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“I imagine that they will probably ask about my lifestyle”

Perspectives on preventive health checks in a socially disadvantaged housing association

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There is generally poor uptake in preventive health checks. Those who are the least likely to participate have the lowest levels of income and education, suffer from more chronic diseases, and lead more so called ‘at risk’ lifestyles. In this article, we explore how people with low levels of education and income relate to health promotion and illness prevention. The article is based on semi-structured interviews with ten people who live in a social housing association. They have been invited to participate in a preventive health check but have not responded to the invitation. Through a narrative inspired analysis, we explore how imaginations, descriptions, and expectations of how life should be lived, influences the ways that people experience and relate with health promotion interventions.

We found that amidst their many social and health-related concerns, our interviewees continued to subscribe to health promotion ideals. The health promotion messages were

integrated into their canonical narratives of their health and illness practices. However, their concrete health and illness practices seemed to discourage them from participating in preventive health checks, since participation was associated with failure to live up to the canonical expectations of health promotion.

Introduction

Within public health, one problem often raised in the literature, is that it is difficult to reach and engage vulnerable and socially disadvantaged people in health promotion activities (Bjerregaard, Maindal, Bruun & Sandbæk, 2017; Dryden, Williams, McCowan & Themessl-Huber, 2012; Hoebel, Richter & Lampert, 2013), and this article explores some of the reasons for this. Explanations are sometimes discussed with reference to individual socioeconomic traits such as financial and educational status (Larsen, Sandbæk, Thomsen and Bjerregaard, 2018), personal abilities and competencies like knowledge, understanding and lifestyle (Baum & Fisher, 2014), and at other times with reference to the wider social, political and economic structures of marginalization and discrimination (Dumas, Robitaille & Jette, 2014). One common theme is that although a wide range of health promotion initiatives are directed at reducing social differences in health and illness, they do not always have the desired outcome or reach those most in need of assistance. This has also been the case with preventive health checks, which usually consists of a physical examination, combined with a health talk focusing on social and psychological issues. In addition to vigilant debates around their effects (Bjerregaard, Maindal, Bruun & Sandbæk, 2017; Hoebel, Richter & Lampert, 2013; Jørgensen et al., 2014), studies have shown substantial social differences in participation, and the adverse socioeconomic profiles of the non-attendees are well known (Bjerregaard, Maindal, Bruun & Sandbæk, 2017; Dryden, Williams, McCowan & Themessl-Huber, 2012). This means that those who are less likely to participate are people who have the lowest levels of income and education, suffer from physical and mental diseases, have bad self-rated health, and tend to smoke more and be less physically active (ibid.). Hence, preventive health checks do not always reach those who potentially stand to benefit the most from participating (Bjerregaard, Maindal, Bruun & Sandbæk, 2017; Dryden, Williams, McCowan & Themessl-Huber, 2012; Flachs et al., 2015) if they, in fact, benefit at all (Krogsbøll, Jørgensen & Gøtzsche, 2019). One approach to improve both effect and uptake has been to target the health checks to populations defined as 'at risk', with reference

to for instance education, income, health status, or residential area, by situating the intervention in the local community. This has been tried with varying success and modest participation rates seem to persist (Jørgensen et al., 2014; Riley et al., 2015). While studies have enriched our understanding of why people have chosen not to participate in health checks (Nielsen, Dyhr, Lauritzen & Malterud, 2004), and reasons for not following official health recommendations such as smoking during pregnancy (Risør, 2002) or being overweight (Grøn, 2004), we know little about why vulnerable and socially disadvantaged people, who may potentially benefit from preventive health checks (and other health promotion interventions) are less likely to attend. Current explanations remain focused on lack of knowledge and understanding, sometimes described as ‘health literacy’ (Friis, Vind, Simmons & Maindal, 2016). As such, they do not take us beyond casual explanations, where knowledge-based behavior change is considered the key to motivating people to attend. Encouraged by recent calls for more locally based public health policy and interventions (Blue, Shove, Carmona & Kelly, 2016), the aim of this article is to explore some of the factors that influence why so many ‘at risk’ people do not participate in preventive health checks. We do this by focusing on what health promotion and illness prevention means in the lives of people who are sometimes considered hard to reach with health promotion initiatives. The study is based on a concrete targeted preventive health check intervention, offered to residents in selected neighborhoods characterized by high levels of unemployment and low levels of income (Larsen, Sandbæk, Thomsen & Bjerregaard, 2018), with the specific aim of reducing social differences in health and illness.

Methods

The study is based on semi-structured interviews with ten people who were invited to participate in a preventive health check during the fall of 2017 but had not responded to the invitation. The health check they were invited to was organized by the municipality and situated at the health centers in the local communities. It lasted approximately one hour and consisted of control of height, weight, blood pressure, cholesterol, lung function, blood sugar and fitness levels, as well as a discussion of lifestyle and quality of life, based on the answers given in a questionnaire. If the results from the health check indicated a potential health problem, participants would be encouraged to talk to their doctor.

Our interviewees were selected from a township in the intervention area, where people generally had a lower income, and a higher proportion of unemployment and non-participants compared to the other parishes that participated in the intervention project. The sole inclusion criteria in this study were that our interview persons had not responded to the invitation to participate in the health check. All interviewees had received the invitation letter to a health check from the municipality approximately six months earlier than we began our study. The invitation letter stated that the municipality would like to invite them to a health check, followed by a proposed time and date when the health check was scheduled. The invitee was asked to confirm or change this date online. Attached to the invitation was a folder, which described what would take place during the health check in more detail. If the invitee did not respond to the invitation with a yes or no online, they received a reminder one month after receiving the initial invitation.

The interviewees were first informed about our study in a letter, and subsequently, the first author contacted them by phone and asked if they would like to participate in an interview. Both authors were part of an independent multidisciplinary evaluation team and given their role as evaluators the team was able to identify non-participants. We sent a letter to a total of 55 persons, to have a large number of people to recruit from, as we suspected that recruitment might prove difficult. This was not the case, however. Based on the information we had about the 55 people (name and address), we were able to obtain phone numbers of 37 of the people. The first author called all 37 people. We made an appointment with eight of the 37 people on the first call. Another eight of the 37 people declined to attend. For the remaining 22, we left an answering machine message. Two of them called back and were interested in attending. We did not get in touch with the remaining 20 persons. We stopped recruiting when we had ten participants, which was the initial number of persons we planned to interview. As the interviews proceeded, we decided to stick with the ten as the new insights and ideas we encountered indicated an adequate sample size (Malterud, Siersma & Gaussora, 2016).

Five women and five men between 49-65 years of age participated in this study. Most of them had no formal education after primary school and eight out of ten were either full-time or part-time outside the labor market, due to early retirement, sick leave, and public pension. They all had some sort of health challenges primarily what may be referred to as lifestyle-related diseases such as diabetes, high blood pressure, and Chronic Obstructive Pulmonary Disease (COPD). Some had other physical or mental conditions or impairments that significantly influenced their daily life and most of them suffered from multiple diseases.

The focus of the interviews and subsequent analysis was to get detailed and varied insight and perspectives on health, illness, and prevention initiatives among non-participants. Our interview guide focused on the specific themes, while also allowing the interviewees to speak freely about their perceptions of health, illness, and health promotion (Kvale, 1997). However, using semi-structured interviews allowed us to change the order of the themes, expand and restructure the interview guide and the questions, depending on how the interview progressed and what themes came up (ibid.). The interviews were carried out in the homes of the interviewees, during a three-week period from January to February 2018. They were all recorded and lasted between 30–70 minutes. They were conducted and transcribed verbatim by Braae, except for one, which was carried out by Merrild. Upon the first contact on the telephone, the authors presented themselves as independent of the project, and underlined that they were not working for the municipal, nor did they have any health professional background. This was repeated when the interview was carried out. The first author presented herself as a student from the university and the second author presented herself as an anthropologist. All participants provided written informed consent to participate in the study, and all have been anonymized in the following analysis.

Data analysis and theoretical approach

The interview transcriptions and notes were read, re-read, and subsequently thematically coded using the software tool NVivo 10. First, we did a semi-focused reading of the transcriptions, where words and phrases centering on health and illness practices were written by hand in the margin (Emerson, Fretz & Shaw, 1995). After the initial semi-focused reading, which directed our attention towards two central themes, we carried out a more focused coding in NVivo based on the two themes. The two themes were: *Trying to be healthy when living with difficult physical and social circumstances* and *Difficulties with health as a barrier to preventive health checks*.

The subsequent analysis was inspired by Jerome Bruner's narrative theory focusing on how canonical expectations to how life should be lived, influence the ways that people portray their lives (Bruner, 1991, Bruner, 1999). A basic conception in narrative theory is that it is through narratives that we communicate what is important in our life (Garro & Mattingly, 2000). However, the stories we tell are often guided by how we think the recipient wants us to be, and what we think

the recipient would like to hear (Bruner, 2004). According to Bruner (1999), narratives are, among other things, anchored in the canonical. The canonical can be defined as that which is commonly perceived as the ideal and the optimum, and one key point is that people most often act according to dominant and culturally informed understandings of reality namely the canonical (ibid). In this article, we approach the narratives that were presented in our interviews as deeply connected with culturally informed perceptions and canonical expectations about ideal health behavior (ibid.). This approach in many ways resembles what some scholars have described as the imperative of health (Lupton, 1995), or even the politics of life itself (Rose, 2006). These bio-power studies have been instrumental in pointing out how neoliberal rationality has shaped the way health is defined and promoted (Ayo, 2012). The bio-power studies offer a relevant frame for understanding the organization of healthcare and for policy development in Denmark, and implementation of various forms of behavioral health promotion and illness prevention (Kristensen, Lim & Askegaard, 2016). They also show how ideal health practices are shaped by discourses of new public health and health promotion, which tend to impose notions of responsibility for maintaining good health and requires that people ascribe to and practice certain types of health behavior. Moreover, they have been instrumental in pointing out social differences in the ways that these obligations are met. Inspired by these perspectives we are interested in how people appropriate public health messages and interventions differently, and in what follows we depart in the example of the preventive health check.

Results

Trying to be healthy when living with difficult physical and social circumstances

Overall the interviewees fitted the profile of the intended at-risk target population of the intervention, as they all suffered from different chronic and lifestyle-related diseases. Most of them had lived with disease and illness for many years. In the face of their illnesses, the interviewees vividly pointed out the importance of having a healthy lifestyle. They explained the significance of actively maintaining their health and were eager to describe the things that they had done, which they

considered good for their health. Several of the interviewees pointed out how they tried to be active by walking and how they tried to eat healthy food. Some were frustrated about how their health seemed inconsistent with their self-image. For instance, Sasja, who is 60 years old and has been living on disability pension for the last five years, describes how it always has been natural for her to eat low fat, go for walks and do gymnastics at home:

I have never been sick before, nothing but flu. So I was very surprised. I live healthily and there is nothing wrong with me (...) I don't understand, why I got diabetes. Usually, they say 'if you eat very fatty food and a lot of sweets such as soft drink, candy, and cakes' but I don't do that.

Sasja is a tiny Asian woman, who lives in a small apartment with her Danish husband with whom she has two grown children. When Sofie visited her in her apartment the smell of tobacco struck her even before crossing the doorstep. A mixture of Danish and Asian decor styles characterized the apartment. When Sasja was young, she came to Denmark from Sri Lanka, but she still maintains close ties with her cultural background. She was trained as a social educator and has been working in that field for many years until she got early retirement. Now her everyday life is more monotonous because she stays at home most of the time. But she tries to get a little exercise by going for walks.

Every narrative is a composition of unique sequences of events, states of mind, and events in which the narrator himself is the main character. These unique sequences all have a meaning in the narrative (Bruner, 1999). As illustrated in the quote above, and elaborated throughout the interview, it is clear that Sasja knows what constitutes healthy lifestyle practices. She associates her lifestyle with this, and therefore it does not make sense to her that she got sick. In her narrative, Sasja seeks meaning and coherence when the unusual or problematic occurs (Bruner, 1991). She also expresses a sense of failure to live up to the recommended lifestyle practices, but there are circumstances in her life, which make it difficult. Her narrative reflects how she tries to live up to these recommendations:

Maybe I should do some more gymnastics or some sport. But the thing is that after I have been operated on (they removed a blood vessel) sometimes I have a little difficulty walking because I feel pain in my legs. I think after they've taken away that vein, my blood circulation in that leg is not good anymore. So that's why I feel pain when I go for a walk. Then I sometimes have to find a curb and sit there for a bit.

In many interviews, physical impairments were pointed out as a big influencer on health practices. Gitte, for instance, is 52 years old and has several health challenges such as overweight, asthma, and pain in the knees and hip. She lives in an apartment with her boyfriend. She has an adult son from a previous marriage. She is in a flex job five hours a day working in a kiosk and describes herself as a rather burdened and fragile person who has several challenges. When she finishes her workday after five hours, she feels very tired, and if she for instance catches a cold, she stays at home for 14 days because she has breathing problems. Currently, she goes to the doctor a little more often than usual because she feels winter depressed and stressed, and she also sleeps poorly at night.

She explains:

Right now, I don't do anything. But once in a while, I try to do some exercise together with a friend. Because I know I should get off my bum and do it, and I have a lot of time.

Gitte also describes that it means a lot that her surroundings back her up and even pushes her a little bit, because she does not think that her willpower is strong enough to find and maintain motivation. However, she also explains how she and her boyfriend negatively affect each other:

We are both lazy, and it doesn't help much that both of us keep lying on the couch. There has to be someone who takes the initiative. None of us are good at that and then nothing happens (...) We talk a lot about exercising and I tell him, 'Would you like to join me and support me, because I need some support'. We totally agree because he is overweight too, but then we end up laying on the couch, thinking 'Oh it's raining a little outside, so we shouldn't go out'.

Gitte articulates how she 'ought to' live a healthier everyday life, explicitly pointing out what she could do better, by for instance doing more exercise or eating less unhealthy food. However, she does not explain why she thinks she should do better, or what she would like to achieve, other than that she 'ought to do more'. She has tried to change her lifestyle more than once before, and as she describes it; she has always been on a diet. She constantly makes demands on herself by setting deadlines for when she should start changing her lifestyle. But these deadlines are exceeded time after time.

Kim, who is 56 years old, also has several health challenges such as overweight and COPD symptoms. He lives alone in a much-worn townhouse. Stepping into the home is like stepping into a cloud of smoke, and in many ways, Kim embodies

the image or illusion, which is often associated with vulnerability. He has a short education, he is unemployed, lives alone, and he smokes a lot. Personal care does not appear to be a high priority for Kim, and he is missing all his cheek teeth and only has a few front teeth left. Currently, he is waiting for an answer from the municipality about whether they will cover the dental treatment costs. His weight and his difficult breathing prevent him from moving around much. For him, going down to the supermarket is a physical challenge. Sofie notices that his bed is hidden behind a bookshelf in the living room, and Kim tells her that it is because he is not able to climb the stairs to the first floor. Kim describes his everyday life as incredibly trivial with no difference between the days, which makes them all merge into one. He knows that he "should" stop smoking and exercise more, but he does not have the energy.

He explains:

I could begin to do more exercise. But it's difficult to get myself together...It just doesn't happen. You think about it and talk about it. My two brothers have exactly the same problem...

In their narratives, Sasja, Gitte, Kim, and the others are fully aware and relate with what may be described as the public health promotion discourse, and what in Denmark is known as the KRAM factors (healthy diet, non-smoking, low consumption of alcohol and exercise), that constitute the official health recommendations. They do, however, not practice what they describe as a 'healthy lifestyle' in the way they feel they 'should'. Nevertheless, throughout the interviews, they describe themselves as being concerned about their health, albeit not being able to do enough to improve it. The KRAM factors figured vividly in their descriptions, and the health promotion and illness prevention discourse were reflected in the ways that they present themselves, through canonical articulations of what constitutes good health behavior (Bruner, 1999; Bruner, 2004). Whether they followed the advice or not is hard to say, but what we want to stress using these examples is that within their sense of moral obligation to 'do more', there was an implicit sense of failure and self-blame for not living up to certain established public health standards.

Difficulties with health as a barrier to preventive health checks

The majority of our interviewees already had established contact with the health care system in the form of ongoing controls, treatments, and rehabilitation, most

often at the hospital or in other specialized settings. Thus, many of their situations resemble that of Anne, where managing diseases, medications and controls are a big part of life. Anne is 49 years old and has been a chronic patient for many years. Her life has gradually become easier to handle because she has learned to live with her chronic diseases (Wikan, 2000; Wind, 2009). When asked about the health checks Anne explains:

Well, I am cautious with this sort of health check. On one hand, it's good to know if you are sick. On the other hand, if you suddenly get to know that you have fat on your liver, but you had not even noticed it, then I don't think it's cool. Then I have to relate to another new thing.

This was also the case for Otto who is 59 years old. Since his youth, he has been living of early retirement pension, unable to work due to chronic back problems. In 2017 he got two blood clots in his heart, and when asked about what was going on in his life at the time when he received the invitation to the health check, he explains:

Yes, I got the invitation. But at that time, I had just returned home from the hospital. I slept, I ate, and nothing else. So, I had no energy to respond to it (the invitation). I thought, 'it doesn't matter, I have to wait until I get better'. I also got an invitation to a cancer check. But I didn't do that either because I had enough concerns with my heart.

As these citations show, the management of diseases takes up much of our interview persons' energy and attention. In the public health literature, it has been shown that people who suffer from multiple diseases are more likely to experience a high treatment burden than individuals with only one disease (Friis et al., 2019; Shippee et al., 2012). The health check may be considered an additional burden or strain that is difficult to deal with when life is already filled with health challenges. Tove, who is 65 years old, expressed an overall sentiment that was underlying in all the interviews, when she expressed her expectations to the health check:

I imagine that they will probably ask about my lifestyle and if there was something else I could do (to improve health).

Tove lives together with her husband. They have seven children and their youngest daughter, who is 24 years old is still living at home, because she suffers from various psychiatric and physical diagnoses, such as brain damage and learning difficulties. Tove is living on early retirement due to asthma and COPD, and she also suffers from several other diseases such as ADHD and high cholesterol, heart

problems, and depression. She is struggling to take care of her youngest daughter while she manages her own diseases. When Camilla asks her what she had thought about the invitation to participate in a preventive health check she says:

They can't do anything for me anyway. I have all my problems and I have had them for many years. What are they supposed to do about that?

This is not to say that our interview persons were uninterested in changing their lifestyle. As Gitte explains:

I was considering participating, but I am aware that I am overweight and in really bad shape. That's why I didn't accept the offer. I don't need to get down there just to be told that my fitness rating is horrible and I have to do something.

Gitte and the others were acutely aware of their health situation, and they had very clear expectations of what they would be told if they showed up to the health check. And these expectations did not encourage them to participate. When our interviewees presented their health status or practices, they explicitly pointed out how they tried their best to adhere to the KRAM messages, and they presented their intentions to live healthy lives. However, their narrations were always shaped by a more or less explicit sense that they ought to be better. Sometimes their disease management got in their way; sometimes it was the contrast between real life and the ideal, or canonical (Bruner, 1999). Bo, who is 56 years old, describes it this way:

Well, you're busy and there are many things to do. Maybe you're just pushing it in the background, even though it's really about you, and you might say it's stupid. (...) I think it's because you don't feel that your health is shaped by alignment and misery, so I think that's probably the others it's about, and not me.

Bo goes to work every day, and he does not feel that there is anything wrong with his health. This sense of irrelevance was one among many reasons, which our interview persons gave when explaining why they did not participate in the preventive health checks. Some of them explained their non-participation by lack of energy in everyday life. Their everyday life was filled with many other challenges and concerns, and an invitation to a health check could therefore quickly be pushed into the background. Others explained that they found the health checks irrelevant and inappropriate to their particular situation. Some of the interviewees were already diagnosed with some of the diseases, which the health check tested for, and they described how the treatments and control of their current diseases

took up most of their energy. Some also expressed concern about the outcome of the health check, and in many of the narratives the timing of the invitation was described as “bad”. As the interviews progressed, however, it seemed that if the invitation had come at a different time, there might have been another reason why they did not attend. Importantly, however, it seemed imperative for all our interviewees that they needed to legitimize why they did not participate, in elaborate ways, rather than just rejecting the offer by asserting that it was not for them.

Discussion

One central point that stood out in all the interviews was the expectation that our interview persons would be reminded of their failure to live up to the canonical health promotion ideals if they had attended the preventive health check. This expectation somehow contrasted the canonical presentation of health practices that they articulated, which may be seen as a reflection of how people feel that they must live up to the demands of the public health promotion paradigm (Lupton, 1995; Lupton & Petersen, 1997), or at least signal their willingness to do so. This ambiguity is important and illustrates the impact that health promotion messages have on people’s perceptions of how they ought to live their lives. It has been amply illustrated how people feel obliged to act as ‘good citizens’ by managing their bodies and utilizing the health care system appropriately (Offersen, Vedsted & Andersen, 2017). One recent Danish study exploring how people respond to health messages on how to live healthy lives, shows how these messages are appropriated differently, albeit within the frames of dominant notions of healthism (Kristensen, Lim & Askegaard, 2016). Likewise, our interview persons wanted, but were not always able, to live lives that were inspired by the KRAM factors of eating healthily, being active, refraining from smoking, and so on. This is consistent with how Bruner argues that narratives can be an expression of the desired way of being in the world (Bruner, 1991; Wind, 2009). As argued by bio-power studies, current health promotion discourses leave little room and opportunity for reflection, and our interviewees expressed the moral imperative as they “ought to pay more attention to their health” and “ought to be more active in everyday life”. This underlines the canonical status of actively engaging in promoting health and preventing illness. However, it has been pointed out how intentions to live more healthy lives are sometimes discouraged when people fail to do it the ‘right way’ (Merrild, Andersen, Risør & Vedsted, 2017), and how lay perceptions of pathways

to ill health are often associated with difficult social circumstances morality and (lack of) personal control (Popay et al., 2003). The fact that our interview persons did not participate in preventive health checks, which was never due to forgetfulness, suggests that they did not wish to be confronted with their failure to live up to the official ideals of healthy and morally acceptable ways of living responsibly by taking good care of themselves (Lupton & Petersen, 1997).

As argued by Bruner, people explain their situations in an attempt to act in a given setting, and the explanations we heard can be seen as ways of containing, solving, or dealing with the challenges of not being able to live up to expectations of the good and healthy life (Bruner, 1999; Bruner, 2004). Through their narratives, our interviewees vividly explained the many reasons for why their health practices diverted from the canonical health behavior and legitimized why they had chosen not to participate in the health check. It is, of course, more than likely that our interest in their health practices, their non-participation in the health check and in their perceptions of what health means in everyday life, underlined the significance that they attributed to healthy living, as well as the overall attention that they expressed towards public health advice and awareness of eating healthily, being active and so on. However, Popay and colleagues draw similar conclusions and refer to how people from socially disadvantaged backgrounds feel the need to justify their lifestyles and construct acceptable moral identities through strategies of coping and control (Popay et al., 2003). These moral identities are reflected in how people use narratives to explain and justify when their lifestyle differs from the canonical (Bruner, 2004).

Another important point is that dealing with illness was an inherent part of the lives of all our interviewees, and the majority of them already had extensive contact with the health care system due to their deteriorating health. Improving knowledge and awareness in order to instigate behavior change remains central in many discussions on social inequality and lifestyle, where for instance low levels of health literacy have been pointed out as explanations of why socially disadvantaged groups do not act in accordance with health promotion strategies (Friis, Vind, Simmons & Maindal, 2016). However, in a recent study of older men who live with multimorbidity Jønsson and colleagues (2020) illustrate how although the men attributed importance to a healthy lifestyle, their actual practices are often shaped by their own perceptions of how a good life should be lived. Like the men in Jønsson's study, our interviewees did not seem to lack knowledge and understanding of health promotion messages. In accordance with critical public health literature, we argue that lack of knowledge and understanding may not be

the main explanation that people do not participate in preventive health checks or live according to the KRAM factors. Explanations for why people may not accept well-meaning public health promotion offers have more to do with their life circumstances and management of their diseases, which seemed to overshadow the management or promotion of good health (Dumas et al., 2014; Merrild et al., 2017). Thus, our findings resonate with points raised in critical health promotion literature, where it has been argued that the failure to live up to the health promotion ideals creates stigmatization and feelings of failure or defeat (Dumas, Robitaille & Jette, 2014; White, Adams & Heywood, 2009; Blaxter, 1990). We found that our interviewees' canonical narratives of their attempts to live healthy lives were shaped by the imperative of health (Lupton, 1995), and when despite their efforts they were unable to live up to those canonical ideals, they felt discouraged and sometimes alienated. This underlines how the neoliberal health ideal has succeeded in moving health practices into the realm of morality (Ayo, 2012), thereby advancing an omnipresent health consciousness that makes people feel obliged to construct canonical narrations of their moral endeavors to live good and healthy lives. By bringing the canonical perspective into conversation with bio-power studies, we have illuminated how preventive health checks, as an example of health promotion interventions, reinforces ideal or 'good' health behavior, and thereby ostracize those who do not live up to these ideals. Not responding to a health check defines you as 'hard to reach' or as someone who does not live up to the responsibilities of being a good welfare citizen (Offersen, Vedsted & Andersen, 2017), and introduces descriptions such as 'at risk populations', 'non-attenders' or 'those who do not understand'. It is therefore not surprising that our interviewees narrated such consistent canonical presentations of their aspirations towards the official KRAM definitions of lifestyle, and that they perceived the health check as an examination of whether they lived according to the health promotion discourse.

Conclusion

Discussions on low participation rates in preventive health checks often focus on personal characteristics (Baum & Fisher, 2014; Larsen, Sandbæk, Thomsen & Bjerregaard, 2018; Friis, Vind, Simmons & Maindal, 2016) and structures of marginalization and discrimination (Dumas, Robitaille & Jette, 2014). However, responding to recent calls to understand health practices beyond explanations of macro phenomena and structures of inequality, or with reference to individual choices and be-

haviors (Blue, Shove, Carmona & Kelly, 2016) our results indicate that people, who do not participate in preventive health checks, many times incorporate health-promoting elements in their daily lives to the extent that it makes sense for them. Our interviewees actively related with health promotion and illness prevention and articulated a canonical image of their health and illness practices, although very much conscious about how they could do better. One central point that we raise is that not attending the health check was often grounded in fears of stigma and blame for not living up to the responsibilities as a citizen in a welfare system – and being healthy enough. Being a ‘non-attender’ brings with it a connotation of failure, and simultaneously places non-attenders as both the causes and solutions of their health problems (Ayo, 2012). One may suggest, however, that due to the lack of evidence in terms of benefits of attending, those who chose not to attend may be the ones who act most responsibly, by refusing to accept an offer, which may not have any real effect. Regardless, our study adds to our knowledge about how people appropriate and engage with the established public health truths, and we show that these truths are not without consequences for how people perceive their own lives. We argue that insisting on offering health checks to externally defined at-risk populations and trying to identify problems and diseases that they already know they have, is a classic example of health promotion that is grounded in ideals that are far removed from the challenges people face in everyday life. The persistence of the narratives we encountered underlines that such interventions are not without consequences, for those who need not be ‘asked about their lifestyle’ and reminded that they are not good enough. Our findings may help establish a new perspective on how people try to promote their health to the best of their abilities, in ways that are not just contingent on their knowledge about and understanding of healthy living (Friis et al., 2019) but grounded in their life circumstances (Merrild, Vedsted & Andersen, 2016). Perhaps it would be beneficial to take seriously the interests and desires that people have in maintaining and improving their health and social situation, and build on these, although they may not correspond with established public health truths about how healthy lives and bodies should be practiced. This, however, requires recognition and acknowledgment that lifestyle and health status may not be the primary source of concern and that we may further marginalize the people we try to assist by defining them as people who ‘need’ certain kinds of assistance.

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