INEQUALITY IN HEALTHCARE

- **Advice for more constructive coverage of inequality in health.**

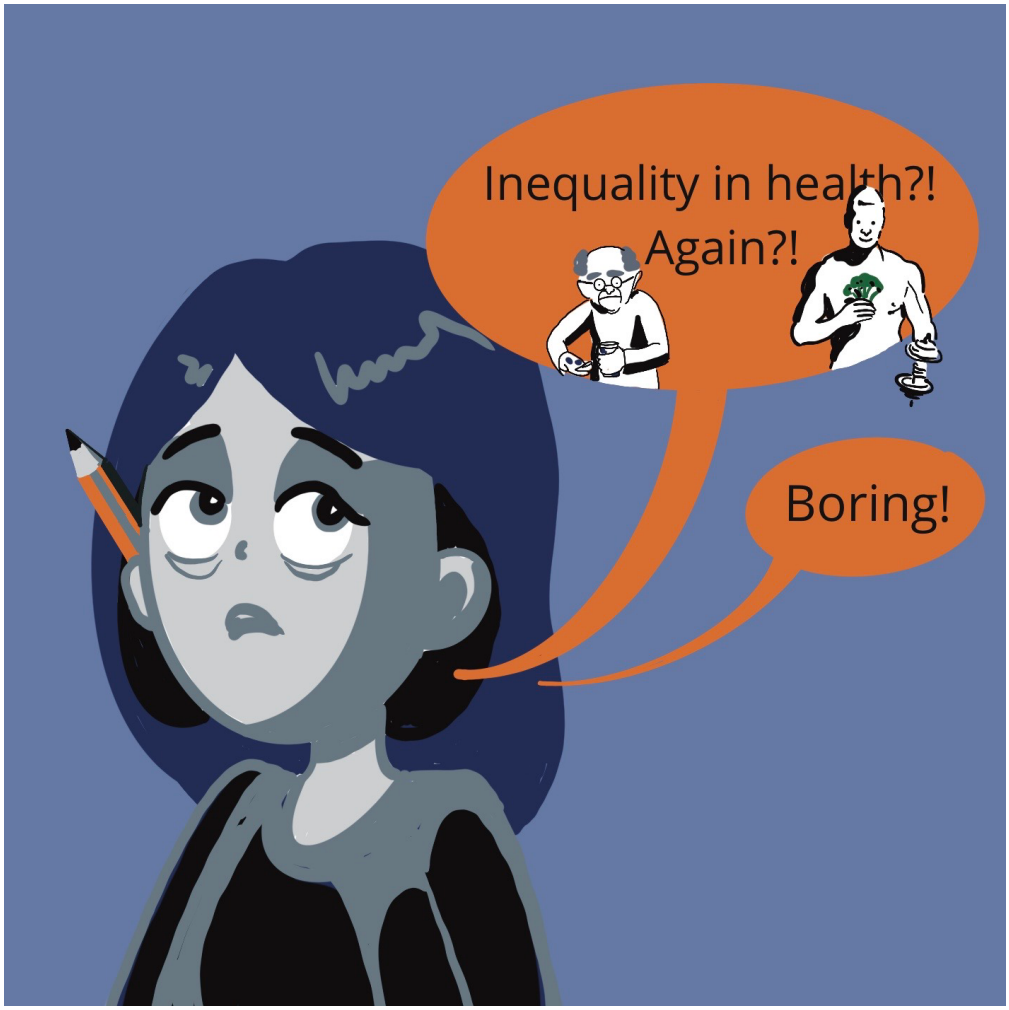


Illustration: Mette Stentoft

Report made by 2022/2023-fellow at the Constructive Institute, Thomas Gam Nielsen.

The report combines a year at the Constructive Institute with two semesters at Aarhus University. The main parts of the report are based on a booklet I made with the same title and aim - to guide other journalists in a more constructive direction when covering inequality in healthcare.

It is extended with case interviews with health journalists, doctors, and researchers. At the end, there is an essay on the knowledge I gathered from the classes I attended during my year as a fellow at the Constructive Institute.

Photo: Peter Damgaard, Constructive Institute

Why should we hear about it again?

Politicians and the media return again and again to the topic of inequality in healthcare - especially social inequality in health. A former Danish Minister of Health once said in parliament, when presenting a report on prevention and public health:[1]:

"*With this statement, the government wants to highlight the importance of preventive work and present the areas that must be particularly strengthened in the coming years. This applies especially to nutrition policy and efforts to* ***reduce social inequality in health****."*

The words were said in 1998 by Birthe Weiss from the Social Democrats. It is 25 years ago, and every government since has worked for a reduction of inequality in health. The average health and average living age has improved, but the social inequality is growing and not slowing.

Right now, a new Danish health structure commission is working with a model that also should combat rising inequality in the Danish healthcare system. The interest organisation Danish Regions also pledge for funds to counter the imbalance in the regional differences in accessing health care. So right now, the focus is here once again.

The evidence of inequality is often presented in scientific literature and media - both internationally and in Denmark. Less focus is on constructive journalism which attempts to describe some of the solutions and nuances to the problem.

My own interest for the subject comes from covering health problems for years as a reporter at TV2 Østjylland. Especially in some of the rural areas there is a lack for general practitioners, and at the same time more patients with a need for treatment. I have made stories with this underlying theme several times, and I wanted to educate myself more on the subject.

With a more refined knowledge and a new set of tools, I hope to make more nuanced stories on the subject and spot new angles and perspectives in my daily work as a journalist. I will start by clarifying some terms, in a Danish and international context. Then I will give some examples of journalism that constructively investigate the problems and solutions.

Finally, there are a few good tips on how to report on the subject.
Thomas Gam Nielsen, Denmark, June, 2023

[1] Government statement on prevention, January, 1998
http://webarkiv.ft.dk/?/samling/19971/redegoerelser_oversigtsformat/r9.htm

It starts outside the hospital…

Inequality in health is used in many contexts, which sometimes can be tricky. Some of the main meanings of the term is[2]:

• **Inequality in health status** - the risk of becoming ill and having to live with the consequences of the disease and
• **Inequality in the use of the health care system** and the treatment one receives as a patient.

The first refers to everything outside the health care system that has a significant impact on people's health. For example, should cigarettes and alcohol be banned, as they are the cause of many deaths, and their side effects are socially skewed?

Some politicians argue such a ban would restrict people's personal freedom and responsibility, while others are more willing to introduce bans or raise duties on cigarettes, alcohol, and sugar.

These basic elements like living standard, level of education, economic and cultural positions are seen as the most important determents for a healthy life by many scholars, but they are also some of the hardest circumstances to change.

But you can just as well see inside the hospital…

The second meaning of inequality in healthcare points to the fact that the well-off have a greater chance of healing and survival once they are in the hospital.

The chief physician at the immigrant medical clinic at Odense University Hospital, Morten Sodemann, says that “the longer your education, the faster treatment you will get at the hospital.”

And journalists, politicians, and healthcare workers need to be aware of this situation, according to Morten Sodemann: “For routine operations, hernias, cataracts, new hips - all quite ordinary operations - the well-educated will get treatment a month earlier than average. And that’s how it is in all areas of the healthcare system. And if you don’t understand that, you’ll never do anything about inequality in health.”

Reducing inequality in health is an oft-repeated aim of politicians, but as a journalist, you must be sure of the context.

[2] Vallgårda, Signild, 2009, Hvordan mindsker vi ulighed i sundhed?

Case interview: Organisational health literacy as a possible solution

Interview with professor Helle Terkildsen Maindal, professor of health promotion, Institute of Public Health, Aarhus University, and chairman of the Danish Society for Public Health.

The Institute of Public Health collaborated with the Danish Health Authority on a new toolbox to promote better health literacy[3]. The toolbox target health care workers, planners and politician with concrete examples and methods to make the health care system more accessible for everyone.

It is not only in how diseases spread that we see inequality, but there is also a large social inequality in access, use, and benefit of the healthcare system. One of our big challenges is that the healthcare system has changed significantly since the structural reform in Denmark in 2007. Before 2007, the general practitioner was the primary health person for many people. They were the gatekeeper. Although this is still true today, many more actors have a role now. With the reform in 2007, municipalities became responsible for citizen-oriented prevention.

Thus, municipalities began to build prevention programs and rehabilitation programs. For example, rehabilitation has been moved from the hospital to the municipality. Every time we make a transition, we lose someone. They had come to the hospital in the first place because they were sick, but if they must figure out how to get to the municipality afterward and how to accept the offer and how to get there by bus, it becomes more complex.

We have an increasingly complex healthcare system. It has simply become more difficult to navigate, so in this way we are really producing inequality within the system.

And that's what some of our research focus on. We investigate approaches to health literacy, which is the ability to understand, gain access to and navigate in the health care system. We work

[3] www.bit.ly/42AxSqI, February 2023. This a small version booklet on a tense report on health literacy in the Danish health system. It is in English. It is called "Health Literacy in Danish Health Care Organisations".

a lot with organisations; we need to find the solutions structurally. We need to find organizations that take responsibility themselves, so that the citizens they serve can also come in, benefit, gain access and get as good an outcome as those who can figure out the healthcare system for themselves.

One example is that organisations change all their all their oral and written communication to be more target oriented. It might be better to give older people a phone call and talk about the new training programme at their local community house instead of sending them an email that they might never see.

And a good advice for journalist covering health?
I have a wish for my own area, which is health promotion: One of the big issues we have is children and young people's mental health. But we must remember that most of our young people are doing well. They are very skilled, active, and well-educated.

What is health literacy?

Health literacy is the combination of personal competencies and situational resources needed for people to access, understand, appraise, and apply information and services to make decisions about health. It includes the capacity to communicate, assert and act upon these decisions.

Source: The Danish Health Authority

But journalists can create the narrative that young people are hopeless, all have diagnoses, and all feel bad, but that's not true. It's less than 20 percent who really have a hard time with challenged mental health. And I think it's a shame for our own children and young people that the other 80 percent are hardly mentioned.

I have received a lot of calls and emails about the success of specific health projects, but I always get concerned about their social and economic sustainability when I hear the term 'projects'. How can we detect whether projects have a lasting effect on people's health?

That's a great question and exactly one you could ask the municipal manager or any other source about: Which lasting initiative are you most proud of?

I'm also the chairman of the Danish Society for Public Health, and I hear a lot about good initiatives both in the private and public sector. I just heard about several private companies that have made good smoking policies. It's not something they have to do. It's because they're leading the way and saying they want to.

I think you can easily find those stories if you're just a little proactive. Because you have a great responsibility for shaping the narrative we have about health promotion, prevention, treatment, and inequality.

Equality or equity?

The Danish Health Act is very clear. Everyone has the right to equal treatment. However, the law does not say anything about the effect of the treatment for different population groups. Therefore, one often distinguishes between the concepts of equality and equity in healthcare.

"The health care system must treat everyone fairly. This means that you do not have to treat all people the same. In fact, you must treat all people differently to treat them fairly," said Søren Brostrøm, former director of the Danish Health Authority, in the spring of 2023[4].

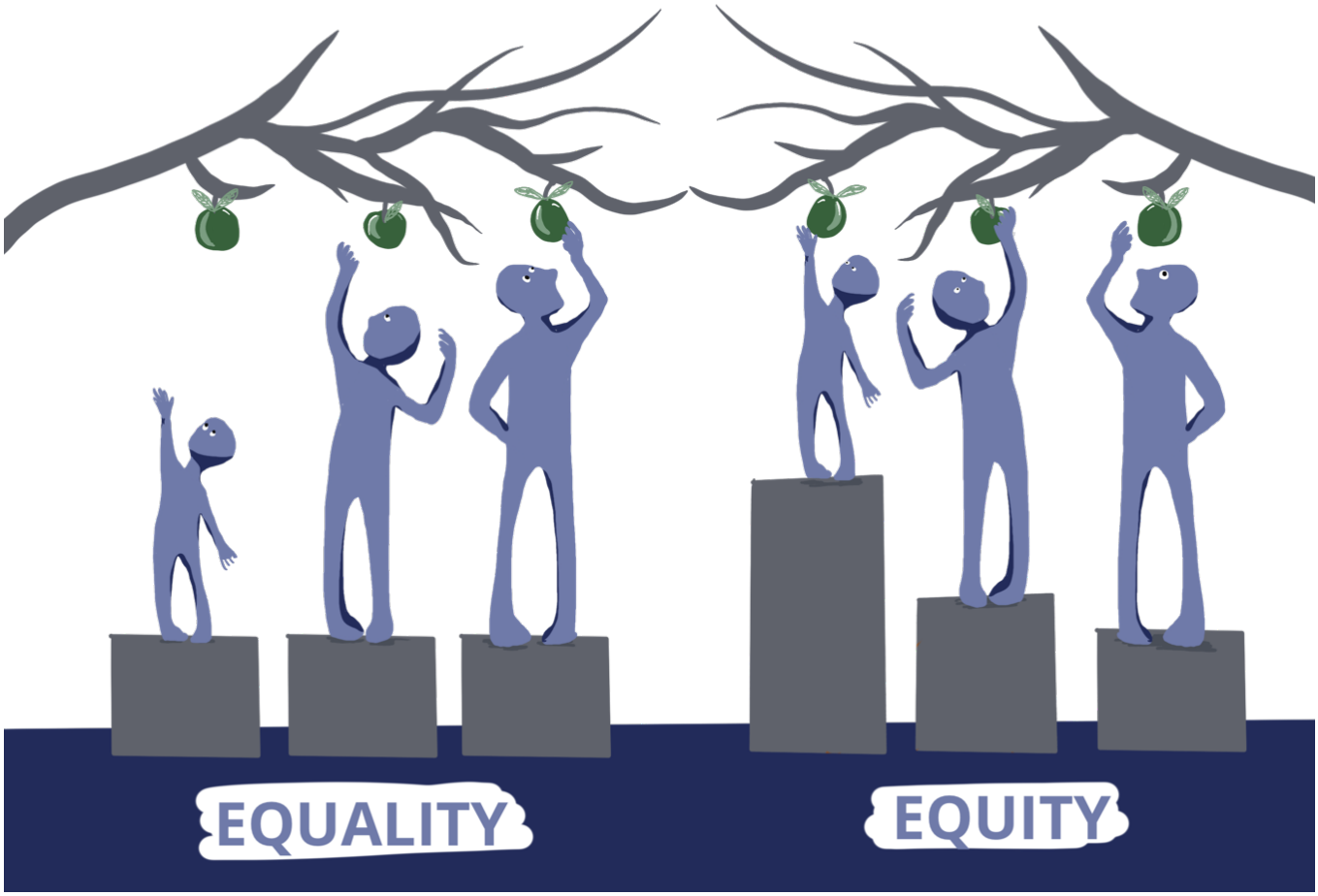


Illustration: Mette Stentoft

[4] https://sst.dk/da/viden/sundhedsvaesen/ulighed-i-sundhed/sundhedskompetence, February 2023. There is an English version of the video at the bottom of the homepage.

He elaborates further: "What worries me when I look at inequality in health in Denmark is that we are not doing enough about it."

So even though equality and equity are often used interchangeably, they have different meanings when it comes to healthcare.

Equality means treating everyone the same, regardless of their individual circumstances or needs. In the context of healthcare, this means providing the same level of care to everyone, regardless of their age, gender, race, or socioeconomic status.

Equity, on the other hand, means giving people what they need to achieve the same level of health and healthcare outcomes. This approach recognizes that people have different needs and circumstances that require different levels of care and support. In healthcare, equity means providing additional resources and support to those who need it most, to achieve the best possible health outcomes for everyone.

Søren Brostrøm, former director of the Danish Health Authority, in a video about health literacy

"

The health care system must treat everyone fairly. This means that you do not have to treat all people the same. In fact, you must treat all people differently to treat them fairly."

For example, let's say two patients come to a clinic with the same condition. Treating them equally would mean giving them both the same treatment plan. However, if one of the patients is homeless and does not have access to basic needs like food and shelter, treating them equally may not be enough to achieve the same health outcomes.

Both the distinction between equality and equity and the official attitude towards inequality in health are important prerequisites for informed coverage of the subject.

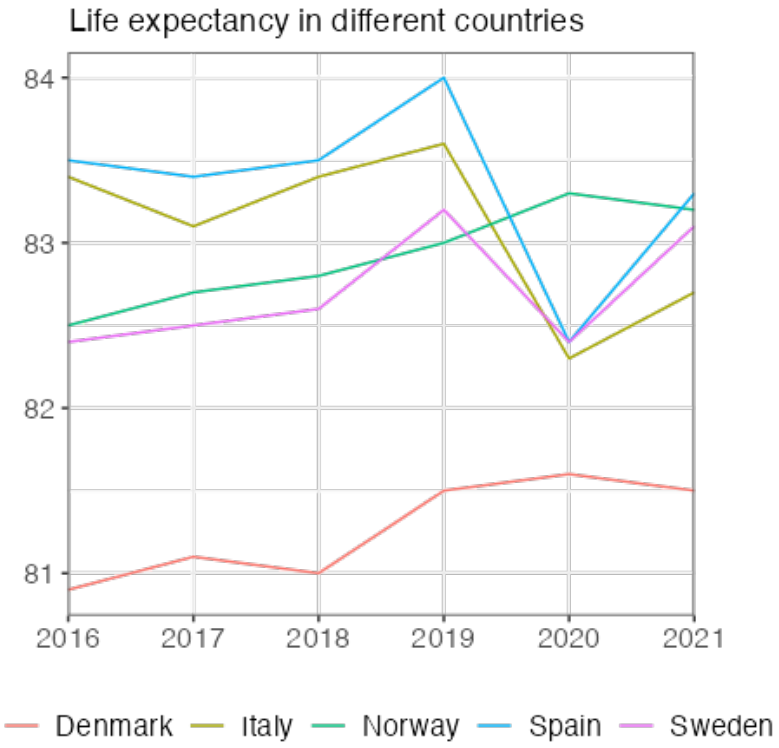
The Nordic Paradox

The Scandinavian welfare model is known for its economic equality. That fact is one of the reasons why some experts are baffled by the lack of social justice when it comes to healthcare in the same region.

This phenomenon is known as the Nordic Paradox.[5]

While many countries in the EU have reduced some health inequalities, the gap has not closed in Denmark – life expectancy is one example.

25% of men born in 1954 with the lowest incomes died between the ages of 50-65 years, compared to 5% of the richest men. Inequality is seen across education, income, and employment. And in general, life expectancy is lower in Denmark than in other countries we normally compare with. The figure on the right side is made from Eurostat data.[6]



At the same time, official figures from the Danish Health Authority show that for several diseases, inequality is still increasing.
For the main illnesses in Denmark, the Danish Health Authority has ranked the level of inequality for both men and women. The report will be updated with new data after a couple of years.
[7] It is a good reference for journalist when covering different diseases.

Therefore, the theme is still relevant to cover journalistically - both when inequality increases and decreases. When and how is it go better in some areas than others?

---

[5] New light on the Nordic Paradox, 30th of November 2017, Nordic Welfare Centre, https://nordicwelfare.org/en/nyheter/new-light-on-the-nordic-paradox/
[6] Mortality and life expectancy statistics, March 2023, Eurostat - https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Mortality_and_life_expectancy_statistics
[7] Social ulighed i sundhed og sygdom, The Danish Health Authority, 2020, https://www.sst.dk/-/media/Udgivelser/2020/Ulighed-i-sundhed/Social-ulighed-i-sundhed-og-sygdom-tilgaengelig.ashx

Is there a doctor?

The subject of geographical inequality will be politically prominent in Denmark in the coming years. The Health Structure Commission will look at the problem[8], and the Danish Regions are pushing for a state inequality fund[9] to ensure better geographical distribution of health personnel.

The problem is old and well-documented. Where there are the most multi-ill, socially disadvantaged, and elderly people in need of medical help, there are usually the fewest health services. Internationally, this is called the Inverse Care Law and was first described in the renowned journal The Lancet in 1971.[10].

The article ends with the sentence: "*In areas with most sickness and death, general practitioners have more work, larger lists, less hospital support, and inherit more ineffective traditions of consultation, than in the healthiest areas… These trends can be summed up as the inverse care law: that the availability of good medical care tends to cart inversely with the need of the population served.*"

You still need to be critical when you cover a positive change:

- How has it worked elsewhere?
- How is it a sustainable solution in the long run?
- What special local conditions have helped the development?

50 years later in 2021 the inverse care law celebrated 50 years anniversary, and according to an editorial in The Lancet[11], the same problems were still present.

[8] Kommisorium for sundhedsstrukturkommissionen, 2023, https://sum.dk/Media/638155858694707988/Final_kommissorium.pdf
[9] Press release from the interest organisation Danish Regions, 31-10-2022, https://www.regioner.dk/services/nyheder/2022/oktober/de-fem-regionsraadsformaend-ulighedspulje-skal-afhjaelpe-geografisk-ulighed-i-sundhed
[10] Hart, James Tudor, The Lancet, February 1971, The inverse care law
[11] 50 years of the inverse care law, The Lancet, Volume 397, February 2021

“Although inequality in health and its many causes are widely understood, inequity in health-care service provision is enduring and fundamental.”

In some regions of Denmark, the trend has been reversed, as was shown in the TV documentary series aired on TV Midtvest, ‘The Doctor’s Promise’, which looked at attempts to combat inequality in medical care in northern Jutland.

Case interview: Ways out of the Deep End

Interview with Mogens Vestergaard, doctor and founder of Deep End Denmark, and member of the Health Structure Commission.

A newly established Danish association, inspired by Scotland, will work to improve the conditions for doctors who have many multi-ill or socially disadvantaged patients. The association is called Deep End Denmark and will both form networks for doctors and gather experiences and measures that can break the geographical inequality in health.

I think that a healthcare system should be measured by whether it manages to help those who have the greatest need. I see that there are some well-defined population groups that systematically receive less than they should.

It's not a new concept at all, but we know that in areas of Denmark where there are particularly large health challenges - where there are many citizens without education or low income, or have many different simultaneous diseases, or there is a lot of obesity or many smokers - these are also the same areas that have few health resources. There is a shortage of doctors, it is further to the nearest private practicing specialists, and it is far to the nearest hospital. So, there is an imbalance between the health challenges that exist and the health resources that exist in those areas. And that's what Julian Tudor Hart described as the inverse care law back in the 70s.

To what extend is there a need for further documentation of inequality in health?
In my opinion, we have come to the point where we say that we don't really need more reports demonstrating that there is social inequality.

> *"It is deeply unfair that one's prognosis or treatment depends on where one lives. It is not a natural, it's man-made. We want to collect and systematise the experiences of the practicing doctors who make a difference to change this development*

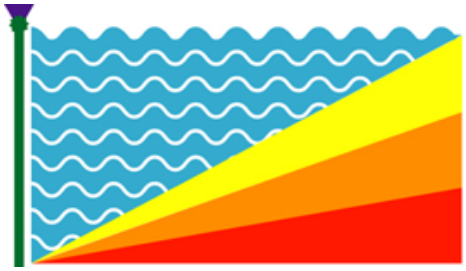
But we have a huge need to do something. And I experience more and more that both the Health Authority and the Ministry of Health and various councils take it very seriously. So, I think the window is open for change right now. We think we should channel that energy into efforts that test different methods to make a difference.

Why have you made the Danish branch of the organisation Deep End?
Many municipalities, practicing teachers, and hospital departments make small efforts. My impression is just that we are not good enough at exchanging experiences.

There are many projects that are launched. But when the project is finished, the project participants spread out and it is not really implemented.

So, I think there are plenty of tests, but there are very few things that are implemented afterward in daily operations. We need to exchange experiences more. And then we need to allocate some resources to research studies to evaluate and measure what works.

What is Deep End?
The Deep End logo shows the deep end of a swimming pool, the steep slope of need, the flat distribution of resource and a sun rise. The idea is, that *general practitioners have the same budget, but some have a deeper end – meaning more vulnerable patients.*



Deep End Denmark is a branch of the international organization Deep End, which was originally established in Scotland 12 years ago by a professor named Graham Watt, who was one of James Tudor Hart's closest associates.

The idea is that we need to start making a difference. And let's consider the general practitioners who work in areas with great inequality as a kind of everyday experts. People who know something about what works and what could work if they had more resources.

So, the idea is to look down over the country's general practitioners and invite the 100 who have the largest proportion of patients who are socially vulnerable.

Can I have some constructive examples, please?

Over the next pages, I will present some four different approaches to constructive journalism – each with concrete examples of journalism that deals with health care and inequality.

- **The Doctor's Promise:** If the audience knows the previous problem by heart, the whole angle of the news piece can be constructive.

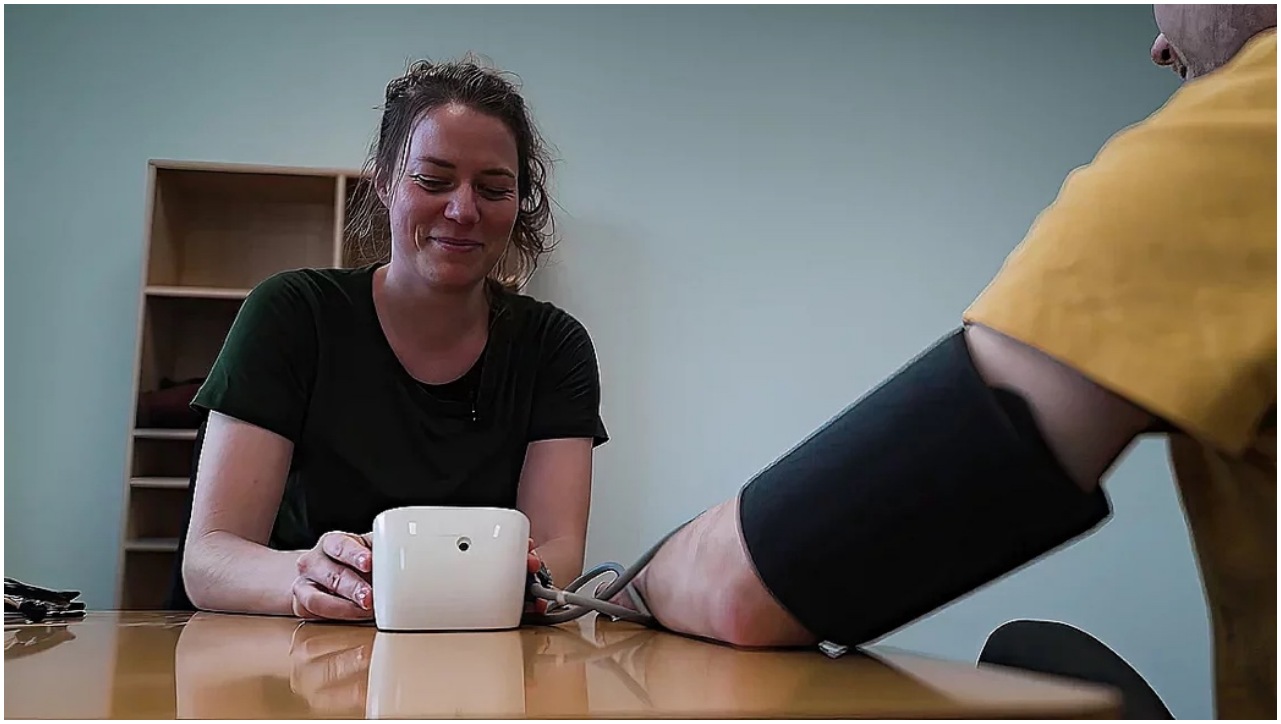
- **Dialogue from the emergency room:** If a media has covered the problems over a longer period, the theme can be followed up with a dialogue meeting focusing on possible solutions.

- **Big problem, but also nuances**: By planning it from the beginning, the constructive angle can be a well-placed supplement to the main angle.

- **Covering waiting lists:** When you publish a story about problems in the health system over many months, the persistent coverage can be both nuanced and constructive.

Panel debate on the possible solutions to a stressed emergency at the Slagelse Hospital in Denmark. Photo: TV2 Øst

Case 1: The Doctor’s Promise



Sara Søndergaard is one of the main characters from the series. She moved to Thy to become a general practitioner. Photo: StoryPark Media/TV Midtvest.

In 2023, the regional public service station TV Midtvest broadcasted a series called ‘The Doctor’s Promise’ from Thy, produced by StoryPark Media.

Over six episodes, the viewer follows several younger doctors, all of whom want to be general practitioners in the Thy area. A few years ago, the place was known for its lack of doctors, but now the curve has been broken and far more want to be general practitioners.

A strong work network aimed at new doctors and engaged volunteers are some of the reasons for the change.

The whole series’ premise is basically constructive. In each introduction to the six episodes, the previous problem of a lack of doctors is outlined using small pieces from old news clips. This is the basic premise, but from there on the viewer sees how the development has been reversed.

Jesper Bredsted, editor in chief, Story Park Media

"The main story is the change and that new doctors are coming and staying in this area. But we also nuance the story by showing some doctors, who are still unsure of they are going to work their entire life there. It makes the storytelling more trustworthy with these nuances."

When the journalist is confident that the target audience is already very familiar with the problem, it is possible to dedicate more time to the nuances and the young doctors who become a symbol of the development.

Case 2: Dialogue from the emergency room

In 2022, the regional public service station TV2 Øst gave curious people unique access to the pressured everyday life in the emergency department at Slagelse Hospital.

In a web documentary and in a longer series, patients are seen lying in corridors, and we follow new doctors and nurses who constantly must navigate to move patients around so there is enough space.

After the last episode of the series, TV2 Øst held a one-and-a-half-hour debate on possible solutions to the problems revealed in the series. The debate was recorded at the hospital with both employees, former admitted patients, and relevant regional and national politicians participating.

Eva Højrup, health reporter, TV2 Øst

"Our goal was also for the national politicians to leave with a list of good solutions to the emergency department's problems. We know that there is not only one solution. It's 50 different knobs to turn. The debate was a good way to supplement our series on the problem at Slagelse Hospital's emergency department."

Those responsible were confronted with the problems, but the focus of the questioning always pointed forward - what concrete measures can they take to change the conditions at the hospital for the better?

The concrete proposals are possible solutions that the TV2 Øst health reporter can follow up on as possible angles going forward.

Besides the debate and the series, shorter news pieces covering other hospitals in the region were made. They face the same problems but have different takes on the situations. Possible solutions, such as home treatment of COPD patients, were also covered.

Case 3: Large problem, but also nuances

Even though the solution-oriented approach is not the main angle, the constructive elements and stories can be part of larger coverage from the beginning.

In January 2023, DR revealed that children of parents with mental health problems more often struggle with mental health themselves and their education suffers.

The revelations were based on a report on the living conditions of 700,000 children in Denmark, published by the University of Southern Denmark.

From the morning, the topic was the main angle on all of DR's platforms. Later in the day, the constructive story came, showing how conversation groups for children of parents with mental illness had made a difference in the North Denmark Region.

The constructive angle was integrated into the coverage from the beginning.

A problem with this model can be that most people see the main angle and not necessarily the constructive angle. It is an editorial decision how the balance between the different parts is weighed, and that balance varies from story to story.

Peter Qvortrup Geisling, doctor and health correspondent, Danish Broadcasting Corporation

I always have a top five of the most important health issues in my head, and that list changes depending on what new research comes up and what we have just covered. Tobacco kills 15,000 people a year here, and that is one of the topics. The other topics are psychiatry, inequality in health, lack of exercise, and alcohol, because 122,000 children grow up with parents who drink too much. If there is something new in those areas, I jump on it. If there is something new in smaller areas, something extra is needed before I cover the story.

DR's health correspondent Peter Qvortrup Geisling works with a small health desk at Danish Broadcasting Corporation and feels privileged that he has a public service media mainly needs to do journalism mainly built on relevance and proportions.

He respects that private media outlets need clicks to convert into advert money but believes that proportions and nuances sometimes get lost.

"When it's Christmas, I sometimes read that cinnamon on rice pudding is healthy. It might be a fact, but on a larger scale it's totally irrelevant," says Peter Qvortrup Geisling.

He understands that different media have different roles but working at the biggest public service station in Denmark, he feels obliged to make journalism that covers the main health-related issues.

A sickly difference

In 2016, DR made a documentary called Den Syge Forskel (A Sickly Difference) based on the health differences in the city of Aalborg. The main cited statistic from the program was that poor men from the eastern part of Aalborg generally die 16 years earlier than rich men from the western part of the city.

Peter Qvortrup Geisling finds that it's still one of the most rigorous pieces of journalism about health inequalities made in Denmark.

He stresses that it's important to have basic knowledge on the main subject you cover and sometimes feels that even beat journalists don't necessarily have the most accurate and newest knowledge.

"If you have an overview, you don't just go with the story you are being presented by authorities or an interest organisation. I don't know the exact numbers, but it feels like most health-related stories are stories brought forward to the media by people with an interest in the story," Peter Qvortrup Geisling says and explains further:

"This leaves room for more independent stories about health-related issues and diseases that are based on relevance for a larger audience rather than the latest press release from a large interest organisation."

Case 4: Jet another story about waiting lists

Erik Mandal was first fully assessed a year after he had started his course. Photo: Thomas Gam Nielsen/TV2 Østjylland

In the autumn of 2019, I was contacted by a frustrated citizen. Her husband's dementia assessment process was postponed indefinitely.

This was the start of a year and a half of coverage of waiting times for dementia assessments, which at its peak had grown to 92 weeks at the Neurological Clinic at Aarhus University Hospital[12]. For the most part, the coverage had a classic focus on the possible consequences of the extended waiting time and the possible causes.

The constructive element was a continuous nuance of why the waiting list was getting longer and longer. At the same time, I produced concrete stories about how other regions succeeded in having shorter waiting lists for the same type of assessment process[13].

As well, I followed the case all the way and into the doctor's office when they finally got the right dementia assessment. My colleagues have also made the story that the waiting time is now shorter[14].

[12] Article, TV2 Østjylland, 2nd of May 2022, https://www.tv2ostjylland.dk/region-midtjylland/ventetiden-stiger-dag-for-dag-og-er-nu-paa-92-uger
[13] Article, TV2 Østjylland, 3rd of May 2022, https://www.tv2ostjylland.dk/region-midtjylland/birger-har-alzheimers-blev-udredt-i-region-med-kort-ventetid
[14] Article, TV2 Østjylland, 23rd of May 2022, https://www.tv2ostjylland.dk/region-midtjylland/efter-rekordlange-ventetider-millioner-paa-vej-til-demensudredning

Advice for a more constructive coverage

Basically, it is about a willingness to give space to critical reviews of the possible solutions to health inequality.

For this to be possible, there are several simple tips you can use in your work.

- **Get a grasp on the concept** and be sure what the source means by health inequality. Is it outside the hospital or in access to the health care system? Is it equality or equity?
- **There are facts about health inequality.** In the Danish context, the Danish Health Authority has several new surveys and reports, while WHO has a tool called the Health Inequality Monitor.
- **How is the solution sustainable?** You should always ask this question if sources mention a solution in the health area that is funded by project funds.
- **A method for each story:** Depending on the problem and the target group's knowledge of the subject, you can choose the constructive approach that best fits.

The different methods are shown in the examples in this report.

Essay: But what have you learned as a fellow?

My fellowship consisted of three parts. One was purely academic research and understanding of the healthcare system – both internationally and especially in a Danish context. I both took a class on healthcare economics and one about inequality and inequities in health at the Department of Public Health.

A second part of my fellowship has been all the lectures and talks about constructive journalism, that all fellows at the Constructive Institute has been presented with during our stay. Most of them at the institute, but we have as well been on several study trips.

Thirdly, I have spent time on coding and data driven research. Through different classes at the Department of Political Science, I have learned to use the code language called R – one of the most intuitive code languages and used my many data journalist around the world.

I will briefly explain what I have gained from my fellowship in those three areas of interest.

Basic knowledge of the health care system
Health economy was my first course, and it gave basic knowledge on how to describe the demand and supply of health services as well as preventive, health-promoting and health-damaging goods and services.

I have a better basic knowledge of economic instruments for controlling and regulating the production and consumption of health promotion, prevention, and treatment, and I can explain funding models for health care and health promotion.

I can describe common methods for economic evaluation of health interventions (cost-effectiveness, cost-utility and cost-benefit analyses). And critically assess available economic analyses related to health.

On my second semester, I took the class on inequality in health, as well at the Department of Public Health. The class was for undergraduate students writing the bachelor exam in this area. The theme was to explore and explain the inequalities not merely on a quantitively level, but as well through qualitative field interviews and fields trips.

A lot of the literature and lectures from these two classes has inspired me for further readings on the subject and has helped to frame my interviews with scholars and journalists concerned with these issues.

As a journalist, I'm being presented with a lot of projects with possible solutions to health issues such as diabetes, overweight, mental issues and so on. With the classes, I've taken I have more tools to ask the right questions critically and constructively.

And what about constructive journalism?
It's hard to pinpoint what exact lectures, talks, excursions, and debates have influenced my understanding of constructive journalism and the effects of constructive journalism.

It's been 10 months with almost endless number of experts in Constructive Institute's lounge, who under Chatham House Rules have both explained their specific knowledge on everything from the war in Ukraine, happiness, nudging, mental health of kids and their view on journalism's role in their field ox expertise.

At the same time, we have met tons of journalist and editors, who reflects on their own work and again journalism role in society. Seeing other colleagues work in depth and debating the small details and nuances, always adds perspective to my own work and gives ideas to new ways of creating content.

On top there's been study trips to San Francisco, London and Copenhagen, where we met with both opponents and supporters of the ideals behind constructive journalism.

What does the data show?
During my 15 years as a journalist, I've done numerous attempts to become a real data journalist. I've used almost every free infographic app available online, participated in online courses on how to scrape, analyse and present data in a correct and beautiful way and tried to code with the language Python on my own.

Even though, I'm decent with Excel and I know basic CSS, HTML, and PHP-coding, I never took it to the next level. The everyday deadline has taken over more of my time, focus and motivation.

During this stay, I've been lucky to have courses, where the programming language R was used. R is great, because it is used throughout academia, it's open source and free of charge. At the same time, it can both gather (scrape or basic download) data, analyse it and also present it in beautiful infographics.

Both classes were at the Department of Social Science: The Role of Geography in Politics and Political Data Science: Digital Skills.

The first course used various models to analyse and debate the role of geography in politics. Large scale data sets with e.g., voters, refugees and classes were analysed and visualised using R.

The second one introduced methods broadly termed 'data science'—from automated data collection and processing unstructured data to visualisation and methods for exploiting big data.

The substantive focus for the course was applying these skills to study public administration and politics, but I can also use it as a journalist.

The public sector produces vast quantities of data. Managing and analysing this information is crucial for academics who study how government functions, for government employees who aim to improve government performance and for the media and businesses who rely on public data for their work.

In that context R is a concrete tool that I will use, when I research and later write stories connected to health issues, and I'm really thrilled that I had the chance to start my journey deeper into this field. It could not have been done without my fellowship at the Constructive Institute.