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ORIGINAL ARTICLE

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'Am I that bad?': Middle-class moralism and weight stigma towards parents of children with higher weight

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Abstract

The purpose of this article is to explore how parents of children with higher weights are represented in policy documents constituted by health authorities in the Danish welfare state. It focuses on how discourses of moral judgements might play a role in child rearing, by framing child obesity as a parental problem in health professionals' practical guidelines. The article is based on a discursive analysis of cases from three guidelines published by two respected Danish health bodies. The cases describe how health professionals should perceive families with obesity when providing interventions. Using sociocultural class theories, we find that the cases in the guidelines display a middle-class hegemony, which implies a preoccupation with moral judgements. Combining this with a post-structuralist concept of discursive subject positions and representations, we reveal how mothers of obese children are subject to these judgements, either as passive and irresponsible lower-class citizens or as morally worthwhile and responsible middle-class citizens because of shame and fear of being judged. We conclude that the ways obesity is discursively constructed by the Danish health authorities is concerning because they build on outdated and stigmatising views on obesity. The moral implications

of this might increase inequity in access to health by distributing stigma and thereby legitimating welfare retrenchment with reference to economic necessities and irresponsibility among the less privileged groups.

KEYWORDS

child welfare, childhood obesity, food & diet, health & well-being, parenting, policy and practice, social class, stigma, welfare

INTRODUCTION

The past 10–20 years have brought changes in the understanding of obesity throughout the biomedical environment, and obesity has come to be seen as a rather complex phenomenon (Herrera & Lindgren, 2010; Nan et al., 2012; Zuraikat et al., 2019).

Along the way, two significant perspectives on obesity have arisen within academia (Patterson & Johnston, 2012: 265): A biomedical perspective, viewing obesity as an individualistic physical issue and a major public health risk—an epidemic. And on the other hand, a constructionist perspective that explores this obesity epidemic discourse as a 'moral panic' framed by political interests and cultural values (Patterson & Johnston, 2012). The constructionist researchers are critical of the normativity and deviant identities produced by obesity discourses and question the underlying premise that there exists a single normalised state for all bodies characterised by slimness (Jutel, 2005; Wright & Harwood, 2009).

This article is positioned within the second perspective, where a growing number of critical fat studies challenge biomedical naturalised assumptions about fatness (Lupton, 2013; Rothblum & Solovay, 2009).

Throughout the article, we view the discursive constructions of obesity in light of post-structuralist cultural theory (Hall, 1993; Rose, 1999) combined with a Bourdieusian class perspective (Bourdieu, 2010; Skeggs, 2004a). It is rather seldom that social class theory is employed in studies of health inequality in Nordic research, apart from a few qualitative studies of healthcare consultations (Aamann, 2020; Aamann & Dybbroe, 2018). These studies point out how class seems to be a decisive factor in achieving an adequate dialogue between patients and professionals. We wish to contribute to this research by exploring how class operates at a discursive level in relation to child obesity.

To this, we add reasoning about healthism as a foundation for a neoliberalisation of welfare. Sociologist Imogen Tyler describes how a 'welfare stigma machine' permeates British society as a constant cycle of judgements (Tyler, 2020: 5); she argues that stigma is a political strategy to establish social differentiation (Tyler, 2020: 9). We wish to explore these perspectives in a context of universal health care and in light of class, morals and healthism.

The obesity epidemic and weight stigma by association

The concept of an obesity epidemic is a powerful discourse influencing the ways of thinking about health worldwide. It is based on biomedical assumptions that obesity rates in

Western countries have increased rapidly since the 1970s, leading to a great political concern (WHO, 2021). Consequently, obesity has been described as a crisis of catastrophic proportions (Rich & Evans, 2009: 158). This results in social rejection of weight gain and fatness in the public conscious (Brewis et al., 2018). Or, to quote Elisabeth Harrison in her PhD in critical disability studies: 'To assert that the dominant cultures of the West in the current moment are profoundly fat-phobic is to state the obvious' (Harrison, 2012: 325).

The naming of obesity as a disease legitimises close monitoring of children falling within the biomedical definition of obesity. This includes a range of intervention in families in order to make them change lifestyle regarding diet and physical activity level.

Literature indicate that the fat-phobic fear of obesity often leads to stigmatisation of people with higher weights (Papadopoulos & Brennan, 2015). Weight stigma is defined as the devaluation of individuals with higher weight, driven by weight-based prejudice and stereotypes. Present analyses indicates that these stereotypes might stem for neoliberal policies and how the public portray people with higher weights (Schorb, 2022). For example, by framing the obesity an issue of personal willpower. Weight-related stigma have presented itself in education, different workplaces, the mass media, in healthcare settings and might even perpetrated by family and friends (Levy & Pilver, 2012). Research evaluating the effects of weight stigma illustrate a range of potential health consequences reducing quality of life for individuals living with obesity and their families (Phelan et al., 2015). The consequences include impaired psychological well-being, social isolation, economic inequalities and may even interfere with the individual's effort to improve health and prevent weight gain (Puhl & King, 2013; Puhl & Suh, 2015).

Parents are held responsible for their children's weight and childhood obesity is in generally associated with poor parenting (Kalinowski et al., 2012; Lusk & Ellison, 2013). Studies have found that especially mothers of children with higher weight are targets of 'weight stigma by association' (Bos et al., 2013): a phenomenon in which the parent is stigmatised because of their child's condition. Some studies suggest that the mothers experience shame and critique of their parenting behaviours and feels unheard by health practitioners (Gorlick et al., 2021). Subject of weight stigma by association, are in risk of internalising the blame, shame and devaluation directed towards them, which might contribute to depression and anxiety and disrupted relationships within the family (Chen et al., 2016; Shi et al., 2019). Given the consequences of weight stigma it is important to examine how policies might contribute to the reproduction of the weight stigma.

Parenting and obesity in Denmark

The focus on obesity is highly present in Danish public health policies, targeting parents, who are considered responsible for both their own and their children's health and well-being (Danish Health Authority, 2021: 19; Niss & Jørgensen, 2016: 2). In this article, we explore how parents of children with higher weights are represented in policy documents distributed by Danish health authorities. We analyse three guidelines from two respected Danish health bodies: the Danish College of General Practitioners and the Danish Health Authority. The guidelines are interesting because they prescribe how professionals should act when detecting child obesity and providing interventions.

THEORETICAL CONCEPTS

A sociocultural concept of class

The concept of class is inspired by feminist sociologist Beverly Skeggs' further development of Wacquant and Bourdieu's perspectives. They claim that classes should be theorised as 'groups of social conflict whose determining factor lies in participation in, or exclusion from, the exercise of authority' (Wacquant, 1991: 48). Therefore, the middle class 'must be constituted through material and symbolic struggles' (Wacquant, 1991: 57).

We use this theoretical framework to view class as a social dynamic, which is (re-)produced and negotiated discursively (Ortner, 1991; Skeggs, 1997; Trautner, 2005). This implies that class manifests itself on the basis of how parents become judged as respectable, or as having the right kind of knowledge or taste (Aamann, 2020; Lawler, 2005b: 797).

Many scholars have pointed out that the core of contemporary class relations is struggles around moral authorisation (Aamann, 2017; Lamont, 2000; Lawler, 2005a; Sayer, 2005; Skeggs, 2004b). Further, in a neoliberal era, the 'field of judgments' (Rich & Evans, 2009: 163), class is constructed as relations and tensions between those who can authorise their moral judgements and those who cannot (Skeggs, 2011a).

Scandinavian ethnologists have found that the middle class has been successful in defining the dominant codes of behaviour, establishing a middle-class hegemony that neglects class differences (Frykman & Löfgren, 1987). They argue that class is highly present in Nordic societies, but the dominance of the middle class has rooted out the recognition of other classes, concealing the existing class systems in the welfare states (Sejersted, 2011: 255).

To understand how configurations of class relations infuse healthcare systems in the Nordic welfare states, one needs to map the present field of judgement. As a means to do that, we draw on the following cultural and political themes: healthism, neoliberalism and the increased focus on parenting.

Healthism and neoliberalism

Despite obesity being recognised as a complex and collective problem, research shows that individuals are still deemed responsible for taking care of their own health (Rich & Evans, 2005). This preoccupation with personal health is at the core of Western society (Crawford, 1980), and hence also of the Nordic welfare states. This is particularly due to the relationship between health and social appearance:

> In a health-valuing culture, people come to define themselves in part by how well they succeed or fail in adopting healthy practices [...] Moreover, health and the qualities of personhood associated with its achievement are key metaphors traversing the moral terrain of contemporary societies (Crawford, 2006: 402). This means that healthiness is at the core of the field of judgements, which characterises the present Western societies.

According to the political and cultural researcher Robert Crawford, this 'healthism' is actually the foundation of neoliberalism:

> Individual responsibility for health [...] proved to be particularly effective in establishing the "common sense" of neoliberalism's essential tenets. In contrasting a vision of autonomous, prudent and self-responsible individuals to images of the careless and the foolhardy, a link was easily made to the burden of social spending (Crawford, 2006: 410). In this light, there is a close connection between neoliberalism, healthism and moral judgements regarding appearance.

Neoliberalism has been framed as a societal logic suffusing people's bodies and minds (Dahl, 2012: 284). For example, neoliberalism celebrates the individual's freedom to choose. It is, however, a well-established point that neoliberal governmentality operates precisely through freedom (Rose, 1999). Thus, as noted by Brown: 'Neoliberal subjects are controlled *through* their freedom...because of neoliberalism's *moralization* of the consequences of this freedom' (Brown, 2005: 44).

This is one of the reasons why health is strongly associated with individual responsibility and why responsibility is a central marker of moral worth. In that light, one of the most significant means for the moral judgements that constitute current class tensions is healthiness.

The parenting turn

Historically, biopolitical interest in public health, along with urbanisation and the growth of the working classes from the late 18th century, led to increased moral regulation of motherhood because of a middle-class fear of the urban poor masses (Finch, 1993; Foucault, 1994; Rose, 1990), 'leaving a potential threat to social order quietly simmering at the doorstep of polite, middle-class society' (Finch, 1993: 16). In this 'public takeover of motherhood', social problems were colonised by a medical gaze (Buus, 2001; Finch, 1993; Løkke, 1998).

Recent years have witnessed an increased political concern about parenting practices on the assumption that childhood and ultimately society can best be improved by improving parenthood (Furedi, 2001; Lee et al., 2014). Research refers to a 'parenting turn' in which family policy individualises and decontextualises social and health problems, such as the concern with child obesity, targeting first and foremost mothers (Geinger et al., 2013). This leads to a situation in which certain parents' (lack of) parenting skills, rather than structural factors, are seen as the cause of society's problems.

The parenting turn in health and social politics can be understood as a symptom of neoliberal responsibilisation in which class differences have melted away, increasing the universalising of middle-class values (Gillies, 2007; Hennum, 2014).

DATA, METHODS AND ANALYTICAL STRATEGY

There exists an extensive body of material on child obesity from the Danish health authorities and other actors. Three key documents were identified, using a purposeful sampling strategy informed by the goals of our research (Howell & Prevenier, 2001; Patton, 2002). These specific guidelines have been selected for several reasons:

A GPs and school nurses are in the frontline of the welfare state, as they (ideally) have a close relationship with the whole family and sometimes even visit the homes. It is,

therefore, particularly interesting to explore how the health authorities construct obesity in guidelines targeting these central healthcare professions.

B The guidelines form the foundation for the Danish effort against child obesity even though they are quite old: Recent publications consist mostly of quantitative research to describe target groups at a population level. However, they still refer to our selected guidelines when addressing concrete interventions (see for instance Danish Health Authority, 2021: 21, 25; Danish Health Authority, 2019a: 40).

C The Danish Health Authority is the highest authority in Denmark with enormous influence on how the state, regions and municipalities organise healthcare practice. Likewise, the Danish College of General Practitioners forms a central anchor for general practitioners who are self-employed in Denmark. The guidelines set a precedent for how the five regions, 98 municipalities and 3326 GPs in Denmark organise and practise obesity interventions.

The guidelines are as follows:

- Opsporing af overvægt og tidlig indsats for børn og unge i skolealderen—Vejledning til skolesundhedstjenesten [Detecting obesity and early intervention for schoolchildren: Guideline for school health services] (Greiffenberg & Andersen, 2014), Danish Health Authority.
- Klinisk vejledning: Opsporing og behandling af overvægt hos førskolebørn [Clinical guideline: detecting and treating obesity in pre-schoolers] (Müller, 2006), Danish College of General Practitioners and Danish Health Authority.
- Stigmatisering—et debatoplæg om et dilemma i forebyggelsen [Stigmatisation: A discussion paper on a dilemma in preventative work] (Finke & Bennedsen, 2008), Danish Health Authority.

The guidelines contain a small number of cases, that is descriptions of specific meetings between families affected by obesity and health professionals. The cases are purpose-built and serve as illustrations to show GPs and school nurses how an intervention or a course of treatment ideally should take place. The situations described are, therefore, interesting to study as prescriptions of how the professionals are supposed to perceive families with obesity and act towards them.

The cases are typically elaborated during the guidelines in order to make the general instructions more specific; for example, in the clinical guideline for GPs the introduction says: 'At each step, we meet 5-year-old Kasper with his family' (Müller, 2006: 9).

After realising the guideline's central role in the Danish efforts to combat child obesity, we began the analysis by reading the entire guidelines, identifying the cases used to illustrate ideal practice. Then we commenced an abductive process that alternated between empirical data and theoretical understandings (of healthism and its moral implications), whereby both were being interpreted in the light of each other (Alvesson & Sköldberg, 2009: 4).

The cases from the guidelines were then analysed using post-structuralist arguments about class and subjectivity. Following that perspective, we may say that class, along with gender, ethnicity, race and other categories of diversity, circulates as discursive representations (Gillies, 2007: 8; Lawler, 2005a: 431; Ortner, 1991; Rich, 2011). However, representations are primarily interesting because they reveal something about those who have the power to represent others.

We have thus not analysed the persons in the cases as reflections of real people; rather, we are interested in what they reveal about the dominating views in the guidelines. Following this, it is important to emphasise that what we refer to as middle class should be understood as a discourse formation, rather than a specific group of people. Similarly, when we write 'the neoliberal subject', it refers to a discursive position, not a real individual.

FINDINGS

Working class linked to obesity

It is a common feature of the guidelines that the case families' work position is mentioned at the point of entry. The case in the guideline from the Danish Health Authority for school family nurses presents the parents of 12-year-old overweight Anna as follows: 'Both overweight, mother is a shop assistant, father is a driver' (Greiffenberg & Andersen, 2014: 65).

Further, the clinical guideline from the Danish College of General Practitioners and the Danish Health Authority represents five-year-old overweight Kasper and his family in this way:

> Kasper loves to watch television with his sister on Fridays. Then they share a bag of sweets and drink coke. Kasper hasn't learned to ride a bicycle due to the busy roads. Karin was sacked from her job as a service worker, so she can easily drive Kasper to the kindergarten in the family's old car. Karin would like to lose weight, she had her weight checked by her GP, but just now she's got no extra energy for that. She's just waiting for it to come.
>
> (Müller, 2006: 15)

The need to mention parents' line of work in continuation of their weight establishes an explicit link between working-class position and obesity.

Furthermore, Karin is represented as a mother without a job and without energy or will to change her situation and body. 'Just waiting for it [the extra energy] to come' appears as the complete antithesis to the neoliberal middle-class subject, where individual responsibility, self-discipline, action competence and health appearance indicate the person's moral worth. By contrast, Karin is waiting, passive, without initiative, lacking self-control. This is reinforced by the expression 'would like to' (lose weight) rather than the more action-oriented 'wants to'.

In relation to governmentality, sociologist Nikolas Rose argues:

> The government of the soul depends upon our recognition of ourselves as ideally and potentially certain sorts of person, the unease generated by a normative judgement of what we are and could become, and the incitement offered to overcome this discrepancy by following the advice of experts in the management of the self.
>
> (Rose, 1990: 11)

Following this, a capitalist 'subject of value' is precisely characterised by a constant motivation to refashion itself to be employable (Skeggs, 2004a: 74; Walkerdine, 2011: 256). The logic of capital underpinning this is further marked by two features: Firstly, a moral obligation to optimise one's human capital and thereby moral value (Türken et al., 2016), especially expressed through the concern with optimising health (Baird, 2008: 300). Secondly, 'people are increasingly expected to publicly legitimate themselves as good and worthy subjects' (Skeggs, 2011b: 496). As neoliberal governmentality works through moralisation, displaying one's responsibility and thereby one's worth and status becomes a key factor of society (Finch, 2007).

Skeggs emphasises how the working-class body is symbolically represented as fat, with an underlying assumption that the inheritance of this body lacks the discipline required to improve and become middle class (Skeggs, 1997: 85). In this sense, the relation between the obese body

and the neoliberal, middle-class subject of value is antagonistic: one cannot be fat and uphold middle-class moral value at the same time.

Seen in that light, governmentality and ideals of upward social mobility are closely linked: neoliberal technologies of the self-rely on class judgements because class is at the core of the normative judgement. Striving to become a certain sort of person simply means striving to become a middle-class subject, and not being an aspiring subject seems to be the constitutive limit (Hey, 2003).

Following this perspective, Karin seems unable to be led to self-management. Karin's laidback attitude suggests she has no real ambition to improve, in the sense of losing weight and becoming a person of moral worth. She is represented as someone who does not strive to legitimate herself as a subject of value; she does not display responsibility and moral worth.

Moral judgement: Irresponsible mothering

Later on, in the guideline for GPs, Karin is represented as irresponsible and immature. This happens as the case further illustrates how the family is guided towards various lifestyle changes such as exercise, diet and daily weight checks at home. At the final step 7, 'Review the weight management plan' the case goes:

> The parents come to see the doctor without Kasper; this morning he weighs 200 grams more than a month ago. They have stopped eating cake and candy daily and the kids only get one bag of sweets on Saturdays....Klaus [the father] laughs a bit shyly and says he's actually lost 2 kilos this month. Karin scowls at Klaus, saying slightly reproachfully to the doctor that it's not fair she hasn't lost weight, even though she hasn't eaten sweets and cakes either. The doctor commends the family for the great result. It shows that they got the will to change lifestyle. He urges them to hold on.
>
> (Müller, 2006: 30)

Here the case shows how to amputate objections. What could be interpreted as Karin's frustration with the lack of effect of lifestyle changes seems in the text to indicate the mother's lack of responsibility: Scowling at her husband testifies to a form of childish immaturity. This is presented as a contrast to the father, who is described in more positive terms: 'he laughs a bit shyly' and has had success in losing weight. When Karin calls her lack of success 'not fair', it represents an attempt to shift responsibility. 'Unfairness' places the issue outside her own sphere of action, in contrast to the neoliberal individualisation of responsibility. In the excerpt, it is also interesting that the GP chooses to ignore Karin's complaint. The GP's lack of interest in Karin's objection appears to need no further legitimation, perhaps because Karin has already been judged as morally inferior, that is not worth listening to.

Also, in the case from the Danish Health Authority guide for school family services, the mother is represented in a negative light:

> Anna, 12 years, comes to see the GP, because the school nurse is unsure about the causes of Anna's obesity and whether the family needs help. Anna's mother is a bit annoyed. 'It's only puppy fat' and it's a pity her daughter has now got a worry she could do without. Anna's mother is fed up with weight hysteria [...] But Anna cries, saying she is the fattest girl in the class.
>
> (Greiffenberg & Andersen, 2014: 69)

Describing the mother's reaction as 'a bit annoyed' invites the reader not to take her seriously. The mother's reaction becomes further devalued as her daughter starts crying. It shows the reader that the mother lacks understanding of her daughter's problems and that she does not take proper responsibility.

In the guidelines for both GPs and school nurses, obesity and working class-ness are closely linked. Further, the working-class mothers are represented as inadequate; Karin just sat and waited and acted immaturely at the doctor's while Anna's mother got annoyed and lacked an appropriate understanding of her daughter. Both cases, therefore, imply a judgement of the being working class mothers as irresponsible.

Moral judgement: Proper mothering through displaying shame

A radically different case is presented in the publication 'Stigmatisation: A discussion paper on a dilemma in preventative work'. The text focuses on stigmatisation in relation to a range of lifestyle interventions and discusses whether stigmatisation should always be avoided (e.g. p. 18). Throughout the guideline, a wide range of narratives are presented from the practices and fields of different health professionals. Regarding child obesity, under the heading 'Am I that bad?' we can read:

> A member of a municipal project on child obesity mentioned a mother who approached her: 'She was a nurse. And she cried like a baby. She found it so embarrassing, because with her education, she shouldn't have overweight children. In doing so, she expressed the prejudice that obesity is partly one's own fault and that only the lowest social groups are overweight'.
>
> (Finke & Bennedsen, 2008: 42)

The description in the text is very brief, but the interesting part is what the writers have chosen to emphasise, namely that the health professional from the project describes the mother's concern in a way where it does not spring from the perceived health risks but rather the shame associated with having a child with obesity. On the one hand, the mother's professional knowledge brings her insight into the health risks of obesity, which might be upsetting to her. On the other hand, this is not presented as the main concern of the mother.

What is also interesting is that the mother is represented as responsible despite having a child with obesity. The mother is not only represented as a health professional but also as a parent disassociating with the lower class. It appears to be the educational status of the mother that makes her ashamed, aware as she is that she should not have an overweight child because of her middle-class position; the shame seems to arise from a fear of being judged as 'that kind of mother'.

Interestingly, the representation of the mother does not contain a moral devaluation; via her class position and the shame, she retains her moral worth, being portrayed as someone the reader must sympathise with. This view is enforced by the narrator's words and interpretation of the situation, which stand as a conclusive sentence in the paper: only the lowest social groups are overweight.

The shame thus reveals the mother as a controllable subject, unlike Anna's mother and Karin. The portrayal of the middle-class mother bursting into tears, therefore, does not lead to a discussion of stigma towards fat people. Rather, the effect of these prejudices—the mother's shame and tears—indicates her moral worth.

In view of her tears and the title of the section, 'Am I that bad?', it thus appears to be her need to legitimate herself through the display of shame that prevents her from being judged in devaluing terms. In this sense, the fear of class stigma i becomes a marker of middle-class respectability (Ehrenreich, 1989).

DISCUSSION

Neither the ashamed mother, Karin nor Anna's mother are real human beings. They are textual representations in guidelines, prescribing how GPs and school nurses ought to act in the detection and treatment of child obesity. We have illuminated how these representations are infused with moral judgements explicitly linked to class. In this light, the guidelines seem to distribute and reproduce a middle-class hegemony. But why?

Distribution of middle-class hegemony

With Skeggs' perspectives, part of the explanation might be the fact that health professionals in Denmark, especially those at strategic and health policy levels, themselves are positioned in the middle and upper parts of society. Back in 1990, the Committee for Health Information in Denmark expressed worries that the one-sided recruitment for the health professions would result in a scenario where the promotion of health would blend with the promotion of middle-class culture (Buus & Brink, 1990: 87). Based on our findings, one could argue that this prophecy has come true.

The cases are probably constructed without an explicit awareness of class. Rather we suggest that a more subtle intuitive class consciousness is involved, as explored by Diana Reay. In her view, class is deeply embedded in everyday interactions and works as a key mechanism for placing self and others, even though it is seldom acknowledged (Reay, 2005: 924).

Despite widespread assumptions of the disappearance of classes in Denmark, our findings show how class plays a significant role in preventing child obesity and promoting parents' responsibility—at least as prescribed by the health authorities. On this basis, we call for further research on how class theories can be relevant when exploring inequality in health and in access to universal healthcare services.

Healthism: Stigma machines in universalist welfare states?

In line with healthism as the foundation for neoliberal governmentality through middle-class moralisation, the middle-class gaze infusing the documents seems to be preoccupied with moral judgements.

This obsession with making judgements is interesting: critics argue that 'moral panic' rather than scientific evidence is driving the overwhelming focus on obesity in Western societies (Monaghan, 2005: 309, Warin, 2019). When neoliberal conduct works by scapegoating the irresponsible and thereby establishing a moral otherness, in contrast to the ideal responsible, respectable and morally worthwhile subject (Tyler, 2013), the moral panic and the preoccupation with making judgements in the guidelines might testify to Tyler's points about stigma as a

political technology deployed in order to establish social differentiation and by extension also legitimate welfare cuts (Tyler, 2020).

It is thought-provoking that reasoning from a British context can be transferred to a Nordic welfare state with a much more extensive redistribution of wealth. The notion of stigma of association as a political technology in a Nordic welfare context certainly calls for further inquiry.

The social gradient and the relevance of studying discursive representations

We are aware that obesity statistically follows a social gradient: the lower the class position, the greater the risk of being obese and having children with obesity (Donkin et al. 2014). We also acknowledge that fighting obesity is a major task for healthcare systems.

However, we insist that discursive representations constitute a significant point of impact because of their possible effects; as noted by Skeggs: 'Representations are central to inscription, positioning, embodiment of value, exchange and the perspectives we take' (Skeggs, 2004b: 99).

Indeed, we call for empirical research that can shed light on the perspectives of working-class people, not only in relation to obesity but more broadly in relation to health care. Obesity curves continue to rise, and we need to know how the cycle of judgements and its institutionalisation in the universalist welfare state is experienced from a position without a mandate to pass judgements but instead is exposed to judgements.

Outdated policies—Where does that leave health professional practice?

Over the last 10–20 years there has been a development within obesity research and the way people of a higher weight is represented—both within the public debate and among health professionals. In 2017 the report 'Weight Bias and Obesity Stigma' was published by WHO. It reflects a new public health ethic emphasising the complexity of health determinants and recognising that body weight does not lie solely in individual choices or lifestyle. This is supported by research finding obesity only can be understood in intersections between genetics, environment and behaviour (Lee et al., 2015).

The problems associated with weight stigma have gradually influenced the view of researchers: the stigmatisation and discrimination against people with higher weights are now discussed as a factor potentially working as barrier against weight loss and health promotion.

In 2019 a new campaign towards weight loss was proposed by the Danish health authority in collaboration with an external working group, consisting of different health-association (Danish Health Authority, 2019b). The proposed campaign presented updated standardised guidelines for weight-loss programs in the municipalities, which was to be carried out in close collaboration with the general practitioners, who was expected to refer citizen of a higher weight to the programs.

The Danish College of General Practitioners (DSAM), which represents 5000 Danish general practisers, opposed this campaign alongside The Danish Psychological Association (Dansk Psykologi Forening) and a couples of other associations. The opposing organisations expressed a growing concern that weight focus is not only ineffective at producing healthier bodies, but might promote weight stigma, lead to reduced self-esteem, eating disorder, isolation and discrimination (Danish Health Authority, 2019c). Consequently, DSAM urged the Danish health

authorities to change their focus from body weight to functional bodies, which conflicted with the campaigns basis procedure of referring citizens according to their weight (ibid.). The disagreement developed into a conflict that ended with DSAM leaving the external working group (Rohweder, 2020).

Despite this, the Danish health authority published the national guidelines for prevention and treatment of obesity in 2021 (Danish Health Authority, 2021). These are described as lifestyle interventions, adapted the individual's specific needs, and the guidelines states that the intervention should be designed with special attention to avoid stigmatisation.

Still, the programs frame obesity as an individual condition and presuppose that the programs encourage and support the individual to lose weight. For example, by first and foremost describing a focus on initiatives towards individual lifestyle (pp. 14–15).

Furthermore, the guidelines refer to the policy document from 2008 we been analysing when mentioning stigma (p. 21). The same is the case regarding the analysed policy documents 'Detecting obesity and early intervention for schoolchildren: Guideline for school health services' and 'Clinical guideline: detecting and treating obesity in pre-schoolers' which health professionals are referred to regarding the detection of children with obesity (p. 18, 24).

In society and culture, the view of obesity and weight are changing, but that is not visible in the newest Danish policy documents. By referring to old documents when it comes to concrete interventions, the same messages and discourses are reproduced, despite greater understanding of the complexity of weight issues.

Outdated policies can pose challenges to health professional, potentially leaving them in a difficult position because they must navigate between following established policies and providing the best care for their patients.

Unequal access to universal health care

Despite free access to health care in Denmark, a range of studies document inequality across illnesses: from delayed diagnosis via less treatment to fewer offers of rehabilitation. Studies show that lower-class parents need significantly more consultations than parents of higher socioeconomic status to obtain a cancer diagnosis. At the same time, children of parents who are unemployed or have low education levels generally receive lower doses of chemotherapy (Pedersen, Erdmann, et al., 2021). Because discrimination is highly taboo and very often happens unconsciously, we know extremely little about why and how these inequalities occur.

Based on our study, we are unable to detect whether inequality occurs because of moralising and stigmatising practices. However, research show that disadvantaged people often avoid seeking healthcare services because experiences of dignity violation in consultations with their primary contacts, GPs and family nurses (Strøbaek et al., 2017). We consider it quite likely that some parents of children with obesity also avoid contact with the healthcare system.

Our findings show that present policy documents still refer to old guidelines when it comes to personal contact and caretaking. This is problematic on more levels as it potentially leads to outdated healthcare practises, dilemmas or conflicts for the health professionals and the reproduction of weight stigma. An ongoing dialogue, research and collaboration between policymakers and health professionals are important to ensure that policies remain up-to-date and responsive to the increased awareness of the complexity of obesity.

CONCLUSION: RE-REDISTRIBUTION THROUGH STIGMA?

In this article, we have explored whether discourses constituted by health authorities related to detection and treatment of child obesity contribute to inequality despite the opposite intention.

The article has argued that the moral panic surrounding obesity has classed implications that are at the core of neoliberal governmentality. As we showed in the analysis, there are two main representations of mothers of children with obesity. The lower-class mothers were described as immature, irresponsible and morally inferior because they demonstrated neither action competence nor a desire for displaying moral worth, while the middle-class mother who burst into tears was represented as responsible and morally worthwhile precisely because she displayed a fear of class-based stigmatisation: her shame indicated that she should be judged as responsible because of her desire for improvement.

The relevance of examining discursive representations lies in their effects. They are not only worth studying as expressions of how the state ideally would like to see its citizens. More broadly, they also affect the struggles for a better society, such as the distribution of privileges, recognition and access to health care.

In the Nordic welfare states, we have seen a health and distribution policy, which increasingly privileges those who are already better off, including a greater use of private health insurance and cuts in public health care. The cause for concern here is the legitimation of this scaling down of the universalist welfare state with reference to economic necessities and a lack of responsibility among the less privileged.

Viewed in this light, the obesity discourses in the documents we have analysed are not only about distribution of middle-class hegemony through morality; they also risk functioning as a legitimating force in a neoliberal re-redistribution, causing increased inequality in health harming the children and families in most need of public support.

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The authors declare that there is no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on the Danish Health Authority's public domain: https://www.sst.dk/en/English. The three report analysed were accessed at the following links: https://www.sst.dk/da/udgivelser/2014/opsporing-af-overvaegt-og-tidlig-indsats-for-boern-og-unge-i-skolealderen; https://www.sst.dk/da/udgivelser/2006/opsporing-og-behandling-af-overvaegt-hos-foerskoleboern---klinisk-vejledning; https://www.sst.dk/da/udgivelser/2008/stigmatisering---debatoplaeg-om-et-dilemma-i-forebyggelsen. 20 September 2022.

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Ethics approval was not required for this article because the data analysed is publicly available.

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