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From policy to reality: early overweight, structural barriers, and the allocation of responsibility in the Danish health care system

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ABSTRACT

This qualitative study explores the structural barriers to preventive interventions targeting childhood obesity in the Danish health care system. Based on interviews with relevant health care professionals, the paper reports on the problems which are experienced by general practitioners and health visitors and which complicate implementation of the policies of the Danish health authorities. Findings show that the current system is not well equipped to treat early overweight. A gap in primary preventive health care for children at age 3–5, indistinct lines of responsibility, inadequate cooperation, and lack of resources together make it difficult for health care professionals to initiate interventions and reach the children in need of support. By analyzing the policy implementation process in a theoretical framework that discloses the discursive allocation of responsibilities, the study is able to provide a deeper description and analysis of the problem. The study makes it clear how preventive health care for overweight children rests on the negotiation of formal and performed responsibilities among health practitioners within a framework of scarce resources and communication deficit.

Introduction

Both public discourse and scientific research on childhood obesity tend to focus on parental responsibility and capability. While it is true that parents exert a critical influence on almost every aspect of preschool children's lives, the scale of the problem of early childhood overweight in the western world indicates that this approach is insufficient. Furthermore, the stigmatization and discursive shaming which flows from this parenting approach suggests that the problem needs to be framed in some other way, and that we should also look for barriers to, and facilitators of, preventive action elsewhere (McNaughton, 2011; Townend, 2009). This paper investigates the delivery of early preventive action on childhood obesity in the current Danish health care system. It aims to provide structural level explanations of failures within this delivery process. By structural level is meant the societal settings which one can act in, in this case: the organization and conditions provided by the Danish health care system.

The problem of childhood obesity grew during the second half of the twentieth century, and although it now seems to have plateaued there are no signs of reversal of the trend (Morgen et al., 2013; Rokholm, Baker, & Sørensen, 2010). International research shows that the highest rates of childhood overweight
are found among groups with low socioeconomic status and among second- and third-generation immigrants from low-income countries of origin (Matthiessen et al., 2014; Van Hook & Balistreri, 2007). According to research, inequalities in health are best approached within universal health care systems, but in many western countries, including Nordic welfare states such as Denmark, the trend in social and health policy, in line with neoliberal discourses, is toward residual provision of services (Carey & McLoughlin, 2014; McLaren & McIntyre, 2014; Vallgårda, 2010).

Early overweight is linked to psychosocial stigma, a higher risk of poor health and premature mortality later in life, and a greater likelihood of obesity in adulthood (Matthiessen et al., 2014). It is extremely difficult to reverse weight development once obesity has emerged, and thus research points to the need for early, preventive interventions (Waters et al., 2011). In Denmark, as well as other western countries, the health authorities have heeded this call for prevention targeting preschool children (age 3–5) at a risk of overweight or obesity (Danish Health & Medicines Authority [DHMA], 2011; DSAM, 2006). Evidence of the effectiveness of current interventions on childhood overweight is, however, not yet clear. A 2011 Cochrane Review found only a few studies of interventions targeting preschool children. In these, a small positive effect was found, but the authors highlight several uncertainties (Waters et al., 2011). In Denmark, the overweight rate for preschool children has not been properly established, but a rate of 5–12% has been suggested (DSAM, 2006; National Institute of Public Health, 2007). Denmark is an affluent welfare state and childhood health issues are covered by universal health care services. Continuing examination and monitoring of the child's health and weight between infancy and school age is the responsibility of general practitioners (GPs) who perform annual child examinations. Although some special programs for overweight children are performed by health visitors (HVs), GPs are left with formal responsibility to detect and counter childhood obesity (DSAM, 2006). During the present qualitative study, it became evident that there is a gap between the formal policy description of state of action and what happens in reality. It proved very difficult to find GPs currently treating overweight preschool children. Even when interventions involving HVs acting as gatekeepers were included, cases were hard to find.

This paper explores the link between policy and practice in the delivery of preventive action targeting overweight preschool children. It identifies the challenges experienced by health care professionals working in this domain of health care, and discusses the consequences for overweight prevention and treatment.

**Methods and materials**

**Theoretical and methodological approach**

The paper explores a mismatch between policy and reality as a question of implementation – a topic that has been treated in the literature on health policy processes (Crinson, 2013; Hill, 2013). Clearly, a successful implementation process is essential to effective policies. Policy statement and implementation should not, however, be seen as simple, distinct entities arranged in a top-down process, but rather parts of a complex dynamic in which different levels (in this case, state level and executive level) interact and define both the policy and its practical implications (Hill, 2013). The successful translation of policy into reality relies, in general, on low levels of ambiguity and conflict in the field in question; it also requires resources and institutional structures to be suitably adjusted (Hill, 2013).

We find that the theoretical understanding of power relations, conflicts, and negotiations in implementation processes can, at a more specific level, be refined and elaborated by introducing a post-Foucauldian perspective on power and policy. Bacchi’s account of policy analysis, known as What’s the Problem represented to be? (WTP), offers such a perspective, with its focus on productive power (Bacchi, 2008). Bacchi’s approach does not address, in explicit terms, implementation; it focuses instead primarily on policy statements. According to Bacchi, policy statements and processes do not just affect each other, but are also productive in a wider sense. Policy statements produce issues in the form of social problems (Bacchi, 2008), thus generating discursive effects, including responsibility allocation, assumptions, and subjectification, as well as the lived, material effects which may result from a successful
implementation process (Bacchi, 2009). In this sense, representations of reality (policy statements) are ‘not merely representations – they are acts or interventions’, as Bacchi (2008, p. 38) quotes Nancy Fraser. In order to understand the full impact of policy, one must therefore ask not just how problems are solved, but also how problems are represented. The general point is that problems are shaped while they are being represented, because, in them, some parts of reality are highlighted and others are silenced and left unproblematized.

Adopting Bacchi’s analytic points to the implementation process allows us to understand the conflicts and negotiations of responsibility among the implicated professionals at two levels. The first is to be found in the formal representation of responsibility for health services dealing with early childhood overweight and the structural barriers and experienced problems in the course of implementation. The second is the performed responsibility, i.e. the production of responsibility to be found at executive-level negotiations over the formal health policy. Here, responsibility for interventions is produced when problems for interventions are stated. We therefore use the implementation perspective to frame failures of intervention as a policy problem and to maintain a focus on structural barriers, and apply Bacchi’s approach as the theoretical tool with which we analyze central aspects of the problem.

WTP was the guiding question in our empirical analysis investigating the challenges of implementation at the executive level. We traced the responsibility for early years’ interventions, and the allocation of responsibility following from the framing and formulation of implementation problems, from state level to executive level. We used qualitative methods to gain knowledge of the complexities and experienced challenges, adopting a strategy of ‘studying through’ (Shore & Wright, 1997, p. 14) to trace the ways in which different sites and levels in the policy processes relate to each other, interact, and negotiate. The analysis of the empirical material begins with state-level initiatives described in public documents. It then explores the perspectives of those delivering the policy in practice – in this case, GPs and HVs.

Study design and data collection

The empirical material was obtained in the course of 16 interviews with 19 health care professionals (9 HVs and 10 GPs) in total. The 15 in-depth interviews and the single group interview (with 4 HVs) were conducted in three rounds between summer 2012 and spring 2014. The interviews were conducted at the participants’ workplaces. GPs were reimbursed for the time spent, and HVs were interviewed during regular working hours.

An interview guide with themes was used as a checklist, allowing new topics to appear and offering the interviewer the freedom to follow the flow of the conversation and allow it to be shaped by the interviewees’ answers and associations. The interviews referred to frequency of early overweight; perceptions of early overweight and its causes; the specific services provided to families; cooperation with parents; and the role of general practice in prevention. The same interview guides were used in interviews with HVs in all three rounds. The guide for GPs was shortened for the last round to bring in more GP participants.

All of the interviews were conducted by the first author, recorded, and transcribed verbatim. The first phase of the analysis was exploratory and designed to draw topics from interviews. Afterward, all interviews were coded in NVivo10, applying the data-generated topics as themes. The coding was used to ensure the quality of the analysis throughout the material, in the sense that it is a way to go through the empirical material systematically and make certain that all aspects of, or perspectives on, a given theme is made visible and included in the analysis.

In addition to conducting the interviews, we approached all 98 municipalities in Denmark in the autumn 2012 and enquired into what services and projects they ran for overweight preschool children. We received answers from 55 municipalities, of which 16 had some kind of intervention. Not all turned out to be relevant to this study, as some municipalities explained that no preschool children or their families had ever actually participated in the program and others were in a start-up phase and had no experiences as yet. Six interventions were relevant and delivered by professionals who were available...
for interview. Further, we approached the Danish Health and Medicines Authority (DHMA) in the fall of 2014 to gather up-to-date information on interventions and projects, and we included official documents in the analysis.

**Participants**

The GPs were randomly chosen in areas with mixed social profiles. Although they saw children in regular consultations, they worked with early childhood overweight to differing extents. In the recruitment process, which yielded 10 GPs from 7 Danish municipalities, approximately 170 GPs were contacted. Some GPs who declined to participate informed us that they never saw overweight preschool children; others that they lacked time to participate as the result of participation in other projects. Given this, a selection bias was expected, and in particular we speculate, supported by expert interviews, that we reached only the GPs most engaged in this area of primary health care. The participating HVs were involved in special lifestyle-changing interventions in six municipalities in Denmark. HVs are nurses with further training in children’s health.

**Ethics**

All participants gave their informed consent to being interviewed, and all interviews have been treated confidentially. Participants are provided with fictional names and anonymized.

**Findings: tracing interventions for preschool children**

In the following, we will identify the policy framework, the problems experienced, and responsibility allocation at state level, at the level of general practice (private sector level), and at the municipal level.

**Policy and formal responsibility allocation at state level**

In Denmark, the health system is structured by four levels: the state, the regions, the municipalities, and the private sector. The allocation of tasks and responsibilities within the system is summarized in Figure 1, which is a simplified version of a model created by Vallgårda (2010, p. 140).

<table>
<thead>
<tr>
<th>Political Responsibility</th>
<th>State</th>
<th>Regions</th>
<th>Municipalities</th>
<th>Private sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parliament Government Minister of health</td>
<td>Regional Council</td>
<td>Municipal Board</td>
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<tr>
<td>Administrative authority</td>
<td>Ministry of Health Danish Health and Medicines Authority</td>
<td>Administration</td>
<td>Social and Health Administration</td>
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</tr>
<tr>
<td>Activity</td>
<td>Regulation and control of health system and personnel</td>
<td>Hospitals</td>
<td>Prevention Health visitors (Etc.)</td>
<td>GPs* (Etc.)</td>
</tr>
<tr>
<td></td>
<td>Reduction of health risks</td>
<td>Midwifery centers</td>
<td>Research and teaching</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Counselling, methods development etc.</td>
<td>Research and teaching</td>
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* In Denmark GPs operate in the private sector but work in accordance with agreements with the regions.

**Figure 1.** The Danish health care system.
(Vallgårda, 2010). Since it is the administrative authority, and the authority responsible for mitigating health risks and methods development, DHMA will be the starting point for the analysis here.

DHMA is the senior health and pharmaceutical authority in Denmark. It sets out a common framework and direction for health, following parliamentary legislation and political regulations laid down by the Ministry. In 2006, DHMA co-authored guidelines for GPs, making it clear that GPs are responsible for detecting early childhood overweight (understood as BMI above the 90th percentile). The guidelines explained that practitioners should monitor weight and height, and guide families toward healthier habits, or refer patients to other authorities (DSAM, 2006). These guidelines were formulated to provide ‘a tool to support work with overweight children in general practice’ (DSAM, 2006, p. 3). They point to the key position of GPs in preventing and treating childhood overweight. The annual child examination was highlighted as the appropriate setting in which to tackle weight concerns. The policy statement on the importance of attention to early overweight was thus translated into practical guidance for the GPs who work at this level.

According to a government funding agreement, DHMA administered 31 developmental projects over the period 2005–2011. These temporary projects were conducted in different municipalities with the aim of combating childhood overweight and promoting healthier lifestyles in families (DHMA, 2012). The evaluation reported that the recruitment of participants was challenging. Approaches to Hvs were the most successful recruitment channel. General practices, by contrast, were found not to be a productive recruitment location. In all, 20 municipalities continued with projects after the project period, 5 of which included preschool children (DHMA, 2012). By December 2014, DHMA was not involved in any temporary projects directly designed to reduce rates of overweight among preschool children (DHMA, personal communication).

To guide municipalities, DHMA published a series of so-called Health Promotion Packages in 2012–2013, including one with guidelines for prevention of overweight (DHMA, 2013; Vallgårda, 2014). The main part of the Danish municipalities found promotion packages useful, even though few reported to have changed their priorities as a result (Christiansen et al., 2014).

Given the low number of actual interventions, it may be concluded that at state level the practical implication of the policy statement is primarily that DHMA points to general practice as the agent responsible for lowering rates of overweight among preschool children, and that the importance of dealing with early overweight is discursively underscored.

Performed responsibility: implementation and negotiating in general practice

Following the initiatives on early overweight into general practice, GPs pinpointed several challenges that made it hard for them to fulfill the tasks they were required to take on: time and resources, the limited effect of consultations, and lack of municipal support.

Lack of time and resources

Although the majority of GPs interviewed thought of prevention and health promotion as core competences of their profession and expressed a wish to work with early childhood overweight, most of them experienced a shortage of time and lack of resources as serious barriers. In some cases, this was combined with frustration at the structural regulation of general practice by the Danish regions. One GP, Ann, explained that general practice was now being saddled with so many tasks that GPs could not take on sole responsibility for preventing and treating early overweight. Ann was very engaged in early childhood interventions, but she felt pressured by structural circumstances to prioritize severe cases of obesity, and to leave the rest of her young patients with weight problems to other authorities. She said:

We do it where it really matters, and a lot of times we have to say: ‘Contact the health visitor or see if it is something the school nurse can follow up on.’

Ann’s frustration at not being able to treat overweight effectively before it evolves into a serious health problem was shared by other GPs. However, the GPs who were interviewed were not all professionally
engaged in the field to the same degree. A young GP, Elizabeth, explained how she saw her role in the prevention of early overweight:

I think that my job is to identify the problems and then, what I can delegate, I should delegate. Otherwise, I won’t have time to see all the patients I should see.

Whereas detection and identification were regarded by Elizabeth as her responsibility, treatment was not, because time restraints would not allow that. Another GP, Mary, reluctantly agreed and referred to the resources available in general practice; but she emphasized the disadvantages of moving the task to other health authorities, pointing out that GPs enjoy a special authority and relationship of trust with their patients.

**Limited effects of consultations**

Several GPs reported that they rarely saw overweight preschool children in their practice, and that parents almost never contacted them to talk about children’s overweight. Some GPs explained that few children attend GP clinics regularly after infancy and many forget the annual child examination. Detection, especially of risk of overweight, was perceived to be difficult because of the lack of contact and the child’s rapid growth in early childhood. Doubts were also expressed about the effectiveness of consultations. Lifestyle changes in families are very difficult to bring about and manage, and the GPs judged it to be insufficient that regional agreements set out consultations as their only possible means of combating early childhood overweight in practice. Short conversations during a GP consultation had a very limited effect in most cases, they felt. Other means and initiatives were needed, according to these GPs, and the resources to provide those were not to be found in the current structural framework for general practice.

**Lack of municipal programs**

One GP, Daniel, saw overweight children in consultations quite often. He explained how he successfully delegated treatment of older overweight children to a municipal treatment facility, which was not open to preschool children. This pointed to a general problem experienced by GPs: lack of municipal initiatives and support. Another GP, Lisa, said:

Well, I do think it would be nice if you, as a general practitioner, had an opportunity to refer to some health services of good quality – such as groups for overweight children, where they receive some quality help. […] Just going home to lose weight is making it an individual responsibility.

Treatment and preventive action in families with overweight required continuous monitoring and special interventions, and perhaps these would be better performed by other authorities – this was the reasoning. Stable, special interventions of this kind were conspicuous by their absence in the municipalities, and the GPs found it hard to keep track of shifting temporary projects.

**Experienced problems and responsibility allocation**

GPs were appointed the formal responsibility of implementing the health policy of early interventions for overweight preschool children. The clinical guidelines that are the practical upshot of DHMA policy were not seen as a useful tool by most GPs, and few reported using them. As no changes in resourcing or structure had followed the policy statement and the publication of the guidelines, the implementation process was experienced as difficult and met with some reluctance at this level. In negotiating the responsibility, the GPs were definitely willing to provide help for young children and their families, but in the case of overweight, they said, they were best equipped to do so when families came to them at their own initiative, already motivated to make changes, and mostly in need of guidance that could be provided through short consultations. The performed responsibility for initiating processes to counteract overweight among preschool children was thus allocated to individual families. Further, due to their structural working conditions, the participating GPs pointed to the municipal level as the level responsible for creating interventions and programs which could facilitate difficult life style changes in families.
Implementation, performed responsibility, and responsibility at municipal level

From general practice, we moved on to the municipal level. In Denmark, municipalities are responsible for prevention and health care for healthy citizens. We were able to identify approximately 16 municipalities with weight management interventions for overweight preschool children in 2012. All of these interventions were performed in the setting of local health care centers, with HVs playing a leading part. Most interventions targeted social and psychological factors in addition to weight control. The HVs participating in this study pointed to the lack of cooperation with GPs and difficulties of overweight detection as their main constraints. During the child’s first year, the health system offers universal primary preventive programs and health services for all children, delivered via HVs. After infancy, children are no longer covered by the HV services unless they have special needs, but on the other hand, preschool children are not yet in contact with school-based health initiatives. For this reason, HV-driven special interventions rely on referrals from other authorities.

Most of the participating HVs involved in the interventions reported never having had a GP refer a patient to them, and this posed a great problem for them. Laura, from a permanent intervention, told us:

But as it turned out, we have not received a single request from the general practitioners […] Despite the fact that we several times during the two-year-long process reminded the general practitioners of the project, and that we sent them booklets several times. And then, you know, we have not had any contact at all.

This lack of cooperation was felt to impact in several ways. First of all, it made it difficult for the projects to reach preschool children and thereby take preventive action before weight problems grew serious at school age. The gap in the health care centers’ primary preventive program for exactly this group posed a problem here, as the perception was that GPs were not taking on the task of detection. Catherine and Ina, from another permanent intervention, said in the group interview:

Catherine: But it would be nice if the doctors could capture them and send them along.

Ina: Because we do not see them. It wouldn’t be a problem if we had our own two- or three year visits in the family. Then I wouldn’t care what general practitioners thought. But we don’t.

HVs said that they sometimes recruited preschool participants through the younger or older siblings they saw during home visits or at school, and that daycare centers sometimes referred children to them. But, in general, problems with detection and recruitment were often encountered. Another concern mentioned by some HVs was that GPs are such a valuable and authoritative resource. Anna said:

It is really difficult and unfortunate for us, because it would matter so much if the doctor did it. The doctor has a great power. And if the doctor said ‘It’s important that you’ll get some lifestyle conversations with the health visitor’ it would be SO much easier for us to get the message through to the family.

It is noticeable that Anna’s experience echoed the point raised by GP Mary when she talked about the downside of removing this preventive task from GPs.

HVs suggested that time constraints may explain why GPs were not making use of the interventions or referring to health care centers. They also spoke of differences in professional perspectives. Several HVs felt that GPs did not always notice early overweight, or tended to regard it as less serious than HVs did as a consequence of their professional focus on treatment rather than prevention.

In sum, limited detection was a serious problem for interventions at municipal level. The municipalities have formal responsibility for preventive programs, but even those providing early childhood interventions and preventive health services had trouble recruiting families to take part in them. Lack of cooperation with GPs was highlighted as a barrier to detection. Negotiating formal responsibility, HVs reported they relied on families to take the initiative and contact them. In this negotiation, the performed responsibility for initiating processes counteracting early overweight was thus handed over to the individual families and back to the GPs.

Who is represented as responsible?

The pursuit of early interventions through the system exposed a series of problems generally impeding preventive action for preschool children who are overweight or at risk of becoming so. Another aspect
here is the transfer of responsibility. Formal responsibility was described in the Introduction section and the first part of the Findings section. The responsibility described in the remainder of the Findings section was, by contrast, performed responsibility (the actual state of action) and discursive responsibility allocation. Figure 2 shows how barriers to treatment in general practice and municipal projects (shown in the boxes) create a process of responsibility allocation (indicated by the arrows). The key point is that general practice and municipal projects are pointing to one another and to families as the agents responsible for initiating health interventions.

**Discussion**

**Structural level barriers for implementation**

Detection and treatment were in general perceived to be difficult, and actors operating at the different levels identified several barriers to interventions. The barriers presented in the qualitative material rely mostly on structural conditions and can be summed up under three different headings:

**Lack of universal primary prevention services**

The particular age group of children (3–5 years) is the responsibility of GPs, but several GPs and HVs report that continuous primary preventive health care is better performed in the setting of local health care centers and HVs. HV services in Denmark are regulated at municipal level and have in general experienced budget cuts in recent years according to participating GPs and HVs. This has reduced the period of time the child is monitored by this authority, and it can be seen as part of a more general national and international trend away from the universal welfare state and toward a residual welfare state where services are provided only in cases of special need (Carey & McLoughlin, 2014; Vallgård, 2010).

**No resources for implementation**

GPs' work is regulated by the agreement reached between Danish regions and GPs, and no additional resources or time allowances accompanied the task of combating childhood obesity. At municipal level,
the lack of targeted projects is connected with financial restrictions and political decisions, where, in
general, early overweight does not seem to be a highly prioritized issue. It is important to note that
health policy in Denmark is organized so that formal responsibility is spread across several levels and
authorities (see Figure 1). The state-level policy statement on early interventions needs to be imple-
mented by the regions and municipalities, and needs to be funded by these levels as well. The process
of implementation and adjustments in resource allocation appear to be incomplete, and funding is
not formally guaranteed (cf. Hill, 2013). For this reason, health promotion projects are often funded by
temporary grants, making it difficult to work continuously with early childhood overweight.

Lack of formalized cooperation
The temporary character of interventions made it difficult to keep track of them, according to partici-
pants, and GPs were not always aware that interventions actually did exist in their municipalities. This
leads to another barrier: lack of cooperation. As the task of detection lies with general practice, and as
the preventive interventions occur in local health care centers, cooperation is essential, but no formal
settings mediate it. This shortcoming has been noted as a serious limitation in previous preventive
projects (DHMA, 2012). If we take the policy statement on the importance of early preventive action to
counter childhood overweight at face value, the above-mentioned barriers need to be considered at the general political
level, as, according to health care professionals, they effectively break the practical link between policy
and reality. Descending from state level, the policy appears to have no real practical implementa-
tion. Systems and resources are not being reviewed and modified, and the implementation process is
characterized by indistinct lines of responsibility which render the process ambiguous and conflictual
(cf. Hill, 2013). At the same time, universal primary preventive health services are being cut back, which
seems to be counterproductive. The lack of practical implementation puts the policy at risk of becoming

The production of responsibility
The material effect, to use Bacchi’s terminology, of the structural barriers described above is a lack of
out-reaching programs and interventions for preschool children with weight problems or emerging
weight problems. The discursive impact is to be found in the production of responsibility, which was
outlined in Figure 2. As a result of scarce resources and structural conditions the participating health
practitioners in this study negotiate, within the given frames, their responsibility for interventions. In
this the responsibility for initiating processes is passed on from general practice to municipal level, and
then from municipal level to general practice, and ends with individual families: all of the interventions
and services required parents to be motivated to make changes and capable of initiating processes by
contacting the relevant authority. This production of parental responsibility emerges in a conflictual
setting, where health care professionals find themselves unable to perform the task handed to them.
In this situation they report barriers, but at the same time they engage in a process of subjectification
in which they not only allocate responsibility, but also produce a narrative of themselves (Bacchi, 2009).
Pointing to barriers imposed from outside, they can represent themselves as capable and responsi-
ble health authorities without having to engage in a more general evaluation of their professional
approach. Staying with this notion, it is remarkable that GPs and HVs agree that GPs are attributed a
special authority by patients, and are important contributors to interventions, even though HVs are
quite critical of GPs’ contributions in general.

When early childhood overweight is pointed to as a health issue receiving special attention in
Denmark it is discursively created as a social problem (cf. Bacchi, 2008). It is given existence as some-
things that needs fixing. The overall structural context of this discursive representation is a health system
which is not well suited to catch and offer treatment to overweight preschoolers. In this context, where
early overweight is problematized, but little help is offered to counter it, the responsibility is passed on
to individual families. Thus, drawing on Bacchi’s framework, it can be questioned if the policy, despite
its declared intention of providing support to affected families, is not in danger of discursively adding to a social shaming of obesity rather than helping children with weight problems.

**Who is left behind?**

The fact that health care professionals say they are often unable to catch overweight preschool children at the necessary point in their development shows that there are gaps in universal preventive health care for children. The gaps in question are most problematic for underprivileged children and their families, which, given their low levels of health literacy and high levels of other social concerns (Sihota & Lennard, 2004; Warin, Zivkovic, Moore, Ward, & Jones, 2015), are least likely to initiate potentially needed processes of change themselves. These are at the same time the groups at the greatest risk of childhood overweight (e.g. ethnic minority children and from families with low socioeconomic status).

This study did not collect medical evidence on the outcome of existing treatment initiatives. However, data in the form of health professionals’ statements show that targeted approaches in health care are often ineffective in reaching underprivileged groups. The study adds to existing research in public health policy which suggests that universal health care services reduce inequalities in health most effectively (cf. Carey & McLoughlin, 2014; McLaren & McIntyre, 2014). It adds to this research by focusing on policy implementation – in other words, by looking behind policy statements and investigating the way negotiation takes place under structural constraints at the executive level. It also deepens our insight into the interlinkage, in the health sector, between the allocation of responsibility and resources, on the one hand, and responses to health challenges, on the other, because it shows how an emphasis on parental responsibility emerges in the interaction between structural barriers and professional discourse. Treatment of childhood overweight is not a strictly medical issue. It is shaped in the bureaucratic process of policy-making and implementation.

**Conclusion**

This study suggests that the current health care system in Denmark is not well equipped to detect, treat and prevent early overweight. Professional support for families with preschool children who are either at risk of overweight or slightly overweight is mainly provided to those equipped to ask for it, or demand it, themselves. There is therefore reason to be concerned that underprivileged, high-risk groups in society may be inadequately engaged in preventive initiatives and that inequality in health is being reproduced. Furthermore, the structural barriers to early childhood interventions promote a framing of responsibility for childhood overweight that ends up putting the emphasis on individual responsibility.

**Notes**

1. The research was conducted during an intensive period of ongoing conflict between GPs and Danish regions about the degree of regulation, the workload and the payment and this was reflected in interviews.

2. As mentioned in the section on state level initiatives, DHMA published a guide on prevention of overweight in 2013. According to their own assessment in 2014, 12% of the municipalities met the recommendations on a basic level (for all age groups), this included services for preschool children and their families (Christiansen et al., 2014). Almost half the municipalities declared to have, or to be in the process of starting, special services to preschool children (Christiansen et al., 2014). This last result differs from what we found in the inquiry to municipalities in 2012 and in interviews with health care professionals. The difference indicates development over time, but based on the available material, it is not possible to assess the character of the greater number of programs or to which degree they, in contrast to several programs we were in contact with, are successful in recruiting preschool children and their families.

3. It is worth remembering that we apparently recruited GPs who were among those most engaged in the subject early interventions on childhood obesity and therefore probably also among the most informed. The problem of communication is probably even greater among less engaged GPs.
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References


