Health Promotion in Denmark: from Critical Potential to Individualisation and Marginalisation

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Health promotion has been a part of the policies, strategies and services of the Nordic welfare states since the beginning of the millennium. This article contributes to analyses of health promotion in political programs, institutions and practices in Denmark in later years, and holds a special interest in how inequality in health is addressed. In the Nordic countries, universalism has been a key tenet of welfare services, with great potential of guiding health promotion towards more equality in health. However, a neoliberal development over the last two decades has influenced the field of health and also the ideas, conceptions and strategies of health promotion. This article looks into how health promotion has taken form in Denmark, through conflicts of interest in health policies, and changes in central health promotion programs, that turn away from earlier universalistic and social political framing of health prevention and promotion. Health promotion in Denmark has been marked by years of conflicts and the interest in influencing the psychosocial environment of health to gain more equality in health has weakened. The analysis shows that central health promotion programs that direct local government practices, do not identify the characteristics of the psychosocial environments of health for various groups of citizens, but identify socially less privileged groups with potential health risks, and are directed towards intervening into the social reproduction of unwanted health conduct. Health promotion plays an increasing role in the categorisation and discrimination of less privileged citizens on the background of their health conduct and social positions and situations. In institutional practices in child and family health promotion the article finds that inequality in health is not addressed as a professional problem, but is none the less present in the way citizens are deligitimised, categorised and marginalised. Health promotion institutions on this background distribute obligations and invite engagement of citizens in socially segregated ways. These categorising and discriminatory practices contribute to excluding and devaluating the problems of social inequality in health promotion in schools, kindergartens and health care institutions for children and parents.

Introduction

The Scandinavian welfare states depart from a redistributive, reciprocal and solidaric origin with universalism as the guiding principle in welfare services. (Esping-Andersen, 1990). Being a citizen is characterised by a communitarian principle in health and social policies in the Scandinavian welfare states. The relation between the citizen and the state is therefore inseparable and a moral question. This principle relates ideologically in inclusive ways to all citizens, regardless of class, age etc. as citizens must be included in forming and producing health care and practices, in ways that may support universalism, and the late modern Scandinavian welfare arrangement. (Vabø, 2007). Health promotion programs and interventions in the sense of the WHO "reaching out to all citizens" in this contextualization, implies that all citizens must support the promotion of health of other citizens regardless of their background, with free access and as a universal right, funded by the state.

A healthy population is politically understood as an important foundation for maintaining a robust, universalistic and coherent state in Denmark (Vallgårda, 2014). The health of the Danish population is however characterised by increasing social differences (Bjerregaard and Hermann, 1994, Brønnum-Hansen and Baadsgaard, 2007), and since 1990 Denmark has experienced rapidly growing inequality in health, to larger extent than in the other Nordic countries (OECD, 2018; Diderichsen et al., 2011).

The following analysis takes its departure at the historical macro level, in order to understand the conflicts influenced by health promotion policies and practices, and pays special attention to the role of neoliberalism in this development. Analysis at the meso level questions the rationalities of the political identification of health challenges and problems of the "health promotion packages" developed by the Board of Health in Denmark. They have had guiding influence on decentral health promotion in Denmark since 2012 (Sundhedsstyrelsen, (The Board of health) 2012). Lastly, at micro level the article zooms in on institutions for child and family health, illness prevention and health promotion. Rationalities at the different levels do not appear as mere representations of each other, but as social practices at micro, meso and macro level, and are analysed accordingly. From greater societal developments, such as the spreading of neoliberal ideas, as well as welfare ideologies of universalism. And to the practices in child health promotion, where inequality in health and health promotion appear in specific forms of interactions in health care and promotion institutions.

Methodology

The methodological approach is to investigate the creation of health promotion through rationalities at different levels of society, and looking into these rationalities at play, not as mere translations from one level to the other, but as different fields of practice. The questions raised are, how is health promotion formed and practised inside fields of conflicting interests in health and social care and influenced by neoliberalism? What are the rationalities at work that seem to marginalise social inequality in health, and to engage citizens in socially differentiated ways in health promotion? The methodological approach is to understand the rationalities driving health promotion in Denmark through a combination of the conflicts at macro, meso and micro level seen from sociological theoretical perspectives.

The analytical approach is tripartite: at a historical and societal level, at a strategic health political level, and at institutional practice level. At all three levels power in relation to influencing health is contested, and the agents in the field fight from different positions and with different dispositions, i.e. possibilities of choice, engagement and influence. This is overall what influences the possibilities of promoting and creating more equality in health. The historical analysis is centred on conflicts of power in the field of health, seen as a structurally bordered field where specific forms of knowledge and access to resources /funding are at play (Bourdieu, 1990). An analysis follows of the specific factors that have influenced the development of local government health promotion in Denmark, and the institutional settings: health centres and out- reach health institutions, which have the responsibility for health promotion.

At the meso level the analysis looks into central government health promotion programs, the "Health promotion Packages" of 2012. This is based on the discourse analysis of Vallgårda, who did a thorough policy analysis two years after the presentation of the programs (Vallgårda, 2014). This is supplemented by analytical points (Bacchi, 2009), probing into how problems are identified, which problems are not addressed and with which possible result and consequence?

This leads directly to the analysis at the third, micro level in institutions working with health promotion: health promotion targeting children and families. This field is chosen, as the health promotion packages had a special interest in reaching out to health in the early stages in life, and to involve parents, children and youth in health promotion. Two case analyses have been chosen, one focusing on how health promotion targeting children and their parents in schools is formed (Aamann and Dybbroe, 2018), from the empirical work of Aamann in the years 2014-17 (Aamann, 2017). The other case focuses on how health promotion targeting families is formed inside an outreach psychiatric unit. The empirical work was conducted in 2011-14 by the author (Dybbroe, 2016). The two cases are exemplary of the way in which health promotion, targeting children, has been formed and structured since the introduction of the programs. In the first case health promotion is a part of the school settings, and in the second case appears in combination with prevention, education, and treatment in out reach child psychiatry (Dybbroe, 2016). In the school based project three school health nurses were followed in 28 health promotion consultations for school starters and their parents. In the psychiatry based project 8 children and their families were followed from first contact to the conclusive phase of either diagnosis, educational offer or health promoting interventions and advice.

The methodology was in both cases extensive multi-sited and critical ethnographic fieldwork, including interviews with professionals. The methodology is inspired by the theory of social framing of interactions in institutional settings (Bernstein, 1977). Individuals are understood as positioned in relation to socially powerful and less powerful institutions and agents, and in relation to structures of difference (class, race, gender, nationality). Seeking identification and to be able to identify oneself inside any social setting is important for exercising agency, and a special challenge in relation to social class and differences are at play. Identification and to be seen as having legitimate identity is understood by Bernstein as an essential part of being able to excert power and play a part in the framing of any social interaction.

Municipal health promotion- in a historically moving field of conflicting interests

In Denmark universalism as a guiding principle has greatly improved health and life expectancy of the whole population in the 1950s and 60s. A social approach to health interventions and capacities, involved conditions of health such as social and living conditions, which were in focus in Denmark at the time. However, the social approach to health promotion was contested by a focus on treatment and specialised health care in the 1970s and 80s. Therefore, when the Danish government in 1987 adopted the WHO Ottawa Charter, (WHO 1984), it was without taking specific political measures. This however impelled civil society organizations and municipal health care institutions, who were closer to citizens and more dependent on civic action, to call for health promotion to become a specific policy and practice, as part of local governance (KL, Local Government Denmark, 2009). European perspectives on political steps to engage in health promotion (Kickbusch, 2003) have also influenced several institutions in Denmark, e.g. in occupational health (Dybbroe and Kamp, 2008), in housing and urban policies (Agger, 2004) and in municipal policies in general (Lau and Dybbroe, 2012).

In 2007 Health promotion was finally put on the agenda with a reform (both a local government reform, and a health reform) that placed it as a key area for municipalities and an inter-sectoral task between several institutions (Andersen and Jensen, 2010). Health centres were constructed close to citizens and with interdisciplinary teams, as the responsible agents of health promotion in municipalities. Some municipalities set up centres in specific buildings as transparent new institutions, accessible for citizens, while other municipalities preferred a more hybrid organisation, so as not to become a special force, excluded from the more traditional part of health care and prevention programmes.

In the introduction of health promotion in Danish health policies, three major conflicts appeared in relation to the tension between central government and decentral government in forming the future of Denmark. First of all: little state financing for universal health promotion. Therefore, in terms of the health promotion work the municipalities had requested and promised citizens, this created local political, as well as local - central government conflicts. Powerful institutions and structures of cooperation between hospitals at regional level, practitioners and central government tried to pursue the road of cure and health care. As part of this development the growing influence from medicine and the "treatment " sector was exceedingly putting a pressure on primary care and on the way municipal governance prioritized health and health promotion(Jørgensen 2008, Lau and Dybbroe 2012). The central government message to the new health centres following the 2007 reform became: try harder to keep citizens out of hospitals, and target your work towards specific diagnoses and patterns of morbidity.

Specific diagnosis groups and groups at risk therefore became a priority in many municipalities, and linked health promotion closer to prevention of risk, i.e. what is labbeled the vertical health promotion. Furthermore the decentralised municipal health centres embraced prevention policies of attention to diet, smoking, alcohol and physical activity (KRAM is the Danish acronym). The third challenge followed from the former two. When horizontal aspects of everyday life, such as housing, work, child care provision etc. were not in focus, and the municipalities were working with short-term horizons for effect, paradoxically this implied that evidence of health effects in health promotion practices became difficult to obtain. Therefore, the low evidence based "cost-effectivenes" of the programmes led several municipalities to decide after some years to cut down on health promotion.

Some municipalities however held onto a horizontal approach within the municipal framework and with organizations outside the political system, in areas such as housing projects, forestry projects, child protection and social work. In these municipalities, it appeared much more inviting for citizens to take ownership. The municipalities could work with several aspects of people's lives in integrated ways, on a more long-term basis, and it became easier to engage citizens, when they became not just *objects* of change but also *agents* of change (Lau et al. 2012).

Powerful positions with influence in the field of health were challenged. The agents in the field, - i.e. municipalities, civil society organisations, health care institutions and local and central government- would fight from different positions and with different possibilities of choice, engagement and influence (Bourdieu, 1990). The field of health became generally restructured, when health promoting institutions and agents in this way moved into this field. They added something new to the field: the involvement of citizens and civil society, new understandings of health problems, and new methods and health practices, often based outside the health institutions. This is how health promotion influenced the possibilities for creating more equity in health, including many overlooked aspects of health in everyday life of people and of institutions. Parallel to this the traditional powerful agents in the field of health also influenced and interfered exceedingly with health promotion.

Neoliberalism, universalism and health promotion - a changing historical/political context

As introduced above, health promotion in the Danish welfare society, is a part of the universalistic welfare state, and relates inclusively to all citizens. Today universalism is being challenged by neoliberal influence, creating a new context for health promotion as a critical potential. Universalism has always been subject to conflicting pressures and been contingent on shifting trends of governance in the Nordic countries (Vabø, 2007). A new set of values and ideas that have their roots in another paradigmatic concept of society, and a new thinking about the role of societal institutions, have gained influence during this historical development just described. The welfare state has been retracting since the 1990íes. Universal entitlement to care was questioned through economic rationalities of New Public Management. Following this, health and social needs of citizens have exceedingly become interpreted dependent on shifting political and economic programs.

Health consumerism as a rationality in health provision and services, is today challenging universalism in the Nordic countries (Christensen, 2012). Citizens needs are politically interpreted and citizens must co-produce in order to get access to several forms of health care and health promoting programs. There are clear signs of how these new forms of differentiated health care and health programs result in inequity in health care access. The result of political choices of differentiation of needs, create higher and unequal thresholds for health care, i.e. in relation to citizens with chronic illness (Vedsegaard and Dybbroe 2020), and in relation to citizens with serious illness (Merrild et. Al., 2016). After 30 years of New Public Management the rationality of consumerism and marketization has become common sense in welfare planning. Welfare is being designed and put into "operation" guided by the rationality of economic cost effectiveness. Tools of standardization to measurable outcome are inserted in welfare institutional practices, as well as the categorization of legitimate and non- legitimate needs. (Kamp and Dybbroe, 2016).

The practices in the welfare sectors in Denmark do not openly form part of a specific neoliberal program, or of an economic plan (Stahl 2018). But neoliberal policies and economic theory legitimize, argue and justify these practices and specific values. At the same time social political debates on the creation of the health policies and services that could enhance equity in health, and which large parts of Danish citizens need, request and imagine, are marginalized.

What is labelled neoliberalism is not just a program, but a gathering of more generalized elitist ideas of what it is to be a citizen, such as radical individual freedom (Trädhgård, 2018) as well as class and ethnic segregation (Waquant, 2009). The widespread presence and power of neoliberalism as ideology in the health and welfare sector in the Scandinavian welfare states today is not seen to lie in its economic program, but rather in the ability to conquer the thinking about social and welfare development. Neoliberalism is depoliticizing big political transformations and performs as a norm, that creates new hierarchies and borderlines for what is of value, and what is not, in society (Boltanski & Chiapello, 2006, Stahl 2018).

Health promotion programs: what are the problems? And how is the position of citizens?

The concept of empowerment in health promotion became paramount in the years following the Danish reform. Empowerment was to be a guideline for authorities and institutions in the experiments of developing municipal strategies for engagement in local settings and for involving citizens. In practical health promotion it was however ambiguous and a very pragmatic concept that was not always welcomed as it could disempower authorities in relation to the citizen (Andersen and Siim, 2004), instead of guiding municipalities in enlarging the power of the local setting. After some years of decentral health prevention and health promotion policies and practices in Denmark, a critique was presented from 60 % of the population, arguing that health had become an obligation and that health goals were more often identified by professionals rather than by citizens (Lau and Dybbroe, 2012). In response to this, together with great internal criticism from the municipalities and the health sector, the Danish National

Board of Health presented new national health promotion policies in the form of guidelines for municipalities. (Sundhedsstyrelsen, 2012) Here they stated that citizens were very important to involve, and that they " request specific help to make healthier choices in everyday life – without letting others manage their lives". This acknowledgement of a problem in everyday life did however not include an empowerment strategy in relation to citizens.

Ten health promotion and prevention program "packages" were launched, each dealing with a different theme: mental health, alcohol, overweight, food and meals, sun protection, hygiene, tobacco, drugs, physical activity and indoor environment. Each package could be adapted to different groups of citizens and different settings, and the Board of Health would recommend what to prioritize, and base it on best cases from the first years of government directed health promotion. These Health Promotion and prevention packages were based on various types of knowledge, from research, best cases in municipalities, evaluations of practice, experiential, and simply "good ideas" not always clearly stated. Danish health political critic and policy researcher, Signild Vallgårda raised a sharp critique of the packages, of not doing what they actually claimed (Vallgårda, 2014). First of all by not addressing health inequality based on research evidence of the social gradient in health. Additionally Vallgårda pointed out that the packages did not create new policies or approaches with which to address inequality, but instead targeted "disadvantaged and marginalized groups". Last point of the critique was, that several interventions were recommended without evidence to support them, notwithstanding the ambition that interventions should be evidence-informed (Vallgårda 2014).

The way in which the program packages presented the challenges for health promotion in Denmark can however be further criticized, and I will add some points to Valgårdas analysis. The way the problems were presented and argued, had the effect of hiding and neglecting other problems (Bacchi, 2009), and must here be analysed and discussed. The program focused on social inequality in health, but constructed it in a very special way, stating that

> *"Social inequality influences the risk factors and illnesses we are exposed to both as children and as adults, i.e. through socially conditioned health behaviour such as smoking and eating habits. There are clear social differences in the occurrence and distribution of health and illness in the population, and these differences have risen markedly over the last 20 years. Unhealthy habits are increasingly concentrated amongst the socially disadvantaged groups" (Sundhedsstyrelsen, 2012).*

Inequality in health became constructed as a problem of inheritance, which obscured present social conditions for healthy lives. The social conduct and choice of lifestyle of parents was seen as the main problem of the present health situation of children, rather than economic conditions, housing etc., as obstacles, possibilities and frames in the present lives of citizens. There was an understanding of a special form of social inheritance in the way of living “chosen by citizens”. This idea of “choice” and the focus on conducts of parents, cast shadows and was silent on the social health conditions of families, and the complexities of parenthood and children’s lives in relation to the psychosocial environment of health (Siegrist and Marmot, 2007), power over their own lives, and options for change. There was here also no evidence or identification of the aspirations and experiences of socially disadvantaged families.

This problem identification and approach can be understood as based on what has been labelled the ”cycle of deprivation” and has been identified in a British context (Welshan, 2007). This is a specific understanding of reproduction of conduct on individual basis- regardless of social contextualisation. Economic factors, social and health factors, and power to act, are not taken into account in the programs in relation to engaging citizens and offering universal health promotion options. Parents and the local cultures and settings they are a part of, become the object of change, and they are to blame for the health situation of children. Early risk detection and guidance in bringing up children becomes the primary solution. The problems of socially disadvantaged citizens were not studied and taken into account when the programs were formed and implemented. In this way problems were designed to fit the solutions that the municipalities already had and preferred, - and not the other way round.

The programs suggested professionals to approach health problems in relation to specific socially disadvantaged parents, and question and evaluate their competencies as parents in relation to healthy conduct in the terms of the Board of Health. Health is in this way defined as social, however not as embedded in conditions and social structures, but linked to the reproduction of socially differentiated and stratified social behaviour. Furthermore, the inclusion of citizens in health promotion is understood as “recruitment” to the programmes of the authorities. To this end, willing and appropriate citizens have to be identified. The programs do not promote the idea of developing strategies in collaboration with citizens, and do not urge to illuminate the experiences of citizens, and to find ways of how to engage citizens specifically in relation to inequality in health. This did however take place in specific areas of Denmark, where local authorities and councillors followed more social and cooperative political inspirations about civil involvement and local planning. They invited citizens to propose how to work with health promotion locally in innovative ways, and to follow the knowledge of citizens (Andersen 2015, Lau 2016).

The universal right of families and children to achieve the best attainable health and be involved in health promotion?

In the Danish Health Promotion Program Packages, the government obliged municipalities and health professionals to identify children and families at risk of developing specific and prioritized health problems, in the above described suggestive way. This advice was based on national data on the greatest health risk factors and their relation to the most common severe diagnoses of children (BEK 1344, Sundhedsministeriet /Department of Health 2011). At this point the article will look into health promotion for children and families at the micro level. Two empirical cases are here presented to illustrate the findings of qualitative research into health promotion practices of professionals (nurses, doctors, teachers, social workers) working with health promotion, and children and parents.

In a case of families seeking help, or being advised to have help from municipal mental health counselling and elucidation (Dybbroe 2016), parents were urged to present the health situation of the child in relation to medically described symptoms- but seldom given space to voice their fears and health aspirations. The professionals urged families to display their lives in specific ways, by recounting selected parts of their life histories, and through questions centering on conduct, competencies and life style. The professionals on this background analysed the social health "inheritance" and the present health performance and conduct of the child. This would lead to scrutinise and in the end decide whether parents were capable of correct social and health conduct, or incapable. The detection of risk appeared here to a high degree to depend on what was displayed in these meetings and on the narrated conduct of the parents. Even though the professionals also looked into other settings of the child, such as school, kindergarten, etc., the conduct of parents and the way they were identified by professionals, and not through their own agency, remained the central focus.

A specific peculiarity was that the health conditions, such as the social problems the parents could not control, i.e. chronic illness, loosing job, having poor economy, not being able to collect a child from school or kindergarten early because of long working hours etc. were of minor importance, or even neglected. In contact with the professionals parents however voiced their health and social concerns, only to have them reconstructed in relation to an understanding of mental health problems as medically and socially what the professionals considered significant. The concerns of parents were of minor importance and they were judged as not resourceful in relation to constructing a healthy environment for the child. The professionals were guided by the rationality of risk detection and categorisation. It even appeared that the actual parents and child could become a disturbing element for the professionals in performing the selection and identification of health risks.

In a case of school health consultations with school starters, (Aamann and Dybbroe,2018) it appeared that the demonstration of parent performance and socially more privileged families were judged by professionals as able to demonstrate responsibility in relation to legitimate risks- or not. In contrast, socially disadvantaged families displayed both engagement and narrations about the health of their child that did not result in identification of health concerns and aspirations of parents. On the contrary professionals were looking to identify problems of lifestyle and conduct, and parenting 'at risk' in relation to health promotion. On the basis of social criteria and the impression of parents, professionals could even overlook vital health problems related to unhealthy housing, poor economy etc. To support this were also the tools of identification of health problems. A number of evidence based standardised ways of measuring children's health would be applied such as assessing weight, height, and motoric and cognitive skills. New standardised tools in the forms of questionnaires, were also employed. The social settings of health were however not identified, and the narratives and experiences of citizens with health and illness, became marginalized because the risks were already defined in the health promotion packages, and by professionals, as the obvious explanations.

Looking into these scenes of health promoting encounters in the two fields, professionals appeared as responsible agents of the health promotion packages, detecting risk and following the understandings of the packages of what correct health behaviour is and is not. It was clearly demonstrated how the silences in the programs and the construction of the health promotion task had laid almost all discretionary power over how to practice health promotion into the hands of the professionals. For professionals there were very few means, insights or resources available in the terms of strategies, knowledge and instruments of health promotion that might invite citizens to participate. Very little knowledge and means were offered to the professionals to enable them to identify, explore and understand the health problems, and to help and cooperate with citizens in finding ways forward in health promotion. The result was that these practices laid a huge responsibility on the shoulders of the citizens to identify themselves with bad health promoting conduct, and to correct their behaviour, and accept their personal major responsibility for the promotion of health of their child.

The dialogues and encounters between professionals and citizens who wanted to be helped and seen as legitimate partners, resulted often in depowering situations, where the socially lower class and less privileged families withdrew when they experienced having no legitimacy or power in these health promoting encounters. The way in which these practices were created, can be understood in relation to the theory of, how social interactions in institutions of society are constructed inside structures of power, while at the same time inviting citizens to take part in the framing of these encounters and practices (Bernstein 1973). Frames of action relate to power in social fields, and in the health promoting interventions health professionals would identify with the power that was in the packages as instruments of the Board of Health. Their practices became legitimate through the way they identified with the programme packages. As they adapted to what should take place, and what cannot take place. The marginalised and lower class parents, the guests in these institutional settings had little chance to exercise any power, and influence the frames, i.e. the topics, time, or priority of what the identity of main health problems were, and how to cooperate in health promotion.

The marginalised families were identified beforehand as illegitimate health promotion agents, and being responsible of "risky conduct and bad social inheritance". Therefore a presentation of the health aspirations and worries of parents and child would often be marginalised. Lower-class parents had little access to controlling what was the "right way" to interact, as well as the right way to practice health. Risk detection and control overrode especially lower-class experiences and health aspirations.

As encounters of health promotion, these interactions between families and children took form as efforts to control public health. They were not settings where the health aspirations of all citizens could be included. At individual and intersubjective level the cases presented can illustrate how the neoliberal regard for the enterprising individual and the non-legitimate socially marginalized citizens, become values of and the interest of professionals in professional encounters with citizens. An open space for dialogue about health aspirations was not created, but the families became objects to categorization, as not having the legitimate social inheritance and the "right healthy conduct". This is a driver that is active in forming what health promotion encounters become. Differences according to class etc. become the source for differences in access to health, and so we may conclude that health promotion becomes an instrument of inequality in health.

Conclusion

Universalism as a precondition for the Nordic form of health promotion was put under pressure and affected health promotion negatively already in its initial phase. In the analysis it is illustrated how health promotion became an assemblage of political ideas, and ideals about government responsibility for healthy societies, healthy living and the involvement of health aspirations of citizens.

Managing people's health became historically more dominant in health promotion institutions in Denmark, in step with a decreasing focus on establishing societal health promoting frameworks and when not supporting the human right of defining health goals and attaining the highest possible level of health. The conditions of citizens and the settings for health became increasingly invisible in health promotion.

The analysis of programs, revealed that the guidelines in the health promotion packages of the Danish health authorities from 2012, were silent on identifying the problems of inequality in health, and silent on how to involve citizens in defining health problems and health promotion, as a psychosocial environmentally based endeavour (Siegrist and Marmot, 2007). This silence in combination with lacking instruments of local health promotion practice, left critical potentials in health promotion to partly live a life in the shadows for many years. It has created a scene for health promotion to be formed on the background of powerful and neoliberally influenced conceptions of health problems and inequality in health in society. The programs of the health promotion packages in Denmark constructed the social conducts in health of lower class and marginalized citizens as the main problem. In the cases analysed it was seen how the active engagement of professionals and local institutions in detecting and categorising risks and risky behaviour, as suggested in the programs, marginalised the health of the less privileged families , and the problems of inequality in health were not prioritised. Instead of general cooperation with citizens in health promotion, only some citizens were chosen as legitimate. The result after several years is a strong guiding rationality in health institutions today, to focus on performance and competencies of citizens in relation to health, informed by neoliberal thinking.

These developments in health promotion have appeared alongside a growing inequality in health. The relation between the two is complex, and not to be answered clearly. However the analysis has here illuminated how systematic selection of health problems and citizens is practiced, due to the way health promotion has been constructed and become interpreted politically and professionally, disadvantaging the parts of the population who are less socially privileged. The critical potential in health promotion, to create better psychosocial environments of health, and to invite citizens to voice their health aspirations in the universal welfare state of Denmark, has been seriously weakened. In the analysis it has been argued that the way health promotion policies and institutions have connected to neoliberal values of individual responsibility, social segregation and de-legitimizing the socially less privileged, has lead towards exclusion of the health problems of these groups, and therefore inevitably must influence inequality in health negatively.

This tripartite analysis has illuminated that practices of municipal health promotion, in the case of children and parents in Denmark, are influenced by the historical conflicts of power in the health field at macro societal level. In this fight the agents of health promotion are newcomers, not powerful and simply not seen as legitimate agents, because of their positions rooted in civil society. The health and municipal reforms of 2007 in Denmark declared health promotion to be a decentralized political focus in broad terms and open to interpretation. This not only required decentralized creativity to evolve, but also allowed powerful agents in the field, with capital and instruments of action such as risk detection and evidence-based knowledge, to conquer these new platforms for action. The decentralization of health promotion to the local level has gradually received less funding since 2014, and in this way the political focus and the expertise has been drawn away from the parts of the country where the settings for health and life expectancy are worst, and health inequality is greatest (Bergin et. Al., 2018). With this unbalance, the role of the state in health promotion in order to secure universalism becomes acute, even in a small country as Denmark.

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