post 2010.

Among the key messages of the review were:

- Reducing health inequalities is a matter of fairness and social justice.
- There is a social gradient in health – the lower a person’s social position, the worse his or her health. Action should focus on reducing the gradient in health.
- Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.

- Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.

According to the review, reducing health inequalities will require action on six policy objectives:

- Give every child the best start in life
- Enable all children young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

Discussion

Addressing the gradient?

In general, health inequalities have been high on the English (British) political agenda for more than a decade. The labour governments in office from 1997 to 2010 produced a number of policies to reduce social inequalities in health. Children and families have been at the heart of the efforts. The policies are both upstream and downstream and include inter-sectoral action, involving government at national and local levels and the voluntary sector in particular. The policies have mainly been aimed at disadvantaged groups and areas and did not reflect a social gradient perspective.

Comprehensive policies/intersectoral collaboration

The policies developed by the Labour government to reduce social inequalities in health among families and children are clearly comprehensive and demands intersectoral collaboration. The policies aimed at committing both the national and local level and aims at a broad collaboration between actors, both within government agencies and also between government agencies and the voluntary sector.

The review of health inequalities in England, led by Sir Michael Marmot, embraced a determinant perspective and had a broad, intersectoral approach. The Marmot review was an assignment by the government for Marmot and his co-workers to assess the situation in England on the basis of the global WHO review. The Marmot review suggests structural measures to reduce social inequities in health. The review is however no committing policy document, but rather a report advising how to move towards a more equal society.

The political shift of 2010 may change the status of the issue of health inequalities and it might not be given the same emphasis by the liberal-conservative government.

Wicked issue

For the Labour governments from 1997 though 2010 reducing inequalities in health were high on the political agenda, and children and families were a central part of the policies. In the Child Poverty Review of 2004 a number of measures were outlined to improve the situation for deprived groups in many areas: health care, child care, education, work life and housing.

The rhetoric in the policy documents was influenced by the equity agenda and states very clearly that the aim is to reduce social inequalities in health both by addressing the gap between high and low income and education groups and also to reduce the social gradient. However, the action plans based on the policy documents are mainly targeted at disadvantaged groups and areas. They are not aiming at changing structural patterns or the general family welfare policies in the society. The policies are only vaguely connected to other areas of welfare policies, like gender equality. They are not addressing issues like the school system or the child care, which is mainly private, or improving women's situation by improved opportunities for maternity leave.

This dilemma and lack of consistency may reflect the wickedness of the equality issue in the English context. The Gradient perspective would imply that structural and universal measures would be in place, however, the measures are mainly aimed at deprived groups

and geographical areas. This might reflect that this type of measures is the ones regarded as legitimate by the British political system.

A new conservative/liberal government came into office in 2010, and it has announced severe cut-backs in public sector spending. At the moment it is uncertain how the former government's policies will be followed up and if and how the Marmot review will have consequences in practical politics and policy development.

Welfare state typology

England (and the UK) is part of what Esping-Andersen refer to as the liberal welfare state typology as described above. In this welfare state type the markets plays a dominant role, and government is expected to play a passive role and enter into families' life when they are not able to take care of themselves. In handling the issue of inequality one could say that on the one hand the government has played a more active role than the liberal model "prescribes", by issuing comprehensive policies, including policies to improve the living conditions for families and children. On the other hand, the measures are mostly targeted, and this would be more in accordance with the liberal model. This balance seems to capture on one hand the Labour party's social democratic policies, developed in a liberal context. On the other hand it also reflects the liberal welfare state typology by not introducing universal measures but mainly focussing on disadvantaged groups.

The Netherlands

The following Dutch policy documents were included in the analysis:

Ministry of Health, Welfare and Sports (2006) Opting for a healthy life. Public health policy in The Netherlands 2007-2010.

Netherlands Youth Institute (2007): Youth Policy in the Netherlands

Ministry for Youth and families (2007): Every opportunity for Every Child. Youth and Family Programme 2007-2011. Shortened version.

Ministry for Youth and families (2008): A Special Ministry for Youth and Families: How does it work? (Leaflet).

Ministry of Health, Welfare and Sports (2008). Government adopts broad-spectrum approach to health inequalities. Newsitem, 19 December 2008

Organisation of Youth and Family policies in the Netherlands

In the Netherlands there is a special ministry for youth and families, which was established in 2007 . The responsibility of the Minister for Youth and Families differs from other cabinet ministers in that he is in charge of areas within other ministries, like the Ministry of Health, Welfare and Sports, the Ministry of Justice, the Ministry of Social Affairs and Employment and the Ministry of Education, Culture and Science. The ministry is special because it has no civil servants of its own. Staff who work for the ministry remain formally employed by other ministries. However, they receive their instructions from the Minister and Director General for Youth and Families. The Ministry for Youth and Families are responsible for the many fields of policy regarding young people, among them several areas related to health and well-being: family policy, youth care, mental health care for young people, preventive policy for young people (healthy lifestyle, alcohol, tobacco, drugs).

The Youth Care Act

The Youth Care Act – came into force on 1 January 2005. The youth care system covers all forms of care available to parents and children to help with serious development and parenting problems. Youth care is for young people up to the age of eighteen who are going through serious development and parenting problems and who cannot be helped through the general systems that provide education, healthcare and social support. The Dutch Youth Care Act has two aims: to ensure that better care is made available to young people and their parents and to strengthen their position.

The Youth and Family Programme “Every opportunity for Every Child (2007-2011)”

This represented a new approach by the Dutch government. It is a strategy focusing on intersectoral collaboration and coordination. The programme consists of three strategies:

1. Confirm the family's role in bringing up children.
2. Concentrate on preventive action by identifying problems earlier and tackling them more effectively.
3. No longer accept a permissive, non-committal approach.

The development of these policies shows that the quality of life of children and families is considered a responsibility for society and the government, and the policies are thus a part of the Dutch welfare state system. However, there is a strong emphasis in the documents that the families have the main responsibility for the upbringing of children. Even though some of the policies are aimed at disadvantaged children and families, this is not part of an explicit strategy to reduce social inequalities in health. The term social inequalities in health are not mentioned in the documents.

The Youth and Family Programme aims at using and consolidating resources families have in place. The measures are both addressing families in general but have particular measures for families at risk. Among the measures will be:

- Parenting support will be offered to all families
- A national network of youth and family centres will be created by 2011 to provide advice and help on parenting at neighbourhood level
- 'One family, one plan' approach. One plan and one contact point for families where they can meet care workers
- Parents will be given a means-tested child allowance to minimise financial obstacles to adequate child rearing
- Parents and children will be given the opportunity to take part in sports and creative and educational activities at local community schools.

When there are problems in a family and more than one agency is involved, the 'one plan, one family' model will be applied. More attention will be given to at risk families (minority families, divorced families). *Youth and family centres* will be set up in every municipality. The centres will be multi-sectoral and social care, health care and schools need to collaborate. The main players to achieve this are the municipalities, in collaboration with housing associations.

‘Opting for a healthy life: Public health policy in The Netherlands 2007-2010’.

The main Dutch national document for public health and health promotion is ‘Opting for a healthy life: Public health policy in The Netherlands 2007-2010’. Policies explicitly aimed at children and young people are addressed in several areas. Life style issues have the main focus, among them overweight and obesity. The measures are mainly aimed at supporting parents and also (mass media) campaigns.

Also in this document it is emphasised that the parents have the main responsibility for their children leading healthy lives. The strategies will be to advice parents, but also to implement structural measures like raised taxes on alcohol and tobacco (Suggested for 2008 budget). One objective was to put the prevention strategy into practice together with the Minister of Health, Welfare and sports.

Inter-sectoral action is also central in the Dutch policies. Particularly in the Netherlands the policies have developed over the last years, starting with Operation young and now a Ministry for Youth and families with responsibilities across government. The comprehensive Youth and Family plan “Every opportunity for every child 2007-2011” has a strong focus on inter-sectoral action and commitment for stakeholders.

Discussion

Addressing the gradient?

Policies, particularly within the field of youth policies will be aimed at disadvantaged groups, but in the documents there are no discussions about concrete strategies that will reduce the inequalities.

Comprehensive approaches/Intersectoral collaboration

The Dutch policies aimed at families and children are based on comprehensive an inter-sectoral organisation form, reflected in the Ministry for Youth and Families. However, in the documents there are no specific aims of reducing social inequalities in health.

There might however, be a change of policy in this area. The Dutch government is planning to tackle health inequalities by means of a broad-spectrum approach. To this end, it is implementing a number of interrelated measures. This emerged from the 'Policy plan for tackling health disparities based on socio-economic backgrounds'. The Council of Ministers agreed on a proposal put forward by the Minister of Health, Welfare, and Sport, on behalf of himself and the Minister for Housing, Communities and Integration. However, I have not been able to find any documents on the Ministry website that follows up this newsletter.

However, there seems to be a development in the field of health inequalities. A News letter published by the Ministry of Health, Welfare and Sports in 2008 reports that "Government adopts broad-spectrum approach to health inequalities" (Newsitem, 19 December 2008)

In a paper Marielle Droomers (Eurohealth Vol 15 No 3) refers to a document which I have not been able to find: "Government of the Netherlands. Towards an Able-bodied Society. A Policy Plan for Dealing with Health Inequalities Related to Socioeconomic Background". The Hague: 2008. In her paper Droomers explains this shift of policies by the change of government in 2007.

Health inequalities as a wicked issue

The issue of health inequalities has so far not been explicitly on the political agenda. Even though public health policies aimed at children and young people are addressed in several areas, the main focus is on traditional life style issues and the strategies are mainly information and facilitation to achieve healthier life styles. Using the rhetoric of Rittel and Webber (1973) one could say that only the "tame" aspects of the problems are being addressed. When emphasising the responsibility of parents so strongly, a large part of the responsibility for the welfare of children is moved from the public into the private sphere. The "wickedness" of the problem thus becomes invisible, since the issue of inequalities is not addressed.

Welfare state type

In the Netherlands a strong point is made that the family is the core unit in society and that the family has the main responsibility for the upbringing of children. These rhetorical statements could be interpreted as a reflection of the type of welfare state regime the Netherlands is a part of. Traditionally the conservative welfare state regimes would emphasize the role and responsibility of the family outside the public sphere, while the social democratic regimes traditionally would include families in their policies and structural measures.

Slovenia

The following Slovenian documents were included

Institute of Macroeconomic Analysis and Development Social Overview 2006 Editor in Chief:
Jana S. Javornik

Ministry of Labour, Family and Social Affairs (2006). Programme for children and youth 2006-2016

National report on strategies for social protection and social Inclusion 2008–2010

Ministry of Labour, Family and Social Affairs (2006). Programme for children and youth 2006-2016

The main objective of the programme is to create and implement a strategy for achieving the highest possible level of health for children and youth in Slovenia with an emphasis on reducing inequalities in health.

The objectives of the programme are to be obtained through efforts in different areas:

Health policy, among them: (p8)

“The main objective is to create and implement a strategy for achieving the highest possible level of health for children and youth in Slovenia with an emphasis on reducing inequalities in health. The strategy will list clearly defined goals that we wish to achieve in the area of health for children and youth”

Among the strategies to achieve these objectives are:

- To involve the young in creating, implementing and evaluating strategies, programmes and measures, as an essential part of all activities.
- Ensuring equality and placing special stress on deprived groups;
- Inter-departmental and inter-institutional activities and cooperation with non-government organizations that will be aimed at influencing the main factors of health;
- Creation of suitable supporting environments (family, local community, kindergarten, school)

In the area of family policies, there is recognition of the government's responsibilities towards families, both regarding the children but also in terms of creating a labour market that would make it possible to combine work with family responsibilities:

- Improve the competitiveness of parents (especially mothers) and young women on the labour market.
- Guarantee conditions for a more seamless coexistence of professional and family lives.
- Guarantee a larger number of non-profit apartments within municipal residential programmes
- Introduce new or use the already existing obligatory or optional child education programmes

Education policies are also included and has an explicit focus on reducing health inequalities, i.a. by ensuring equal possibilities for education and improve its accessibility.

In the area of social policy the overall aim is to reduce Poverty and Social Exclusion of Children and Families by:

- Carrying out the established goals of fighting poverty and social exclusion of children and youth in line with the national programme of social inclusion.
- Continue with measures that would be aimed at reducing poverty in families with a larger risk factor (single-parent families, large families, families with children with special needs, children and youth with growing-up difficulties, the unemployed young, etc).

Parental protection and family benefits act 2007 (Official consolidated text) (ZSDP-UPB2)

This act outlines the social rights and social benefits that families with children are entitled to. Among these are right to maternity and paternity leave with economic compensation. Parents are also entitled to part time work until the child is 3 years old, compensated by the government. There is also a child benefit for low income families. The child benefit is an important social transfer in Slovenia, especially as a form of assistance aimed at improving the quality of life of children and mitigating financial distress in low-income families.

National report on strategies for social protection and social Inclusion 2008–2010

In this report a number of measures were introduced to increase social inclusion and reduce social inequalities in health. From September 2008, kindergarten became free of charge for the second and any subsequent child from the same family who is simultaneously attending kindergarten; a 50% reduction in the payment for kindergarten for children aged 3 and above will be gradually introduced for all parents.

The majority of the Slovenian population is guaranteed access to social welfare services in the Republic of Slovenia. Yet in practice accessibility is still limited by an inadequate network of services and programmes (insufficient capacities and uneven regional distribution), difficulties in financing and frequently the poor provision of information or even stigmatisation of potential system users. All people with a permanent residence are entitled to services; others only have access to the most urgent ones.

Discussion

Addressing the social gradient?

Slovenia seems to be building up a comprehensive welfare state where the government accepts responsibility for families and children in a number of areas, including work life and child care. Generally, the policies have two several aims;

1. Developing a comprehensive welfare society with universal arrangements for all citizens.

2. In areas of family life this includes i.e. support for kindergarten, right to parental leave in connection with child births and children's disease.
3. Support to disadvantaged children and families, i.e. child benefits, subsidised school meals and economic support.

The programme for children and youth has an explicit focus on reducing social inequalities in health. Even though the term "social gradient" is not mentioned in the documents, the universal, structural measures that have been introduced would contribute to reducing the differences between social groups.

Comprehensive approaches/Intersectoral collaboration

As shown above, policies in a number of areas are suggested to improve the quality of life and reduce social inequalities in health. The policies cover many areas of society, like health, social services, schools and work life. Even though the term social gradient is not used, several structural measures are in place, among them a progressive tax system, where persons with low income pay less income tax.

Health inequalities as a wicked issue

There seems to be recognition in Slovenia that health inequalities is a wicked issue, and that it may be difficult to reach all national objectives. One example mentioned are the social services. Even though the majority of the population is guaranteed access to welfare services, there are limitations. Services are not adequately built out, and there is still limited service provision so that all who are entitled to services don't receive them.

Welfare state type

Esping-Andersen's classification of welfare states did not include the former communist countries in the Eastern and Southern parts of Europe. Slovenia belonged to former Yugoslavia, which was not a part of the Soviet sphere, but represented a different form of communism under their leader Tito.

It is interesting to see that Slovenia now aims at building up a comprehensive welfare state. An overall aim of this welfare state is to reduce social inequalities in health, and families and

children are among the most important target groups. An overall aim is to mainstream social policies in a number of areas, like housing, parental leave, child care etc. By introducing universal and structural policies aimed at families with children, Slovenia seems to be moving in the direction of the social democratic type of welfare state.

Sweden

The following Swedish documents were included in the review¹:

Health on equal terms .Government White paper 2002/03:35. (Mål för folkhälsan, Stockholm. Regeringens Proposition 2002/03:35

Government Report 2007/08:110: A renewed public health policy (Regeringens proposition 2007/08:110 En förnyad folkhälsopolitik)

A monitoring system for policies for children. Final report from the working group assigned to develop indicators for a policy for children (Ett uppföljningssystem för barnpolitiken Slutrapport från arbetsgruppen med uppgift att utveckla indikatorer för barnpolitiken Socialdepartementet (Ds 2007:9))

Government report 2007/2208:11 Child policy – a policy for the rights of the child (Regeringens skrivelse 2007/08:111 Barnpolitiken – en politik för barnets rättigheter) Sweden's strategy report for social protection and social inclusion 2008-2010. Ministry of Health and Social Affairs, 2008 – 2010

National Strategy for a developed parental support. The Government 2009 (Nationell strategi för et utvecklad föräldra stöd. Regeringskanselliet 2009).

Governmental paper 2009/10:53 A Strategy for the youth policy. (Regeringens skrivelse 2009/10:53 En strategi för ungdomspolitiken).

Swedish Public Health Institute/ The national board of health and welfare. Swedish lessons from the Marmot commission's report Closing the Gap in a Generation (Statens folkhälsoinstitut/Socialstyrelsen Svenska lärdomar av Marmot-kommissionens rapport Closing the Gap in a Generation).

¹ The titles and the content of the documents have been translated from Swedish by me.

The present and the former conservative/liberal Swedish government has living conditions for families, children and young people as one of their highest priorities, and the policy takes its point of departure in the UN Declaration on the right of the child. The government also points to the fact that Sweden is one of the best countries in world for children to grow up in (p3).

National strategy for developed parental support (Nationell strategi för et utvecklad föräldra stöd. Regeringskanselliet 2009)

The main government strategy over the last years is the National strategy to develop parental support. This is a universal strategy aimed at all families, targeted at children between 0 and 17 years.

The objectives of the strategy is threefold:

1. Increased collaboration between actors and institutions which have activities aimed at persons.
2. Increase the number of health promoting arenas where parents can meet
3. Increase the number of educated actors to support parents.

Among the suggested measures is economic support to families that choose to stay home with their children below 3 years of age, or more specifically don't use public child care institutions.

Governmental paper 2009/10:53 A Strategy for the youth policy (Regeringens skrivelse 2009/10:53 En strategi för ungdomspolitiken,

The Swedish government has also recently launched a new strategy for youth policy. The target group for the youth policy is all young people between 13 and 25 years. A national youth policy has existed in Sweden for a long period of time and has developed from a focus on leisure time and cultural activities to a comprehensive perspective on the living conditions for young people.

The overall targets for the present youth policy is that all young people should have access to welfare and influence in society .It is acknowledged that young people may be different and that different living conditions exist. A monitoring system to follow up on the living

conditions for young people is being developed. However, there are no specific policies aimed at reducing socio-economic differences, and no mentioning of using the monitoring system to map the situation in order to reduce social inequalities.

Health on equal terms. Government White paper 2002/03:35. (Mål för folkhälsan, Stockholm. Regeringens Proposition 2002/03:35)

The Swedish public health policy that was launched in 2003 has its main focus on health determinants. It has got 11 areas of priorities. The policy was initiated and implemented by the social democratic government.

A renewed public health policy. Government White paper 2007/08:110 (Regeringens Proposition 2007/08:110 (2008): En fornyad folkhälsopolitik, Stockholm: Sveriges Socialdepartement)

In 2008 the conservative/liberal government published a report called “renewed public health policy” which was a revision of the report “Health on equal terms” which was published in 2002. The report has a stronger emphasis on the personal responsibility for health and life style issues and health education are the preferred strategies.

Swedish Public Health Institute/ The national board of health and welfare. Swedish lessons from the Marmot commission’s report Closing the Gap in a Generation (Statens folkhälsoinstitut/Socialstyrelsen Svenska lärdomar av Marmot-kommissionens rapport Closing the Gap in a Generation).

The Swedish review was based on the template from the Marmot review. The reports aimed at identifying the situation in Sweden and develop tools to monitor health inequalities. In general social differences in mortality and morbidity are increasing, reflecting the social gradient in health. The situation for children in general are good, but children from who are exposed to difficult circumstances (low socio-economic status, parents’ excessive use of alcohol etc) are at risk for developing problems. Among young people the mental health problems have increased, independent of social background.

Discussion

Addressing the social gradient

The present government has a strong focus on children and adolescents, but there is no explicit focus on reducing social inequalities in health in the recent policy documents.

However, the policy document outlining the Swedish strategies for social protection and social inclusion takes its point of departure in the Swedish welfare model, where redistribution and social equity are explicit aims. Swedish policy in this area will continue to build on the model of universal policies, combined with measures targeted at disadvantaged groups.

Sweden has published a national report based on the final report from the Marmot commission. The report describes and discusses the Swedish situation within the areas outlined by the Marmot commission and makes suggestions where and how the situation may be improved. The report was commissioned by the present government. At the moment it is unclear if and how the report will influence government policies.

Health inequalities as a wicked issue

In Sweden there seems to be a shift in priorities from the social democratic to the liberal-conservative government. In the recent documents regarding families and children, there is no explicit focus on the social inequalities in health. The main aim of the policy is to support families, especially parents in their role as care givers. On one hand the policy aims to strengthen the parent's role, but on the other hand structural measures are introduced, like counselling for all parents.

The policy that supports parents for not having their children in public day care, has raised debate and the conflict dimensions run through the right-left political axis. The political left views this as undermining the public child care arrangements and even the social democratic welfare state, since the money may be spent on private child care arrangements.

The revisions of the Public health policy also illustrates that reducing social inequalities in health is a wicked and political issue. A Swedish “Marmot” review was undertaken, but it has not gained status as a policy document, it was even difficult to retrieve from the web-pages of the National Public health Institute which were responsible for the publication of the report.

Comprehensive approaches/Intersectoral collaboration

The current policy documents reflect comprehensive inter-sectoral collaboration among relevant institutions in the policies aimed at children and families. Also the public health policy argues for contribution from many sectors of society.

However, at the moment Sweden does not have an explicit policy aiming at reducing social inequalities in health. In the assessment of Sweden, this finding has to be balanced against the comprehensive family and public health policies and the extensive universal welfare state arrangements.

Welfare state type

Sweden belongs to the Social democratic welfare state regime, according to Esping-Andersen and has a long tradition of providing structural and universal services for the population, including strong family policies.

The present government seems to continue this tradition. When assessing the Swedish policy, it is not enough to study the explicit policies issued by the national government. It is also necessary to look at the political structures and support systems. A strong characteristic of the social democratic welfare states, where Sweden is an example, is the government responsibility for families, which manifests itself in generous welfare arrangements, like housing support and subsidised full day child care. Furthermore, there is an element of redistribution built into the system, in principle aims at reducing social inequalities among social groups. Welfare state type thus needs to be taken into account when assessing the Swedish policy.

Comparing four countries

All the four countries have policies in place for children and families, and these policies are also high on the political agenda in all the countries. The policies are both general policies regarding education, and general welfare policies for families and children. All countries also have public health policies in place and children are a main target group in all the countries. However, the policies have different focus in the four countries, and in the following the similarities and differences will be discussed along the same dimensions as each country was analysed, but in a slightly different order.

Focussing on the social gradient

None of the four countries have an explicit policy to reduce the social gradient in health. England had and Slovenia has an overall objective to reduce social inequalities in health. The strategies are, however somewhat different between the two countries. While England had a policy mainly aimed at supporting vulnerable groups and geographic areas, Slovenia combines targeted measures with universal support to families and children, like rights to parental leave and subsidised day care and pre school for all. Slovenia has thus introduced policies that will contribute in reducing the social gradient.

Neither Sweden nor the Netherlands have formulated explicit aims to reduce social inequalities in health. In both countries there is mentioning of supporting disadvantaged groups, but this is not the dominant focus in the documents. There are however, clear differences between the two countries. In the Dutch documents the families' responsibility for the health and wellbeing of children is strongly emphasised. In Sweden a policy to support parents in their role is also strongly emphasised. The main difference between the Dutch and the Swedish policies seem to be that the Swedish government recognises its responsibility in this matter and suggests universal measures to support families in their role as parents.

Comprehensive strategies/intersectoral collaboration

All countries have comprehensive, inter-sectoral policies in place for children and families. The Netherlands should be particularly mentioned, having a Ministry for children and families with a portfolio from all ministries with responsibility for children.

The two countries with particular policies aimed at reducing social inequalities in health also have developed comprehensive intersectoral institutional arrangements. England has been building on their governmental structures particularly aiming at committing both the national and the local level. Also non-governmental actors have been strongly involved.

Slovenia is also developing policies in a number of sectors to develop their family policies, where reducing social inequalities is an important objective.

Welfare regimes

The four countries participating in this study represent different welfare regimes. An important question is therefore if the differences between the countries reflect the welfare regime each belongs to. The conclusion so far is that they do to some extent, but that there are elements that don't fit in.

England belongs to the liberal welfare regime, where the main ideology is that government should be passive and that families basically are a part of the private sphere. This picture does not fit with the English policies over the last 13 years. On the contrary, families have been at the core of the policies and interventions aimed at reducing social inequalities in health. On the other side, the measures are mainly targeted at disadvantaged groups and areas, which would be in line with the ideology of the liberal welfare regime.

The social democratic regime is at the other end of the continuum regarding policy interventions in the family sphere, and families are one of the main target groups for policy interventions. Reducing social inequalities in health is at the core of the social democratic regime, and therefore it may seem like a paradox that the Swedish policy does not have this as an aim. On the other hand, the Swedish welfare system exists as a buffer and provides the basic protection against poverty and there is a basic ideology of redistribution via the tax system.

As a former communist country, Slovenia is not part of Esping-Andersen's typology. Slovenia seems to be in the process of building up a comprehensive welfare state, with clear characteristics from the social democratic regime. Family policy is an important area to build the welfare state and the principles of redistribution among socioeconomic groups are introduced, both in taxation and also in welfare arrangements for families.

The Netherlands seems to be the country most representative for the welfare regime it belongs to. In the conservative countries family policies are regarded as a main responsibility for the families themselves and the government enters when the family systems break down. The families' main responsibility for bringing up children is strongly emphasised in the Dutch policy documents and measures are mostly aimed at children and families who fail these tasks. There is no aim to reduce social inequalities in health, but there is recognition that disadvantaged groups may need extra support.

Health inequalities as a wicked issue

Health inequalities are a so-called wicked political issue. There are no clear cut "correct" solutions to the problem and it is a highly politicised issue. Based on their traditions left wing parties will support policies to reduce social inequalities, while conservative government seldom has this issue high on their political agenda.

In England the wickedness of the problem has been quite visible. After the conservative regime of Margaret Thatcher, social inequalities has increased dramatically in the UK and particularly hit poor families with children hard. The first Labour government saw the improvement of living conditions for these groups as one of their most important tasks when they came into office in 1997. This is the background for the strong efforts to reduce health inequalities in the UK.

In the Netherlands a conservative government has been in government most of the last years. In the Netherlands the problem of inequalities have held no high priority. The term inequality is not mentioned in political documents. It seems that the issue has been redefined into a "tame" issue, being a question of parent' responsibility for the upbringing of their children and the strategies are mainly interventions to adopt healthy life styles.

Sweden has also taken a conservative turn, and even if the policies of the government builds on the Swedish welfare model, the focus on the social determinants of health applied by the former social democratic government has been adjusted and the policies are more clearly aimed at changing individual life styles. The issue of social inequalities is not mentioned in the policy documents.

As a former communist country Slovenia had a good social security net, and in many of the Eastern European countries the security nets have been replaced by market oriented health care solutions based on individual insurance schemes. At the same time social services and job security have been reduced. Slovenia seems to have moved in a different direction being the only among the four countries to build up and develop a comprehensive welfare state. The government in office is social democratic.

Conclusions

In all the four countries there are policies aimed at families and children. However, only England and Slovenia the policies explicitly aim to reduce social inequalities in health, and none of the countries aim to reduce the social gradient in health. Slovenia and Sweden have developed universal, redistributive policies aimed at children and families, these policies may contribute to levelling the social gradient.

All the countries represent the welfare regimes they belong to, but in all countries there are characteristics that do not fit well with the ideal model. Politics seems to contribute to this, it seems that social democratic governments would address the issues of inequality more seriously than conservative governments, independent of the welfare regime the country belong to.

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