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Can inequality be tamed through boundary work? A qualitative study of health promotion aimed at reducing health inequalities

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ABSTRACT

This paper examines the organisational dynamics that arise in health promotion aimed at reducing health inequalities. The paper draws on ethnographic fieldwork among public health officers in Danish municipalities and qualitative interviews from an evaluation of health promotion programmes targeting homeless and other marginalised citizens. Analytically, we focus on 'boundary work', i.e. the ways in which social and symbolic boundaries are established, maintained, transgressed and negotiated, both at the administrative level and among frontline professionals. The paper discusses three types of boundary work: (i) demarcating professional domains; (ii) setting the boundaries of the task itself; and (iii) managing administrative boundaries. The main argument is that the production, maintenance and transgression of these three types of boundaries constitute central and time-consuming aspects of the practices of public health professionals, and that boundary work constitutes an important element in professional practices seeking to 'tame a wicked problem', such as social inequalities in health. A cross-cutting feature of the three types of boundary work is the management of the divide between health and social issues, which the professionals seemingly seek to uphold and transgress at the same time. The paper thus contributes to ongoing discussions of intersectoral action to address health inequalities. Furthermore, it extends the scope and application of the concept of boundary work in the sociology of public health by suggesting that the focus in previous research on professional demarcation be broadened in order to capture other types of boundaries that shape, and are shaped by, professional practices.

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1. Introduction

The task of reducing health inequalities is a complex one and has been called a 'wicked problem' (Blackman et al., 2006). It is characterised by multiple definitions and understandings, several causal levels and complex solutions, with no promise of clear success (Blackman et al., 2006). Tackling health inequalities calls for several complementary strategies (Solar and Irwin, 2010), ranging from population level intervention (e.g. legislation or taxation) to targeted strategies aimed at improving the health of the worst off (Frohlich and Potvin, 2008). In practice, these strategies may cover a variety of approaches, both in terms of the target group and the content of programmes. However, a common feature of most approaches to tackling health inequality is intersectoral collaboration (World Health Organization, 1997). The underlying idea is that health inequalities cannot be tackled by the health sector alone. They require active involvement of other sectors, e.g. education, labour market and employment, social services etc. (Solar and Irwin, 2010; Ndumbe-Eyoh and Moffatt, 2013). Particularly programmes targeting marginalised people call for close collaboration between the health sector and the social services sector, and thus for the integration of health promotion and social work. Health and social problems are typically strongly intertwined for this target group (Pedersen, 2013).

In this article, we aim to explore the organisational dynamics inherent in health promotion programmes targeting health inequalities in Denmark—programmes characterised by intersectoral collaboration. We do this from the point of view of the professionals involved in such programmes, analysing their experiences and practices. Thus, we contribute to the existing body of knowledge by providing detailed knowledge about the everyday realities and

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practices of intersectoral collaboration (Chircop et al., 2015) as well as the process, nature and context of intersectoral collaboration (Ndumbe-Eyoh and Moffatt, 2013).

We will analyse the practices of professionals through a particular conceptual lens: as examples of boundary work. In sociology, boundary work refers to the processes through which social and symbolic boundaries are established, maintained, transgressed, negotiated and dissolved (Lamont and Molnár, 2002). Gieryn (1983) introduced this concept as a rhetorical style used by scientists to separate science from non-science. Thus, boundary work comprised 'strategic practical actions' (Gieryn, 1999, p. 23) that scientists employed to draw, redraw and maintain boundaries in order to demarcate and justify their position and gain professional respect and authority (Gieryn, 1999). Allen (2000) made an important further development of Gieryn's concept by applying a microsociological perspective, focused on practices and discourses, to analyse processes of occupational demarcation in a hospital context. Allen understood boundary work as "micropolitical strategies through which work identities and occupational margins are negotiated" (Allen, 2000, p. 348).

A common feature of boundary work literature in medical sociology is the focus on the ongoing production, adjustment and management of boundaries among and within groups of professionals. In this literature, some studies have focused on collaboration across professional boundaries (Meier, 2015; Mizrachi et al., 2005; Mizrachi and Shuval, 2005). Others have focused on boundary work as a manner of constructing, defining and maintaining professional identities (Allen, 2000; Håland, 2012; Hotho, 2008). In their study on leadership in healthcare teams, Chreim et al. (2013) took a broad perspective on boundary work to include boundaries between, for instance, different professions, different levels of leadership and between personal life experiences and professional work.

In our study, boundary work serves as a heuristic concept that enables us to better understand the practices of public health professionals, and we bracket the issue of boundary work as an intentional practice or 'strategic action' (Gieryn, 1999). In other words, we seek to identify the most salient types of boundaries that emerge in professional practices aiming to reduce health inequalities and the work that goes into their (re-)making. Thereby, we expand the use of the concept of boundary work to encompass not only boundaries related to professional demarcation but also administrative boundaries, as well as boundaries related to defining and forming the health inequality problem itself, in order for it to become manageable in practice. A pressing issue for professionals working with health inequalities is how to deal with the divide between the domains of health issues and social issues, which, as we will suggest, needs to be maintained and transgressed at the same time. In suggesting this, we view boundary work as a pervasive feature of professional practices that is not only concerned with the making of professions, but is also a matter of taming social complexities (in this case the 'wickedness' of health inequalities) at a more fundamental level.

Most previous studies have analysed boundary work in a healthcare/hospital setting. In this study, we apply the concept to the settings of health promotion and intersectoral action for health, which have not previously been explored from this analytical perspective.

2. Study context

The study takes place in a Danish welfare state setting, which is based on a universalistic system that promotes redistribution of goods and status, and where all citizens are endowed with similar rights, irrespective of class or market position (Esping-Andersen, 1990). In principle, this means that all Danish citizens, regardless of their labour market position, have equal access to welfare benefits and services, e.g. health care and education. The Danish welfare model is based on general taxation and divided into three administrative levels: the state, five regions and 98 municipalities. Furthermore, it is characterised by a high degree of political, financial and operational decentralisation to the municipalities and regions. Issues of disease prevention and health promotion fall under the municipalities' areas of responsibility.

It is considered a paradox that countries like Denmark, with generous welfare structures, have not been able to reduce health inequalities (Mackenbach, 2012). Furthermore, the Danish case exemplifies several larger trends in the development of public health systems: a move towards decentralization with the very purpose of achieving better conditions for intersectoral collaboration (Larsen et al., 2014; Holt et al., 2017) coupled with an increased emphasis on evidence-based interventions and standardised services (Rod and Høybye, 2015). This provides an important context to the practices of intersectoral collaboration.

3. Methods

The article is based on two case studies. The first case study is an evaluation of four municipal outreach health promotion programmes. The second case study is an ethnographic study among municipal public health officers. We have chosen to combine these two studies, as this enables us to analyse the practices of public health professionals working at the administrative level (in municipal public health offices) as well as the frontline level (in the outreach programmes). Both research studies have been approved by the Danish Data Protection Agency but did not require further ethical approval (in accordance with Danish legislation).

3.1. An evaluation of municipal outreach health promotion programmes

The first case study focuses on four municipal outreach health promotion programmes (in the following termed outreach projects) in Denmark carried out from August 2010–June 2014. They aimed to develop relevant and accessible health services targeting marginalised people struggling with multiple and complex issues.

The first and second authors of this article conducted an evaluation of the outreach projects and analysed the progress and implementation of the projects.

Three of the outreach projects were organised with a project team of 2–4 key employees. Project employees were nurses (about 60%) and health care assistants (about 40%; education length: 20 months). One project had only one key employee (a nurse), who was supplemented by a social worker working relatively few hours on the project. Project employees were predominantly female; only one was male.

In the project period, the outreach projects reached a total of 710 citizens, varying from 119 in the smallest municipality (about 35,000 inhabitants) to 264 in the largest municipality (about 82,000 inhabitants).

We conducted qualitative interviews at two full-day site visits to each of the four outreach projects in August/September 2011 and March 2014 (see Table 1). In the site visits, we visited different project locations, e.g. project nursing clinics and shelters. In addition, our data material included project employees' presentations of project status and progress at a mid-term seminar in October 2012 and a final seminar in April 2014.

All informants were selected by the researchers except the collaborating partners, who were selected by the municipalities based on directions given by the researchers in order to ensure that

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