International Journal of Qualitative Studies on Health and Well-being

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/zqhw20

Bridging gaps in health? A qualitative study about bridge-building and social inequity in Danish healthcare

Merete Tonnesen & Anne-Mette Hedeager Momsen

To cite this article: Merete Tonnesen & Anne-Mette Hedeager Momsen (2023) Bridging gaps in health? A qualitative study about bridge-building and social inequity in Danish healthcare, International Journal of Qualitative Studies on Health and Well-being, 18:1, 2241235, DOI: 10.1080/17482631.2023.2241235

To link to this article: https://doi.org/10.1080/17482631.2023.2241235

Published online: 01 Aug 2023.

INTERNATIONAL JOURNAL OF QUALITATIVE STUDIES ON HEALTH AND WELL-BEING
2023, VOL. 18, 2241235
https://doi.org/10.1080/17482631.2023.2241235

Taylor & Francis
Taylor & Francis Group

EMPIRICAL STUDIES

Bridging gaps in health? A qualitative study about bridge-building and social inequity in Danish healthcare

Merete Tonnesen and Anne-Mette Hedeager Momsen

DEFACTUM, Central Denmark Region, Aarhus, Denmark

ABSTRACT

Attendance to health appointments may pose challenges to patients, especially when living in socially disadvantaged situations, with a fragile network. Inequality in health is increasingly highlighted in Denmark. To enhance social equity in health, a non-governmental organization introduced *bridge-building*, where healthcare students volunteer to accompany persons in socially vulnerable situations to health appointments.

The purpose of the study was to explore what *bridge-building* entails and which gaps bridge-building attempts to span, in a welfare state, based on equal rights to healthcare.The study is based on an ethnographic fieldwork among the stakeholders in bridge-building, using interviews and participant observation in the form of "walking fieldwork".

Informants emphasized safe-making and wayfinding as important components in bridge-building, with bridge-builders acting as as-if-relatives. Bridge-building navigates in borderlands, the in-between spaces with fluid and contested borders, encompassing public, civic society, and family spheres. All informants emphasized that bridge-building covers a need in contemporary Danish healthcare.

Bridge-building entails a double temporality, a here-and-now intervention where persons in vulnerable situations get social support to make it to health appointments, and a future investment in future health professionals' understanding of vulnerability in lives and barriers to health access; insights that may be valuable in their future job positions.

ARTICLE HISTORY
Received 2 January 2023
Accepted 17 July 2023

KEYWORDS
Bridge-building; inequity in health; inequality; health attendance; social support; Denmark

Background

The Danish healthcare system is based on a right to equal access to healthcare. However, social inequality in health is highlighted on the political agenda in Denmark, acknowledging that social position and social conditions matter in relation to human health, disease, life expectancy, and health-related quality of life (Sundheds- og ældreministeriet, 2019; Udesen et al., 2020).

While social inequality in particular among men has decreased in other western European countries (Diderichsen, 2020), social inequality increased in Denmark over the past decade; the lower income and education, the lower are expected years of living. In population groups with low levels of education, social inequality is marked in relation to nearly all diseases/comorbidities, feeling unwanted alone, and self-rated quality of life (Udesen et al., 2020). Seven percent of all Danes show signs of living disadvantaged and marginalized lives, due to homelessness, addiction, imprisonment or mental illness; a complexity is hidden in the percentage: the group is diverse concerning abilities to work and to live "well-functioning lives" (Benjaminsen et al. 2018). Socially marginalized persons tend to have a lower frequency than the average Danish population concerning consultation with specialist doctors, dentists, and therapists, yet use general practitioners (GPs), psychologists, and emergency wards more (Strøbæk et al, 2017). However, persons with extremely low income have significantly fewer contacts with general practice (Arendt et al., 2010).

It is well described how several interrelated aspects may impact social inequity in patients' meetings with the healthcare system. These include organizational aspects such as time, resources, educational competences among health professionals, and specialized healthcare systems that may challenge navigation and coherence between sectors (Ahlmark et al., 2017; Kjeld et al., 2022; Pedersen, 2018; Scott et al., 2019; Sodemann, 2018). They include relational aspects such as health professionals' assumption about patients and their situation or, as some studies show, that patients with lower socioeconomic status may be less proactive in health appointments (Kjeld et al., 2022). Generally, there is a tendency that "deprived populations" face multiple barriers to attend health appointments (McLean et al., 2014, p. 73), e.g., affordability, transportation, accessibility, and

CONTACT Merete Tonnesen merete.tonnesen@rm.dk DEFACTUM, Evald Krogs Gade 16A, Aarhus 8000, Denmark
This article has been republished with minor changes. These changes do not impact the academic content of the article.

a strained interaction between users and providers (Ramsay et al., 2019). They may experience staff shortage and staff with limited time, and a healthcare system with complex procedures (Loignon et al., 2015). Further, some experience multiple challenges in life. Indeed, concerning health checks, a poor uptake seems more usual among persons with a low socio-economic status (Dryden et al., 2012), with educational attainment and occupational status as the strongest predictors of attendance, according to a Danish study (Larsen et al., 2018). However, little is known about the poor uptake amongst "vulnerable and socially disadvantaged people" (Braae & Merrild, 2021). While one Danish study points to health literacy as an explanatory factor (Friis et al., 2019), another finds that informants did not lack knowledge and understanding of health-related issues but rather that life circumstances and trying to manage their illness overshadowed promotion of good health (Braae & Merrild, 2021).

While social support may enable patients' access to health interventions, patients with lower socio-economic status tend to have several problems to deal with besides health, often finding their network fragile concerning ability to support them in regards to health-related issues (Kjeld et al., 2022; Pedersen, 2018).

There is, however, a knowledge gap concerning the significance of social support in contexts comparable to the Danish context, and of interventions that aim to enhance equity in health meetings (Kjeld et al., 2022).

In this article, we attend to these knowledge gaps, as we explore *bridge-building*, an intervention intended to enhance equity, where students of health provide social support, accompanying persons in socially vulnerable situations to health appointments.

If we understand a bridge as something that conjoins land, then it follows that there must be a gap. We aim to explore what *bridge-building* entails and which gaps it attends to, by literally following the intervention as it unfolds, exploring stakeholders' experiences. As an analytical concept, we use "borderland" (Mattingly, 2010) which designates the betwixt spaces where healthcare takes place, encompassing not just hospital and doctor clinics, but also peoples' homes, and other venues beyond the hospital world.

A note on vocabulary: some describe the people in question in particular terms (socially marginalized/disadvantaged/vulnerable persons) even if it seems an established fact that such groupings are diverse and non-static (Benjaminsen et al., 2018; Vallgårda, 2019), and vulnerability an elastic concept (Sundhedsstyrelsen, 2022). To avoid static categorization, we prefer the term "in vulnerable situation". Also, in lack of a better term, "user" signifies a person in need of bridge-building.

The bridge-building concept and intervention

This idea of bridge-building won a competition on how to minimize social inequity in the Danish health system and was transformed into practice via an NGO, SocialHealth, now operating in several Danish cities.

Students, primarily within health professions volunteer to accompany and support persons who are in socially vulnerable or marginalized situations. The aim is 1) to enhance equity in health by enabling health attendance, 2) to educate future health professionals, expecting bridge-building to generate useful insights adding to their formal education, assuming that by "meeting the person not just the patient", and experiencing the "often invisible barriers that vulnerable persons meet in the healthcare system", students can "develop tools to communicate with and create a respectful relation to vulnerable persons in vulnerable situations" (socialsundhed.org, accessed 18 July 2022).

Health appointments vary in terms of location and type of appointment (dispensing medicine, GP examinations, dental work, psychiatric or cognitive evaluations, physiotherapy, x-rays, scans, and more). A baseline survey ($N = 187$) concerning the bridge-building intervention found most visits were at hospitals (35%), GPs (20%) and dentists (8%) (Momsen & Søndergaard, 2022). The respondents (users of bridge-building) were in their 20s to 80s (mean age 59), slightly more women than men. Half had children; almost 4 out of 5 lived alone. The vast majority was not working, however, a third received old age pension. More than 90% lived on state subsidies (including pension).

Professionals either *facilitated* contact with SocialHealth (e.g., social workers, nursing home assistants) or *received* users (e.g., GPs, nurses involved in the actual health appointment).

Among approximately 200 bridge-builders, the majority are women, primarily students from healthcare educations (public health, medicine, nursing, physiotherapy, occupational therapy, psychology, radiography), and a handful from anthropology, sociology, and communication studies. They participate in a mandatory 20-hour course, and are offered group-based professional supervision. Figure 1 provides an overview of how bridge-building works.

Methods

To gain an understanding of bridge-building and the gaps it attends to from different perspectives, we decided on a qualitative design, using participant observation and interviews as primary methods (Hammersley & Atkinson,

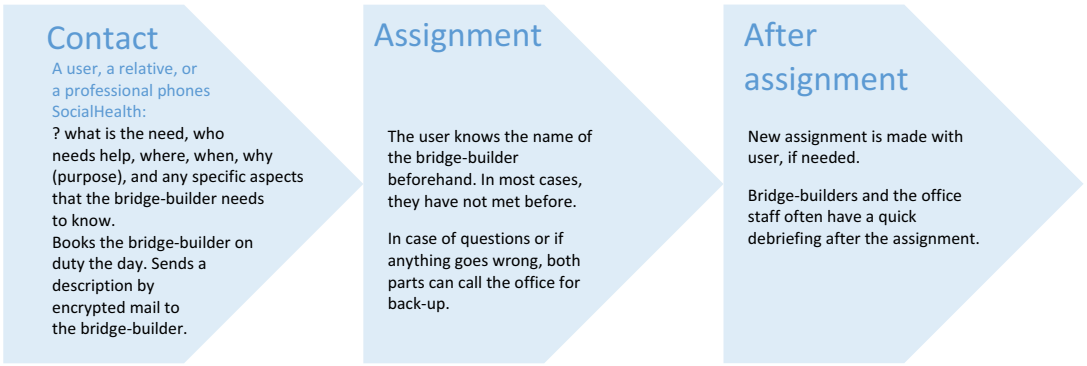

Figure 1. How bridge-building works.

2007). An ethnographic fieldwork was conducted by first author, from January to June 2022.

Sampling and recruitment

Informants were users, bridge-builders, and professionals in the bridge-building assignments, in a large Danish municipality. To avoid selection bias (i.e., that informants were sampled by SocialHealth), specific dates for following bridge-building assignments were set.

It quickly became apparent that access to users required *presence*. Trying to gain access through SocialHealth asking users and bridge-builders if a researcher could observe the bridge-building and conduct interviews, several users declined. Instead, users were asked if a researcher could come along. Informants were asked for an interview during the assignment which proved conducive.

Users were between 40s-70s, five men, five women. Nine lived alone, one with a spouse. Seven had children. Most had primary, lower secondary school education, or short vocational training, one had a university degree. No one was working. They had different health related problems such as drug or alcohol abuse, depression/anxiety, brain damage, neuro-degenerative diseases (including dementia); some had multiple diseases.

Bridge-builders represented different health educations, with experiences from bridge-building from 6 months to 4 years, with assignments once or twice a month.

Professionals worked in nursing homes, substance abuse/other institutions, and specialized health clinics, including a psychiatric clinic.

Participant observation was chosen to explore how bridge-building is enacted in practice, expecting that following assignments would yield valuable insight to users' lives and the gaps that needed bridging, but also acknowledging that "doing together" provides informants with a chance to consider whether to trust the researcher enough to agree to be interviewed.

To get acquainted with the concept, first author spent four days in the SocialHealth office, listened to how appointments were booked, joined an introduction about SocialHealth to hospital staff, and participated in a bridge-builder meeting.

Ten bridge-building assignments were followed. Most were half day events which started and ended at the user's place of accommodation. It resembled a walking fieldwork (Irving, 2017), or a moving fieldwork, as we would walk, take the bus, or bicycle to and from appointments, and this "moving time" yielded a space for much small talk, illuminating many aspects of the users' lives, experiences of health appointments, and a very concrete understanding of gaps. Descriptive fieldnotes were taken straight afterwards (Emerson et al., 1995).

25 semi-structured interviews (Kvale, 1997) were conducted to explore what bridge-building entails from the views of different stakeholders in the bridge-building assignments observed and to gain knowledge about the gaps, as they see them (see Table 1 for an overview). To make room for nuanced reflections without predetermined sub-topics, interview-guides with open-ended questions were followed (Table 1). Semi-structured interviews were recorded and transcribed verbatim, primarily by first author, and by a research assistant.

Access to interviews with professionals was not easy; it took several emails and phone calls to make arrangements. In some cases, it made no sense to ask for an interview, e.g., when the user had a scan without the bridge-builder present. In other cases, professionals said they were too busy for interviews. Professionals and bridge-builders were primarily interviewed face-to-face at a place of their choosing; three by phone.

Most user interviews were conducted on the day of assignment at a location of their choosing, two were conducted by phone the following day. Interviews with users differed greatly concerning how fragmented or coordinated responses were, it required taking the time needed, and making space for detours and

Table 1. Overview of interviews.

Data – interview	Interviews	Focus
Users	9	Experiences of using Social Health's bridge-building, knowledge about the possibility for companionship, why the need (challenges experienced concerning making it to appointments), would they use bridge-building again, if yes why, reflections on the concept bridge building (which bridges, gaps attended to), reflections whether bridge-building might help minimize inequity in health.
Bridge-builders	8	Road to become a volunteer, reflections about being a bridge-builder, the role of a bridge-builder (describe the last three assignments), reflections on the concept bridge building (bridges, gaps attended to), the need, experiences of health meetings, and whether bridge-building might help minimize inequity in health.
Professionals	7	Short introduction to workplace, knowledge about and experiences with Social Heath and bridge-building, why the need, reflections about bridge-building: the need, the bridges built and the gaps, whether bridge-building might help minimize inequity in health.
Social Health staff	1 (manager) Several unstructured interviews.	On bridge-building: the background, the ideas behind, and the actual intervention. Reflections on the concept bridge building (bridges, gaps attended to), the need, why bridge-building might help minimize inequity in health.

long pauses, and getting the questions back on track after a while. Some interviews resembled Desjarlais (1994) description of interviewing homeless persons whose struggling along matched the way they talked during interviews.

Analysis

The empirical material encompassed interview transcripts and fieldnotes which were read through in full length, then coded by first author to find chunks of information and "first order" themes that go across data (e.g., *bridge-building tasks*), and then discussed among authors and research assistant (Madden, 2010). A second round of coding was made to refine the codes, i.e., "second order" themes (e.g., *safe-making*). Attention was paid to vernacular expressions (e.g., *tryghed)* (Jackson, 2012), and disparities in the material were important markers (Kvale, 1997). Data from each informant group were analysed separately then themes were compared, allowing an identification of variations between the groups. Nvivo was used to manage data.

To ensure a transparent approach, themes were critically discussed among authors and research assistant. To enhance trustworthiness, points from the analysis were presented and discussed with professionals from the municipality and with a group of bridge-builders.

Analysis was formed in an iterative process between coding, discussing themes, and studying literature, during which attention to the notion "borderland" (Mattingly, 2010) materialized.

Ethical considerations

The study was approved by Central Denmark Region (reference number: 1-16-02-22-22), and guided by the principles of the American Anthropological Association. In accordance with the local legislation and institutional requirements, ethical review and approval is not required for the study.

Before and during participant observation, bridge-builders and users were asked if anthropologist could follow the appointment; users decided what the first author could attend.

Informants signed letters of consent concerning the use of anonymized data from interviews and observations, the letters included ethical matters such as access to own transcripts and procedure to withdraw from the study. A verbal introduction to this study was supplemented with a written, crafted in plain language. One ethical consideration concerned how consentual the oral and written consent actually was in case of cognitive impairment. To address this concern, aspects of confidentiality, anonymity, and independence of the researcher, i.e., not affiliated with SocialHealth, were repeated. To protect sensitive and potentially identifiable information, we use pseudonyms, provide no information of places of appointments, and slur recognizable aspects.

Results

Most informants described *bridge-building* in terms of a here-and-now intervention of accompanying persons to health appointments that they might have missed if not for the bridge-building, but also as an investment in the future life as a health professional, bridging experiences in the now to future competences. Results are presented to show how both temporalities are at play. The here and now bridge-building is represented through three themes that developed during analysis, safe-making, wayfinding, and as-if-relative, and presented through cases, chosen because they show noteworthy aspects of these themes and thus what bridge-building entails. We then briefly focus on building bridges to the future.

Bridge-building: Bridging a citizen with a health appointment

Questions about which bridge is built and why yielded quite similar responses among informants.

> [The bridge] spans from the ordinary citizen to the health system, I think. So you make it to the appointment that you have been offered when ill – because they help you keep your appointment, you know, knock on your door so you don't miss it. (user)

> I build a bridge to good treatment: a person who needs the support I can give will get the health treatment needed, which other persons would be able to get on their own. That's how I see it. That you generally get the same treatment even if you are vulnerable. (bridge-builder)

> You can be vulnerable in many ways. Here, we have the socially vulnerable, typically with a lot of challenges. (professional)

> The need to be accompanied signifies a gap between what you *can* and *must* do concerning health appointments. (professional)

Informants emphasized three interrelated themes when describing their experience of bridge-building. Their descriptions made visible how the social support may bridge a gap between a person and a health appointment.

Safe-making

Safe-making materialized as an important component to bridge-building. The interviews conducted with users reflect a considerable span concerning depth of reflections. Asked why they needed bridge-building, they responded with concrete examples.

We met and walked together with John, in his late 60s, from the bus station to the specialist clinic. On the way, we learnt that he has no family, lives in an apartment, has an acquired brain damage and uses a local day-shelter.

> I needed help to find the right place. Because it was urgent, you know, I was in pain, so to find the right place at the right time … I knew the place but to find the right entrance. [for a specialist clinic]

> Could you have managed on your own?

> That's hard to tell. Do you think I could have climbed those steep stairs?

> I don't know. What do you think?

> I believe it would have been difficult.

Sandra, in her 40s, lives at a halfway house for persons with substance abuse. We met her there, and went by bus for her medicine dispensing. She prefers not to burden her adult son with her problems, and therefore didn't ask him to accompany her.

> I suffer from anxiety – to a point where I lose awareness of where I am heading. I panic - where do I go and how. So I feel more secure being with someone who knows where I have to go. I am VERY relieved now that it's over! I didn't sleep last night. Got up at 5 am, smoking cigarettes, drinking coffee, and thinking whether to cancel or not: fetching my medicine. My Danish is not flawless so at times I wonder what they actually said - did I get it right?

Troels, in his 50s, stays in a specialized home after a stroke. We talked with a social worker about the assignment before being introduced to him at his apartment, then accompanied him to the hospital, waited during a check-up, and accompanied him home.

> [Name of staff member] asked if I wanted someone to accompany me.
> *And why did you?*
> It makes me feel more safe.
> *More safe, how?*
> Then I feel good instead of just sitting there – it's difficult for me going alone, you know. [It's a big place], she also helped me with my health ID. I don't know how to do that so she did it for me which was really good.

Sandra and Troels use words such as "more secure", "more safe", "difficult going alone" which mirror how users generally highlighted emotional safety (*tryghed*, being confident that others protect and take care of you), as an important component to bridge-building. Other informants also referred to *tryghed*:

> My role is just being there to make them feel safe. Often, there are some issues of feeling unsafe, what exactly that entails vary but what I can do is to attend to some of the practical issues to create that feeling of safety - that's actually what they need. (bridge-builder)

> A typical [bridge-building] function here would be to provide emotional safety, or remember what was said, or be someone to talk it over with. (professional)

Safe-making thus seems to be an essential component to bridge-building. A professional from Sandra's case believes that she and other users would not have made it to appointments "if it wasn't for the bridge-builder. You may think 'what's the problem—take a bus, do something!' But there are actually many people who simply cannot do that—even calling the doctor to make an appointment".

The informants' statements expose multiple challenges to make it to health appointments: a discord in pace and place related to clock time and punctuality, being overcome by anxiety (what will they tell me, scared of leaving home), communication aspects (understanding health staff, feeling insecure—"did I get it right"), and finally problems with managing on their own, or finding it discomforting to go on their own, or challenges concerning wayfinding.

Wayfinding. Accompanying to health appointments

Wayfinding was another essential component of bridge-building, i.e., to tackle obstacles on the way to a health appointment, find the right place(s), know

how to register one's arrival, or climb stairs. The bridge-builder, Emma, called it "a straight forward assignment", her accompanying (by foot), Bent, to a specialized health clinic. Emma recalls having expected the nursing home staff to help Bent get ready, "you know, found his jacket, helped him with breakfast". She was surprised that they only came "two minutes after I arrived at his apartment":

> I was told he had problems remembering which was very useful to know. He wanted us to turn opposite from where we were going. Generally, I try to fit in as naturally as possible, stay calm –you know, being there, listening, saying it's gonna be okay. There was some confusion concerning his treatment. The clinic staff asked me if I knew. I told them we had just met. After that things went well, they communicated well with him, even if he had been a bit nervous to go. I noted his new appointment. [agreeing with Bent to pass it on to the nursing home staff]

After the appointment, we drink coffee. Emma leaves. Interviewing Bent, he answers in short sentences, and tends to lose track of the line of conversation. He talks about a rough up-bringing, finding relief in alcohol, how lonely he feels, and how he has hardly any family left and no children nor a spouse, but also that he likes jazz. His family relations appear difficult, which comes through in sentences such as "I told my sister goodbye", meaning he does not want to see her. Asked if he has any relatives to help take him to health appointment, he says no. I ask how he experienced bridge-building:

> I am proud of myself! I didn't want to go because I was scared it might hurt. […] She did it in such a nice way. That really matters, you know, because I have had many coming to my home and some of them I have [asked to leave]. They talk with high squeaky voices and think they are funny. But she was a nice young girl. Lovely how she asked questions and took part of the conversation, I like that. I have dyslexia. I like others to start [the conversation] and then I will follow. […] I liked having her with me. Otherwise, I'd not done so well. It has to do with me getting nervous or insecure. So it really matters. It gives me self-confidence.

Bent's case exemplifies a typical bridge-building situation with accompanying as the main task, revealing how accompanying entails wayfinding, emotional support, getting and passing on information between e.g., a clinic and a nursing home, debriefing with users, sharing relief if the consultation went okay. Bridge-builders generally emphasize the need to "be present", here played out as behaving calmly, preparing the route, generally accommodating to Bent's pace of walking and talking.

Bent is surprised that Emma is a volunteer, "Really? That's incredible. But she did good".

Asked about his contact with the health system in general, he says: "I don't have much to say—it's not to criticize them but I don't think they listen when I speak". Asking him explain this further, he cuts me off and says, "no, that's as far as I can explain it to you".

Interviewing two staff members at the clinic, they emphasize the chaos surrounding users' lives:

> Even if we send an sms as a reminder, they are not necessarily in control of their lives … or have lost their phone, as often happens. So there is really a need for these helpers, helping them get here.

A staff member at the nursing home agrees:

> If it wasn't for SocialHealth, he would not have made it to the appointment […]. It's actually a task for relatives, taking him to the clinic but in some cases we make an exception and go – but often we cannot spare a staff member […] He needs someone with him - while we might put him in a taxi, telling the driver where to drop him off, he still wouldn't have a clue where to go. That sense of orientation is lost; they are so damaged cognitively.

Asked specifically about the gap that needs bridging, she says, "I think of it in terms of a relational gap … because it has to do with them not having relatives and because the system, here as well, doesn't have the resources, it all comes down to money".

She mentions the Danish idiom "falling between two chairs", referring to not fitting into the right "boxes" of the compartmentalized health system. Bent's age combined with living in a nursing home failed to meet the criteria for the public assistance. However, staff shortages made it difficult to accompany Bent to health appointments.

The stakeholders point to several challenges in making it to a health appointment. To Bent, the challenges concerned a mix of anxiety, dyslexia, and having no relatives to help him. To the bridge-builder and the nursing home staff member, it concerned his cognitive impairment. Having lost his sense of orientation, Bent could not perform the coordinating role that patients are required to, i.e., provide the needed treatment history, a knowledge that the bridge-builder did not possess. The professionals at the clinic related challenges to users "living chaotic lives, definitely not according to schedules".

As-if-relative

Most informants mentioned the role of family in helping to make it to health appointments. However, some users had no family or significant others, whereas others could not or would not ask family or other network to accompany them; afraid of being a burden, wanting children to live their own lives without worrying about their parents, or finding relatives incapable of providing the help needed.

We meet Mette, in her 50s, by her flat and take the bus to her hospital appointment (somatic). Prior, she used bridge-building services in connection with psychiatric treatment. Preparing for the consultation, Mette goes through a questionnaire with the bridge-builder, Ann. They later recapture what happened. Mette wished she had asked Ann to introduce herself as "a relative or a friend or just some extra ears". I later, in separate interviews, probe into this comment. Ann feels sorry for introducing herself as a bridge-builder, when the doctor asked her who she was, as this (to Mette) conveyed an impression that she could not make it on her own and, "It cannot be nice to think you are being looked at as an unresourceful person". In a later group discussion of this particular case, several bridge-builders emphasized the importance of professionals directing questions to the user, rather than to them, as this would also enable users to decide how to present the bridge-builder. Mette, however, found Ann's company "very comforting", because:

> It makes me feel less alone in all those public health systems. When I look around, I see a lot of people with their parents, a close friend, or some close relative, right, and then you just sit there feeling more alone and more vulnerable because you don't know, at times, what awaits you. So therefore, it's been nice. [. . .]
>
> Today, she was my extra ears, and we could talk about it afterwards when we had coffee – did she hear what I did. I asked her to remember some specific questions, so I didn't forget them or risked getting ignored [. . .] at times it all goes a bit too fast and you have to keep listening and keep track of what they say next, with no time to ask what that word meant. Or you hear doctor-words that you don't understand any of and then it's good to have it translated to plain Danish.

When asked why she preferred no mentioning of bridge-building, Mette reflects:

> I forgot to tell [. . .] I ought not to care, but I do! Somehow I feel extra vulnerable if they say who they are, as if I need some kind of helping intervention, that I cannot make it on my own. Presenting themselves as bridge-builders creates a boundary, I think. Between public and non-public or maybe personal and impersonal, a kind of an unequal relationship. But I prefer it to be equal [ligeværdigt] no matter who we are, right. So you feel safe.

Mette uses the Danish word "ligeværdig", which translates to "equally worthy", linking it to feeling "safe". Other informants also alluded to equally worthy, like Sandra who emphasized "good chemistry" in the relation, and found it important that the bridge-builder "talks to me like a pal. You know—just the person".

While Mette could "probably" go on her own to the consultation, she worries about getting information twisted, an issue mentioned by most users. Having problems on her own, her daughter would not be interested in coming, nor be able to grasp what was going on, or they would get irritated with each other, "just causing more stress". As her own network could not, in Mette's opinion, serve as the relatives she needed, bridge-builders seem to function like as-if-relatives, or proxy family.

Professionals primarily reflected on relational challenges, absent relatives and strained relationships within families, in relation to persons with addiction. Bridge-builders noticed, however, that social support could be strained if users frequently needed to be accompanied. A bridge-builder commented after a bridge-building assignment: "Considering how often she needs help, I don't feel I waste my time going with her instead of her family, it allows them a break, not having to ask permission—again—to take time off from work to take her to appointments".

Through observations and informants' reflections, it becomes apparent that to understand barriers to make it to a health appointment necessitates a focus on what happens before and after the actual consultation (see Figure 2).

Generally, professionals stressed how users "fall between two chairs", "fall into holes with nobody to catch them", or "get lost". They valued the social support of bridge-building and its flexible and "non-boxed" approach, "dealing with the person without having as a criterion that the person needs to have a bipolar diagnosis or have tried this and that", as "our welfare system lacks the sort of intervention they provide, the flexibility, swiftness and openness". However, they also emphasized that not all users are eligible for bridge-building, arguing that some cases require professional skills, e.g., in case of aggressive behaviour, or if users find it difficult to "deal with strangers".

Several said they used bridge-building services, "when we don't have an option to go ourselves". There was a certain ambivalence in most interviews with professionals. They acknowledged the need for the bridge-building provided by the volunteers, yet questioned whether such service ought to be a welfare state obligation:

> Personally, I regret that it has to be on a voluntary basis and not part of a professional duty, because it's a sign of welfare disappearing and because it matters [. . .] It's regrettable that it's not an issue solved at municipal level - that we rather turn to other solutions. But at the same time, it is an amazing intervention, because we need it. (professional)

Another mentioned the highly specialized and bureaucratic health and social system that users have to navigate: "maybe bridge-builders make

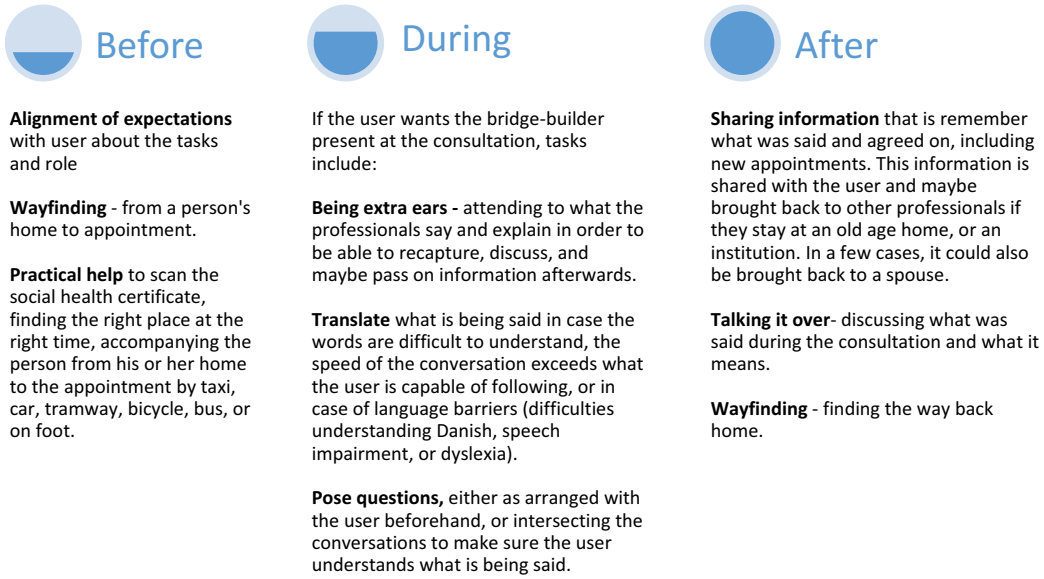

Figure 2. Bridge-building tasks.

a welcome break with users getting the feeling that some people just wanna help without demanding much or they use another vocabulary—well it's just what I imagine, you know, more freedom from bureaucracy—though there are some dilemmas in that as well, the movement towards volunteers intermixing the professional sphere." She goes on to exemplify how volunteers may not always make the right choices in the interaction with users.

Bridge-building: bridges to the future

Informants pointed to a reciprocity inherent to bridge-building: bridge-builders helped users but probably also learnt about "real life" (a emic term used by several users), making them more knowledgeable health professionals in the future. As a user said, "I think you learn from other than books—by feeling it".

Bridge-builders volunteered for two reasons: to help users and to gain clinical skills. They gained insights into different ways of living, "seeing the health system from the other side of the desk", or realizing how "behind that curtain lives a woman with no social network", emphasizing how bridge-building sharpened and fine-tuned their observational skills, required to become a competent clinician, "it takes practice to notice his skin, his tattered sleeves; nuances that are easily missed".

> I observe. How it works and how you do it. I can use that later. Sometimes you feel that to the doctor it's kind of just everyday stuff, they just have to make it through the day and may not have enough time, but sometimes it's a big thing for the patient. I think that's something I will take with me. (bridge-builder)

Others emphasized that assignments offered understanding of problems in health:

> The statistics I study cannot illuminate why people don't just consult the doctor with their health related problems. So it's interesting to meet them and discover what's at stake, what are the barriers for them to seek the help they need, experiencing the problems they encounter in the health system. (bridge-builder)

The interviewed bridge-builders came to value the human to human encounter, meeting persons that they might not normally meet in their ordinary everyday life, yet often generating a common third, a common topic to discuss—music, enjoying a cup of coffee, or having the city as a shared home. These insights nuanced their view on vulnerability, finding the user group considerably more varied than first expected.

> There are some stereotypes and prototypes of what vulnerability and marginalization entail but it really can be anyone you pass on the street. The homeless man at the corner of the street, his vulnerability is visible, whereas the woman at the supermarket till, who smiles and says hello may not have any relatives, and it's not visible that she cannot make it to her health appointments. (bridge-builder)

Discussion

Following bridge-building to explore what it entails, we found a built-in reciprocity and a double temporality: in a here-and-now intervention, students help users in socially vulnerable situations who find it difficult making it to their health appointments on their own, whereas users provide students with an opportunity to observe and learn from their situation. This learning may contribute to the future with

understandings that can be used in bridge-builders' coming professions.

We found three predominant characteristics of the social support provided by bridge-builders: emotional safe-making, wayfinding, and as-if-relative, i.e., a proxy to the family who did not exist or could or would not accompany the person.

Walking along during assignments revealed that a health appointment starts before the actual meeting and ends well after. Approaching the health appointment as a process, extends the social activity of health consultations both temporally and spatially (Stimson & Webb, 1975)—the preparation and anticipation before, the face-to-face interaction during, and the sense-making and evaluation after the consultation, involving multiple venues (e.g., home, transport, hospital).

Walking along also paved way to see the challenges, that formed gaps which needed bridging.

From a user perspective, *before the appointment*, challenges included anxiety, feeling emotionally unsafe, physical barriers such as steep steps, navigating a wheelchair in new places, wayfinding issues (finding the right place at the right time), or handling issues with health id, *during the appointment*, challenges included communicational issues, i.e., not understanding messages, or feeling the health professionals do not listen, having dyslexia, not feeling good with words, or experiencing a shortage of time, and *after the appointment*, challenges included having no one to share, discuss, translate what happened, or debrief with.

The challenges described may appear small to others, but considering how they could make users feel unsafe about the health situation and pose major barriers to make it to their health appointments, it becomes evident not only why emotional safe-making is an essential social support component in bridge-building, but also that understanding barriers to health access requires that clinical practice attends to what happens before and after a consultation.

The exposed gaps, or challenges, concerned structural issues, i.e., a complex and rigid system making navigation difficult, as well as staff shortages, transportation and accessibility, aligned with other findings (Loignon et al., 2015; Ramsay et al., 2019), relational issues with limited network to draw on for social support, as also found by Pedersen (2018), and communicational issues as found in other studies (Ramsay et al., 2019; Sodemann, 2018). Comparatively, however, communicative problems seemed less marked in our study. This could relate to an issue mentioned by several informants, namely that bringing a companion probably affected the effort put into communication by health professionals. Or it could reflect that problematic communicational issues were simply not marked in the relatively small number of consultations observed.

Informants' descriptions of bridge-building expose how bridge-building takes place in borderlands (Mattingly, 2010), between voluntary work, paid public work, the obligations of the welfare state, and family obligations. Borderlands are thus betweenlands, fluid constructs, that form as healthcare takes place between spheres (family, public sector and social volunteer work), and across venues.

In such borderlands, responsibilities were discussed, negotiated, and contested. For instance, a bridge-builder questioning why staff had not prepared the user before an assignment, and professionals insinuating that if they had the resources, they would prefer to accompany the person themselves, but also contesting the boundary between who does what, i.e., voluntary contra public work, and the "ought" of a welfare state. Several professionals expressed an ambiguity, worrying if bridge-building is a sign of a strained welfare state no longer offering the services needed, yet praising bridge-building for its value and flexibility.

Boundary discussions do not seem unusual in voluntary work. According to La Cour (2014), a political logic based on regularity, security and planning, may clash with a voluntary work logic.[1] This logic is characterized by an oscillation between the formal principles of the organization (here: SocialHealth) and the informal interaction conditioned by the actual meeting between a volunteer and a user, often involving innovative dynamics (La Cour, 2014). The flexibility in bridge-building, praised by professionals, is thus possible because it is voluntary, but because it is voluntary, it is also unruly, situational, and dependent on the social interaction between users and volunteers—in this interaction, choices not considered "right choices" by professionals may occur.

Borderlands also designate how bridge-builders are not yet health professionals but in a state of becoming. In this betwixt and liminal position, bridge-building offers students insight to the influence of vulnerability on health encounters and access to health.

Informants generally portrayed the health and social system as compartmentalized, made up by "boxes" that a person has to fit into, with users of bridge-building tending to be un-box-able. Indeed, bridge-building entails dealing with complex lives with plentiful add-ons concerning challenges in life, i.e., not "just" being old and having dementia, but also with no network, and not "just" being without a home, but also with cognitive damages and substance abuse or a damaged childhood. Our findings expose several shades of vulnerability. Vulnerability is

an existential phenomenon that we all live with (Martin, 2021), but vulnerability can also be linked to ways and conditions of living, and it can be visible or invisible. In this study, living with serious illness, including psychiatric illness or substance abuse, having no home, and/or living on a small income contributed to vulnerability. Family or intimate others seemed to be a limited (or absent) resource, exposing a relational vulnerability. The notion of family was strong even in its absence. Relying on others to make it to health appointments makes visible one's network or lack of network. In the borderland between family obligations and voluntary work, bridge-builders became as-if-relatives. However, as shown in one of the presented cases, users may express discomfort to disclose a need of an as-if-relative, which we may interpret as wanting to uphold impression management (Goffman, 1959), not exposing relational vulnerability. As self-presentation can be used as a matter of control in a consultation (Stimson & Webb, 1975), it would appear important that health professionals let the patients present their companions.

Acknowledging the multidimensional nature of social support (Ranjan, 2011), it seems relevant to examine the term related to bridge-building. Based on our findings, social support may be viewed as relational (enacted between people) and bidirectional. The etymology of support is to carry or bring forward (etymonline.com). In bridge-building, users and bridge-builders potentially bring each other forward, to health appointments, using safe-making, wayfinding, and as-if-relative as mechanisms, and to a potential improvement of professional skills, using lived experience as a mechanism. Considering that bridge-building aims to enhance social equity in health, we suggest that this played out not only in making it to a health appointment thereby gaining access to health, but bridge-building may be an asset in health students' understandings of social vulnerability, possibly enhancing their relational competences which may contribute to enhancing equity in health. Further research is warranted to support these preliminary findings.

We think it safe to claim that bridge-building, in the cases shown, potentially prevented non-attendance to health appointments. Bridge-building was established as a response to social inequity in health, and in the short run the intervention does seem to make a bridge between persons in vulnerable situations and health appointments. In the long run it remains to be seen which impact the intervention might have on future health professionals and the transferability of experiences to practice. Future research will tell.

Strengths and limitations of the study

Our exploratory study, examining bridge-building from different viewpoints, made visible the core aspects of the intervention. Our "moving fieldwork" proved conducive to understand barriers to health access, and interviews with different stakeholders provided nuances to understanding gaps. Given the complexity of bridge-building and the variety in health appointments, we supplemented observations by asking bridge-builders to describe their three last assignments. However, future research based on a larger number of observations could add a deeper understanding of this complexity, exploring perspectives from each stakeholder group in greater detail, or focusing on the communicative aspects to gain more in-depth insight into potential barriers.

An ethical consideration during fieldwork concerned when to conduct interviews. Straight after the health appointment, with bridge-building clearly remembered and access to the user conveniently easy? Or days later, when reflections might be less tainted by a supportive encounter, though some aspects might be forgotten, and access more difficult? Here, we took a pragmatic approach, taking the opportunity when it arose to make interviews. This may have affected users' response.

Conclusion

Concludingly, through empirical cases, we have illustrated how in bridge-building situations, structural matters (complex health system, falling between chairs, staff shortage) entangle with the (non)availability of family, disease related aspects, and communicative challenges (dyslexia, difficulty understanding "doctor words"), which can pose as barriers for users to make it to a health appointment. We found that in order to expose barriers to health access for persons in vulnerable situations, it is required to give attention to what happens before and after the actual health appointment. Bridge-building is a social support intervention, helping a here and now situation, but also a possible investment in future health professionals who get first hand insight into vulnerability in lives and in barriers to access to health as experienced by users.

Acknowledgement

We thank all participants in the study for their openness to let us follow bridge-building and for

valuable reflections. We thank Professor Claus Vinther Nielsen, DEFACTUM, for constructive comments on draft versions of the article. We thank reviewers for inspirational comments and suggestions.

Funding

The work was supported by the Folkesundhed i Midten, Region Midtlylland [A3691]; Folkesundhed i Midten, Region Midtjylland [A3691].

Note

1. La Cour (2014) refers to the type of voluntary work aimed at providing increased welfare and social care and based on face-to-face social interaction. Such form of social care is more personal than the professional care, yet less personal than the care we associate with family or friends.

Notes on contributors

Merete Tonnesen is a social anthropologist, PhD, and part of a research group at DEFACTUM, Central Denmark Region, that specializes in Public Health and rehabilitation. Her research interests include hope, temporality, and how persons navigate in everyday life when living with diseases and social vulnerability. She has a particular interest in life with Parkinson's disease.

Anne-Mette Momsen, physiotherapist, MPH and PhD, has since 2010 been a senior researcher at DEFACTUM, Central Denmark Region. Her research interests are broad, including work life/return to work interventions, prevention and rehabilitation, and inequality in health. She has a particular interest in systematic reviews.

Disclosure statement

No potential conflict of interest was reported by the authors.

ORCID

Merete Tonnesen http://orcid.org/0000-0001-9186-8259
Anne-Mette Hedeager Momsen http://orcid.org/0000-0002-8670-867X

References

Ahlmark, N., Sørensen, I., Davidsen, M., & Ekholm, O. (2017). SUSY UDSAT - Sundhedsprofil for *socialt udsatte i Danmark og udviklingen siden 2007*. [Health profile for socially marginalized in Denmark and the development since 2007]. Rådet for Socialt Udsatte.

Arendt, J. N., Jensen, B. T., Nexoe, J., Muntzberg, G., & Sorensen, J. (2010). Low income and number of contacts with general practice. *Ugeskrift for Laeger*, *172*(21), 1591–1597.

Benjaminsen, L., Birkelund, J. F., Enemark, M. H., & Andrade, S. B. (2018). *Socialt udsatte borgeres brug af velfærdssystemet. [Use of the welfare system among socially marginalized persons]*. København. Vive.

Braae, S., & Merrild, H. C. (2021). I imagine that they will probably ask about my lifestyle: Perspectives on preventive health checks in a socially disadvantaged housing association. *Tidsskrift for Forskning I Sygdom Og Samfund*, *18*(35), 33–50. https://doi.org/10.7146/tfss.v18i35.129992

Desjarlais, R. (1994). Struggling along: The possibilities for experience among the homeless mentally Ill. *American Anthropologist*, *96*(4), 886–901. https://doi.org/10.1525/aa.1994.96.4.02a00090

Diderichsen, F. (2020). Baggrund og kommentar. I *Social ulighed i sundhed og sygdom: Udviklingen i Danmark i perioden 2010-2017* (1 udg., s. 18-25).

Dryden, R., Williams, B., McCowan, C., & Themessl-Huber, M. (2012). What do we know about who does and does not attend general health checks? Findings from a narrative scoping review. *BMC Public Health*, *12*(1), 723–723. https://doi.org/10.1186/1471-2458-12-723

Emerson, R. M., Fretz, R. I., & Shaw, L. L. (1995). *Writing ethnographic fieldnotes*. Chicago. University of Chicago Press. https://doi.org/10.7208/chicago/9780226206851.001.0001

Friis, K., Lasgaard, M., Pedersen, M. H., Duncan, P., & Maindal, H. T. (2019). Health literacy, multimorbidity, and patient-perceived treatment burden in individuals with cardiovascular disease. A Danish population-based study. *Patient Education and Counseling*, *102*(10), 1932–1938. https://doi.org/10.1016/j.pec.2019.05.013

Goffman, E. (1959). *The presentation of self in everyday life*. Doubleday.

Hammersley, M., & Atkinson, P. (2007). *Ethnography : Principles in practice*. Routledge.

Irving, A. (2017). *The art of life and death : radical aesthetics and ethnographic practice*. Hau Books.

Jackson, M. (2012). *Between one and one another*. University of California Press.

Kjeld, S. G., Brautsch, L. A., Svartá, D. L., Hansen, A. F., Andersen, S., & Danielsen, D. (2022). Social ulighed i mødet med sundhedsvæsenet - en systematisk litteraturgennnemgang. [Social inequity in health meetings - a systematic review]. Report. Udarbejdet til Sundhedsstyrelsen af Statens Institut for Folkesundhed, Syddansk Universitet.

Kvale, S. (1997). *InterView: En introduktion til det kvalitative forskningsinterview*. Hans Reitzel.

La Cour, A. (2014). *Frivillighedens logik og dens politik*. Nyt fra samfundsvidenskaberne.

Larsen, L. B., Sandbaek, A., Thomsen, J. L., & Bjerregaard, A.-L. (2018). Uptake of health checks by residents from the Danish social housing sector - a register-based cross-sectional study of patient characteristics in the 'Your life - your health' program. *BMC Public Health*, *18*(1), 585–585. https://doi.org/10.1186/s12889-018-5506-6

Loignon, C., Hudon, C., Goulet, É., Boyer, S., De Laat, M., Fournier, N., Grabovschi, C., & Bush, P. (2015). Perceived barriers to healthcare for persons living in poverty in Quebec, Canada: The EQUIhealThY project. *International Journal for Equity in Health*, *14*(1), 4–4. https://doi.org/10.1186/s12939-015-0135-5

Madden, R. (2010). *Being ethnographic : A guide to the theory and practice of ethnography*. SAGE.

Martin, H. M. (2021). Sårbarhed og sundhed: En perspektivering. *Tidsskrift for Forskning I Sygdom Og Samfund*, *18*(35), 23–31. https://doi.org/10.7146/tfss.v18i35.129991

Mattingly, C. (2010). *The paradox of hope : Journeys through a clinical borderland*. University of California Press.

McLean, S., Gee, M., Booth, A., Salway, S., Nancarrow, S., Cobb, M., & Bhanbhro, S. (2014). Targeting the Use of Reminders and Notifications for Uptake by Populations (TURNUP): A systematic review and evidence synthesis. *Health Services and Delivery Research*, *2*(34), 1–184. https://doi.org/10.3310/hsdr02340

Momsen, A. H., & Søndergaard, K. V. (2022). *Forebyggelse af ulighed i sundhed - Social Sundhed. Resultater af en spørgeskemaundersøgelse [Preventive measures concerning inequality in health – Social Health. Results from a questionnaire]*. DEFACTUM.

Pedersen, P. V. (2018). Socialt udsattes møde med sundhedsvæsnet. *[Socially marginalized persons' meeting*

with the healthcare system]. Statens Institut for Folkesundhed.

Ramsay, N., Hossain, R., Moore, M., Milo, M., & Brown, A. (2019). Health care while homeless: barriers, facilitators, and the lived experiences of homeless individuals accessing health care in a canadian regional municipality. *Qualitative Health Research*, *29*(13), 1839–1849. https://doi.org/10.1177/1049732319829434

Ranjan, R. (2011). *Social support, health, and illness : A complicated relationship*. University of Toronto Press Incorporated.

Scott, A., O'Cathain, A., & Goyder, E. (2019). Socioeconomic disparities in access to intensive insulin regimens for adults with type 1 diabetes: A qualitative study of patient and healthcare professional perspectives. *International Journal for Equity in Health*, *18*(1), 150–150. https://doi.org/10.1186/s12939-019-1061-8

Sodemann, M. (2018). *Sårbar? - det kan du selv være: Sundhedsvæsnets rolle i patienters sårbarhed*. [Vulnerable? Talk for yourself. The role of the health care system in patients' vulnerability]. Eget Forlag. http://www.ouh.dk/saarbar

Stimson & Webb. (1975) . *Going to see the doctor: The consultation process in general practice*. Routledge & Kegan Paul.

Strøbæk, L., Davidsen, L., & Pedersen, P. V. (2017). Socialt udsattes dødelighed og brug af sundhedsvæsnet. *[Mortality and use of healthcare services among socially vulnerable]*. Rådet for Socialt Udsatte & Statens Institut for Folkesundhed (SDU).

Sundheds- og ældreministeriet. (2019). *Nationale mål for sundhedsvæsenet [National health goals]*. https://sum.dk/publikationer-sundhed/2019/oktober/nationale-maal-for-sundhedsvaesenet-2019

Sundhedsstyrelsen. (2022). *Sundhedsindsatser målrettet socialt udsatte borgere Udvalgte eksempler [Health interventions targeted socially marginalized persons. Selected cases]*. 2022, October 10. https://www.sst.dk/da/udgivelser/2022/sundhedsindsatser-maalrettet-socialt-udsatte-borgere

Udesen, C. H. S. C., Petersen, M. N. S., & Ersbøll, A. K. (2020). *Social ulighed i sundhed og sygdom. Udviklingen i Danmark i perioden 2010-2017. [Social inequality in health and illness. Development in Denmark between 2010-2017]*. Socialstyrelsen [Danish Health Authority].2022, October 10. https://www.sst.dk/da/udgivelser/2022/sundhedsindsatser-maalrettet-socialt-udsatte-borgere

Vallgårda, S. (2019). Hvordan mindsker vi uligheden i sundhed? *[How do we reduce inequality in health?]*. *København*. Informations Forlag.