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ORIGINAL ARTICLE

Are universal measures sufficient in reducing child poverty in the Nordic countries? An analysis of policies and political commitments

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Abstract

Background: The five Nordic countries (Denmark, Finland, Iceland, Norway and Sweden) have long traditions of social welfare policies that have eradicated poverty as part of their goals. The purpose of this study was to increase our understanding of why child poverty is still significant in the Nordic countries despite existing strategies. *Methods:* A qualitative analysis of Nordic government documents and reports between 2007 and 2019 was carried out to track changes in public health priorities and political measures and to determine the similarities and differences between the five countries. *Results:* In all countries, most of the measures were universal, such as benefits during pregnancy, paid parental leave before and after the child was born, paid parental leave related to children's sickness, child allowances, day care, free health care for children and support for disabled children. National policies aimed to reduce social inequalities and child poverty exist in all five countries, but unaffordable housing, unequal disposable family income distribution and unequal income distribution at local municipality levels seem to be obstacles to reaching national policy goals. ***Conclusions:* Despite comprehensive universal measures to eradicate child poverty, inequalities are significant and increasing in some of the Nordic countries. This might be due to a lack of proportional universalism, where universal measures are in place in all Nordic countries, but with a lack of scale and intensity proportional to the children and families at risk. The significance of eliminating social inequalities needs to be emphasised at the local level.**

Keywords: *Nordic countries, child poverty, policy, document analysis, social welfare model, social determinants of health*

Background

Growing up in economic poverty is a threat to the well-being and life chances of children and adolescents [1]. Economic poverty in childhood is associated with poorer educational, social and psychological outcomes and is a predictor of long-term ill-health [2]. Growing up in poverty means starting life at a disadvantage [3]. The World Health Organization [4] emphasises that health and well-being are essential to global wealth and sustainable development and that this requires collective action, good governance and political commitment to promote social equity.

The five Nordic countries (Denmark, Finland, Iceland, Norway and Sweden) have long traditions of social welfare policies that are fairly similar to each other. They are classified by Esping-Andersen [5] as social democratic welfare states characterised by solidarity, universalism and the redistribution of resources among social groups, mainly through a progressive tax system. In addition, groups at risk of poverty (such as

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children of single, unemployed, low-educated or immigrant parents) are entitled to individually assessed subsidies.

Responsibility is shared between the state, regional and local/municipal levels [6,7]. In all the Nordic countries, the local level has the main responsibility for services that are important in reducing social inequalities in health, such as schools, day care, elderly care and social services. Municipalities have an independent role to prioritise services. The municipalities are funded partly by local taxes and partly by grants from national budgets and they must make their priorities based on their budgets. National governments mostly have soft governing tools, such as advice and information, at their disposal. This means that even if legislation and policies are in place to reduce social inequalities, national governments have few governing tools to control implementation in the municipalities [8]. As a result of decentralisation and local government, differences in policies and measures may thus occur at the local level. We compared national policies in the five Nordic countries.

Poverty eradication is an implicit part of the ideology behind the social democratic welfare state model [9], followed by the fact that the Nordic countries have fewer income inequalities than most other countries [10,11]. Social inequalities are still, however, a profound problem in the Nordic countries and increasing social inequalities have been identified [12–16]. When economic poverty is addressed in public documents and statistics from the Nordic countries, the concepts of relative poverty and risk of poverty (ROP) are applied and children living in a household with a disposable income <60% of the median equivalised disposable income are considered to live in economic poverty [17]. Despite a long tradition of social welfare policies and poverty rates below the average for Europe [18,19] between 10 and 20% of Nordic children are living in economic poverty and, particularly in Sweden and Norway, the proportion has been increasing during the 2000s [17–19]. The characteristics of children living in economic poverty are similar in the five countries and are related to their parents' level of education and employment, single-parent households and – in Denmark, Norway and Sweden – the immigrant background. In Finland, poverty among children is linked to low income in employed households [17].

Children living in economic poverty are likely to suffer larger shortages than children in more well-off families. However, even though Nordic families with children have experienced increasing economic difficulties during the last decade, Povlsen et al. [17] concluded that economic poverty rates are not necessarily connected to the families' ability to make their money last. This could suggest that social benefits and political strategies, at least to some extent, may compensate and act as buffers for the consequences of living in economic poverty.

Present challenges and ways to establish social equality

Economic poverty may be conceptualised as a problem for only a minor disadvantaged part of the population, but it may also be seen as a structural problem [9]. In the latter case, the political focus should not merely be on improving the conditions of economically poor groups, but also focus on reducing the steepness of the social gradient. Marmot et al. [20] recommended universal actions with a scale and intensity proportional to the level of disadvantage (i.e. proportionate universalism). Universal measures, such as high-quality day care institutions for all children, would, for example, be vital. An example of proportionate measures could be that children with special needs are particularly addressed in these institutions. Marmot et al. [20] argue that the actions taken by society to reduce inequalities and increase health and well-being are the most important measures because these actions will subsequently lead to economic benefits as a result of fewer public payments and increased tax revenue. Because the social democratic welfare model is primarily financed by taxes, it presupposes a high rate of solidarity and employment [6]. The model has been challenged during recent decades, not least by major societal changes as the consequence of increased neoliberalism, migration, globalisation, an ageing population and a labour market with an increasing need for skilled and specialised workers [6,21–23].

Lynch [24] states that one important component of the wider political environment is the dominant neoliberal economic policy paradigm, which creates obstacles to reducing social inequalities. Instead of focusing on social inequalities in health, the problem may be reduced to individual problems or problems for particular groups. This, in turn, would influence which policies and measures are suggested and make it more difficult to address the social determinants of health and apply structural measures.

The economic poverty among Nordic children and adolescents is most prominent among the children of single parents, the children of unemployed parents, the children of low-educated parents and the children of parents with an immigrant background [17,25,26], which indicates a clear risk that the social gradient may not only be maintained, but even steepened. There is therefore a need to explore the social and political measures in the Nordic countries that may moderate the consequences of economic poverty in childhood and thereby improve the life chances of children at ROP. The purpose of this paper is to increase our understanding of how child poverty is significant among the Nordic countries by exploring and comparing the similarities and differences between these countries regarding strategies to counteract childhood poverty and inequality.

Methods

When comparing different countries, it is vital to have an understanding of the institutional contexts of the countries studied and to classify institutional differences across countries. Vining and Weimer [27] outlined two different types of comparative studies: the study of the institutional design itself and the policy instruments used as mechanisms of the institutional design. Although the first tradition has its focus on policy design, including the content of the policy, the second tradition studies the implementation of policies. This study focused on the design of policies, analysing the content of national documents as the source of data. Document analysis is a research strategy within qualitative methods [28]. When using documents as a data source, it is important to study them in context and to understand the purpose of the documents. It is also important to critically assess the authenticity, credibility, representativity and meaning of the documents [29]. We used authoritative political documents such as government white papers and government action plans as our data sources. Political documents usually meet the criteria of authenticity and credibility because they are expressions of formulated government policies. Representativity in this context is linked to the question of whether the document is typical or atypical.

There are limitations to using political documents as the sole source of data because 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. Most research shows that, in many policies, there is a discrepancy between the intentions and the implemented results [29]. However, policy documents still serve as valuable data sources because they are produced by governments and have credibility and authority. They serve as guiding principles and tools for government action and thus reflect government ideology and intentions regarding the choice of policy instruments to deal with policies regarding health promotion and health inequalities.

National documents (from 2007 to 2019) were collected and analysed during 2017–2019 by the authors, who are all fluent in one or more of the Nordic languages. The documents included central political statements, national strategies, government documents and reports that were accessible from the official and public websites of the central national authorities in each of the five Nordic countries (see Appendix 1).

Even though there are strong similarities between the Nordic countries regarding political administration and organisation, there are also some differences. These differences also reflect the fact that the countries use documents from different sources in their policy-making [30]. Examples of this can be policy documents issued by international organisations (e.g. the United Nations), non-governmental organisations and even research. The timeline and significance of political documents may vary between countries. This means that concrete policies cannot always be directly compared, although the profile and content of the policies can be understood in the broader context applied in this paper.

We applied qualitative document analysis [28] by systematically reviewing and evaluating selected documents to elicit meaning, gain understanding and develop new knowledge. The analysis process included data selection, thorough reading and interpretation of the documents, and the selection of data units within the documents contributing to the issues being explored. According to Bowen [28], documents can provide data on the context within which research participants operate as well as historical insights, which may allow comparisons between contexts. Background information based on national strategies and various government documents and reports helped our group of Nordic researchers to understand the historical roots of the issues connected to our main study question. This enabled us to describe the conditions that impinge the phenomenon of child poverty in the Nordic countries. Documents over a time period of a decade and during various governments provided us a means of tracking changes in public health priorities and the strategic focus regarding tackling child poverty. The documents provided us with both background and context, data to ask more detailed analytical questions and the means of tracking similarities and differences between the countries.

The documents referred to in the Results section are marked with an asterisk (*) in the text and can be found in Appendix 1. In the first round of document review, we identified meaningful and relevant passages of text or other data to answer the study questions. The data extraction and analysis entailed identifying and selecting text and data contained in the included documents and was guided by the following research questions: (a) what are the national level policy initiatives to limit or eliminate the consequences of living in economic poverty during childhood and adolescence; (b) which social benefits and services are currently provided to families with children in general – and to families with children living in economic poverty exclusively; and (c) what are the similarities and differences between the Nordic countries regarding strategies to counteract childhood poverty and inequality?

The selection of the text extractions to be included was discussed continuously, agreed in Skype meetings and confirmed in writing via email. The process involved several rounds of careful, more focused rereading and review of the data. To distinguish the similarities and differences between the Nordic countries of the benefits, we decided on predefined codes (the sub-questions/indicators in Table I) to guide our extraction of data from the texts.

Our basic research approach was a qualitative description which, according to Sandelowski [30], is not highly interpretive, but aims to present the facts of the case or phenomenon in concern in everyday language. Qualitative description offers a comprehensive summary of an event in the everyday terms of the events and is especially useful in obtaining straight and largely simple pragmatic answers to questions of special relevance to practitioners and policy-makers.

Ethical issues

No ethical approval by an ethics committee was required for this study because it was based exclusively on documents publicly available from the websites of the ministries and public health organisations and did not involve any human participants.

Results

The first part of these results consists of a compressed description of how the governments in the five Nordic countries have addressed issues concerning children and adolescents at ROP and the increasing inequality in society from 2007 to 2019. The second part describes national initiatives to eliminate the consequences of living in economic poverty during childhood and adolescence. The third part compares the social benefits and services provided to families with children and to families with children living in economic poverty.

National level policy initiatives to limit or eliminate the consequences of living in economic poverty during childhood and adolescence

Denmark. In Denmark, all governments from 2008 onwards described intentions to initiate special measures to improve the conditions of children, adolescents and adults at ROP. However, the social benefits for families and children at ROP have changed with changes in political commitment. In the last 10 years, some social benefits for the poorest in society have been scrutinised (*Ministry of Finance 2012, *2016; *Regeringen 2019). Some of the recent cuts to these social benefits are expected to double the proportion of Danish children living in poverty (*AE 2016). Some of the successful interventions for reducing the vulnerability of children and adolescents have been prevention-focused (e.g. relief care, contacts, personal advisers) and placements (e.g. foster care, residential homes, boarding schools) (*SFI 2010).

Finland. All Finnish governments of the last decade have described intentions to improve the living conditions of children. The Finnish welfare system aims to prevent children from falling into extreme poverty. However, several weaknesses in the system seem to cause problems, particularly for single-parent families and families with several children (*Sauli et al. 2014).

The emphasis of the Finnish Child and Family Policy (*MSAH 2013; *Sauli et al. 2014) has been on strengthening fatherhood and ensuring an adequate level of income for all families. Support for families consists of three elements: financial support, services and family leave. Family benefits are aimed at offsetting some of the costs resulting from children and therefore at emphasising society's shared responsibility for children and the prerequisites for their well-being. The most important forms of support for families are child benefit and day care services (*MSAH 2013). The comprehensive school student health care and student counselling (by curator) system in Finland have significantly prevented social exclusion (*Valtioneuvosto 2013). The Finnish government's social guarantee programme for young people to ensure their education an important part of tackling the risk of exclusion (*Valtioneuvosto 2013).

Iceland. The single most distinct initiative on behalf of Icelandic governments to tackle poverty in Iceland is the setup of Welfare Watch in 2009 to monitor the consequences of the financial crisis and propose measures to counteract these. Welfare Watch is an adviser to the government and is expected to submit reports to the Minister of Social Affairs to address specific subjects and proposals for improvements that the authorities will decide on at any given time (*Governmental Office 2019).

The social transfers in Iceland seem to be effective in raising many people above the minimum thresholds of income (*Stefánsson 2019). Nevertheless, there are also indications that these social transfers only raise people just above the minimum thresholds,

Table I. Social benefits and services in 2019 for Nordic families with children aged 0–17 years[a].

	Denmark	Finland	Iceland	Norway	Sweden
Benefits during pregnancy	Health controls during pregnancy free of charge for all pregnant women[b] Employed women entitled to paid leave for pregnancy controls[b] If being employed in a job that poses a risk to the mother or baby's health, then the employer must find suitable alternative work for the mother[c]	Health controls during pregnancy are free of charge for all pregnant women[b] After five months of pregnancy, both parents are entitled to a maternity grant, either a tax-free sum or a package containing baby clothes and care products[b]	Health controls during pregnancy are free of charge for all pregnant women[b] Employed women are entitled to paid leave for pregnancy controls[b]	Health controls during pregnancy are free of charge for all pregnant women[b] Employed women are entitled to paid leave for the pregnancy controls[b] An employed woman may be entitled to pregnancy support from the state if she is not able to do her ordinary work and it is not possible to find suitable alternative work for her[c]	Health controls during pregnancy are free of charge for all pregnant women[b]
Paid parental leave (total)	Total of 52 weeks (children aged 0–9 years) [b]	Total of 44 weeks (children aged 0–3 years)[b]	Total of nine months (children aged 0–2 years)[b]	Total of 49 weeks (children aged 0–3 years)[b]	Total of 480 days (children aged 0–8 years)[b]
Father or other partners right to parental leave	Two weeks immediately after the birth and 32 weeks to be split between the mother and other parent (children aged 0–9 years)[b]	Nine weeks in total; can be taken in several shorter periods (children aged 0–2 years)[b]	Of the total of 36 weeks, 12 weeks are conditional to each of the parents and there are also 12 weeks that the parents willingly can share[b]	Two weeks immediately after the birth; whether this is paid leave is negotiated between the employer and the employee	Two weeks immediately after the birth[b] 90 days of the total parental leave can only be used by either of the parents, i.e. it cannot be transferred to the other parent[b]
Parents' care of sick child (mother or father/partner)	Parents of children aged 0–17 years are entitled to be absent from work in case of acute illness or accidents for a maximum of 52 weeks within a period of 18 months[b] Most employees are paid a normal salary for the first day of absence Special, individual subsidies are possible in case of severe disease and disability[c]	Parents of children aged 0–10 years are entitled to stay away from work for a maximum of four days in case of acute illness[b] Employers are not required to pay a salary during temporary childcare leave Parents who undertake the care of a seriously ill or disabled child aged 0–16 years receive special care allowances[c]	Parents of children aged 0–12 years are entitled to 12 days of absence with salary each per year to take care of their children in case of illness or accidents; this is included in the collective wage agreements, but can differ between trade unions[b]	Parents of children aged 0–12 years have the right to 10–15 days of paid leave when the children are sick; the number of days depends on the number of children[b] A single parent or parents with chronically ill or disabled children may have the right for more days[c]	Parents of children aged eight months to 12 years are entitled to paid leave for a maximum of 120 days per year caring for a sick child. This is an income-based reimbursement up to 80% of salary[b]
Paid child and youth allowance	For children aged 0–14 years and young people aged 15–17 years; not income-based[b] Single parents, parents in education, and low-income families are entitled to additional economic subsidies[c]	For children aged 0–14 years and young people aged 15–17 years; not income-based[b]	For children aged 0–18 years; income-based[b]	For children aged 0–18 years. A single parent with a child under 18 years is entitled to a higher child benefit[b] A cash benefit for parents of infants aged 13–23 months for families who do not have their child in a kindergarten in that period[b]	For children aged 0–16 years; not income-based[b] Families with more than one child receive an extra family supplement, which increases with each additional child[b]
Day care (nursery, kindergarten, before- and after-school care, clubs for adolescents)	Children aged 0–17 years are entitled to day care[b] Regulations and prices set by communities[b] Based on income, parents may apply for a subsidy or exception from paying Children from 26 weeks to 6 years are entitled to nursery (from 6 months to 3 years) and kindergarten (for three to six years)[b] Parents can take care of their child before school age by applying a child home care allowance fee[b] From six years, school children are entitled to after-school care, where different pedagogical activities are initiated[b] Children aged 10–18 years may join leisure, junior and youth clubs[b] Special individual subsidies are possible, also for additional support[c]	Children aged 0–6 years are entitled to day care[b] Regulations and prices set by communities and most often income-based[b] Morning and afternoon activities (playing, doing homework, snacks) before or after school, towards income-based fee for school children aged 7–8 years as well as pupils in other age ranges if taken or transferred to a special education[b] If a father or mother (or care-giver) takes care of a child <3 years old at home, the parent can apply for child home care allowance[c] Special individual subsidies possible, also for additional support[c]	Children aged 0–6 years are entitled to day care in form of preschool. The preschools are considered the first stage of the educational system[b] Regulations and prices set by municipalities at maximum charge of the actual mean cost for placement of one child; in some municipalities the child has access to the preschool first at age 1–2 years, then the parents have the possibility of access to day care in private homes at subsidised costs[b]	Children aged 1–6 years are entitled to day care. The municipalities decide how much families should pay and whether to have lower payments for low-income groups (maximum 4000 NOK/month)[b] 20 hours a week free time for low-income families[c] Children aged 3–5 years are entitled to "core time" The target group is immigrant families with unemployed mother/parents[c] All municipalities are mandated to provide day care and activities for children before and after school. This is partly financed by parental pay. Some municipalities offer price reduction for low-income families[c]	Children aged 1–6 years with parents who work or study are entitled to full day care/preschool. Children of unemployed parents and parents on maternity leave are entitled to a minimum of 15 hours per week. Regulations and costs are set by municipalities and are income-based, but with a limit to maximum charge. School children <13 years of age are entitled to school-based leisure home/hours before and after school[b]
Child health care (includes hospitals, doctors, health visitors and dentists)	Children aged 0–17 years are entitled to free health care, including regular check-ups and vaccinations; dental care is free until 18 years of age; expenses for medicines are subsidised[b] Special, individual subsidies possible[c]	Children aged 0–17 years are entitled to free health care, including regular check-ups, vaccinations and dental care; expenses for medicines are subsidised [b] Special, individual subsidies possible[c]	Children aged 0–18 years are entitled to free health care, including regular check-ups and vaccinations; emergency ward is free of charge for children; primary and specialist health care does not have a consultation fee; expenses for medicines are subsidised[b] Dental care is free until 18 years, except for an annual consultation fee [b]	Children aged 0–18 years are entitled to free health care, including vaccinations and regular check-ups; free dental care for children aged 3–18 years and 19–20 year olds receive subsidised dental care[b] People with a low income may apply for economic support for dental care[c]	Children aged 0–18 years receive free vaccinations, child and school health care, regular health care and free hospital treatment; dental care is free of charge to children and young people up to 23 years of age[b]

(Continued)

Table 1. (Continued)

	Denmark	Finland	Iceland	Norway	Sweden
Aids and appliances for children with disabilities	Children aged 0–17 years are entitled to borrow or receive subsidies for purchase of aids[b] Special individual education, support and subsidies possible[c]	Children aged 0–17 years are entitled to borrow or receive subsidies for purchase of aids[b] Special individual education, support and subsidies possible[c]	Children aged 0–17 years are entitled to borrow or receive subsidies for purchase of aids[b] Parents can receive care benefits[c]	Several arrangements for parents with disabilities (including disease or injury); nursing support for long-term need for parental leave; to receive nursing support, you must have had some source of income, either paid employment or some public benefits. If the need for support is permanent, there are other types of economic support for parents and children, including support for aids[c]	Parents of children aged 0–18 years are entitled to apply for care subsidy and/or personal assistance[c] Special individual education, support and subsidies are possible[c]
Primary and upper secondary education	Children must complete 10 years of education. Public schools include books and necessary aids such as school nurses, psychological and pedagogical support are free of charge[b] Parents can choose to pay for private schools or private education[c]	Children must complete 10 years of education. Public schools include books and necessary aids such as school nurses, psychological and pedagogical support are free of charge[b] Parents can choose to pay for private schools or private education[c]	Children must complete 10 years of education. Public schools include books and necessary aids such as school nurses, psychological and pedagogical support are free of charge[b] It differs between municipalities whether personal writing material (e.g. pencils, notebooks) is provided, but in most cases the child must bring themselves[c] Parents can choose to pay for private schools or private education[c]	Children must complete 10 years of education. Public schools include books and necessary aids such as school nurses, psychological and pedagogical support are free of charge[b]	Children must complete 10 years of education. Public and private schools include educational material and school health care is free of charge[b]
Free meals in school	Schools choose if they wish to introduce school meals. This is paid for by parents. There are no regulations stating schools must provide (free) meals for students[c]	All children up to upper secondary education are entitles to free school meals, including special diets[b]	All children up to upper secondary school are entitled to school meals, but most municipalities charge a fee[b]	There is no national free school meal scheme; however, there is a trend that both primary, secondary and upper secondary schools offer school meals that are not always free; this varies between schools[c]	All children up to upper secondary school are entitled to free school meals[b]
Upper secondary education – qualifying for higher education, vocational or technical training	Upper secondary education is free of charge; students 18 years or older can apply for study grants[b]	Upper secondary education is free of charge; students 18 years or older can apply for study grants[b]	Public upper secondary schools have a registration fee of a maximum 95 EUR/year; writing material, books and other school material are not included; public schools have permission to charge the students the cost price for some items (e.g. printouts, photocopying, lockers, car parking and access to software)[c]	Upper secondary school is universal and free of charge[b]	Upper secondary education is free of charge; students from the age of 16 years are entitled to study grants
Leisure activities and sports	Covered by the welfare check that all parents receive[b] Families can receive a subsidy to cover costs of leisure activities and equipment[c] Special individual subsidies possible[c]	Special individual subsidies possible[c]	Each child receives a yearly subsidy to cover costs for leisure time activities; the amount varies between municipalities (about 160–400 EUR/child/year)[b]	Leisure activities cost money, but several municipalities support low-income families with equipment and fees[c]	Municipalities support organisations that offer children's leisure, culture and sports activities; the financial support varies between municipalities[c] Special individual subsidies possible[c]

[a]The information provided applies to the large majority of families with children aged 0–17 years, but potentially not to all.
[b]Universal, for all families irrespective of income.
[c]Individual, case-specific.

which is not providing poor people with a sustainable shelter from poverty. Public spending for social transfers supporting families decreased following the financial crisis in 2008 and have not increased again despite increased prosperity.

In 2015, Welfare Watch proposed specific measures to be taken to improve the conditions for children in low-income families (*Ministry of Welfare 2015). To what extent these measures have been realised is unclear, but some steps have been taken. Appointing a Minster of Children's Affairs in 2019 can be considered as a step in the right direction.

Norway. In Norway, the issue of social inequalities has become increasingly politicised and the red–green governments' (2005–2013) point of departure was based on an understanding of the social determinants of health and the social gradient in health. The aim was structural reforms to reduce social inequalities. The Public Health Act, adopted in 2012 (*Lov om folkehelsearbeid, 2011), aims to level the social gradient in health by addressing structural factors (e.g. education, housing and the work–life balance) and mandates municipalities to make overviews of the health status of their population. The conservative and conservative/centre governments (2013–2021) still aimed to reduce social inequalities and child poverty, but the emphasis has been more on individual rather than societal measure (*Dahl et al., 2014; *Helsedirektoratet, 2018). This change in direction is reflected in two government public health reports published in 2014 and 2019 (Stortingsmeld nr. 19 (2014–2015), Stortingsmeld 19 (2018–2019)).

The main suggested measures were to improve mental health among children and adolescents and promote physical activity in the population. The municipalities' responsibility for improving the quality of services, such as child care, primary schools and health services for children and adolescents, were emphasised.

Sweden. All Swedish governments from 2006 have given attention to the increase in relative child poverty. The conservative–liberal coalition from 2006 reduced work taxes to encourage work and employment instead of subsidies. The Swedish government of 2014–2018 emphasised strengthening economic equality and combatting unemployment. In 2018, the social democrats and the green party prioritised welfare services and decided to increase the child allowance and the income threshold in the housing allowance.

Although the disposable family income per consumption unit has increased for almost all Swedish family households since beginning of the 21st century, the poverty-reducing effect of the economic family welfare policy was impaired the first decade of this century. In the state budget for 2017, the Swedish government announced an increase in child and youth allowances, but the effects of this has not yet been assessed. Despite these reforms, *Salonen (2019) points out that the Swedish aims of combatting poverty and decreasing differences between households have not been fulfilled.

In 2018, the Swedish government appointed a Commission on Equality to present evidence-based recommendations to reduce the unequal distribution of income. The Commission's final report is under political review (*SOU 2020).

Social benefits and services provided to families with children in general and to families with children living in economic poverty

There are a number of social benefits available in all the Nordic countries. Table I provides an overview of the benefits in each country. The benefits are, to a large extent, comprehensive and universal, such as benefits during pregnancy, paid parental leave before and after a child is born, paid parental leave related to children's sickness, child and youth allowances, day care, free health care for children and support for disabled children. All the Nordic countries also offer aid and appliances free of charge and have a health scheme for children, vaccination programmes and other health programmes, including dental services. Some are also targeted at socially disadvantaged groups. All countries support families with children by an allowance; this is an income-based support in Iceland. Children are entitled to day care in all the Nordic countries. Costs for day care are subsidised and parents pay a monthly fee, which is income-based in all the countries except Iceland, where instead extra subsidies are offered to single parents, students and parents with disability pension.

Ten years of education are compulsory and free of charge in all the Nordic countries. Upper secondary education is free of charge in all countries except Iceland, where there is a registration fee. Support for clothing and personal needs in upper secondary school is universal in Denmark and Norway and targeted in the other countries. Only Finland and Sweden offer free school meals. In the other countries, families pay or are responsible for packed lunches. Even though there is support for leisure activities and sports in all countries, this support is only universal in Denmark and Iceland. In the other Nordic countries, this support is targeted and has different funding schemes.

Discussion: Measures to reduce social inequalities and counteract childhood poverty and inequality

In our research questions, we addressed both how the Nordic countries explicitly address social inequalities in general and the policies aimed at families and children in particular. Our point of departure is an understanding in which we study policies to reduce poverty among families with children in a context of reducing social inequalities in health.

In general, governments in all the Nordic countries have living conditions and the well-being of families and children high on their agenda. There are measures in place in all the Nordic countries to compensate families for lack of income. Norway and Sweden have connected these issues to the social inequality agenda; Norway in their report on Social Inequalities in Health and in the Public Health Act, and Sweden with a new national public health policy that emphasises health inequality. Based on our findings, it is obvious that there are more similarities than differences between the Nordic countries. We found that there are a number of both individual and structural measures available for families with children in all the Nordic countries. Most of the measures are universal in all the Nordic countries, which means they are available for everyone in the relevant target group. There are national policies aimed at reducing social inequalities and child poverty in all five countries, but the measures suggested are to a large extent general/universal and do not compensate children and families at risk to the extent that poverty can be disclosed.

Compared with the global, and even the Western context, the policies and measures aimed at families with children in the Nordic countries are comprehensive [18,19]. However, we are still seeing increasing social inequalities and child poverty in these countries [17]. One explanation for this may be developments such as neoliberalism and globalisation, including increased immigration. Another explanation may be that existing policies and measures lack extent and effectiveness as a result of insufficient political commitment to tackle health inequalities [31].

Michael Marmot's concept of 'proportionate universalism' may be useful in understanding why the rates of child poverty increase even if there are universal welfare measures in place [20,32,33]. According to this concept, in addition to universal measures, it is necessary to also have targeted measures aimed at those who need them most. In the Nordic countries, these measures are mainly a responsibility for local governments – for example day care, schools and social services. These institutions and services have the responsibility to follow up national goals and one of their aims is to compensate for disadvantaged living conditions and poverty. The municipalities have limited budgets and many may struggle to meet the needs of the population, particularly where there is large proportion of disadvantaged families. Immigration, particularly from poorer countries and war zones, increases the pressures on welfare states, where generous welfare arrangements are based on a majority of people paying tax from employment. The decentralisation of service provision is an important feature of the Nordic welfare states and the municipalities are central in providing services and communicate with citizens. Most national policies allow the municipalities to adjust the content of policies to their own context and the relative freedom of the independent municipalities may result in differences in implementation at the local level [34]. This may also increase social inequalities, both between municipalities and between different social groups.

As Lynch [24] describes, addressing the social inequalities in health demands addressing not only the social aspects, but also the political aspects of this problem. When shifting towards an increased focus on the social determinants of health, there is a need to also address the concept of equity, which in the recent literature has been mixed with the concept of equality [35]. The concept of equity in health has been attenuated or even forgotten in the Nordic health promotion context and needs to be re-established. Decision-makers should acknowledge the importance of fair social benefits to the children and families at most ROP. This demands stronger redistributive policies in other areas of society, such as housing and labour market policies. Decision-makers should acknowledge the importance of fair social benefits to the children and families at most ROP, as pointed out by the UNICEF Committee on the Rights of the Child [36] in the fifth periodic report for Sweden [37].

It is necessary to recognise the uneven distribution of resources from national to local levels as a driver for inequality. National governments need to have the issue of reducing social inequalities and poverty on their national agenda. To reach political targets to reduce social inequalities and level the social gradient in health, the national level will have to support the local level more adequately than at present.

Conclusions

The conclusion from our study is that there is still a strong social security system in the Nordic countries, with comprehensive measures for families with children. The measures are mainly universal, although some are targeted, and they capture the needs of most families. However, they do not sufficiently compensate children and families at ROP. There are therefore significant social inequalities that are even increasing in some of the Nordic countries and an extensive number of children still grow up in poverty. The significance of eliminating social inequalities needs to be emphasised at a local level, with a stronger emphasis on directed measures towards risk groups.

Strengths and limitations

The analysed documents were national policy documents, including white papers, green papers and reports. Such documents hold a high level of credibility because they reflect the current policy in the country [29]. The selection of documents for each country was made by researchers with a genuine knowledge of the national context in each of the Nordic countries. Such a preunderstanding is a strength in selecting documents relevant for answering the questions. There is, however, a risk that the documents are not fully comparable as they had been selected by several researchers focusing on one country. Covering a period of 10 years of policy development in this field meant a rough selection of material and we therefore did not provide a complete cover of the policy discourse. However, to our knowledge, there are no previously published articles presenting descriptive facts of the measures taken to eradicate child poverty in the Nordic countries. The strength of summarising the similarities and differences in national policy goals and measures to modify child poverty in the Nordic countries gives an overview of the current state and relevance to politicians, practitioners and policy-makers.

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Appendix 1. National documents and websites included in the analysis.

Denmark	AE. Arbejderbevægelsens Erhvervsråd. The Economic Council of the Labour Movement. *Danmark på fattigdomskurs* [Denmark on poverty course], https://www.ae.dk/publikationer/danmark-paa-fattigdomskurs (2016, accessed October 2019).
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Appendix 1. (Continued)

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