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Access to intervene. An ethnographic study of public health practices targeting health inequalities

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1 **Access to Intervene. An ethnographic study of public health practices targeting health**

2 **inequalities.**

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8

9 **Abstract**

10 Much public health research has devoted attention to the question of how interventions aimed at

11 reducing health inequalities can access so-called 'hard-to-reach' populations. This work has

12 generally reflected an instrumentalist approach, which implies the preexistence of particular target

13 groups characterized by specific public health problems. The key research interests are to find ways

14 to effectively alleviate health inequalities and to identify the best ways to intervene to address

15 disparate health problems among certain groups of people. Based on ethnographic research with

16 public health officers in four Danish municipalities, this article turns the issue on its head by

17 examining how public health officers gain access to intervene in practice and, as part of this

18 process, define and delineate target groups and public health problems. Through detailed

19 descriptions of two ethnographic cases, we develop the argument that public health interventions

20 carry with them moral differentiations that may contradict the overall intention of reducing health

21 inequalities. We adopt a theoretical perspective developed by Lakoff and Collier, suggesting that

22 public health interventions can be understood as 'regimes of living'. This leads us to the conclusion

23 that the practices of gaining access result in the production of unforeseen target groups and new

24 moral configurations where the value of health becomes linked to other types of value, most

1 importantly economic value. For public health officers, the complicated issue of gaining access to
2 intervene is not simply a matter of finding practical solutions; it also defines and delineates the
3 scope of public health itself.
4

1 **Introduction**

2 "*It's relation work really*", the public health officer says as we cross the room to get coffee,
3 "*visiting the others [other departments] and trying to understand what is important to them*". She
4 explains that she always tries to test the waters to understand how busy the schools she is working
5 with are and whether they are preoccupied with other tasks. "*It's about speaking to their everyday*
6 *setting and their needs".* […] to get a sense of when schools might be ready for an enquiry from the
7 municipal public health office to test new interventions related to exercise and movement as part of
8 the curriculum or other health promotion initiatives. A colleague joins in*: "There are different*
9 *'kings' who set and prioritize the agenda, I guess.*". They both laugh and agree that, yes, keeping
10 on good terms with the 'kings' and speaking to their agenda is a priority if you want to get things
11 done around here. *(Field notes, February 2012).*

12

13 Gaining access to implement health interventions in non-health sectors is an important part
14 of public health practice in Danish municipalities (Holt et al., 2018a; Holt et al., 2017; Larsen et al.,
15 2014). As this excerpt illustrates, access is largely driven by relational strategizing and framing. In
16 this article, we argue that practices shaping access to intervene within a population also condition
17 the target group. In this way, negotiating access to intervene is also a process of defining the health
18 problem. A population with more vulnerable health conditions is thus not a constant; it is
19 continuously defined by the process of gaining access to intervene.
20 The question of how to intervene among specific disadvantaged groups within a population
21 is of great concern in public health research and applied health promotion efforts (Bonevski et al.,
22 2014; Marmot et al., 2008). This study aims to explore access practices employed in municipal
23 health promotion to reach and intervene in population groups considered to be at risk for certain
24 health problems. During ethnographic fieldwork with Danish public health officers, access

appeared as an emic notion (Harris, 1976). We noticed that immense efforts were made to gain access to intervene in certain settings and the process of gaining access appeared to be time-consuming and demanding in many ways. This directed our attention to the practices through which access was produced and, further, how those practices influenced the ways in which problems and target groups were delineated in health promotion interventions. We found that access was shaped through the practices of public health officers aiming to place themselves in situations where they could intervene in particular health challenges experienced by specific groups of people. In this article, we demonstrate how the ways in which health inequalities are addressed and target groups are identified are not determined by linear policy implementation processes (Bernier and Clavier, 2011; Hill and Hupe, 2006; Pressman and Wildavsky, 1984) nor exclusively by the discursive framings accompanying perceived solutions (Bacchi, 2016; Koon et al., 2016). To public health officers, gaining access was understood as a practical matter. However, we suggest here that it involves potentially unforeseen ways of defining and delineating public health problems and target groups.

Health promotion interventions are generally either designed as broad interventions targeting the general population with the aim of changing the distribution of ill health across the social gradient or they are designed to promote health equality through targeted interventions in selected population groups (Marmot, 2015; Pons-Vigués et al., 2014). Public health research addressing this issue tends to adopt an instrumentalist approach (Andrain, 1998), which is based on predefined categories of health and seeks to identify the most effective strategies for addressing health inequalities in particular population groups defined by gender, age, socioeconomic characteristics, geographical areas, etc. (Bonevski et al., 2014; Pons-Vigués et al., 2014). From this perspective, access is a matter of reaching the hard-to-reach populations.

Coming from a different theoretical stance, sociological perspectives on interventions targeting health inequalities have looked into the ways in which health inequalities are constructed as an object for intervention (e.g., Blackman et al., 2012; Frohlich & Potvin, 2008). This line of research tends to be concerned with the discursive framing of both health inequalities and the target groups singled out for intervention. A main contribution of this type of research has been to point out that health problems and target groups do not exist independently of interventions and policies addressing them (Frohlich & Potvin, 2008). In contrast to the instrumentalist approach, public health interventions may thus be conceptualized as social technologies that carry with them inherent ideas about the very nature of public health problems and the "publics" that are addressed (Koch and Nordahl Svendsen, 2005). In other words, interventions and policies are not neutral solutions developed in response to problems and target groups that exist *a priori* (cf. also Bacchi, 2009; Blackman et al., 2012). It then becomes pertinent to examine assumptions inherent in particular interventions and policies related to public health problems and target groups.

By tracing such assumptions in our ethnographic material, we examine how access practices shape the intervention objects. This adds to previous discussions of the ideological factors and interests shaping health promotion practices on inequality at a policy level (Baum and Fisher, 2014; Qureshi, 2013; Raphael, 2015) by demonstrating the contingencies of local social practices and their normative implications. We are inspired by Didier Fassin's observation that social practices of governance have immediate or long-term consequences in terms of making or unmaking inequalities of life (Fassin, 2009:55). Biopolitics is not simply a means of exercising power, which normalizes and regulates a population; biopolitics create inequalities in life by 'deciding the sort of life people may or may not live' (Fassin, 2009:49).

Our study examines the ways in which inequalities are made and unmade as the public health intervention object is shaped through processes of gaining access to intervene. Although

1 many interventions are designed with the intention of eradicating health inequalities, they also make
2 moral differentiations and hence generate new types of inequality (ibid.). Through two ethnographic
3 cases, we examine how the intervention object is continuously shaped and reshaped when Danish
4 municipal public health officers seek access to intervene and promote health in the population.
5 These differentiations and the ways they are negotiated, justified, and practiced in shifting social
6 settings are the object of our analysis.
7

8 **Theoretical framework**

9 Our prime theoretical inspiration is Andrew Lakoff and Thomas Collier's notion of
10 "regimes of living" (2004), defined as "congeries of moral reasoning and practice that emerge in
11 situations that present ethical problems – that is, situations in which the question of how to live is at
12 stake" (ibid.:420). We use this concept as an analytical tool to examine the interplay between
13 normative, political, and technical elements in the access practices of public health officers. As
14 noted above, public health interventions carry specific assumptions about health, life, and behaviour
15 and, following Lakoff and Collier, we suggest that they represent particular ways of answering the
16 ethical question "How should one live?". As a regime of living, public health "assumes concrete
17 substantive form only in relation to the exigencies of a given situation, and may even be reshaped,
18 or reworked in a given situation. The relation between a problematic situation and a regime of
19 living can, thus, be understood as one of co-constitution or co-actualization" (Collier & Lakoff,
20 2008:32). Accordingly, we propose that in the process of defining problematic situations to gain
21 access to intervene, public health officers are involved in co-constituting public health as a regime
22 of living. We regard public health interventions as answers to the question "How should one live?",
23 and our analysis will be guided by (1) the techniques and ideas of practice ("how"), (2) the implied
24 notion of the subject ("one"), which in our case involves the delineation of the target group and the

assignment of certain characteristics to a particular category of people, and (3) implicit norms or values ("should") (ibid.: 22). This analytical framework allows us to pay attention to the intricate and situated nature of the practices of public health officers while maintaining an interest in more general characteristics of public health as a regime of living.

The setting

In Denmark, legislative structures and recommendations for health are governed by the state. The local governments of Denmark's 98 municipalities are charged with primary responsibility for health promotion and disease prevention (Andersen and Jensen, 2010). The Danish Health Act states that municipalities are responsible for creating healthy environments. They are in charge of health promotion planning and intervention with a clear policy agenda to integrate public health policies and interventions into non-health municipal services, such as social work, primary education, and unemployment services, as well as to work in partnership with public and private partners outside the municipal jurisdiction to improve health and health equity (Holt et al., 2018b). Great efforts are made by municipal public health officers to ensure intersectoral collaboration in order to gain access to intervene in relevant settings for health promotion (Holt et al., 2017; Holt et al., 2018c). These access practices are of great significance in shaping health inequality as an object of intervention.

Methods, data and analysis

The study was carried out from May 2012 through April 2013 in four municipal health offices that were purposefully selected to represent different sizes (geographical area and number of inhabitants), regions, urban/ rural locations and socioeconomic characteristics. Further, the selected municipalities reflected diverse political constellations and administrative organizations.

The ethnographic fieldwork used interviews and participant observation as research strategies (Hammersley and Atkinson, 2007) to gain insight into the intertwined nature of policy and practice related to individual and collective health challenges and concerns in the municipalities.

Key public health officers were identified in each municipality, and their everyday practices of meetings, negotiations, and project work were the ethnographic focus of participant observation. In addition, we interviewed public health officers, administrative leaders, and politicians engaged with policy and governance of health promotion in each municipality. A researcher followed the work in each of the four public health offices over a period of 3-6 months, depending on the ongoing projects and policy process at the time of fieldwork. The main method was shadowing (Czarniawska, 2014), which meant that we joined officers during their daily professional practices and followed their work at their desks, at meetings, and during lunch and coffee breaks, as well as in informal conversations and discussions with colleagues. During the same period of time, we also participated in national meetings and seminars related to local health promotion issues and presented our project at conferences and network meetings attended by representatives from a broader range of municipalities and the national health authorities. This enabled us to gain broader insights into the experiences of Danish public health officers and provided us with opportunities for refining our findings and testing their applicability beyond the four identified field sites. In keeping with recent developments in social anthropology, we constructed the field not as a bounded place or organization (i.e., the four municipalities) but as a more dynamic entity that emerged through our interaction with a broader set of actors in Danish health promotion (cf. Amit, 2000).

For formal interviews, we developed a template interview guide, which was structured according to the study's main analytical foci. Before specific interviews, we adapted the template to ensure its fit with local conditions and allow us to cover topics and questions that came up during fieldwork.

The head of the health promotion office in each of the four municipalities signed a collaboration agreement with the researchers. Verbal consent was obtained from all individual persons interviewed and shadowed during fieldwork. Data management and security with regard to this study was approved by the Danish Data Protection Agency (j.no. 2012-54-0150). The ethnographic fieldwork and interviews did not address personal identifiable or sensitive data, and no clearance from the Danish National Ethical Review Board could be obtained under Danish research regulations.

The empirical material consisted of field notes, interview transcripts, and documents (meeting minutes, public health policy documents, policy drafts). We began the analytical process by identifying central ethnographic moments across the diverse material from the four field sites and discussing the significance and implication of these moments. Ethnographic moments refer to key interactions in the field representing the matters at stake or the phenomena in question. We combined different material related to ethnographic cases of particular relevance to describe such moments. As Mason points out, ‘contextual’ or ‘holistic’ data organization is useful as an alternative to the more traditional analytical approach of coding or cross-sectional indexing when the objective is to understand ‘intricately interwoven’ parts of a data set relating to complex social processes (Mason, 2002: 166). For the same reason, to document the ethnographic moments in this paper, we recorded our findings through descriptions of particular episodes and practices, rather than singular quotes. We repeatedly read and annotated the material and discussed various analytical points and interpretations. The analytical process proceeded through an abductive movement between the ethnographic moments and different theoretical perspectives (Tavory and Timmermans, 2014).

Based on ethnographic fieldnotes, the findings are presented as two cases that are exemplary of the ethnographic moments that emerged in the analytical process and were refined as cases

1 during the process of writing.

2

3 **Findings**

4 Although the local government makes political decisions to ensure equal access to health in
5 the population, the actual implications of such decisions are largely determined by the agility of
6 public health officers at identifying and negotiating access across the municipal organization and
7 into other arenas by addressing various rationales important to different collaborators. An area of
8 general concern to health policy and of specific concern to the municipalities in this work was the
9 health of young citizens beyond primary education, a group of citizens to which the municipality
10 lacks direct access. This means that alternative access pathways must be pursued to affect lifestyle
11 behaviours that may have detrimental long-term health consequences.

12 *Case 1: Accessing prospective Social and Health Service Helpers*

13 In one municipality, a public health officer initiated a process of developing a lifestyle
14 intervention to improve the physical fitness of students attending a Basic Health Care College that
15 offers vocational education and training for the degree of Social and Health Service Helper
16 (SHSH). The 14-month long educational program focuses on theoretical subjects in health and care
17 and comprises two mandatory vocational periods. A focus on improved physical health of the
18 students was consistent with both general health recommendations and an overall imperative to
19 prevent or reduce inequality in health. The public health officer explained to the researcher that the
20 students were mainly young women with a number of lifestyle challenges, such as smoking, excess
21 weight, and sedentary lifestyles. From the municipal perspective, they represented municipal
22 citizens who may suffer poor health in the future due to risky health behaviors. A concept of a
23 common health risk in this population was established that contained several implicit norms about
24 healthy living and the value of physical activity, which created the moral authority for intervening.

Access to intervene with the student population was achieved through negotiations with college administration and staff about the possibility of developing a collaborative, school-based lifestyle intervention. Through several shared meetings, the public health officer and a teacher collaborated on intervention design and planning. Their discussions revolved around the intervention components they wanted to implement (i.e., increased physical exercise, improved dietary behaviors, and smoking cessation) and how these could fit into the existing framework of the college curriculum with only minor changes and no substantial use of college resources.

On the way to one meeting, the public health officer explained that it was essential to design the intervention based on the educational curriculum and the college's core mission of educating future health care workers. This both ensured that the collaboration was meaningful to teachers, students and college administration and facilitated gaining access. Consequently, in meetings, the public health officer stressed the link between the intervention and the ability of students who had completed training to perform as health care workers for years in a demanding part of the health sector known for high attrition rates. The intervention should convey the need for physical exercise as a way to prevent work-related injuries in the future and teach students about ways to devote time to exercise despite busy work schedules.

Using existing physical education content in the program curriculum as a starting point, the public health officer and teacher aimed to identify students with particular health challenges and intervene through existing educational practices. In this way, they hoped to avoid stigmatization and to promote more social interaction between students who were encouraged to exercise in peer groups. This resulted in the development of the specific intervention, for which the teacher would seek approval from the college dean and engagement from other teachers.

The intervention focused on increasing physical strength, particularly in areas that would be at risk in students' prospective jobs, such as the back and knees. In addition, the intervention would

1 provide dietary advice to students at the outset of the program and referral to municipality smoking
2 cessation courses as needed. Structural modifications to the existing course work included
3 introducing additional physical education courses, giving all students increased access to the gym
4 during and after school hours, and establishing an official agreement with internship nursing homes
5 to allow students to exercise during working hours. The intervention depended on the engagement
6 of teachers and other college staff to support a new culture of physical activity among students
7 during school hours and did not require substantial financial support. In fact, the college required
8 that the intervention was largely integrated within the existing schedule, involving only minor
9 structural modifications to existing course work and few additional resources.
10 Central to negotiating access was the fact that the intervention spoke to key concerns of the
11 college (i.e., students having healthy work lives after completing their education). Linking access
12 practices to the overall problem of work attrition is an illustration of access practices producing a
13 'regime of living', as individual student health became entangled with an agenda of safeguarding
14 the health of prospective employees through physical fitness. Similarly, we found that gaining
15 access to intervene in certain arenas depended on the ability of the public health officer or public
16 health team to frame an intervention as meaningful within the context that was significant to the
17 intervention partner. It takes considerable effort on the part of public health officers to promote
18 health in non-health arenas because they need 'to make health speak to the goals of the other
19 departments' or collaborators in other arenas.
20 This case illustrates the implications that access negotiations have for techniques and ideas
21 of practice that constitute the health problem (e.g., risky health behaviors such as smoking,
22 unhealthy dietary choices, and sedentary lifestyle) and the target group. A number of rationales and
23 present and future interests in shaping the health of students emerged, co-constituting the target
24 group and normative and moral concerns. First, students were regarded as prospective employees of

the municipality because most potential jobs in the social and health care sectors entail municipal employment. This view was associated with the educational rationale of preparing the students for future work in physically demanding jobs involving high levels of musculoskeletal stress that often lead to work-related injury or attrition. A strong and healthy body is key to avoiding future attrition, the health officer explained, and stressed that the intervention with this group of students was at the intersection where the interests of the municipality met those of the college.

Second, he added that the union, which organized students as they entered the labor force, had indicated interest in and support for the project because of its perceived benefits to prospective members. He explained that this was quite unusual because the union tended to oppose the municipality in disputes over work-related injuries and similar concerns. However, in this case, the municipality and the union found common moral ground in maintaining the health of students as prospective union members and employees and formed a collaboration supporting the municipal agenda and access for the intervention. The unusual alliance strengthened the rationale of protecting future workers as an emergent target group for intervention.

Third, another key rationale was that the healthy lifestyle intervention in this group of students would be an investment in preventing or at least minimizing future physical disability expenses for the municipality. Finally, the health officer explained that the young women who were students in the program would eventually become municipality frontline personnel, meeting and caring for municipal citizens. As such, it was important to encourage them to be healthy role models for the citizens they would meet.

These rationales represent a particular framing of risk that delineates the target group in specific ways. The students who would receive the intervention were no longer emerging simply as a group of individuals with well-known risk factors posing a challenge to the political objective of the municipality of ensuring equal health to all. Through access negotiation, established as a social

1 practice of governance that speaks to concerns of a wider number of stakeholders, students emerged
2 as targets for intervention with obligations to live in certain ways. The public health officer framed
3 the public health problem in this group in terms of risky health behaviour and need for positive
4 health changes (exercising, not smoking etc.) to both prevent or reduce potential future individual
5 health problems and increase the sustainability of the students as future employees of the municipal
6 workforce and the alignment of their health-related behaviors with municipal health values.
7 As we have shown, students were defined as a target for intervention with different
8 'imperatives for health' (to paraphrase Lupton, 1995), as prospective role models delivering
9 municipality service, as prospective employees at risk for physical disability due to work-related
10 injury and attrition, and as a vulnerable population at risk for poor health due to negative health
11 behaviours. Access practices situated in the collaboration between the municipal health officer and
12 the college teacher were essential to defining students as a specific target group for health
13 promotion with a particular set of current and potential future health problems.
14 To summarize this case, we suggest that the practices of gaining access to intervene serve to
15 shape public health as a regime of living that involves (1) techniques and ideas of practice where
16 promoting healthy lifestyles must be integrated with existing practices in the schools to avoid using
17 extra resources and (2) an ideal notion of the target group as simultaneously being healthy citizens,
18 responsible potential employees, and future role models. Consequently, the value of individual
19 health becomes linked to a collective responsibility for the future capacity of the health care system.
20 *Case 2: Targeting the ordinary child but accessing the athlete*
21 A recurring question in municipal health promotion practice is how to access the population
22 not reached by current efforts. Targeted strategies, negotiating access, and promoting cross-
23 sectional efforts are some of the approaches taken to prevent and reduce inequality in health.
24 However, once access is obtained, new dilemmas emerge when access practices create new

differentiations and distinctions within a target group. The following ethnographic case illustrates this point.

As part of a policy focus on positive health behaviors among children and adolescents, one municipality we followed had initiated projects to support healthy dietary options in sports centers. A general practice of limiting unhealthy food was intended to incentivize healthy diets. As part of this policy, the health promotion department had collaborated with the municipal culture department to participate in a national project, supported by private foundations and a large patient advocacy organization, to bring healthy food into sports venues and change the sports food culture. The municipality was offered participation in the national project, focusing on the largest sports arena, which was intended to serve as one of four 'lighthouses' nationwide that would set new standards for introducing healthier food in sports environments and implement a food concept and product line developed for the project. The municipality participated in the program with a joint financial endorsement from the municipal health and culture counselors.

During fieldwork, we followed a public health officer to an introductory meeting for the project at the sports center, at which various stakeholders in the project met for the first time. As we were preparing to leave for the meeting, the public health officer explained that the health department found the project interesting because it offered a way to reach the large and diverse population using the sports center for physical exercise or attending sports events. As such, it provided important access to intervene to make healthy dietary options easily available and remove less healthy options, improving dietary behaviors among sports center users. The public health officer explained that the health councilor was particularly concerned about ensuring that the municipality developed health interventions that prevented inequality in health by focusing on the broad population of children and adolescents, to which the sports center provided an access opportunity. Access to intervene depended on collaboration between municipal departments, as

well as with external local and national partners, and the program was financially supported by local politicians.

After the group of stakeholders arrived at the sports center, the general manager a tour of the premises, explaining current food and drink procedures and big events hosted there. The national project manager explained the vision of making changes to the food and drinks selection in the center to reach a population that was usually hard to reach by health promotion interventions. The group agreed that this would be a very desirable project outcome. However, the sports center general manager also stressed the potential for the project to affect revenue, explaining that ice hockey spectators generated five times more profit than spectators at a handball match. He could not afford to lose this profit by not selling beer or sausages at games.

The tour ended at a small cafeteria area, which would be the focus of the intervention with the menu transformed towards healthy food options and the area itself reorganized and redecorated. The cafeteria was adjacent to the indoor swimming pool, and the manager explained that the main customer segment was people who had used the pool.

Back in the meeting room, the national project manager introduced the project, stressing that they wanted to prove that it could be profitable to sell healthy food in sports centers. Financial sustainability was very important to them, she explained. This was why it was important to involve the sports clubs using the center, the key users buying food. Representatives from the municipality said that they expected this to become a flagship project in the municipality that could inspire smaller sports centers.

The other representative from the national project introduced eight personas developed for the project to better understand who was using the sports center and customers who would be buying the new foods in the cafeteria. She asked the group collectively to debate which users to prioritize and describe the kinds of food they were currently eating and asking for.

The manager of the cafeteria held the key insights, and it became immediately apparent that users at this sports center were very different from those at the other sites that had been chosen for the project. The center hosted no large, general sports competitions for children and adolescents. A representative from the talent development department at the center explained that it was primarily a training facility for elite athletes. The center hosted elite sports competitions for child/adolescent athletes once or twice a year, but it was not packed with children and their parents every weekend for regular sports events. Therefore, he saw a need for better dietary options for elite athletes in the cafeteria. He said they needed to eat a lot of protein, and they constantly struggled to teach young athletes how to manage this diet. The manager of the cafeteria confirmed that elite athletes were their primary users. Families also used the swimming pools but did not buy as much food.

This process of user prioritization illustrates how it became increasingly clear that the young users of the sports facility did not reflect the general population. The program would provide access not, as intended, to a large and diverse population but to a select group of young citizens with different dietary challenges than those of youth in the general population. Unexpected differentiations emerged within the intervention target group through this access practice, drawing new lines in access negotiation and the regime of living it constituted.

To sum up this case, the national project representatives concluded that this sports center was clearly very different from the other participating centers, which they found interesting. They wondered if the food options in this center should include other products and options suitable for child and adolescent elite athletes. The national manager said that the main focus of the project was on quality and flavor, and they wanted to provide access to good quality products. For instance, although it wasn't a goal *per se*, they wanted 60% of project foods to be organic. She stressed the aesthetics of food and that the concepts developed by the national project were less about health than about food quality and taste. New value distinctions about food and diets were drawn, with a

moral differentiation of taste and quality that moved beyond the problem of dietary health as it was conceptualized at the outset.

Key actors from the municipality and the national project had all explicitly stressed the ambition that the project would provide access to intervene in the health behaviours of the general population of children and adolescent users of a public facility, including access to disadvantaged and at-risk children and adolescents. However, it became clear that most individuals using this particular facility were not at risk for the health behaviour problems that had been defined at the outset. The problem was redefined to providing calorie dense snacks and meals for athletes, producing a new target group for the intervention. In other words, the problem was reframed as the target group changed, and the intervention took on a new form. What seemed at the outset to be a clear access pathway for health promotion intervention in a high-priority policy population in this municipality did not materialize. The access created through this project was to a target group that did not have the same high level of need for public health interventions.

The sports center general manager and the manager of the cafeteria were concerned about a potential obligation to eliminate unhealthy products from their selections. They feared that project participation would require that they entirely remove beer, soft drinks and ice cream. The project manager said that they had given up on removing beer and ice cream due to resistance from all participating sports centers. However, she said that soft drinks had to go. The national program would provide alternative products in the cafeteria, such as fresh juices. The project manager also said that they would appreciate it if candy was completely removed and replaced with small bags of nuts and, possibly, a high-quality dark chocolate. These changes thus constituted a dietary health regime of living that pragmatically balanced business needs but simultaneously created distinctions related to health and morality that aligned with new distinctions about food quality and aesthetics.

The sports center manager and cafeteria manager were visibly relieved that they did not have to lose the existing brisk sales in beer and ice cream. The national project manager said that she thought it might be good if they could agree to move the ice cream freezer to the back of the cafeteria, out of the direct veiw of people entering the cafeteria. The temptation to buy ice cream would be less if the freezer was not adjacent to the counter. Also, the freezer was not very aesthetically pleasing, so the aim of improving the cafeteria's décor would also benefit from moving the very colorful freezer to the back. The managers did not see a problem with moving the freezer a bit, as long as they would still carry ice cream. As this discussion drew to an end, the project manager said that the sports centers could also consider replacing the mass-market ice cream brand they carried for a higher-quality ice cream, such as an organic artisan brand that was popular in Copenhagen. They could then keep ice cream in the center's product line, but it would be a much better ice cream. The discussion moved on to the pricing of new products, and the center and cafeteria managers asked for any experience or thoughts the project manager had related to making a profit from the new products.

The emerging rationale of aesthetics and quality of the products introduced a different valuation of health than what was originally intended, which contrasted with the initial rationales of healthy food and sustainable business that they had accepted as part of the agreement for participation in the project. Through the repositioning of target groups and the emerging dilemma about which public health problem would in reality be addressed, distinct new valuations emerged through the project's focus on food aesthetics. The moral reasoning around food quality and aesthetics of consumption was lodged in an upper middle-class rationale and distinction based on food choice and consumption (Wills et al., 2011), pushing the public health rationale into a secondary position.

1 The public health officer, despite being ambivalent about the project after the meeting at the
2 sports center and highly skeptical about its implementation, remained in the steering committee of
3 the project; she explained that continuing on the committee was important to ensure that their
4 municipal health councilor received credit for the project and public recognition for his
5 endorsement of the intervention.

6 This case demonstrates that access practices reshape public health as a regime of living.
7 First, the basic idea of structural change as a technique for promoting equity in health narrows to
8 more pragmatic changes in a cafeteria in a single sports arena. This implies that the target group for
9 intervention becomes a mix of spectators at sports events and elite athletes and that the value of
10 health becomes linked to concerns about profitability, food aesthetics and quality. In sum,
11 numerous interests and rationales become intertwined and the health promotion agenda is
12 fundamentally reshaped.

13

14 **Discussion**

15 In this article, we analyzed the access practices of public health officers that are intended to
16 allow them to intervene in accordance with explicit health promotion policies. Through two
17 ethnographic cases, we illustrated how the access to intervene relies on their ability to form
18 intersectoral alliances and collaborations, but also how such negotiations come to constitute
19 regimes of living that may reshape the health promotion agenda in unforeseen ways.

20 First, we examined the role of ideas and techniques of access practices. Gaining access
21 requires a high level of agility to navigate and speak to the concerns of other actors in different
22 sectors, even as it reshapes the agenda of health promotion itself. This is sometimes referred to as
23 boundary spanning (Rugkåsa et al., 2007; Williams, 2013, 2002). The access practices in the cases
24 we discussed fundamentally reshaped the final focus of interventions as public health officers

1 navigated specific negotiations to make the intervention meet the needs and concerns of
2 collaborators, while also supporting their own health promotion agenda.
3 Second, we proposed that the target groups for health promotion intervention are shaped
4 through the techniques involved in gaining access. When SHSH students are identified as
5 individuals at risk while designing an intervention to fit their curriculum, the health promotion
6 problem is represented as the future risk of work-related attrition that may be potentially reduced
7 through increased physical exercise, dietary advice, and other lifestyle interventions (e.g., smoking
8 cessation courses). However, as we describe, an intervention to ensure equality in health of the
9 future worker is steeped in moral reasoning that is negotiated through the access practice. The
10 municipality seeks to reach a group of citizens by employing a moral logic of healthy lifestyle
11 within an educational program. In doing so, it speaks to potential future workers who are also
12 expected to serve as healthy role models to fellow citizens who need municipal services. This
13 demonstrates that the demarcation of target groups is embedded with particular valuations of health.
14 Moreover, despite its aim to create equal access to health, the practice of access to intervene creates
15 moral differentiations in the target population and excludes certain types of behaviour. There seems
16 to be a continuous aggregation of ethical reasoning and practice in local health promotion work,
17 where specific access practices produce certain forms of living that are intended to align with the
18 policy recommendations of national and local governance. This ties back to Fassin's notion of
19 biopolitics as producing inequalities in life by laying out practices for how life should be lived
20 (2009).
21 In the second case, the contingencies of gaining access to intervene resulted in an
22 unforeseen change to the target group. Rather than reaching a broad group of children and families
23 through local sports facilities, public health officers became involved in a 'flagship' project
24 ensuring nutritious foods for elite athletes. Furthermore, the project promoted a particular food

aesthetic emphasizing artisan and organic goods, which the public health officers found challenging to relate to the aim of reducing health inequalities. Instead, health promotion became entwined with a moral concern for promoting a particular regime of dietary living as well as a monetary concern for making a profit in the cafeteria.

We have shown how moralities of health and living are constituted through the practices of gaining access to intervene. At national level, the overall political rationale for placing the responsibility for health promotion in municipalities is that they are perceived to have *a priori* access to intervene across sectors due to their responsibility for many welfare services and proximity to local settings. An emphasis on lifestyle and behavioural risk factors frames the general attention of the national and local health promotion interventions (Diderichsen et al., 2015; Rod and Høybye, 2015). However, the value of health takes on diverse actual forms in health promotion interventions. Generally, our ethnographic cases indicate that the value of health is the subject of ongoing reconfiguration, where it becomes linked to other forms of value. In the two cases, economic values (i.e., related to the future workforce and profitability of sales in a cafeteria) appear to be particularly important.

By exploring how access to certain domains and populations is achieved, we suggest that vulnerable populations and target groups for health promotion may be defined as much by circumstance in practice as by policy priorities. The definition of the citizens who are in need of an intervention is negotiated through the practices of gaining access to intervene.

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References

Amit V (2000). Introduction: constructing the field. In: Amit V (ed) *Constructing the Field: Ethnographic Fieldwork in the Contemporary World*. London: Routledge, pp.1-18.

Andersen PT, Jensen JJ (2010) Healthcare reform in Denmark. *Scandinavian Journal of Public Health* 38(3): 2460-52.

Andrain C (1998) *Public Health Policies and Social Inequality*. London: Palgrave MacMillan.

Bacchi C (2016) Problematizations in health policy: questioning how "problems" are constituted in policies. *SAGE Open* 6(2): 1-16

Bacchi C (2009) *Analyzing Policy: What's the Problem Represented to Be?* Sydney: Pearson Education.

Baum F, Fisher M. (2014) Why behavioural health promotion endures despite its failure to reduce health inequities. *Sociology of Health & Illness* 36(2): 213-25.

Bernier NF Clavier C (2011) Public health policy research: making the case for a political science approach. *Health Promotion International* 26(1): 109-116.

Blackman T, Harrington B, Elliott E, Greene A, Hunter DJ, Marks L, Mckee L, Williams G. (2012) Framing health inequalities for local intervention: comparative case studies. *Sociology of Health & Illness* 34(1): 49–63.

Bonevski B, Randell M, Paul C, Chapman K, Twyman L, Bryant J, Brozek I, Hughes C (2014) Reaching the hard-to-reach: a systematic review of strategies for improving health and medical research with socially disadvantaged groups. *BMC Medical Research Methodology* 14: 1-29.

Collier SJ, Lakoff A (2008) On regimes of living. In: Ong A, Collier SJ (eds) *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems.* London: Wiley-Blackwell, pp.22-39.

Czarniawska B (2014) *Observation of the Move: Shadowing, Social Science Research: From Field*

to Desk. London: Sage.

Diderichsen F, Scheele CE, Little IG (2015) *Tackling Health Inequalities Locally: the Scandinavian Experience.* University of Copenhagen, Copenhagen.

Fassin D (2009) Another politics of life is possible. *Theory, Culture & Society* 26(5), 44–60.

Frohlich KL, Potvin L (2008.) Transcending the known in public health practice: the inequality paradox: the population approach and vulnerable populations. *American Journal of Public Health* 98(2): 216–221.

Hammersley M, Atkinson P (2007) *Ethnography—Principles in Practice, 3rd ed.* London: Taylor & Francis.

Harris M (1976) History and significance of the emic/etic distinction. *Annual Reviews in Anthropology* 5: 329–50.

Hill M, Hupe P (2006) Analysing policy processes as multiple governance: accountability in social policy. *Policy & Politics* 34(3): 557-573.

Holt DH, Frohlich KL, Tjørnhøj-Thomsen T, Clavier C (2017) Intersectoriality in Danish municipalities: corrupting the social determinants of health? *Health Promotion International* 32(5): 881-890.

Holt DH, Carey G, Rod MH (2018a) Time to dismiss the idea of a structural fix within government? An analysis of intersectoral action for health in Danish municipalities. *Scandinavian Journal of Public Health* 46(22_suppl): 48-57.

Holt DH, Waldorff SB, Tjørnhøj-Thomsen T, Rod MH (2018b) Ambiguous expectations for intersectoral action for health: a document analysis of the Danish case. *Critical Public Health* 28(1): 35-47.

Holt DH, Rod MH, Waldorff SB, Tjørnhøj-Thomsen T (2018c) Elusive implementation: an ethnographic study of intersectoral policymaking for health. *BMC Health Services Research*

18(1): 54.

Koch L, Nordahl Svendsen M (2005) Providing solutions-defining problems: the imperative of disease prevention in genetic counselling. *Social Science & Medicine* 60(4): 823-32.

Koon AD, Hawkins B, Mayhew SH (2016) Framing and the health policy process: a scoping review. *Health Policy and Planning* 31(6): 801-816.

Lakoff A, Collier SJ (2004) Ethics and the anthropology of modern reason. *Anthropological Theory* 4(4): 419–434.

Larsen M, Koudenburg OA, Gulis G, Rantala R (2014) Intersectoral action for health: the experience of a Danish municipality. *Scandinavian Journal of Public Health* 42(7): 649-57.

Lupton D (1995) *The Imperatives of Health: Public Health and the Regulated Body*. London: Sage.

Marmot M, Friel S, Bell R, Houweling TA, Taylor S (2008) Closing the gap in a generation: health equity through action on the social determinants of health. *Lancet* 372(9650): 1661-1669.

Marmot MG (2015) *The Health Gap: The Challenge of an Unequal World.* London: Bloomsbury.

Mason J (2002) *Qualitative Researching* London: Sage.

Pons-Vigués M, Diez È, Morrison J, Salas-Nicás S, Hoffmann R, Burstrom B, Van Dijk JP, Borrell C (2014) Social and health policies or interventions to tackle health inequalities in European cities: a scoping review. *BMC Public Health* 14: 198.

Pressman JL, Wildavsky AB (1984) *Implementation: How Great Expectations in Washington Are Dashed in Oakland: Or, Why It's Amazing that Federal Programs Work at All, This Being a Saga of the Economic Development Administration as Told by Two Sympathetic Observers Who Seek to Build Morals*. Berkeley: University of California Press.

Qureshi K (2013) It's not just pills and potions? Depoliticising health inequalities policy in England. *Anthropology & Medicine* 20(1): 1-12.

Raphael D (2015) Beyond policy analysis: The raw politics behind opposition to healthy public

1 policy. *Health Promotion International* 30(2): 380-96.
2 Rod MH, Høybye MT (2015) A case of standardization? Implementing health promotion guidelines
3 in Denmark. *Health Promotion International* 31(3): 692-703.
4 Rugkåsa J, Shortt NK, Boydell L (2007) The right tool for the task: “boundary spanners” in a
5 partnership approach to tackle fuel poverty in rural Northern Ireland. *Health & Social Care in*
6 *the Community* 15(3): 221-230.
7 Tavory I, Timmermans S (2014) *Abductive Analysis: Theorizing Qualitative Research*. Chicago:
8 University of Chicago Press.
9 Williams P (2013) We are all boundary spanners now? *International Journal of Public Sector*
10 *Management* 26(1): 17-32
11 Williams P (2002) The competent boundary spanner. *Public Administration* 80(1): 103-124.
12 Wills W, Backett-Milburn K, Roberts ML, Lawton J (2011) The framing of social class distinctions
13 through family food and eating practices. *Sociology Reviews* 59(4): 725–740.
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