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*Published in:*  
Medical Anthropology

*DOI:*  
[10.1080/01459740.2024.2349512](https://doi.org/10.1080/01459740.2024.2349512)

*Publication date:*  
2024

*Document Version*  
Publisher's PDF, also known as Version of record

*Citation for published version (APA):*  
Bach, J. S., Bjerger, B., Eilerskov, N., & Merrild, C. H. (2024). As Long As it Lasts - Older Substance Users, Brittle Ties and Danish Health Care. *Medical Anthropology*, 43(4), 324-337.  
<https://doi.org/10.1080/01459740.2024.2349512>

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# Medical Anthropology

## Cross-Cultural Studies in Health and Illness

ISSN: (Print) (Online) Journal homepage: [www.tandfonline.com/journals/gmea20](http://www.tandfonline.com/journals/gmea20)

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To cite this article: Jonas Strandholdt Bach, Bagga Bjerger, Natasja Eilerskov & Camilla Hoffmann Merrild (2024) As Long As it Lasts—Older Substance Users, Brittle Ties and Danish Health Care, *Medical Anthropology*, 43:4, 324-337, DOI: [10.1080/01459740.2024.2349512](https://doi.org/10.1080/01459740.2024.2349512)

To link to this article: <https://doi.org/10.1080/01459740.2024.2349512>



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Published online: 16 May 2024.



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# As Long As it Lasts—Older Substance Users, Brittle Ties and Danish Health Care

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## ABSTRACT

In this article, we examine a group of older marginalized substance-using citizens and their relations to Danish health care. We offer empirical examples collected through ethnographic fieldwork, about how they handle their health situation and encounters with the Danish healthcare system. Analytically, we particularly draw on the concept of disposable ties, and suggest the term “brittle ties” to nuance the term and examine how perceived individual autonomy is weighted against health care trajectories and how these citizens often prefer to fend for themselves or lean on provisional networks rather than enter into health care trajectories and follow-up treatment.

## KEYWORDS

Access to health care; Denmark; inequality in health; marginalization; substance use

## Introduction

Laurits smiled good-heartedly at the ethnographer’s question. In his 50s, Laurits had experienced the shadowier sides of life. He had lost close family members as a young adult, and by his own account, that had played a role in accelerating his alcohol intake, and he had been drinking heavily and steadily ever since. He proclaimed himself an “alcoholic” but also highlighted that he now drank significantly less than he had earlier in his life and generally tried to avoid the city’s heavy drinking and drug scenes. The ethnographer repeated the question. “So, where would you go if you would like to do something to improve your health?” When his smile broke, Laurits briefly replied, “Heaven,” and began laughing hoarsely. The ethnographer joined in, and when they had stopped laughing, the ethnographer asked what Laurits would do if he one day felt really bad, if the chest pains he had described earlier in the interview returned. “Well, then I’ll go for a walk. And stop drinking for a bit. . . then it passes (. . .), then you can start all over again.”

Laurits was part of a group of mostly alcohol users hanging out in a shed at a public square on the outskirts of a provincial city in Denmark. He was part of a population of socially marginalized citizens about whom we have limited knowledge, both in Danish and international research: older citizens with active substance use and no or limited relations to next of kin (Danish Board of Health 2020; Han et al. 2018; Rasmussen 2019).

In the article, we explore the experiences of older substance users in relation to health problems, access to and use (or lack of use) of health care services. Subsequently, we analyze such experiences in relation to “next of kin,” by which we mean close relatives or relationships (partners, siblings, adult

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**Media teaser:** How do you handle challenging health conditions as an aging alcohol or drug user when you want to keep your distance to healthcare professionals?

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children, parents, long-term friendships, et cetera) upon whom a person can supposedly rely; those who can provide support in the event of health crises and treatment, but also less formal social networks. We do this, because next of kin often play an important part in health care as an indispensable extension of health care professionals both in terms of psychosocial support and practical assistance (Ågård et al. 2017; Bergerød et al. 2018; Gullestrup and Avnsbøg 2016). The lack of, or poor relations with, next of kin means that older substance using citizens often face health care services on their own, or with the often limited support of transient social networks. In this article, we examine how citizens like Laurits manage interactions with health care professionals, based on accounts by some of these citizens, and how they often find other alternative ways to handle their health crises and attempt to, and sometimes succeed in, avoiding health care services altogether. Specifically, we examine the role of a “drinking group,” a loose community based on drinking and hanging out together in a semi-public shed, as a form of stand-in next of kin. While avoiding health care services may potentially increase health-related risks or exacerbate existing health problems that could successfully be treated, we want to highlight how this can be interpreted as expressions of individual agency. We point to how actions and inactions that may from a biomedically informed perspective be interpreted as careless, self-destructive, negligent, or forgetful can also be understood as ways to perform agency and fend for oneself and preserve room for action. Further, we discuss how to expand existing notions of who “counts” as a next of kin in the health care system and point to the potentials and limitations of this form of alternative next of kin. We do that by discussing and developing the notion of disposable ties (Desmond 2012) in relation to what we term as “brittle ties.”

### **Background: The Danish health care system and socially marginalized citizens**

Although there have been many debates about dismantling the welfare state and its re-configuration by neoliberal ideas targeting social investment and competition, the Danish welfare state is still categorized as a “social democratic” or Scandinavian welfare model (Bjerge 2012; Bonoli and Natali 2012; Esping-Andersen 1990). Welfare services are in principle available for all Danish citizens; many are free of charge at the point of delivery and independent of one’s family situation and financed through general taxation. However, some services are partly self-paid (e.g. dental care or psychotherapy) or regulated in relation to income, for example, childcare and housing benefits. The public sector is, therefore, quite comprehensive and includes different types of services and covers areas that in many countries are managed, for instance, by private organizations, the family, the individual, or the church (Esping-Andersen 1990).

Yet, when it comes to the health care system, it does often not support *all* citizens equally (Merrild et al. 2016), particularly not citizens who live lives that, in medical and social senses, diverge from emergent ideals of being a good “welfare-citizen.” Despite that equal and free access to healthcare has been on the Danish health political agenda for decades, inequality in health has in fact increased since the 1990s (Bjerge et al. 2021; Vallgård 2013; Pedersen 2019; Sundhedsstyrelsen 2020). There are various explanations for why this inequality continues. Some relate to specific styles of living, such as smoking, some to social conditions such as unemployment, and still others to the fact that not all citizens have access to the same types of knowledge, information, and help when they face health problems, despite principles of equal access to health care (Bjerge et al. 2021). It is particularly these latter types of explanations that we focus on in this article.

The health care system is by far the largest and most expensive of all Danish welfare services. It consists partly of an extensive primary care sector, which offers several different services ranging from general practitioners (GP), specialized home nurses, and a wide range of municipally provided preventive services. General practice can be contacted free of charge (paid by general taxation) for all kinds of health-related concerns. Thereby, all Danish citizens are, in principle, able to contact their GP when in need of medical assistance, if they manage to follow the sometimes implicit rules of how contact should be made (Andersen and Aarhus 2019). It is usually through the GP that people are referred further into the system, except in emergency situations when the ambulance services are

called. The GPs serve as the gatekeepers for the more specialized secondary health care system (Møller Pedersen, Christiansen, and Bech 2005). The general rule is that one has to call or book online in advance and explain to the secretary what the main health concern is, and only then can an appointment be made (Andersen and Aarhus 2019). In general practice, appointments are structured in 10–45 minutes slots, depending on the nature of the problem, and with reference to special needs and sociodemographic markers, but the typical consultation time is 10 minutes. The usual structure of the consultation is that the patient should present one main health issue to keep focus and pace in the consultation (Andersen et al. 2014). Outside general practice, the secondary health care services have moved toward increasing specialization, with large and highly skilled specialized hospital departments. This requires very structured behaviors of the patient in order to profit from the treatment plan, and this way of organizing health care services has proven to be efficient in relation to patients who have well-defined health problems and/or are leading stable lives. However, it does not sit well with patients suffering from multiple diseases and/or struggling with difficult social situations (Merrild et al. 2016). For those patients, having to explain one main concern in 10 minutes at the GP may be difficult, particularly when one is troubled by numerous pains and concerns. Likewise, treating or providing care and assistance for more complex challenges is not always easily managed within the time frame (Andersen et al. 2014). More recently, however, new initiatives that offer more time and more flexible structures are starting to emerge that focus on patients with multimorbidity and complex health problems, such as severe mental illnesses (Rozing et al. 2021). In hospitals, social nurses, nurses schooled in dealing with marginalized citizens with psychiatric diagnoses and/or substance use, have been implemented to aid these citizens in navigating the system. Likewise, the civic initiative, Social Sundhed (EN: Social Health) has been spread out over the country, where students at medical, nursing or vocational schools for care and health staff on a voluntary basis accompany vulnerable and marginalized citizens to their health appointments at GP's and hospitals (Social Sundhed 2023). Such initiatives can enable marginalized citizens to stay long enough to get results from X-rays, remain overnight for observation, or avoid getting into a conflict with the health professional over painkillers, because the social nurses have special knowledge of enhanced tolerance for medication when people are, for example, in substitution treatment. Yet, the problem is that these nurses operate only within the realm of a specific context, often the hospital, and the health students cannot provide all functions of a next of kin. They do not necessarily know the medical history of the citizen. In that sense, they can help to alleviate the difficulties of not having next of kin but cannot solve the problem in itself.

When people live on the edge of the welfare system, struggling to get by (Desjarlais 1994), or when they become ill, ideas about what being healthy entails may not correspond with the expectations of the welfare society (Merrild et al. 2017). In effect these ideas can diverge from the “average” and “ideological normal,” where the statistical construct of the normal is confused with actual well-being (Lock and Nguyen 2010:45). Such lives and practices of the body are way outside what has been referred to as “the ordinary” (Offersen et al. 2016), and they prompt us to expand our ways of thinking about what welfare citizenship may also be like, and how rights, obligations, and deservingness are established.

One group of patients that poses particular challenges to the health care system and understandings of the “ordinary” patient is that of older socially marginalized citizens<sup>1</sup> now live longer due to, among other factors, different types of specialized health services such as safe injection rooms, outreach social workers, and health professionals through which they can access medical treatment. However, they still have a significantly shorter life expectancy than other citizens. Recent reports on the health situation of marginalized adults aged above 50 in Denmark (what we refer to as older) indicate a large gap between the group of marginalized citizens and the general population in terms of health condition, life expectancy, and contact with the health services (Sundhedsstyrelsen 2020; see also Ahlmark et al. 2018; Pedersen 2019). The health problems of these citizens are often very complex and require many different types of services. Besides the harm from living a hard life on the streets or in other rough environments, many suffer from lifestyle diseases due to smoking, malnutrition, obesity,

inactivity, and – not least – drug and alcohol use and related comorbidities. As the Danish health authorities express it, this amounts to an “accumulation of risk factors” (Sundhedsstyrelsen 2020:2). The everyday lives of these people are characterized by much more instability than the lives of many other older citizens, and it is often very difficult for health professionals to establish contact to and maintain such contacts with substance using marginalized citizens. Further, many health professionals lack knowledge and expertise on how to help this group. They are often considered to be difficult to manage by health care staff due to, for example, instability, intoxication, unwanted behavior, or lack of “willingness to cooperate” (Bach and Bjerger 2021). Adding to this, the severity of substance use may also often surprise professionals in the elder care field as the problems related to substance use have been under-identified and under-discussed for decades (cf. Klausen et al. 2020; Kuerbis et al. 2014). Among other reasons, this is often because many aging users have managed to stay on the edges of the health care system and, to some extent, “go under the radar” (Bach and Bjerger 2021). Users themselves often have low trust in the systems due to prior unfortunate experiences, which might also affect the implications of more recent attempts to reorganize the structure of primary care like prolonged time slots (Rozing et al. 2021). Additionally, many users value independence and freedom from society over conforming to the rules and procedures of the health care system, which is often a prerequisite to receiving help (Bach and Bjerger 2021; Brandt et al. 2009; Pedersen 2009; Rasmussen 2019). Wider mental health problems, loneliness and lack of networks are also widespread in this group (cf. Han et al. 2018; Sundhedsstyrelsen 2020). Loneliness in particular is considered to pose a specific type of problem<sup>2</sup> as next of kin is increasingly seen as a resource in treatment and someone who can support individual autonomy. Entering the health care system without this kind of resource seems to amplify the challenges facing these citizens, even though other types of network can also take on supportive functions (Abad et al. 2010; Bergerød et al. 2018). In the following sections we focus on one type of network and describe how it offers some level of support and sympathy while at the same time also being characterized by fragility and volatility.

## Methods, data and ethics

The data in this article comes from an ethnographic fieldwork that was conducted by author 1, over an initial period of 14 months, from September 2019 to December 2020, with additional visits to the field in 2021, 2022 and 2023, as “step-in-step-out” fieldwork (Atkinson 2015), totaling upwards of 140 hours. The data used in this paper were primarily collected in 2019–2020 as part of a wider research project on marginalized alcohol using citizens in urban spaces and the project follows the ethical guidelines of Aarhus University for research.

The primary field site was a shed at a small square situated between several social housing estates on the outskirts of a Danish city. The history and embeddedness of “The Shed,” as it was referred to locally in the local community is discussed elsewhere (Bach and Bjerger 2021; Bach 2022; Bach, Grønnestad and Selbekk, *forthcoming*), but briefly told it was the result of a joint effort of local community workers employed by housing associations, local lot and shop owners, and the local church looking, about 20 years ago, to find a place for a local group of drug and alcohol users who often hung out at the square. The scene was at the time of the Shed’s construction dominated by harder drugs and consisted of sometimes upwards of 20 people. It was described by a local community worker who had been a driving force in establishing the Shed as “more hardcore” than the current scene. Often the hangout spot for the group had been around the entrance to the local supermarket or on the steps leading to the church, causing many of the local shoppers and churchgoers to feel unsafe and avoid the square. The Shed was constructed to give the group a place that “shielded them from the eyes of passerby, but also shielded passersby from them,” in the words of the community worker and had since become an integrated part of the square. The Shed was not systematically monitored or policed but functioned as an autonomous and informal meeting place and was also occasionally visited by municipal outreach workers and local community workers. At the square, there was also a supermarket, a kiosk, a pizzeria, a church, a mosque, and a combined library and community center,

the supermarket and the community center also serving as secondary fieldwork sites. Access to the primary field site was secured by “knocking” on the wall of the Shed and asking those present whether the ethnographer could sit down with them occasionally and hang out. The research project and themes were introduced both at the beginning of fieldwork and continually during fieldwork periods and again at interview sessions, and informed consent forms were signed by the interviewees. During the fieldwork periods, access to health care emerged as a theme in informal chats, and a second round of interviews was organized with questions circling contact with the health care system. The first round of interviews centered on life stories, relationships between users and sociality in the Shed, and relations to the surrounding local community. This article draws on data from both rounds of interviews and field notes referring to informal discussions and chats that took place during fieldwork.

The field site and all interlocutors quoted here have been pseudonymized, and some of the interlocutors’ personal details blurred, as has the location of the Shed. That the interlocutors featured here are part of a vulnerable group does not mean that they do not have opinions on our analyses of their lives, living conditions, and statements. The ethnographer has previously circulated a published article among the group, allowing them to comment on how they were represented. This resulted in a few comments on the pseudonyms selected by the ethnographer. Two of these have been altered in this and other publications as per the particular wishes of two interlocutors. Apart from comments on pseudonyms, the comments have mainly been positive, and the interlocutors found their presentation and analysis to be generally precise.

### **The companionship of the shed, autonomy, and the fear of losing it**

“I won’t be going to a retirement home!” Viola exclaimed. “I hope, I will end my days the way my mother did. Quietly in bed. Her false teeth didn’t even fall out.” Viola, a woman in her late 60s, had recently been cleared to live in a supported housing unit designed for older and disabled citizens who need daily assistance but are still able to live a somewhat active life. She was talking to Martin, who was around 50 years old and almost twenty years her junior, but like Viola was a diabetic and had suffered some disabling effects of the disease. He had recently been cleared for early retirement after many years of processing in the municipal bureaucracy. The two were sitting at the head of a table in the Shed with a few other neighborhood residents who were sipping beers and chatting. Most of the people hanging out at the Shed were in their 50s, a few in their 40s, some in their 60s, most of them were on early retirement pensions, with non-existing, flawed, or at best unstable relations with their families, and a daily drinking habit. Some also smoked cannabis, a few also used other drugs like prescription painkillers (opioids or benzodiazepines primarily) and at least one was a heroin user. Health and aging were among the regular topics of conversation. While few considered themselves “old,” they were acutely aware that they were aging and becoming more fragile as the years passed. They were aware that it was slowly becoming harder to manage the everyday, more difficult to get over the hangovers, and harder to stomach large quantities of alcohol. It was feeling colder outside in autumn and winter, new ailments were occurring, and old ailments worsening. Death had long been a regular visitor among their friends and acquaintances (at least 6 of the 40 people registered in the study died during the fieldwork period). Some had fallen ill or been in accidents that had disabling effects. Like Viola, some were considering their own departure from life already; the deaths of friends and acquaintances were acute reminders of their own mortality. However, seemingly worse than death loomed another fate: the nursing home.

Personal autonomy enables, for some, seemingly irrational choices, like wanting to reject the nursing home in favor of living on the streets. Respect for patients’ autonomy in health care, and patient-centered assistance in achieving “the good life,” has long been on the health care political agenda (Gomez-Virzeda et al. 2019; Mol 2008; Pol et al. 2017). In Denmark, numerous national and local policies have pointed to the importance of being active and involved as a patient (see Birkedal et al. 2021; Klausen et al. 2023). Often, the kind of autonomy referred to in these policies is related to individualistic perspectives on autonomy and involvement in patient treatment, which bypasses

relational, situational, and contextual aspects of how such autonomy of the patient might be carried out. The individual patient is considered autonomous, able to make rational choices informed by the advice and recommendations from health professionals and expected to have some level of health literacy (see for example Ferzacca 2000; Whitmarch 2009). Yet, as the example with Viola and the following example with Otto will show, choices are not based purely on recommendations from health professionals, but rather are socially informed.

Otto already lived in a supported housing unit. Dependent on a motorized wheelchair to get around, he had several daily visits from the municipal health and care assistants, who helped him in and out of bed and assisted him with visits to the bathroom. One day when he came to the Shed, he disclosed his fears that the municipality wished to clear him for alcohol treatment, and then, when he returned, he would find himself forced into a nursing home instead of his supported housing unit. For that reason, he did not want to participate in the screening process (da: *visitation*) that the municipality wanted to submit him to or enter alcohol addiction treatment. He feared that the result of the process would be him ending up in a nursing home which would limit his autonomy and opportunities to come and go as he pleased, to indulge in his drinking and smoking habits, and maintain his social network. Otto's social network consisted of drinking buddies who came and went and in whose company he spent several hours a day. While they to some extent kept tabs on him they could do little to assist him in his interaction with the municipality and health care staff, or his volatile relationship with a sibling who shuttled between jail and the streets and often came by Otto's place. However, the companionship in the Shed allowed Otto to maintain some level of autonomy. It offered him a place to spend his days in the company of others who were also drinking, to share weed and stories of the old days, and the ears of people who sympathized and understood his way of life.

### **Analytical frameworks: Next of kin, disposable ties and companionship**

Next of kin are often considered an extension of health care professionals in treatment (Bergerød et al. 2018; Gullestrup and Avnsbøg 2016). When signs of illness occur, in treatment and in rehabilitation processes, partners, children, parents, and close friends have proven important for the individual patient. This relates, for example, to if, how, and when to seek medical assistance, accompanying the patient to consultations with health professionals and helping them remember and explain symptoms, assisting the patient with practical and emotional issues during hospitalization, driving patients to and from rehabilitation, or assisting in managing a patient's medication. The Institute of Medicine has asserted that next of kin's collaboration with health professionals is one of the most important preconditions for the avoidance of misdiagnosis (2015). Further, research suggests that especially patients with chronic diseases profit from the assistance of their next of kin (Chen et al. 2016). Patients who do not have next of kin are thus to some extent much more likely to be vulnerable as they are at greater risk of becoming victims of unintended events, emotional suffering, and incoherent care and treatment (Abad et al. 2010). Many of the older citizens in our study had none or few close relations and were thereby examples of individualized patients, often with little or no involvement from relatives in health care.

However, they sometimes relied on their social networks for support, even though the people in these networks were rarely relatives or partners. While this begs the question: who counts as "next of kin," we have found the concept of "disposable ties" useful to describe relationships and networks similar to the kind that older drug and alcohol users in this article have. Therefore, we draw on (and eventually challenge) the concept developed by the American sociologist Matthew Desmond (2012:1296, 1311), who has pointed to how insecure housing conditions and frequent relocation are typical of the living conditions of marginalized inner-city poor in Minneapolis, and among the causes of the increasing interdependence on people with whom the inner-city poor in the areas have only limited social ties. Desmond terms these "disposable ties:" provisional, often superficial, and short-term relationships with random acquaintances who have replaced more long-term relations with steady neighbors and family members "characterized by accelerated and simulated intimacy, a high



amount of physical copresence (time spent together), reciprocal or semi-reciprocal resource exchange, and (usually) a relatively short life-span” (Desmond 2012:1311). As Desmond notes, several of these characteristics also define other relationships in other socioeconomic groups, but “only the poor [who] routinely rely on disposable ties to meet basic human needs, such as housing and food. This entails placing weighty demands on strangers” (2012:1312). Bourgois and Schonberg (2009) describe similar relationships between the Edgewater homeless and point to a “community of addicted bodies,” and a “moral economy of sharing” (2009:6), where companionships between individuals can form and sometimes last for years with the companions entering into reciprocal or semi-reciprocal practices of sharing and helping each other out and becoming “running partners” (2009:215), until they would fall out or one or the other might be incarcerated or die. While the Danish context we describe in the following may not be as volatile as the drug scene at Edgewater Boulevard or eviction may not shape the Danish housing market for the poor as much as it does in the US, there are striking similarities in the forming of social ties.

### **Being counted for nothing? The importance of a next of kin in selfcare**

Several of the users of the Shed contended with the feeling of being treated differently by health professionals on account of their drinking or drug habit and social position. Michael, a man in his 50s had, by his own account, visited his general practitioner only twice in the past 20 years. In conversation with a field assistant he said that “people who drink are counted for nothing” [da:“ikke regnet for noget”]. His most recent visit with his GP had been two years ago, after five months of having a fever and suffering from sinusitis. He was treated with antibiotics and eventually recovered. However, he still considered himself able to grapple with most health issues on his own and did not feel comfortable with seeking out assistance from health services. He also spoke of how having a girlfriend or wife might have nudged him to be more active and reach out to health professionals if he ever found himself in a similar situation. He vividly described how he might ignore an abscess on his back “until it would reach [his] butt,” but if he had a female partner, she could encourage him to have it checked before it got to such extremes, he believed. Regardless of the nature of a close next of kin, the examples of Michael and Otto support the idea of the importance of having next of kin in times of illness (cf. Abad et al. 2010; Balogh et al. 2015; Bergerød et al. 2018).

While a few of the Shed’s users had long-term relations with GPs whom they trusted, most did not. Jacob, for example, was nearing 60, had fathered two children, now adults with whom he had little contact, and had worked as a carpenter as a young man. He had also been deployed as a UN peacekeeper. Returning to Denmark, he had built up a drug habit, beginning with methamphetamine before turning to heroin, and he had worked as a street dealer to make money for his habit. He had also served time in prison. After getting an apartment in an estate near the Shed ten years ago, his life had quietened down, and he mostly stayed away from the more volatile drug and alcohol scenes in the city center. He had been diagnosed with a chronic health condition that caused him constant pain. In an interview, when asked about his relationship with his GP, he replied, “Relationship? I don’t have one.” By his recollection, he had spoken with his current GP only twice. The GP “did not pay attention” to what Jacob was saying, he explained, and had been unwilling to prescribe painkillers that were sufficiently strong to relieve his pains due to his history as a drug user. While this may very well have been the entirely correct course of action from a medical perspective, for Jacob, this meant that he had to self-medicate. He did so with heroin, when he could afford it, and with prescription opioids bought on the black market when he could not afford heroin. When he could not afford opioids, he drank more excessively to suppress the pain. Likewise, he avoided his GP when it came to other health issues and preferred to “handle his own problems.” In an interview, he said that his adult son, with whom he had taken up sporadic contact recently, had suggested he get cleaning assistance from the municipality due to his health condition, but he “did not want people snooping around his apartment” if he could handle it adequately himself. Instead, he drew on informal networks in the Shed, particularly a woman

called Anette, who would do his grocery shopping and helped him save money for the end of the month by safekeeping his bank card so he would not be tempted to spend all the money in his account on drugs. Similarly, other people hanging out in the shed had temporary, and sometimes more long-term, relationships that involved exchanges of care (see also Bourgois and Schonberg 2009).

As the case of Jacob illustrates, the users of the shed often preferred the advice and assistance of their networks and relied on their own capability to overcome health issues rather than frequent contact with health services, and they preferred the relative freedom of regular and supported housing to the perceived confinement and control of a retirement home. Likewise, particularly the men were very vocal about avoiding doctors and other health services as long as possible, as the examples of Michael and Jacob show.

### **Wariness and longevity: From disposable ties to brittle ties?**

The lack of (the right) next of kin, we argue, is potentially a particular form or source of inequality that affects the older substance users' encounters with health care professionals and their general approach to health and health treatment. The perceived contradiction between access to care and the preservation of personal autonomy was often highlighted during fieldwork and in interviews because the members of the group in the Shed had to navigate in the Danish healthcare system with its implicit expectations regarding behavior and lifestyle or find their own ways of dealing with their health problems and care needs. The solution for several of the users of the shed was to avoid the health care system as much and as long as possible and rely on the often fragile relationships to some extent similar to the ones Desmond (2012) has described as "disposable ties." Although Desmond describes a particularly American (perhaps even particularly Minneapolitan) context, socially marginalized citizens in Denmark and elsewhere also tend to have histories of frequent relocations and flawed and dysfunctional relations to family and friends, often relying on more provisional networks revolving around particular activities, like drinking, in their everyday lives. While the users frequenting the Shed in the Danish context could often find some assistance and sympathy through their networks in the Shed and elsewhere that were enough to get by in most situations, their lack of strong family relations and steady relationships could often be a drawback when trying to navigate the health care system. Advice on dealing with GPs and other health care professionals and on the intake of medicine and other health strategies was often shared in the Shed. However, there were only a few examples of users accompanying each other to health care appointments, or supporting contact with health professionals in emergencies. Laurits, for example, readily explained that he had been running to catch a bus in snowy weather and had slipped and hurt his foot. He had not thought much of it until a few hours later, when he was sitting in the shed with a few others. His foot had still hurt, and the others eventually convinced him to call the emergency health services. He was picked up by an ambulance and taken to the hospital with a broken foot. While the others in the Shed in this case helped nudge Laurits to seek out health care, no one accompanied him to the emergency room. Another regular at the Shed, Britta, had crashed on her electrical mobility scooter and was incapacitated for a few weeks and had to pay others – with beers or cash – to help her out with grocery shopping and walking her dog.

The types of networks, marginalized citizens engage in can, to some extent, alleviate some of the problems these citizens face, such as a meal, a bed for the night, lending money, or calling emergency services, if someone takes a drug overdose or is subjected to a critical health condition (cf. Bach and Bjerger 2021; Desmond 2012). However, when it comes to more long-term care or help in relation to, for example, severe acute or chronic illness, the extent of help one can expect or count on is limited (Bach and Bjerger 2021). Further, the relations of such networks are often marked by ambivalence (Desmond 2012; Bach and Bjerger 2021; Bourgois and Schonberg 2009), and as pointed out by Bourgois and Schonberg (2009:5), balancing "on a tightrope of mutual solidarity and betrayal [. . .]" In the context of the Shed, there was a wariness that one's acquaintances might not be trusted to not

cheat or let one down, or they might disappear from the social context due to their precarious living conditions.

Examining Desmond's concept of disposable ties in our Danish setting, there are some important nuances to consider. The major difference is the longevity of relations: the community in the Shed *did* include long-term social ties that have been maintained over several years, and, in some cases, decades. During fieldwork, some of these relations were challenged and, in some cases, paused temporarily or dissolved over disagreements, arguments or unpaid loans, or fluctuated between close companionship and gruff co-dwelling in the same location. Some people disappeared from the scene and lost contact with it, and others resurfaced. However, tabs were kept on most people who were part of the scene by the "core" regulars, who kept in touch via their mobile phone texts and calls and social media, particularly Facebook and the Messenger App. Yet, as Britta put it, "When you call them [to ask for help] they either don't answer the phone, or they have diarrhea or something else. No, there are no close relations here." While not entirely disposable, the relations or ties between the individuals forming the scene around the Shed did not seem to be easily disposable, but perhaps rather unstable and fluctuating. To suggest the both fragile and unstable, but paradoxically also sometimes long-term and strong bonds formed by the group of Shed-goers, we suggest the term "brittle ties," as brittle suggests both fragility and the risk of splintering, but also of something that appears solid when not under pressure. Brittle, it should be noted, is also among the adjectives Desmond uses in his description of disposable ties. By foregrounding it, we wish to emphasize the above properties of the ties described here and downplay the disposability.

### Fending for oneself, but with a little help

As noted above, consultations with the GP, specialized health personnel, or care professionals is in general considered the domain of family. This meant that the users were more likely than not to face consultations and other encounters with health and care professionals alone. They were thereby at greater risk of not receiving the right kind of diagnosis and treatment at the right time (cf. Abad et al. 2010; Balogh et al. 2015).

While the Danish health services are based on principles of equality in access and treatment, research shows that marginalized groups still often struggle in their contacts with the health sector (Bach and Bjerger 2021; Bjerger et al. 2024; Kappel and Johansen 2022). The examples from the Shed illustrate attempts to maintain personal autonomy and tinker with treatment and interventions by avoiding follow-up, self-medicating, and steering clear of particular encounters with health professionals. Would anything have been different if Jakob had a wife or his adult son accompanied him to the doctor? Would he have been more willing to seek out his GP? Would Viola warm to the thought of living in a nursing home? Would the health care system have met them differently if a relative had accompanied them? While these are hypothetical questions, several of the informal talks in the Shed about access to health care pointed to the role of next of kin, or more precisely, to what it meant *not* having next of kin who could accompany or nudge you. While the brittle relations in the Shed sometimes offered a shoulder to lean on and sympathetic support, they could easily splinter when push came to shove, as in the case of Britta, who had to pay for practical assistance from people she otherwise socialized with daily. That people, who had otherwise been close and helped each other out, fell out, periodically or more permanently, was not an unusual event in the Shed. Another example occurred when Jacob, having built up a mood with a heavy intake of vodka, commented derisively on Annette's daughter while Annette was within earshot. The sleight was not easily forgiven and Annette effectively shunned Jacob for months afterward.

Returning to the case of Laurits, we might examine the further course of his broken foot. Some weeks after he had broken his foot, the ethnographer met Laurits in the shed. He was limping and had a bandage around his foot. The ethnographer asked whether a follow-up examination of the foot was planned. Laurits brushed the question aside, saying he was already walking much better and probably would remove the bandage before he was called in to have it removed by a doctor. As he saw it, there

was no need to return to a doctor, even though he had received a time slot for follow-up, as he had already received immediate treatment and was mending on his own. The following week, he had cut off the bandage himself and insisted he was mending fine on his own. Again, here a next of kin might have been able to nudge Laurits to go into rehabilitation, but his network in the Shed did not want to push him on the subject.

While the cases of Laurits, Michael, and Jakob are but three examples of avoidance or reluctance in seeking out health assistance from professionals, they were confirmed as typical in interviews and informal talks with other interlocutors. The reasons for being reluctant differed, but also had some common traits. Often it was stated that “it would not make a difference” and that they “were doing ok by themselves.” They had learned to look after and fend for themselves and preferred that to “being looked after” by professionals, who might also offer advice that they disagreed with or otherwise did not want to follow. Here, we might return to Laurits and the time he, by his own account, “nearly died.” Laurits referred to the story in an interview, speaking lightly of it. He had had chest contractions, which gave him trouble breathing, and he could hardly walk, he said. A social support worker, who happened to be nearby, had helped him get to his GP. The doctor had given him some form of medication, Laurits did not know what, which had made him go into a state of shock, and his heart had almost stopped beating. He was rushed to the hospital and survived. The staff at the hospital had told Laurits that his trouble breathing was caused by his alcohol intake, but to Laurits, that made little sense. He put it like this: “I’ve been drinking heavily for many, many years, so why should it suddenly result in that? They never found out what it was. They blame the alcohol. I don’t think it was [the alcohol].”

Several of the Shed’s users referred to previous meetings with the health care system, where they had felt misunderstood, patronized, or otherwise poorly treated, like the example with Jakob and his GP. One had woken up from sedation during surgery, and others had been medicated with medicine that made them feel bad. Entering treatment or care also threatened their self-images of being autonomous individuals who could take care of themselves under challenging conditions and bared weaknesses in their bodies that risked making them more vulnerable and less able to get by on the streets. While this was particularly at play among the male interlocutors, several of the female interlocutors stated similar concerns. The fear of losing autonomy through the loss of physical capacities was general and seemingly loomed larger than the fear of dying.

## Conclusion

Even in a Scandinavian welfare state like Denmark, where there is an intensive focus on equality through “good, fast, and safe treatment for all citizens” (The Danish Ministry of Health 2023), some people fall through the cracks in the system. As illustrated in this paper, the reasons can be manifold and complex. By examining a particular subgroup of marginalized older substance-using citizens, we shine a light on some of the experiences of how marginalization can play out in health care and how individual agency and structural obstacles can intersect and increase marginalization in health care.

In addition to this, there seem to be some indications as to how the lack of next of kin can have serious consequences for the users of the shed and add to the many factors suggesting that inequality in health care must remain on the political agenda. Even with an increased focus on autonomy as not limited to the individual but also being relational (Sherwin and Winsby 2011), older substance-using citizens are still often left to fend for themselves or with more provisional networks as their primary source of support. They may do so by choice or because they lack close relatives or next of kin to help. They also may prefer to maintain their own form of autonomy rather than participate in health promotion or in health care trajectories with a pursuant perceived loss of autonomy.

However, they do, to some extent, rely on more fragile networks, somewhat similar to the disposable ties Desmond (2012) describes, that offer some support as surrogate next of kin. Here, we suggest the term “brittle ties,” that offers nuance to the term. If we want to improve conditions for older citizens with substance use and other “complex” citizens, we must reconsider the organizational setup of health services (e.g. standardized slots at the GP), how marginalized citizens experience health professionals, their lack of

training or interest in how to process and act on health information, and their lack of support from next of kin, which in many cases seems necessary in order to profit from the health care system.

Introducing social nurses and volunteer support into the health care system uncovers how “close relatives” increasingly play an important role in the provision of care by the Danish health care system. While integrating close relatives might bring all kinds of benefits, it might also create a larger gap between those who have close relatives and strong networks and those who have no next of kin and rely on brittle networks. As close relatives have become a more integrated function in health care, the need for someone to fill out this function (such as social nurses) additionally must increase. If not, close relatives become yet another resource unequally distributed between people in need of health care. Another option would be to widen the scope of who “counts” as next of kin, offering room in health care for drinking buddies, running partners, neighbors, who ever is willing to support an individual during health crises. While this might pose practical, legal and ethical challenges, it might also improve conditions for the most marginalized citizens.

Further studies on marginalized groups of citizens may help us shed more light on what it is like to suffer diffuse health inequalities in a welfare state like Denmark. This article shows how a particular group of older, marginalized, substance-using citizens strive to fend for themselves, sometimes and somewhat aided by their social networks. While these networks may be closer to “disposable ties,” and more brittle than relationships with long-term friends, partners, and relatives, they play an important role in maintaining autonomy and exercising agency even during health crises, however fragile and volatile they may be.

## Notes

1. We use the definition of marginalization from a report published by the Danish Board of Health in a 2020 report on marginalized older citizens: “Marginalization is defined as: Individuals living with one or more of the following conditions: Alcohol misuse – Drug misuse – Homelessness – Psychiatric illness” (Our translation, Sundhedsstyrelsen 2020:2).
2. Mikkelsen (2016), in an ethnographic study of older men living alone, writes critically on how loneliness is constructed as problematic in Danish elder care.

## Acknowledgments

A large thanks is owed to the participants in the study. The ethnographer was on a few occasions in the autumn 2020 assisted by an intern, Karoline Krause Carlsen, functioning as a fieldwork assistant.

## Disclosure statement

No potential conflict of interest was reported by the author(s).

## Funding

The research was internally funded by Aarhus University.

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