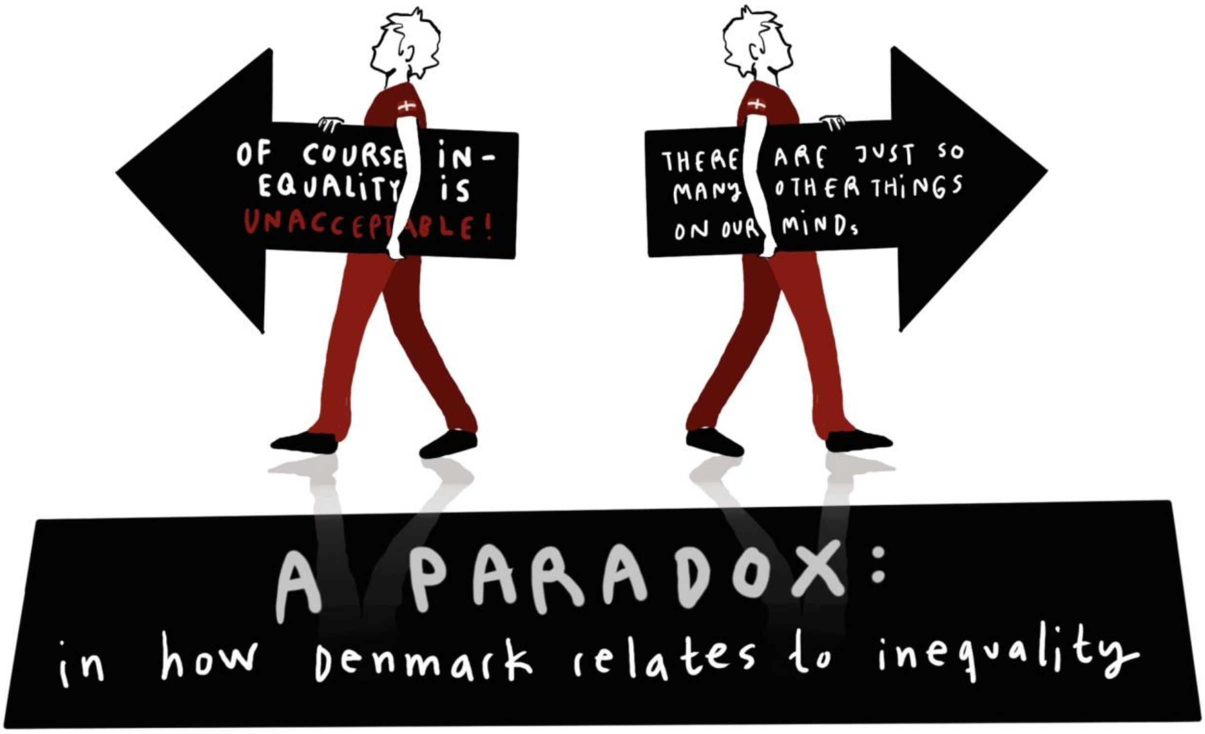

Illustration: Mette Stentoft

THEME: Social inequality in health

How do we give voice to vulnerable citizens?

How can we, as a society and the media, give voice to those who do not shout the loudest about their health, but who often have the greatest need?

Text: Eva Højrup, health reporter, TV2 ØST & fellow at Constructive Institute 2024/25, June 20

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Introduction

Social inequality in health is increasing in Denmark. The purpose of this report is to examine how we, as journalists and as a society, can give voice to the citizens who are often overlooked in the healthcare system and in the media, people in vulnerable positions who go unnoticed by the system.

The report is based on interviews with healthcare professionals, researchers, and NGOs and shows how social problems such as poverty, loneliness, and mental illness can make it difficult to take care of one's health.

The report examines:

- Who falls through the cracks in the system – and why.
- How healthcare services can be adapted to be more flexible and hands-on.
- How the media can use constructive journalism to uncover problems and solutions, without reinforcing the stigmatization of the groups in question.

In November 2024, the largest healthcare reform in two decades was adopted. The reform primarily addresses geographic inequality in the healthcare system, but what about social inequality? Here, the media have a responsibility. Not only to uncover the problems, but also to give space to those it concerns: What do citizens themselves think? What do they need – and how do we respectfully ask them?

It requires an understanding of the complex mechanisms that create social inequality in health, as well as an organization of the healthcare system that better accommodates different types of patients. Several of the health actors I have spoken with point out that it is necessary to involve more ministries than just the Ministry of Health, and that entirely different and more "hands-on" services must be put together for citizens in vulnerable positions. Services that, to a much greater extent, consider that social problems can overshadow taking care of one's illness.

When I applied to the Constructive Institute (CI) in March 2024, I formulated the following research question: Are there citizens in vulnerable positions whom the healthcare system and the media overlook, and how can we bring them to light?

I brought that question with me when I started at CI in August. I wanted to examine whether constructive journalism can be a tool to ensure that we, as media and as a society, give voice to those who do not shout the loudest about their health, but who often have the greatest need. How do we ensure that this group becomes part of our coverage and thereby is represented in the media?

The background for my questions is that I have repeatedly heard healthcare professionals say that there are patients they don't reach. There are "pockets" in the population of poverty, marginalization, and vulnerability, and that often means these people do not get their health taken care of.

One of my first meetings was with Kristina Louise Bliksted, director of the NGO Social Sundhed[1]. She expressed the issue like this:

– In the part of the population that is behind in the figures on social inequality, the social aspects of life take precedence over the health-related ones. You can walk around with the most unregulated blood sugar, but there is so much other crap in your life that you don't get around to it, she said.

And that image recurs, no matter who I have spoken with. Ordinary people struggle with problems that overshadow their capacity to take care of their illness. I have received accounts from the frontlines of people fighting to pay rent, barely holding on to the labor market, or outside of it. Those who do not have a car or can't afford the bus fare. Those who live with mental illness. Who lacks a network.

According to the healthcare professionals I have interviewed, this group often flies under the radar in the healthcare system. And when the professionals do not meet them, neither do the media.

There are, in other words, citizens in Denmark whom we never talk to – and never interview. It is a democratic issue for society and a political concern that affects us all. Inequality in health burdens both patients and relatives and undermines the prerequisites for a life with a high quality of life.

So, how do we ensure that this group is seen and heard?

There is a fundamental paradox: Denmark has one of the world's most advanced healthcare systems and a long-standing political ambition to ensure equality in health, and yet social inequality continues to grow.

We know who falls through the cracks. We have extensive data, dedicated professionals, and decades of knowledge. Still, many citizens are left behind.

The paradox lies not in a lack of awareness but in how we as a society, as professionals, and as the media respond. What does it take to build a system that doesn't just work for the majority, but also reaches those who are hardest to get?

This report includes interviews with healthcare professionals and interest organizations offering different perspectives on the issue and suggestions for how we can cover it. At the same time, the sources offer ideas for possible solutions—initiatives that can create change in small ways and maybe fundamentally shift the social inequality in health, if there is the will.

At CI, we naturally talk constantly about what constructive journalism is. It takes as its starting point a complex societal problem and investigates how the problem can be solved and what works in other places. In one chapter, I therefore go through how the media can cover social inequality in health using tools from constructive journalism.

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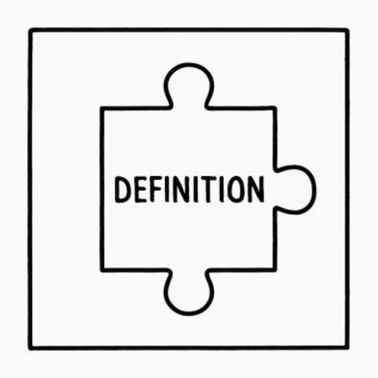
[1] Social Sundhed is a national NGO that builds bridges for vulnerable people in their encounters with the healthcare system and civil society. They train volunteer health professionals to understand the barriers behind social inequality in health.

The report concludes with a chapter on the role of the media, including concrete advice on how journalists can protect citizens in vulnerable positions—even when they're on the front page.

Explanation: Vulnerability can affect everyone – it's not "them and us"



Social inequality in health is not just about "them and us." It is a phenomenon that can affect all of us during certain periods of life or as a life condition. To understand the background for my research questions, I have dedicated this chapter to explaining how social inequality in health should be understood. It is important to be aware that a large part of the population can experience inequality in health, because being in a vulnerable position can happen to anyone.

To better understand the mechanisms behind social inequality in health, I participated as a CI fellow in a bachelor's course on inequality in health at the Department of Public Health in Aarhus in the spring of 2025. Through my work as a health reporter at TV2 ØST, my colleagues and I have especially covered the geographic inequality in health that characterizes Denmark – for example, how there are few doctors for many patients in doctor-shortage areas in Region Zealand.

The bachelor's course especially described social inequality in health. There is extensive knowledge in the field, thoroughly described in several reports, including those from the Danish Health Authority. The best explanation – and most nuanced definition – I encountered, however, was during a lecture by health anthropologist Michael Fehsenfeld, assistant professor at the Department of Public Health at Aarhus University.

According to Fehsenfeld, it is generally true that we are not bound to our social position, but statistically, many remain in the class they were born into. In addition, risk factors are socially distributed: Your health is affected by whether you work in an office or on a factory floor. Your income, your housing, and your local environment also influence your health. Your social position simply determines what risks you are exposed to, both physically and mentally.

What arises, according to Fehsenfeld, is what he calls a “syndemic”: When several risk factors reinforce each other, e.g., smoking, poor working conditions, and stress. At the same time, the consequences of illness are also socially unequal. It can be significantly more difficult to be ill if you work in a warehouse than if you sit at a desk.

Inequality can be viewed as either a dichotomy or a gradient. The perspective matters for how one understands the problems and what solutions are chosen.

The gradient perspective shows how the entire population is placed on a scale. If you sort by educational level, for example, you see that the prevalence of disease decreases the longer the education is. People with higher education have better health than skilled workers, who again have better health than unskilled workers.

The dichotomy perspective divides society into two: The vulnerable/disadvantaged and the rest of the population. Here, the focus is on social problems, substance abuse, homelessness, and complex multimorbidity, and one typically works with “hands-on” and tailored interventions for the target group.

Initiatives inspired by the gradient perspective, on the other hand, focus on reducing overall inequality, often through structural approaches. This can, for example, involve making the healthcare system easier to navigate, increasing the price of tobacco, or improving prevention. These are initiatives that all citizens can benefit from, but where the effect is often greatest among those with the poorest health.

In Denmark, both the gradient and dichotomy perspectives are used, but the two directions require different types of interventions. Both are necessary if one wants to understand and act on inequality in health.

What data is available?

I have based my research on two recent reports to find the latest figures, namely *Social inequality in health and disease in Denmark – Trends in Denmark in the period 2013–2021* from April 2025 and the Health Structure Commission's report, *Decision-making basis for a more equal, coherent, and sustainable healthcare system* from June 2024. Both reports provide a thorough overview of developments.

The report *Social inequality in health and disease in Denmark – Trends in Denmark in the period 2013–2021* states that 2024 marked the 40th anniversary of Denmark, together with other countries in the WHO European Region, agreeing on a set of health targets.

Target number one stated: *"By the year 2000, the actual differences in health between countries and between groups within countries should be reduced by at least 25 pct. by improving the level of health of disadvantaged nations and groups."*

Denmark began drafting a national public health plan, and across 11 ministries a prevention program was developed in both 1989 and again a public health program in 2002, where inequality in health was specifically highlighted.

When inequality continued to rise in the following years, the Danish Health Authority later prepared a more detailed account of the causes of inequality and possible efforts to reduce it. Since 2020, the authority has implemented systematic monitoring of inequality through this report, examining inequality using 68 indicators, ranging from child poverty to dental health, smoking, and education.

The report shows that life expectancy in Denmark has increased by 7 years. Forty years ago, 48 percent of a birth cohort died before turning 75. Today, the figure is 30 percent.
The development has benefited everyone, but to varying degrees. For citizens with higher education, mortality has decreased on average by 2.7 percent per year. However, for citizens with only primary school as their highest completed education, mortality has only decreased by 0.8 percent per year.

Illustration: Mette Stentoft

The report primarily measures social inequality based on education level, income, poverty, and unemployment, and it shows that there are still groups in the population who are systematically more ill than others and experience more severe consequences of illness.

The main report from the Health Structure Commission from June 2024 has also examined social inequality in health. The differences in life expectancy and disease profiles reflect, among other things, differences in living conditions and lifestyle. For example, there are about four times as many daily smokers among people with a primary school education as among those who have completed a long higher education, according to the report[2]. The same differences are seen for unhealthy eating habits and sedentary leisure activities.

Education and income also influence how the healthcare system is used. For example, people with higher income have more planned hospital visits compared to people with lower income. Conversely, people with lower income have more frequent emergency contact with hospitals than those with higher income: *"The income-related differences in the use of planned and emergency health services indicate that differences in resources influence*

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[2] Appendix 44.4, p. 119

whether citizens seek healthcare early in their illness or at a point where the disease is advanced and severe," the report states.

The differences in the use of healthcare are also reflected in the chance of surviving a serious illness. For example, the chance of surviving cancer varies by income level, regardless of cancer type[3]. The relative survival for people with high income is about 69 percent, while the relative survival for people with low income is about 53 percent[4].

Another indicator of social inequality in health relates to chronic disease and multimorbidity. Rural municipalities have a significantly higher proportion of citizens with chronic diseases than urban municipalities. For example, more than 20 percent of citizens on Langeland have a chronic disease compared to 12 percent of citizens in Copenhagen[5]. Similarly, rural municipalities have a significantly higher proportion of elderly and multimorbid individuals than other municipalities.

The Commission's report concludes that if one truly wants to tackle social inequality in health, it places great demands on all parts of the healthcare system: *"In addition to handling all citizens with both simple and complex health needs, staff across sectors must also be able to collaborate and create coherent care pathways,"* it states.

Some of the recommendations from the Commission have been translated into initiatives in the new health reform, particularly efforts to address geographic inequality by ensuring that more doctors are placed in remote areas.

The report states: *"It appears paradoxical that inequality is rising during a period when the efficiency of health policy has improved, both in preventive efforts against risk factors and in treatment for better survival. This is partly because many initiatives do not reach everyone or have unequal effects."*

Thus, social inequality in Denmark is increasing because there are citizens the healthcare system does not reach. This leaves us with a fundamental paradox: the knowledge exists, but many citizens still fall outside the system's reach. So, what can we, as a society, healthcare system, and media, concretely do? I have asked several key figures for their suggestions.

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[3] Annexes 4.45 and 4.46, p. 122

[4] Annex 4.47, p. 123

[5] Figure 4.48, p. 124

Voices on inequality in health

Kristina Louise Bliksted, Director, Social Sundhed: We have the world's best healthcare system – for those who can find their way

Social Sundhed works to reduce inequality in health, not through treatment, but through relationships. The organization helps people who fall outside the system and trains future health professionals to meet vulnerable citizens with empathy and understanding.

– The healthcare system is the best in the world at treating the middle and upper classes, but we need to include the last 20 percent.

So says Kristina Louise Bliksted, Director of Social Sundhed, an NGO where volunteers offer support and networks to vulnerable citizens when they have various appointments within the healthcare system. At the same time, Social Sundhed works to ensure social equality in health across Denmark and equal access.

– The healthcare system cannot eliminate social inequality in health, but the employees can address the encounter they themselves offer, and it is not good enough. There is a class divide when staff meet society's most vulnerable and marginalized people, and the system is built for the white middle class, says Kristina Louise Bliksted.

– It's about employment and housing policy. It's about many things. But instead of being confused by the complexity, one should focus on the encounter with the healthcare system. That is something the healthcare system can take responsibility for, she says.

– We can see that something happens in the encounter with the healthcare system. The conditions we carry with us as people are reinforced in the encounter with the healthcare system. This means that if you come with resources, you get better treatment, a better experience, and a better effect from being in contact with the healthcare system. If you come with difficult conditions, they are reinforced; if you have a worse experience, you receive less treatment, and the effect of being there is poorer. We can see that there is differential treatment, she explains and elaborates:

– It's because it is another class that works in the healthcare system. They are all white, well-educated women who have completed a long higher education. It's not intentional, and they can't help having had a good childhood. But there is a class divide that means professional competencies can be absent.

If people in vulnerable positions are to benefit from going to the doctor and the hospital, the staff need to develop their competencies.

– It's about how you meet people with empathy. You're afraid of those you don't know. But no matter whether you meet them as nurses, as someone who has studied public health and is evaluating, or as a politician making health policy, it's important that they understand the problem and have spent time with the people it's about. Otherwise, we continue to develop a system that is still one of the world's best at treating the middle class and upper class. We need to include the last 20 percent, she says.

The problems Kristina Louise Bliksted wants healthcare staff to open their eyes to are about the fact that not all people have the opportunity to prioritize their health.

– In the part of the population that is lagging behind in the figures on social inequality, the social aspects of life take precedence over the health-related ones. One has to take care of their children, focus on their home, how to pay the rent, make food, take care of animals and dogs, and make it all fit with the ex-husband, she says.

– Those who are the sickest from, for example, diabetes, are overwhelmed by their lives. You can walk around with the most unregulated blood sugar, but there's so much other crap in your life, she elaborates.

Specifically, Social Sundhed links volunteer students from the health sciences with people who want to be accompanied to their doctor and hospital appointments. So the volunteers in Social Sundhed take responsibility and help vulnerable citizens find their way through a complicated system, but according to Kristina Louise Bliksted, the healthcare system itself must, to a much greater extent, consider how they can adapt to the citizens they are there for.

– There needs to be an understanding that the system must be adapted, and one must consider what can be done for vulnerable citizens: Who are they? What do they need? That someone come to their home? Are there flexible time slots? That they can just show up without an appointment? says Kristina Louise Bliksted.

She calls for the healthcare system to use very concrete tools – for example, the fact that a citizen is alone is an indicator that they are vulnerable.

– Citizens should feel that someone cares, ask whether they have someone to accompany them, because that says something about their resources and ability to benefit from the treatment, she says, and adds:

– All the money we spend should be able to do more; otherwise, it's a waste of money. The healthcare system is the greatest gift to the population; it's free, but so many people don't feel helped, don't benefit from it, or use it far too late.

Until now, Social Sundhed has operated in the major university cities in Denmark but is now moving into Region Zealand in collaboration with Steno Diabetes Center Zealand and the professional programs at Absalon.

The first stop is a base in Køge, where the University of Copenhagen has just opened a full medical education program at Zealand University Hospital, and where the idea is to link, for example, medical students with citizens who need accompaniment and assistance. Then the concept will be expanded to other areas in Region Zealand.

- As it stands today, we are the “relatives,” a network for those who don’t have many in their network. But the system relies on strong relatives, and that’s not possible for everyone. Not everyone has a strong wife saying, “Now you have to go.” So, we try to level the playing field. We are far from finished creating a healthcare system for everyone, says Kristina Louise Bliksted.

Janne Lorenzen, Program Director, Steno Diabetes Center Zealand: When patients fall under the radar, we must work differently

Through its work with diabetes, Steno Diabetes Center Zealand[6] encounters the practical challenges of being a citizen in a vulnerable position while managing one’s diabetes. This applies both in the region's hospitals and in the primary sector.

- Some may be affected by guilt and shame; they may maintain a façade while at the outpatient clinic, but then disappear into the crowd. Others simply do not show up for various reasons.

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[6] There are five Danish Steno Diabetes Centers in Denmark, established as public-private partnerships. The centers are run by the regions with financial support from the Novo Nordisk Foundation.

So says Janne Lorenzen, Program Director at Steno Diabetes Center Zealand, located in Holbæk.

- It's important to remember that we can all end up in a vulnerable position. You can move in and out of it – sometimes life hits you. But the challenges people face can lead to complications later in life, she explains.

Traditionally, hospital outpatient clinics have been based on offering regular visits to all diabetes patients, but that is about to change.

- This meant that some well-managed patients were offered check-ups they didn't necessarily need, while other patients in vulnerable situations didn't get the services they could benefit from most, says Janne Lorenzen.

Region Zealand faces many socioeconomic challenges, with more citizens having lower education and health levels than the Danish average. The number of people with chronic illnesses and multi-morbidity is increasing not just in Region Zealand but throughout Denmark. The number of children, youth, and adults with one or more psychiatric diagnoses is also rising[7].

- We all know the story that Region Zealand is struggling: We have lower education levels, poorer health conditions, and people are sicker on average. At the same time, we have significant geographical inequality, such as a lack of doctors, says Janne Lorenzen.

But according to her, the negative statistics don't make health professionals give up.

- In fact, it means we see a great willingness to innovate and collaborate. There is a strong desire among all our regional and municipal partners to strengthen prevention and partnerships, says Janne Lorenzen.

When she describes the patients, they miss seeing in the diabetes outpatient clinics, she talks about the quiet patients.

- There are some people who just accept their fate; they fall under the radar. They need more from us, and they occupy our thoughts. We don't see missed appointments as the patient's problem – it's us, the system, that must do better, because it's not the patient who's flawed. It's the system that's wrong – it was built by and for the middle class and is not adapted to everyone, says Janne Lorenzen.

According to her, it is important not to give up on vulnerable citizens and to try to find them, for example, through community psychiatry. Often, just a few citizens occupy a lot of resources, and they can often be identified by looking at who keeps coming back.

- Their diabetes is often the least of their problems. They have other daily life challenges that overshadow their diabetes. Maybe they don't have a car and can't afford various expenses, she says.

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[7] See the main report from the Health Structure Commission from June 2024, Chapter 4, p. 81 https://regeringen.dk/aktuelt/publikationer-og-aftaletekster/sundhedsstrukturkommissionens-rapport/

The challenges of "the quiet sea" mean there is a need to think creatively to solve problems. Steno Diabetes Center Zealand therefore wants to challenge what they currently do – ideally in collaboration with other stakeholders.

- Maybe there is a need for more differentiated treatment than we have today. Some citizens may be handled virtually, while others need a more hands-on offer that cuts across our health sectors, says Janne Lorenzen.

She has several very practical ideas that can be used on the frontlines, where health professionals meet vulnerable patients.

- We see that small pilot projects from the ground up drive change. It could be using social nurses with extended authority who can perhaps offer patients a free meal and get them into the outpatient clinics, or other practical approaches like involving home care to remind them about appointments and hand out free bus tickets, says Janne Lorenzen.

At the same time, she emphasizes that it takes courage to jump in and create change from the bottom up. It takes a leader with the will to do so, and who backs up their staff.

- Start small with, say, five citizens. The great thing is that when you start with a small group, it shifts the way you work. I believe everyone goes to work because they want to do good things and want to help create development and innovation – so if the leader leads, the staff will follow.

Merete Labriola, Professor of Health Challenges, Region Zealand: Inequality kills – but is too rarely treated

Merete Labriola calls social inequality in health a silent killer. This means that social differences in health lead to earlier death. But social inequality in health is not a diagnosis, and therefore it is rarely systematically addressed, she explains:

- People with low income, short education, poor housing conditions, mental illness, etc., live shorter lives, are more ill, and die more often from diseases that could have been prevented or treated. This is well documented, including on Lolland, says Merete Labriola.

She is a professor of health challenges, interventions, and inequality at the Department of Social Medicine at the Department of Public Health at the University of Copenhagen and head of the Center for Health Research at Zealand University Hospital in Nykøbing F, and she has a sincere wish to turn health policies into good, sustainable health initiatives – including for the most vulnerable.

In this interview, she highlights two central barriers that should be addressed: lack of self-care and lack of a relational approach in the healthcare system.

- The problem is, on one hand, patients who lack trust and self-esteem – and on the other hand, a healthcare system that too often gives up on precisely those patients who have the greatest needs, she says.

- There are patients who never show up and therefore are never registered as patients. They don't seek help because they have low self-esteem, because they feel stigmatized, or because they don't believe the healthcare system can accommodate them. So, they don't go to the doctor because they don't want to hear that they should stop smoking. They know what they should do, but they don't feel worthy of care, she says.

Merete Labriola points out how something as simple as the waiting room can be off-putting.

- Imagine sitting there, and your name is called out loudly in front of everyone, and everyone knows you come from a drop-in center. Many drop out before they even get in, she says.

The second problem is the lack of a relational approach in the healthcare system. Merete Labriola teaches medical students and tries to give them something more than just guidelines and diagnosis codes.

- I hear staff saying: 'Oh no, not him again.' How do we remove that mindset? Empathy is not enough. It's about compassion and presence – meeting people at eye level, knowing their name, and reading the chart first. Being aware of your role – when we are privileged, we have an obligation.

For Merete Labriola, it's about showing vulnerable citizens that you have the resources to care about them.

- Say to them, 'I know it's hard for you to be here.' Say when you'll be back. Will anyone be back? Who will follow up? That creates an alliance and a sense of safety. It matters in terms of recovery and having a better experience, she explains.

She refers to the experiences from the Flex Clinic[8] at Bispebjerg Hospital in Copenhagen, where there's no waiting room, but instead, patients are greeted immediately by a healthcare professional.

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[8] The Flex Clinic works to ensure easier access to treatment in the healthcare system for socially vulnerable and marginalized patients and to improve cooperation between municipalities, general practitioners, and hospitals. Citizens can show up without referral and without an appointment. In 2023, the Flex Clinic won an award for Patient Experience of the Year.

- It's not just about professionalism. Doctors themselves get a better work environment and less burnout when they work relationally, she says.

At the same time, she calls for differentiated treatment.

- There are patients for whom things go well. It's super fun to talk to this national football player who has a knee issue and gets a lot of time because it's interesting. But how do we learn to say no to them and spend our time on those where it might be a bit harder? I talk with the students about daring to prioritize and distribute resources fairly, she says.

But Merete Labriola is also realistic: the healthcare system alone cannot eliminate social inequality.

- But we can stop making it worse. We can meet people as human beings. And that starts with seeing them, she says.

Søren Bredkjær, former Deputy Director of Psychiatry in Region Zealand: There are invisible patients whom psychiatry fails to identify

Far too many citizens with mental illness in the southern municipalities of Region Zealand go under the radar in psychiatry because the system fails to reach them, find them, and keep them engaged, says Søren Bredkjær, who knows the area extremely well. Until March 1, 2025, he was Deputy Director of Psychiatry in Region Zealand for 35 years and has now retired.

- In the southern part of Region Zealand – in Lolland, Guldborgsund, and Vordingborg – there are significantly fewer patients in psychiatry than one would expect, considering the population size and health status. We have been puzzled by this for many years; we've known there were these imbalances. It can't be right that there are more people with mental illness in, say, Roskilde than in Nakskov, he says.

The explanation, according to Søren Bredkjær, lies in the underperformance of the so-called primary sector: there are too few general practitioners. In several areas, the traditional, regular family doctor has been replaced by tender-based clinics, where doctors work as short-term substitutes, and this affects continuity.

- This first level of care is normally the one that has a close relationship with patients who need long-term support. These doctors know the patients' medical history and can help detect problems in time. In tender-based clinics, the doctors only have time to deal with the most acute issues, there's a waiting time of several weeks, and many people then choose not to go at all, he says.

- The people we are talking about here die much earlier. It's outrageous when seen because this is partly due to such poor access to healthcare down there, he says.

At the same time, the municipalities are under pressure when it comes to resources and professional competencies in the social sector and schools.

- There are children and young people in some of these municipalities who are disadvantaged if the schools and municipalities don't help them move forward when they have serious problems. It can take a long time before they get help if they truly become ill. We've seen adults who suddenly become very sick, and when you look back at their history, you can see it started when they were 12–14 years old. You think, why did no one intervene? says Søren Bredkjær.

But according to Søren Bredkjær, there is hope. Solutions are on the way with the new healthcare reform and the merger of the Capital Region and Region Zealand into a single Region East Denmark, which aims to create better structures and cooperation.

- If we get better doctor coverage, for example, in the three southern municipalities and also in the western ones in the region, then that would make a difference – there's no doubt about that, says Søren Bredkjær.

Another example is that municipal acute nursing services are now being gathered under the regions, so the cooperation with the hospitals can improve, partly because the funding will come from the same budget, and partly because everyone working with a patient will have access to the same medical records system.

- That can make the positions more attractive and create a professional community, instead of each nurse sitting alone in the municipalities, says Søren Bredkjær.

At the same time, the new national psychiatric action plan is bringing more money into the psychiatric field, and Søren Bredkjær highlights three initiatives as important tools in addressing social inequality in health: outreach staff, social nurses in hospitals, and a strengthening of the so-called PSP cooperation between the police, psychiatry, and the municipalities.

For now, a mobile nurse has been hired in Psychiatry in Vordingborg.

- We've been puzzled that when we looked at people who had been diagnosed with schizophrenia for the first time, there were relatively fewer in the southern part of the region, so the nurse's job is to find citizens who are under the radar. There are places where people live far down country roads, and no one comes out to them, and they just stay out there. There are drop-in centers and networks we want to talk to and ask if they know anyone who hasn't received help and might need a little support, says Søren Bredkjær.

Another example of an effort that makes a difference in terms of social inequality in health is the social nurses employed at the hospitals.

- They come in and meet patients who arrive in poor condition – not just physically, but also socially – and they can catch them. We'd like more of them, because they can make a unique difference specifically for these groups, he says.

Social nurses work in the hospitals' emergency departments and can assess whether something special needs to be done for a patient.

- We have some who come in many times, and we work a lot on identifying these top scorers who come in and out of hospitals – who are they, and can we do something differently? says Søren Bredkjær.

- Here another team can also come into play – namely the PSP cooperation between police, psychiatry, and municipality, where they meet and discuss special patients and can do outreach work, for example at individual residences, he says.

All in all, according to Søren Bredkjær, there are a number of new, important initiatives on the way in psychiatry and across the new collaboration that is to take place in the upcoming new mega-region, when Region Zealand and the Capital Region merge.

Anna Aaby, MD, postdoc, researcher in health literacy, Aarhus University: It is the organization's responsibility to support where the need is greatest

The concept of health literacy is a relatively new way of addressing a complex phenomenon. It is partly about people's ability to understand, assess, and act on health information.

- But health literacy is not only about the citizen, about the individual citizen's ability to understand, assess, and use health information. Today, we talk more about health-literate organizations and the responsibility of health professionals to meet citizens where they are.

So says Anna Aaby, MD, postdoc, and researcher in health literacy at the Department of Public Health at Aarhus University.

- In our research, we have primarily focused on how we, as a healthcare organization and as health professionals, can work when people walk through the door with such different prerequisites. How do we reach them all? explains Anna Aaby.

Thus, the work with the concept of health literacy is important because people with, for example, low education, chronic illness, low functional levels, or language barriers often find it difficult to understand health information due to the complexity of the system.

- For many years, there has been a tendency for the system to place more responsibility on the citizen, and we also have a responsibility to prepare them properly. It is we who create the complexity – so it is we who must ensure the support, she says.

Research documents a connection between low health literacy and poorer health. A large American study has shown a strong social bias in relation to health literacy[9]. The study showed that low health literacy can lead to more hospitalizations and use of emergency departments. At the same time, there is lower participation in preventive measures such as mammography and influenza vaccination.

Clear patterns are also seen in Denmark. A study among patients with cardiovascular disease, led by Anna Aaby, showed that low health literacy was significantly associated with poorer health behavior, including less physical activity, poorer diet, and an increased incidence of both underweight and overweight, as well as smoking[10].

These findings show that low health literacy is not merely an individual problem but also requires structural attention. Therefore, Anna Aaby points out that it is not enough to better inform citizens – it is also very much about how the healthcare system organizes itself:

- Social inequality is caused by several fundamental conditions that extend far beyond the reach of the healthcare system, so it is crucial how citizens are met there. When vulnerable citizens enter the healthcare system, it is too late to fix several of the problems that overshadow their health, says Anna Aaby, and elaborates:

- So fundamentally, the task is to accommodate those people so that we do not worsen that tendency or distort things further. Organizational health literacy is about gaining a sense of who can manage on their own – and who needs an extra hand, she says.

According to Anna Aaby, employees in the healthcare system must take more responsibility – it is not enough to give vulnerable citizens information, because the system is complex and therefore not accessible to them.

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[9] Berkman, N. D., Sheridan, S. L., Donahue, K. E., Halpern, D. J., Viera, A., Crotty, K., Holland, A., Brasure, M., Lohr, K. N., Harden, E., Tant, E., Wallace, I., & Viswanathan, M. (2011). *Health literacy interventions and outcomes: An updated systematic review.* Annals of Internal Medicine, 155(2), 97–107.

[10] Aaby, A., Friis, K., Christensen, B., Rowlands, G., & Maindal, H. T. (2017). *Health literacy is associated with health behavior and self-reported health: A large population-based study in individuals with cardiovascular disease.*

- It’s about being aware that patients are different. They should listen and talk to the citizen about how well they manage their health. And also, how an organization can be structured so that it gives something extra to those who need an extra hand – that is, differentiated treatment, she says.

This points to a broader issue: that the system still knows too little about how to reach the groups who do not show up.

- We can see a tendency that those with low health literacy are the ones who do not come, who drop out, and who should have been there. Patients who, for example, have had a blood clot and never show up for rehabilitation. Where you must make an extra call to get them through the door, says Anna Aaby, and elaborates:

- Very practically, if you’re sitting in a rehabilitation unit, for example, then you shouldn’t take it at face value when people don’t show up. It’s important to contact them and explain why it’s important that they come. There is an offer that can help the individual if it’s hard to show up. It requires both time and resources, but there are solutions – both practical and structural, says Anna Aaby.

According to Anna Aaby, researchers know very little about how to reach the overlooked group of patients.

- Our health policy has focused on treatment for many years. So, everything that comes before – that’s about identifying and preventing disease – we haven’t dealt with to any great extent. It requires both time and resources, and it’s not always something the system is geared for, she says.

To address the lack of knowledge and outreach, Anna Aaby points to several paths – both outside and within the healthcare system. Because if we want to change something fundamentally, it requires, according to Aaby, that we start much earlier:

- One could start in the school and education system and talk about how to create formation around health. If we want to reduce social inequality in health, it requires that health is incorporated into several policy areas – from school to healthcare, she says.

Jes Bak Sørensen, Public Health Researcher, DEFACTUM, Central Denmark Region: As a society, we have chosen to accept social inequality in health

Jes Bak Sørensen is a public health researcher at DEFACTUM in the Central Denmark Region and has worked for many years with social inequality in health. According to him, social inequality in health is the result of political and societal choices.

- If we eliminated child poverty and genuinely took seriously that some children grow up in very poor environments, we could reduce social inequality in health. But we have chosen to adjust certain factors, such as welfare benefits, with political goals other than reducing inequality in health – goals that, in practice, are counterproductive, he says.

According to Jes Bak Sørensen, there are a number of so-called social determinants that are crucial for how an individual's health develops. These are underlying social conditions that are not directly about health, but which significantly shape it, and some of it is completely out of our hands:

- It all starts nine months before one is born. So, if you want to ensure the best possible health throughout life, it's a good idea to choose your parents carefully, he says.

The social determinants include upbringing, education, working life, and finances, and they can become decisive for one’s health.

- You don't become a smoker just because you have a short education, but you are more likely to have unhealthy habits, and you are influenced by those around you. If you have a short education, you are more often at risk of being unemployed for shorter or longer periods, and that greatly affects your finances and life opportunities, says Jes Bak Sørensen, elaborating:

- We know that when you remove the ability to control and define your own life, it affects our well-being and stress levels. Then things start to spiral. So, when you look at health behaviors, and you're under pressure from all sorts of things, the likelihood that you'll eat healthily, exercise, and quit smoking is close to zero, he says.

So, according to Jes Bak Sørensen, we each hold very different cards in the game of life.

- Some people hold the bad cards, and those bad cards tend to make the other cards even worse.

Illustration: Mette Stentoft

Therefore, Jes Bak Sørensen believes we should broaden our understanding of inequality in health to include a wider view of health inequality as a condition that exists as a gradient throughout the entire population. Health inequality is not just a problem for a group of the most vulnerable, such as the homeless or people with substance abuse issues, but something that gradually worsens the further down the social ladder one is. It is a structural condition that affects many, just to varying degrees, he explains.

- There are some groups that are overlooked precisely because they are just ordinary people. It's all those who get up every morning and go to work, but who have a lot of challenges. It takes many years for an unhealthy lifestyle to manifest as disease. It's not acute, but a slow, creeping death that arrives too early.

Jes Bak Sørensen is critical of the way we in Denmark have chosen to prioritize, and that we as a society have chosen not to use the most effective tools.

- In Denmark, we have chosen not to increase the price of cigarettes. We could choose to direct more money toward physical activity in primary schools and kindergartens. So, we are opting out of structural measures and leaving those with the fewest resources to fend for themselves, he says.

The labor market is another example of political choices that do not promote greater equality.

- If we wanted a labor market that was more inclusive and could accommodate more people, including those at the bottom of the social pyramid, we could choose that. COVID was a brilliant example of how we could steer our national economy in a specific direction. One could choose to take on the task and allocate more resources to better take care of people, he says.

So overall, according to Jes Bak Sørensen, it's about political choices and other political agendas.

- It’s as if we’re looking into the toolbox but don’t dare to pick up the big tool that we know is effective. This may be because no one in the established system has a particularly good understanding of what it means to have a vocational education, to live in Ringkøbing, to go to work every day but to have some health challenges that are not dramatic, but you’re a bit run-down – and then you’re expected to keep working until you’re 70, he says.

Jes Bak Sørensen calls for a reckoning with the distance between decision-makers and the reality many citizens live in:

- I think it would be a good thing if more politicians and key decision-makers went out to where ordinary, real people live.

Part of the problem, he says, is that the people making the decisions are far too removed from reality. And it’s not just the politicians, but also civil servants in agencies and ministries. There needs to be a desire and a willingness to focus on the areas where many are struggling. All of us with good resources, jobs, and surplus gather in the same places and leave others behind,” he says.

The Local Clinic in Kalundborg: There are men we never see – this is how a local clinic and local volunteers want to get men to see a doctor

- If you want to get men to the doctor, you must make sure they can get an appointment quickly and don't have to wait too long in the waiting room.

So says Søren Holme Nielsen, who has volunteered as a local activist to help start a men's user council in Kalundborg.

- Maybe it has something to do with men not wanting to waste the doctor's time, and they think it will probably pass on its own. They're busy at work and think, 'it's probably just because I'm a bit stressed today,' he says.

The Danish Health Authority's professional proposal for Cancer Plan V, published in January this year, shows that since 2010 there have generally been more new cancer cases among men than women, and this difference is expected to grow in the future. At the same time, survival rates are lower for men than for women.

Therefore, the Region Zealand Local Clinic in Kalundborg, as part of an initiative to detect cancer early, wants to encourage more men to see a doctor, because they too often seek help too late.

- Women come with their children and are used to visiting the doctor. But men feel insecure and think they don't have time to take off work. It's also about our accessibility – there are waiting times, and men don't want to deal with that, says Lars Burchardt, a physician at the clinic.

An Australian study[11] shows that men find it more difficult to seek help from their general practitioner. Although the study is based on international data, the conclusions are also relevant for Denmark, where similar patterns are seen: Physical and organizational factors such as opening hours and the clinic's atmosphere – including the waiting room – can be discouraging for men. There are also several psychological factors, including that men perceive seeking help as a weakness and prefer to handle health problems on their own.

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[11] A. Smith et al., *Men's help-seeking and engagement with general practice: An integrative review*, Journal of Advanced Nursing, 2023, vol. 79, no. 5, pp. 1537–1554.

According to a study[12] by researchers from, among others, the University of Copenhagen, women, on average, visit general practitioners more often than men – even when accounting for lifestyle, illness, and social factors.

When excluding visits related to contraception, pregnancy, and similar issues, women still have an 18 percent higher usage of general practice compared to men. While one cannot equate lower doctor visits by men with worse cancer survival, it may be a contributing factor.

This is why Region Zealand has launched the project with the Local Clinic in Kalundborg to address the barriers that men, among others, face when seeking medical care upon experiencing symptoms.

The Local Clinic in Kalundborg is operated by Region Zealand, which in 2019 received special permission to establish its own medical clinics due to a shortage of general practitioners.

- The doctor shortage doesn't help. The more rural the area, the harder it is to get a doctor's appointment, says Lars Burchardt.

Sascha Fich, the practice manager and nurse at the clinic, adds:

- There is a severe shortage of all types of specialists for citizens. Sometimes people have to get up at 4 a.m. and wait for flex transport. It basically requires owning a car to visit a doctor, so infrastructure plays a role too, she explains.

At the Local Clinic in Kalundborg, the practice manager handles all the organizational tasks, such as scheduling for the clinic's three nurses and two permanent doctors, who work in the clinic two and three days per week, respectively, in addition to locum doctors.

- We want to find new ways of doing things. That's why we called a town hall meeting and formed a group of men who act as ambassadors. They help us reach the men who aren't showing up and provide good suggestions and ideas, says Sascha Fich.

25 men showed up to support the initiative, including Søren Holme Nielsen.

- They invited me to the user group meeting, and I had recently lost my wife, so I needed to spend time on something else. I thought it might be a good idea, he says.

- It's also because I lost my wife very suddenly to cancer, so I know the kind of grief it brings. If I can do just a little to help others avoid ending up in the same situation I was in – if we can save just one life – then I think I can spare three or four evenings a year to attend meetings, he says.

The next step is for the newly established men's user council to meet quarterly with staff from the local clinic and representatives from Region Zealand to develop new ideas together for how to reach the invisible men who fall under the radar.

- We need to try to identify exactly who is not coming. Which age group are we talking about, and what are the reasons they aren't coming? We need to reach those at risk of becoming ill or who are already ill and ask them and find out what worries them about seeing a doctor, says Sascha Fich.

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[12] Jørgensen JT et al. (2016). *Determinants related to gender differences in general practice utilization*. Scandinavian Journal of Primary Health Care. DOI: 10.1080/02813432.2016.1207141

Various initiatives have already been discussed – for example, informing about the option of online video consultations that don't require taking a half-day off work, and holding after-work sessions at workplaces to communicate the importance of seeing a doctor when experiencing symptoms.

The user council is also discussing whether it's possible to reach out in some way to patients who haven't been seen in a long time. Finally, the clinic has now decided to eliminate the restricted phone hours, so patients can call the clinic throughout the day, as many men have expressed difficulty remembering to call during a specific time window.

Søren Holme Nielsen believes in the project and is happy to be involved:

- It's incredibly exciting to get these men to talk and ask them: 'Why don't you go to the doctor? You take your car in for service. Maybe your heart and body also need a check-up now and then?' he says.

Johanne Kure, Chief Political Consultant, Danish Patients: The healthcare system contributes to reproducing social inequality in health

Social inequality in health is a so-called "wicked problem," meaning it is complex, multifaceted, and lacks easy solutions.

These are the words of Johanne Kure, Chief Political Consultant at Danish Patients[13].

– Inequality in health does not originate in the healthcare system. It is the result of social structures and living conditions. At the same time, social inequality in health can be viewed in several different ways, which makes it difficult to fully grasp what it is and where to intervene. It is an extremely complex phenomenon, says Johanne Kure, and elaborates:

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[13] Danish Patients is an advocacy organization representing 109 patient and caregiver associations with a total of more than 900,000 members.

– You can view social inequality in health from a so-called gradient perspective, where the lower your education and income, the poorer your health will be. But you can also see it from a group perspective, focusing on specifically vulnerable and invisible groups who have significantly poorer health, such as the homeless, people with mental illness, substance abusers, people on disability pensions, and citizens with an ethnic minority background, she explains.

According to Johanne Kure, there is no doubt that we have a well-documented problem with social inequality in health in Denmark. Countless studies have shown this.

– Regardless of which of our member organizations you ask, they will say that there is inequality in health – also for their patient group. But one area where we can see major societal challenges is for patients with mental illness, she says.

– They may have less trust in the healthcare system and are hesitant to seek care. They are massively overlooked, and this leads to underdiagnosis, so we see that people with mental illness have poorer health on many parameters, she explains.

The healthcare system's difficulty in addressing the somatic health of, for example, people with mental illness is also, according to Johanne Kure, due to the fact that the system itself contributes to reproducing some of the existing inequality.

– The way the healthcare system is structured and the way healthcare professionals unconsciously interact with patients reproduces inequality that affects treatment, she says.

– For example, studies from breast cancer departments show that the women staff members could best identify with those who resembled them. These women unconsciously received more favorable treatment because the staff was better at advocating for those they could relate to, says Johanne Kure.

People in vulnerable situations may also fear encountering the healthcare system because they are afraid of being stigmatized.

– They may worry that a doctor on the other side of the table will tell them what to do, scold them for their lifestyle, and enroll them in a treatment plan they don't have the capacity to manage, says Johanne Kure.

In addition to unconscious bias among staff, there's also the structural issue of how the healthcare system is organized. The healthcare system is difficult to navigate – even for the well-educated – but the complexity especially impacts those with the fewest resources.

– It's a huge hassle for everyone to figure it out. You have to go to many different places. You're in contact with many different people. You receive appointment letters written in a language that's hard to understand. You also deal with the municipality – and is that the same? There are so many elements. There's a lot about this organizational aspect that is incredibly difficult to navigate, says Johanne Kure.

So, what is needed to find better solutions for treating vulnerable people? Johanne Kure points out that the healthcare system must adopt systematic methods to identify vulnerability and tailor treatment accordingly.

– The root of how to address the inequality that arises in the encounter with the healthcare system lies in becoming much better at seeing who you're dealing with and not taking anything for granted. Healthcare staff should have systematic dialogues and methods to uncover what matters to the patient: What is your current capacity? What is your vulnerability right now? Then they can assess how much treatment the individual can engage with, she says.

If we truly want to tackle the growing social inequality in Denmark, political attention is also needed, according to Johanne Kure.

– We must do this as a society, and we owe it to each other. It requires more than just lip service. It's about taking action and prioritizing and saying, "Now we want to focus on this." We will begin monitoring it. We will start managing based on it. We will begin to change our own practices. We will train our staff to care for these people. We will ensure that there is sufficient time and the right resources to meet people. It's about fundamentally rethinking how the healthcare system and patient interactions are organized, says Johanne Kure.

At the same time, she emphasizes that outreach work is needed to get people "to the trough."

– If there are groups who are not showing up, then we must do something. It's not just about organization – it's about trust, it's about relationships. Should we organize the healthcare system based on what works best from an operational perspective, or for the patient? We must look ourselves in the mirror and ask, do we really want to do something about this? Then we have to say that we actually want to prioritize helping these people in a way that is more meaningful to them. That can help them take care of themselves and become part of society, says Johanne Kure.

The Role of the Media: How Can the Media Help Make Social Inequality in Health Visible and Reduce It?

As the journalist responsible for covering health at TV2 ØST, which covers 12 municipalities[14] in Region Zealand, you quickly realize that social inequality in health is a major concern for all the institutions you encounter in the healthcare system: Citizens in Region Zealand have lower education levels and poorer health than the Danish average.

Therefore, in this report, I have asked my sources what role they believe the media should play in covering social inequality in health.

The media should hold those in power accountable and ensure that political promises are followed through, according to several of the sources I interviewed.

– You have a role in acting as a watchdog and keeping those in power on their toes. To focus on the fact that inequality still exists: What has been done? That is the media's most important role, says Johanne Kure, Chief Political Consultant at Danish Patients.

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[14] Lolland, Guldborgsund, Vordingborg, Næstved, Slagelse, Sorø, Faxe, Ringsted, Stevns, Holbæk, Kalundborg og Odsherred are municipalities located in Region Zealand, one of Denmark's administrative regions.

Jes Bak Sørensen agrees. He also calls on the media to take on the task of being a watchdog for those voices that are not being heard:

– Where I would most like to see the media step up is in exposing hypocrisy. Politics is politics; you may believe and act however you like, according to your convictions. But to say one thing and do another, that to me is hypocrisy, and it should be made visible.

– The Minister of Health should be able to stand up and justify the 16,000 deaths each year caused by smoking, compared to the revenue loss in the state budget from increasing cigarette prices, he says.
– Instead, we put grotesque pictures on cigarette packages, raise the price by four kroner, and tell municipalities to offer smoking cessation programs. I'm still waiting for answers about what we as a society lose when we actively choose to do too little, says Jes Bak Sørensen.

But that very task – going in-depth with structural problems – is something several sources find difficult to "sell."

– I fear that readers and viewers can't bear to keep hearing about it, because they don't know what to do about it. I think it's obvious that the media should do more, but I get the impression that there's some reluctance, because it's not a page-turner. It doesn't sell, says Søren Bredkjær, Deputy Director of Psychiatry in Region Zealand.

Jes Bak Sørensen adds:

– It would be interesting to communicate the gradient perspective, to show that social inequality in health affects people across the population. The problem is, it's a non-story – it's not super easy to tell, so you rarely see it in the news.

– These issues are more often seen in entertainment programs, where the rest of us can wipe our foreheads and think, "Phew, I'm doing better than that guy."
– So we lack giving voice to those who appear negatively in the statistics. But I struggle to see how that gives the clicks you want, he says.

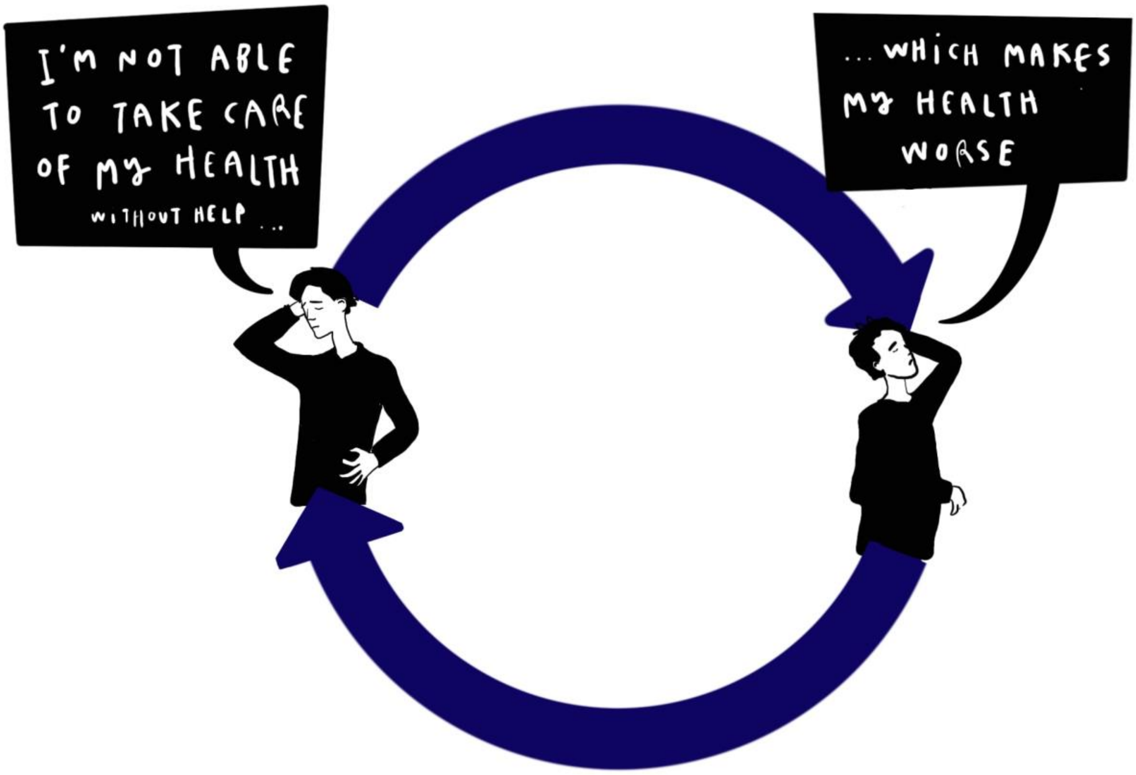

Illustration: Mette Stentoft

The media naturally have a responsibility for nuanced representation, because if vulnerable citizens are not seen in the media, they risk not being prioritized in political decision-making.

Therefore, it is important that vulnerable citizens are not portrayed in a simplified, stereotypical, or sensational way, as this can reinforce prejudice. A nuanced media coverage is important to provide the public with insight into the complex challenges these citizens face.

Johanne Kure believes that the media can help make health a shared concern – even for those who do not feel seen by the current system:

– I don't think the media is the solution, but they can help inform in a non-judgmental way. They can help convey knowledge that you can't always be responsible for your own health.

– One single article won't do it. It requires a commitment from the media to help raise awareness about how important it is to pay attention to one's health. And that no one will judge you when you show up asking for help, she says.

For Janne Lorenzen, Program Director at Steno Diabetes Center Zealand, the role of the media is clear:

– It is important that the media helps make different needs visible. Those who are strong and have relatives will manage, and they speak loudly. But others need more help, and they often go under the radar. The media can help by addressing the need to treat people differently.

– It is not at all unethical that you cover social inequality in health and talk to vulnerable citizens. You help point out the problems. At the same time, you can help break down stigma and make vulnerability more understandable to the public, she says.

Merete Labriola, Professor of Inequality at the University of Copenhagen, however, sees another problem:

– Many people manage despite the odds. But the media often only show vulnerability when it's dramatic or filthy.

She warns against portraying the target group as passive and unworthy:

– When we speak with drop-in centers and residential facilities, they tell us that people take showers and take care of themselves – even when they have nothing. But we risk reinforcing a narrative that they are a burden.

Several sources call on the media to use their platform more to show ways forward, and not just problems.

Søren Bredkjær, for example, suggests highlighting the important work done by volunteer organizations and local actors:

– They do an enormous job. They really reach out to people. If that could somehow be made interesting, it would be a good thing to show, he says.
He also hopes the media will follow up on how the new structural reform affects the most vulnerable areas:

– The media has an important role here in telling the stories of the people who need to be made visible with the new structural reform and Region East Denmark. If we really want to make a difference, we need to tell the stories and engage with these vulnerable areas so that in 10 years we can say: "Wow, we made a difference."

Merete Labriola adds that the media also has a responsibility to strengthen pride in local communities and foster a positive identity:

– Let's talk up our region and make it an exciting and attractive place for healthcare professionals to work. They should be proud of their work and help take ownership of social inequality in health. This is about us. We are the ones who need to make a change, she says.

Constructive Journalism: A Tool to Highlight Social Inequality in Health

Constructive journalism is about covering problems in a nuanced way – while also exploring possible solutions and inspiring initiatives.
As described, social inequality in health is a so-called *“wicked problem”*: a complex societal challenge without a single, clear solution – there are no easy fixes. But constructive journalism on the topic can enhance the audience’s understanding, inspire action, and help make vulnerable citizens visible and heard in society’s decision-making and prioritization.

Focus on the problem – with nuance

A constructive approach should first and foremost highlight the nuances and experiences associated with social inequality in health. This can be done by:

- Interviewing health professionals who interact with vulnerable citizens – e.g., general practitioners, psychiatric nurses, municipal actors, hospitals, Steno Diabetes Centres, and NGOs.
- Using relevant data and reports to document the scale of the problem.
- Including real-life case stories: vulnerable citizens sharing their experiences and the consequences of, for example, missing doctor appointments or not following prescribed treatment. It is important to select case subjects thoughtfully so that they are representative and not exposed or stigmatized.

Focus on solutions – show what works

A core of constructive journalism is showing where action and hope exist – without falling into the trap of uncritical success stories. This means that journalists ask:

- Which actors are trying to solve the problem?
- What initiatives are effective – and can they inspire others across the country?
- What barriers stand in the way of change – and how can they be overcome?

In my project, I have encountered several examples of initiatives that aim to reduce social inequality in health. They can serve as case studies in a constructive journalistic approach:

- **Men have higher mortality from cancer**: A men's user council at the Local Clinic in Kalundborg aims to make the health system more accessible for men.
- **Fewer people are mentally ill in the southern part of Region Zealand?** A new outreach initiative in psychiatry with mobile nurses is being tested.
- **Social Health** – accompanies citizens in vulnerable situations into the healthcare system and helps them navigate it. The organization is establishing itself in Region Zealand – starting in Køge/Zealand University Hospital.
- **Profile of the Flex Clinic at Bispebjerg Hospital for vulnerable citizens**: One can show up without an appointment or health insurance card. Can something similar be established at hospitals in Region Zealand?
- **The Fusion Clinic in Psychiatry in Slagelse** is expanding its service from West Zealand to the entire region. For five years, it has been the only place in Denmark to treat patients with both diabetes and severe mental illness in one combined service. Nurses visit patients at home to carry out both assessment and treatment.
- **How is the healthcare system working with health literacy?** Are there relevant projects? If not: Why not? Should it be a subject in health education programs? And a focal point in hospital departments?

Promoting democratic dialogue – citizen involvement and follow-up

Constructive journalism also invites democratic conversations.

This can be done through:

- Articles and segments where a vulnerable citizen meet a politician or decision-maker.
- Dialogue meetings between citizens, regions, municipalities, volunteer organizations, and politicians – these can be livestreamed and followed up with articles or opinion pieces.
- Conclusions with idea catalogs and recommendations from the citizens themselves to the politicians.

Follow-up is crucial
Remember to check back after some time – what happened afterward? Did anyone follow up? Did it lead to political action? All too often, we in the media forget to return. But follow-ups can yield new insights and stories of change.

Recommendations: Talk to Citizens in Vulnerable Positions – So They're Not Overlooked, but Do So Thoughtfully

When covering inequality in health, the most important task is to identify case stories from people who are willing to share how their socio-economic conditions negatively affect their lives and, often, when the media becomes involved, their patient pathways.

As journalists, we are always on the lookout for case stories, and especially in health journalism, such cases are in high demand because they put a face to the issues being covered. But how can we ensure that the citizens who appear on the front page don't have a bad experience, and that we don't add to their vulnerability?

In my experience, vulnerable cases are difficult to find, and it takes time, care, and patience to approach them thoroughly and with dignity. Cases can be identified through outreach workers at hospitals and in municipalities, and NGOs can often assist as well.

Once the right case has been found, a preliminary interview can be conducted to uncover what challenges they face, and what they think about the issue being addressed. When covering social inequality in health, it is useful to ask about their lives and the barriers that prevent them from seeking medical help or using health services. What are their hopes and dreams? Ideally, what would their situation look like if they were the ones in charge?

None of the interviewees I have spoken to believe that the media should refrain from talking to citizens in vulnerable positions. On the contrary, all agree that it is important to give citizens a voice and help highlight the problems so that change can occur. So, the question is not whether they should participate, but how to do it ethically.

I have asked the Council for Socially Marginalized People (Rådet for Socialt Udsatte) and Better Psychiatry (Bedre Psykiatri) how they believe journalists can best involve citizens in vulnerable positions – that is, how to use them as case stories – and also requested practical advice on how to treat them ethically and responsibly, so as not to aggravate their vulnerability, but instead provide them with a genuine voice.

The Council for Socially Marginalized People: Take Your Time – Even If You Don't Have It

Kristian Volden, press and communications consultant at the Council for Socially Marginalized People (Rådet for Socialt Udsatte), previously worked as a news journalist at DR News and Ritzau. Today, he interviews socially marginalized people when the council[15] collects knowledge about homelessness, drug use, sex work, and other forms of social marginalization.

With his experience from both sides, he points to a key challenge for news journalists: the time factor.

– Time is a huge factor. There's an inherent challenge in that news journalists are expected to meet and interview vulnerable people who often need time to build trust, and news journalists usually don't have much time, says Kristian Volden.

According to him, interviews with people in socially marginalized positions require extra care and preparation. It's not just about asking the right questions, but also about avoiding the reactivation of trauma, as many have lived through severe experiences, from childhood or life on the street.

– We're talking about people who may be extremely vulnerable, and we risk re-traumatizing them if we ask about all kinds of personal experiences and past events without consideration. We need to give them a voice, but we must avoid exacerbating their vulnerability, he explains.

That's why Kristian Volden and his colleagues at the Council for Socially Marginalized People place great emphasis on both preparation and the meeting itself.

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[15] The Council for Socially Marginalized People was established by the Minister for Social Affairs and functions as an independent advisory body. Its purpose is to provide advice on how to address social marginalization and to ensure that socially marginalized individuals are heard and included in the public debate, so that their experiences are considered in the development of the welfare state.

They do this in part by working with support workers or organizations such as SAND – The National Organization for the Homeless (De Hjemløses Landsorganisation) and the Users' Academy (Brugernes Akademi). In this way, they can get a sense in advance of whether there are particular considerations to be aware of in the encounter with the individual.

– It enables us to speak with people in a good and responsible way, he says, emphasizing that trust is a key word:

– It is crucial for us that the people we talk to have a good experience. And that only happens if they trust us. Which brings us back to the issue of time, because it takes time to establish a safe connection before turning on the recorder or taking photos. So, it's important to take your time – even if you don't have it, says Kristian Volden.

Better Psychiatry: The stories of vulnerable citizens are crucial and important – they reflect the shortcomings of the welfare state

Jane Alrø Sørensen is the Secretary General of Better Psychiatry[16]. She often receives calls from journalists asking for help finding a case for a story they are working on. When possible, they are happy to help, because it is important that the media share stories about vulnerable citizens.

– Their stories are just as valid and just as important as anyone else's. Their stories are a testimony to our welfare state and our healthcare system – both when it works and when it doesn't, she says.

Better Psychiatry works to improve conditions for relatives of people with mental illness or developmental disorders. The organization has 12,500 members.

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[16] Bedre Psykiatri is an association for relatives of people with mental illness or developmental disorders.

Stories about vulnerable citizens can help set the agenda and show that social inequality in health exists in Denmark, according to Jane Alrø Sørensen.

– Your access to public services depends on your background and how skilled you are at negotiating. So, I believe that the testimonies and stories of vulnerable people are crucial, and they are a completely legitimate way to show the shortcomings of our welfare state, she says.

Jane Alrø Sørensen also acknowledges that the media do cover stories about vulnerable people, but she is concerned that there is often a focus only on the very weakest individuals.

– Unfortunately, I often find that there is a tendency to chase stories that can't be bleak enough. The spotlight is placed on very extreme cases. That can be problematic – I understand that it sells newspapers and gets viewers. But it is not very relatable or representative of the majority of people in vulnerable situations, she says.

This, according to Jane Alrø Sørensen, can become a problem for the segment of the population who then cannot see themselves represented or reflected in the public debate.

– A large portion of the Danish population will, at some point in their lives, need help from psychiatry[17]. So, most people will at some time be in a vulnerable position, and they can't identify with the citizen whose case includes multiple complex issues like homelessness, prostitution, and a lifelong career in psychiatry.

Jane Alrø Sørensen emphasizes that the multi-complex stories are also important, but if the goal is to create more openness and break taboos around psychiatry, it matters that we also meet people who are more representative.

– Many people with mental illness struggle and manage to hold on. They might have a flex job, and at other times be outside the labor market. I often miss seeing those people given a voice. I wish the media were also interested in telling their stories, she says.

Jane Alrø Sørensen also points to the existence of a kind of "invisible trade" between the media and interest groups like her own.

– It's never stated directly, but it's implied that if you journalists get a good case featuring a vulnerable citizen, then we get airtime, and we do want to get our messages out in the media, she says.
– That creates a dilemma for us, where in order to gain access to the microphone, we "push" a citizen forward and ask them to go public, she explains.

The media want so-called cases to add identification to the article or segment. But Jane Alrø Sørensen raises a critical question for journalistic reflection: Is the case merely used to provoke emotion and grab attention, or does the case – and the article/segment overall – contribute with knowledge, insight, or solutions?

– We do want to help, and we spend a lot of time doing it properly and ethically. But sometimes it feels like we are asking people to go public just so we can get a voice. So, we are

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[17] A large Danish registry study published in *JAMA Psychiatry* shows that nearly half of the population receives a psychiatric diagnosis or psychiatric medication at some point during their lifetime.
Pedersen, C. B., & Momen, N. C. (2023). *Lifetime Cumulative Incidence of Psychiatric Disorders and Psychotropic Medication Use*. JAMA Psychiatry, 80(9), 928–938.

very conscious of this, and sometimes we say no, because the vulnerable citizen might not be able to fully understand the consequences of going public, says Jane Alrø Sørensen.

When the media need to use someone with a mental illness as a case, the journalist must act ethically. That includes preparing the case well and explaining what it may mean to go public.

– They need to understand that they might be recognized in the local supermarket tomorrow and that everyone will know they have a son who committed suicide. We take that seriously, but sometimes we wonder: Was he resilient enough? That's why we need to be able to trust journalists and hope that you act ethically, she says, and elaborates:

– We ask a lot from people when we ask them to go public with something so painful. We get a glimpse into a very taboo side of someone's life. But at the same time, we also believe that openness breeds openness, and we must talk about mental illness. So, the conclusion must be that the media and NGOs like ours share a collective responsibility to ensure that the cases we present understand the consequences of going public – and that they also consent to it being shared on social media, says Jane Alrø Sørensen, adding:

– It's important to monitor comment sections on social media and ensure people are treated with respect. I don't think the media are good enough at that. If the media allow hateful comments to run freely on social platforms, they are also responsible for moderating them.

Another question is how journalists can best approach vulnerable citizens. Is it, for example, acceptable to contact them via social media?

– If people choose to write and be open on social media and to share their story, then they have already taken the first step toward openness. Then it's okay to contact them. After that, journalists need to inform them about all the consequences: We're going to use this on social media. We moderate it, but ugly things can appear before we delete them, says Jane Alrø Sørensen.

Practically speaking, Jane Alrø Sørensen has several good tips for journalists working on stories with vulnerable citizens.

– Put the person before the story, and approach the person with openness and curiosity. Listen and talk to them about what it means to go public and about what they might be exposed to.

In the end, it's not just about getting your story through – it's also about making sure that those who go public are treated with respect, even after the story is published.

– So, remember to call them afterwards and ask if it was a good experience. That shows you take the person you've worked with seriously, says Jane Alrø Sørensen.

Mødrehjælpen: We Live in Bubbles – The Media's Blind Spots

When vulnerable citizens share their stories with the media, it can make a difference and give them a voice in public debates.

– Of course, their voices should be heard. Many of them are resourceful and manage to make things work despite quite difficult circumstances. They are not just vulnerable — they also possess a certain power, and that deserves to be voiced, says Tasja Norre Parize, Head of Policy, Analysis and Communication at Mødrehjælpen[18].

Mødrehjælpen also uses case stories in its own communication and has a family panel with over 2,400 families who have agreed to participate. The organization uses the panel to ask questions on various issues, which are then used in analyses they share with the media.

– We ask what challenges they face, and we're fortunate to get a high response rate. They often elaborate in the text fields. They have a lot on their minds and want to share it. But speaking on behalf of families and sharing their stories is one thing, she says.

In general, Mødrehjælpen experiences that stories about vulnerable people can be difficult to pitch to the media. There is some openness around Christmas, but news stories about difficult living conditions rarely make it into the media. This may be partly because journalists don't meet people in vulnerable positions themselves.

– We live in ghetto lands — we surround ourselves with people just like us in small bubbles — and journalists tend to use their own reality as a starting point. At Mødrehjælpen, we have a task: to explain child poverty. It actually exists in Denmark. But then journalists look around at their own kids and friends and say: 'We don't know anyone.' It's an uphill battle. There's not much interest unless someone is truly caught in the system or there's a strong news hook. A general story about inequality doesn't attract much attention, she explains.

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[18] Mødrehjælpen is a social-humanitarian organization that provides advice and support to pregnant women and families with children in difficult situations.

– It’s easier to go with an influencer loudly complaining about how hard it is to be a family with kids. That’s not a major problem, but they’re famous, and they have a voice, so suddenly we’re talking about family policy. It’s the resourceful who are being heard. We just did a study on work-life balance, showing how the problems are exaggerated in the public debate. But the families who really struggle, we don’t hear from them. And that means we don’t properly address the real problems or get the right political responses, she adds.

Unfortunately, stepping forward publicly can come at a cost, as families often receive hateful comments on social media after appearing in an article or on a news segment. The press team at Mødrehjælpen, which is often asked on short notice to help find cases for journalists, experiences this regularly.

– That makes more people hesitant to participate, and short deadlines don’t help. Sometimes journalists drop their story because we can’t deliver a case quickly, says Tasja Norre Parize.

This is why Mødrehjælpen often discusses internally how they can ensure that the more vulnerable voices are heard.

– We’re concerned that it’s mostly resourceful families filling the media space. The more vulnerable ones rarely get a voice, but they do exist. We think giving them that voice and bringing them into the debate is incredibly important, she says.

Mødrehjælpen is happy to help facilitate case stories but also reflects on how to support vulnerable families through the process, and what it means to go public.

– It means you can be exposed to all sorts of things, and we have a duty to inform them about that. We also ask about what their children think. How do the kids feel about their parents talking publicly about poverty? Many children do everything they can to keep up appearances, so their classmates don’t find out. So yes, it can affect the children too. We have an ethical responsibility, says Tasja Norre Parize.

This creates a dilemma: How can the media give space and voice to people in vulnerable positions while also protecting them?

Earlier this year, Mødrehjælpen and five other organizations published eight recommendations for journalists, editors, and others covering domestic violence in the media. The background was that the organizations sometimes see people affected by violence getting caught in difficult situations after media appearances, and that important nuances are lost.

– It’s also about asking open-ended questions and trying to understand everything that’s at stake. It’s rarely just one problem. So, it’s important to allow for complexity, she says.

Tasja Norre Parize encourages journalists to understand that this is different from calling up a politician for a statement. It’s people’s personal lives, and what they’re asked to talk about may be shameful.

– It’s about building trust and investing time in gaining their confidence. You can’t come in with a prewritten story and just collect four quotes. It can’t be wrapped up in five minutes, she says.

Tips for Interviewing People in Vulnerable Positions

After speaking with Mødrehjælpen, Bedre Psykiatri, and the Council for Socially Marginalised People, I have compiled the following advice on how to take care of vulnerable individuals when using them as case stories.

Before the interview:

- Seek background information: If possible, speak with the organization, shelter, NGO, or contact person who facilitated the case. Get insight into the person's situation and potential vulnerabilities.
- Clarify what the interview involves: Have a clear understanding of the story and consider how the case's narrative will be used, and what you expect to discuss and ask about.
- Call ahead – and do a pre-interview: Talk with the person beforehand to explore: What do they want to share? What experiences and dreams do they have? What does going public mean to them?
- **Clearly explain what participation entails:** Make it clear that the story may be published online and on social media, that they could be publicly recognized, that the comments section might be positive — but also harsh — and that they can withdraw at any time.

During the interview:

- Allow enough time and create a safe space: Allocate sufficient time — it can't be done in five minutes. Consider extending your deadline to ensure both quality and ethical care. Begin informally, listen, and build trust before starting the actual interview — this also applies to photography.
- Ask open-ended questions and allow for complexity: The issue is rarely "just one thing." Ask open, curious questions and let the person speak freely — even about things outside your planned angle.

- Listen to the whole person – not just the story: The case subject often has more on their mind than what brought you there. Respect what is personal and vulnerable — and make room for the complexity real life contains.

After the interview:

- Monitor the comments on social media: Close the comment section if it turns negative or hateful. This is a key part of your responsibility.
- Follow up with a call: Ask how the experience was and whether it felt safe and respectful.
- Offer quote approval: It provides reassurance when the person can approve quotes and/or how they are portrayed. This isn’t about changing facts, but about ensuring they feel accurately and respectfully represented.