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Salute e Società

Vulnerability and social frailty
A theory of health inequalities

edited by
Mauro Niero
Giovanni Bertin

FrancoAngeli

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EDITORIAL

David Mechanic*

Almost everyone at the intuitive level understands the idea of vulnerability, but it becomes clear in efforts to define it precisely that it is a slippery concept with many possible levels of analysis. Context is extraordinarily important. Vulnerability involves not only individual attributes and circumstances, both inborn and acquired, but also the environmental and community aspects that shape definitions and reactions and either facilitate or restrict the resources needed to deal with adversity. Understanding vulnerability also inevitably involves ideological and moral concepts that influence whether people are punished and stigmatized or supported and assisted. A core conception that underlies much of the dialogue about vulnerability is "personal responsibility" and the extent to which difficult personal circumstances are believed to be due to individual decisions and behavior or a consequence of influences over which individuals have little control or just bad luck. These are cultural and ideological frames that have significant impact on how peer groups, communities and societies deal with issues of vulnerability.

Vulnerability can be seen as the discordance between the challenges individuals and communities face and their uncertain resources to manage them (Mechanic, Tanner, 2007). As the gap grows between the magnitude of threat and coping resources, vulnerability increases. This explains why vulnerability is commonly associated with disadvantaged individuals and groups characterized by low socioeconomic status, stigmatized racial and ethnic characteristics, dependency and incapacities as reflected in very young and old ages, serious illness and disability and exposure to traumatic life circumstances.

* David Mechanic is René Dubos University Professor di Behavioral Sciences and Director of Institute for *Health, Health Care Policy, and Aging Research* at Rutgers University, mechanic@rci.rutgers.edu

Most studies measure vulnerability at particular time points but vulnerability, or its obverse resilience, develops over the life course and influences are cumulative. The timing of events and challenges, their persistence over time, and the particular historical context that shapes responses to individual and community stressors are all relevant to how the vulnerability process unfolds. The social determinants of vulnerability are commonly characterized as "upstream" influences and important influences are identifiable early, even beginning in prenatal stages, such as birth weight, nutrition and growth, and early developmental factors. Such early factors influence cognitive capacities, educational achievement and chronic disease later in the life course. Indeed, some influences are intergenerational depending on the health, nutrition, and social resources of mothers and even grandmothers (Mechanic, 2007).

Socioeconomic status and poverty are key to understanding most endpoints of interest. Low education and income are associated with longevity and most other important health indicators. They influence vulnerability by shaping the environments and challenges to which individuals and groups are exposed and the resources they develop to address challenges and threats. Their influences occur through many pathways that influence the prevalence of threatening events or the capacities and resources to avoid or deal with adversity. As Phelan, Link and Tehranifar (2010) have persuasively argued, status, power, money and privilege give the advantaged early and abundant opportunities to access relevant knowledge, social supports and effective interventions that help avoid risks, maintain health and limit the consequences of sickness.

Vulnerability comes in many forms and from a wide array of biological, environmental and social influences. These range from inborn errors of nature to natural and man-made catastrophes. The extent to which preparation is effective in ameliorating the impact of these events depends on the social institutions and cultural forces that help build the knowledge base and the social and political influences that allow intelligently applying what we know. Many of the barriers to limiting vulnerability arise from the divergent value systems, ideologies , conflicting interests and politics present in all complex societies.

Many politically acceptable health and social welfare programs seeking to limit vulnerability demand individual initiative and motivation. Such programs inevitably favor those within the defined eligible groups with greater social and personal resources who can more easily take advantage of these opportunities. Persons who more vigorously seek such benefits, and who are more knowledgeable in navigating what are often complex eligibility processes, obviously benefit more. It is not surprising that such programs commonly fail to reach those most in need. Ironically, many such

interventions, however well intentioned, often lead to increased disparities in relation to the most disadvantaged parts of the population (Mechanic, 2002).

This need not be so. Many typical barriers to program participation can be simplified and made less demanding. In many instances it would be practical to assume eligibility of all people in particular population groupings and then make it possible for individuals who don't want to participate to opt out. The literature refers to this as nudging as contrasted with coercion (Thaler, Sunstein, 2008). Most important is the fact that there are many types of population interventions that promote health, safety and welfare whose success does not depend on individual initiative. These range from fluoridation of water and fortified foods to transportation and workplace safety. The opportunities in population health are abundant to meaningfully reduce vulnerability and improve health throughout the life course for all.

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INTRODUCTION

Mauro Niero, Giovanni Bertin*

Over the last 20 years, epidemiological studies have increased the attention paid to a classic health sociology issue: the relationship between social stratification and health status.

While this puts health systems under scrutiny as far as policy effectiveness and social justice are concerned, sociology can push the analysis further by trying to suggest possible approaches in order to contextualize the health inequalities that are emerging in the post-modern society of the beginning of the XXI century.

This is the topic of the present issue of *Salute & Società*, which revolves around the concepts of vulnerability and frailty.

The use of such concepts in the contemporary sociological context is more than emblematic. In fact, these apply to a world in constant uncertainty, where economic and institutional issues are interwoven as both interfere with people's daily lives and their health.

The theoretical capability of sociology to anticipate the future, as exemplified in Beck's, Luhmann's, and Giddens's risk theories, should be underlined, where risk can be interpreted both as a sense of "danger," as well as a "hazard" and a "gamble".

Vulnerability is a related concept, though it cannot be considered a cause or a factor, but a property either of persons or of systems. Vulnerability decreases with the increased capacity to absorb uncertainty triggered by social or environmental events. Indeed, vulnerability does not include only disease or threats, but also the means to face them, which, paradoxically

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enough, could contribute to worsening situations instead of improving them. It is, in fact, a dispositional concept and, as such, it leads us to wonder which mechanisms foster its development so that we may identify reasonable coping strategies.

We decided, therefore, to organise the issue around what T.K. Merton called middle-range theories. This intermediate theorization could help in decoding the various types of complexity that lie behind the so-called social determinants of health.

We must also stress that the subject of vulnerability was chosen by the editors over the course of their research activity (on quality of life, welfare systems, and life/health trajectories), whose common threads led them to a scholar to whom health sociology is particularly indebted. He is acknowledged, in fact, along with Talcott Parsons, as one the founders of said discipline: David Mechanic.

In 2007, Mechanic edited a special issue of the journal *Health Affairs*, in which he compared the US situation of poverty and marginalisation to the one occurring 20 years before, when he himself had edited another special issue of the same journal on a similar topic.

By realising that the groups at risk in the US were the more or less the same (homeless people, ethnic minorities, one-parent families, etc.), the author wondered what had changed in that 20-year time span. Consequently, he stressed some issues that highlighted the discrepancies between health and daily life systems. He suggested, therefore, a sort of contextual theorization, which he called *upstream theorization*, that could contribute to enriching the concept of vulnerability and to studying its connections with other theoretical streams.

Mechanic, who is currently director of the *Institute for Health, Health Care Policy and Aging Research* at the Rutgers University in Newark (NJ),[1] has agreed to write the foreword of our current issue. Therein, he anticipates several of the aspects that will be discussed in the contributions that follow, throughout which the concept of vulnerability will be contextualized to the Italian situation. In particular, he will underline the systemic nature of the concept. It follows that health interventions should be seen not only as activities carried out in response to disease or disability, but also as something that, paradoxically, can contribute to the generation of diseases and disabilities. This opens interesting perspectives within the sociological analysis of health, as well as within health service provision.

[1] We take here the opportunity to thank Prof. Mechanic for his contribution, along with Prof. Maturo, for his willingness and availability in contacting him.

The articles in this issue refer to some of these theories in their applications to health inequalities. Mauro Niero will provide some definitions of vulnerability, as well as of frailty, showing their origins and their meanings in the health domain. Giovanni Bertin analyses the social dynamics that contribute to the actualisation of situations of vulnerability. Stefano Campostrini writes about lifestyles, while Mara Tognetti will discuss the relationships between immigration and health. Rita Biancheri describes health-related gender inequalities, and Cristina Lonardi will enhance the phenomenology of stigma. Luigi Tronca analyses social capital and health, while Apolone and Greco will report on a study in which the concepts of frailty and vulnerability are applied to the problems of access to preventative health services.

In the column *International perspectives*, Erio Ziglio and colleagues describe WHO policies regarding the social determinants of vulnerability and inequity. Their contribution will be commented upon by Antonio Maturo and Cleto Corposanto.

Since vulnerability is a dispositional concept that includes a new perspective on social determinants, we should not leave unattended the possible questions regarding the place of social class within this new cadre.

In light of the fact that the relationships between health, diseases, and social classes have dominated a good bit of the scientific debate in health sociology, we have invited some Italian scholars to express their opinions in response to the following questions: Do social classes still exist? If so, how do they impact health systems? How will they affect health systems in the future? Mario Cardano, Paola di Nicola, Mauro Palumbo, and Domenico Secondulfo agreed to participate, and the reader will see their contributions in the column *Round Table*.

THEORY

Health, vulnerability and frailty: between determinants and dispositions

Mauro Niero*

Boundary lines between medicine and the social sciences have often been crossed in either direction over the course of their history. Lately, the rediscovery of social determinants in health inequalities has harkened back to the tradition of the socio-medical inquiries that characterized the XIX and the XX centuries, while the epidemiological scenario of the latter has long included social daily life functioning in the evaluation, prevention, and care of most important chronic diseases. Vulnerability is a new concept for the explanation of health inequalities. It is not a causal, but rather a dispositional concept. This means that it triggers events under certain environmental circumstances; it is systemic in its essence, complementary to the concept of resilience, and was first applied to the socio-ecological environments of the third world. Recently in health sociology, it has come to be regarded as suitable for Western post-modern risk societies, in particular, by describing both systems undergoing fatal shocks (i.e., pandemic/epidemic risk fatalities) and vulnerable trajectories over the courses of individual lives. By including basic factors such as the social determinants of inequality, vulnerability contends with frailty and its importance in medical sciences, while, as a disposition, it can be increased or decreased through socio-structural and individual action. Its inclusion in health sociology studies requires middle-range theories, such as those on coping and on social capital at both the individual and community levels.
Key words: vulnerability, frailty, life trajectories

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Introduction

For those who like to follow Kuhn's line of reasoning about science as a scenario for the manifestation of scientific paradigms[1], medicine is conceived as a monolithic entity revolving around the bio-medical approach. This field, then, would be surrounded by boundary lines that would strenuously protect it from the frequent attacks from other scientific disciplines, particularly the social sciences. Those who prefer instead to consider the relationships between medicine and social sciences through the violations of such boundary lines may witness a more interesting and revelatory scenario.

Without claiming to be exhaustive, I shall start by discussing some of the relationships (intrusions; or should we say, "contaminations"?) between medicine and the social sciences that have given place to a sort of *Middle Earth*. This shows that the so-called bio-medical model is not, in fact, as impermeable as many scholars once argued. This is the background of the concept of vulnerability, which is among the concepts that populate such a Middle Earth scenario. While vulnerability is often related to the so-called health determinants, these two concepts are actually separated by an epistemological leap, since the former is non-deterministic. It requires, therefore, a special terminology (conditions, dispositions) that, though remaining part of the debate on determination, evokes the complexity of scenarios characterized by uncertainty, likelihood, and multi-factorial relationships.

1. Medicine, society, and social sciences. Synergies and intrusions

From an outsider's perspective, the history of modern medicine (Canguilhelm, 1966) seems to be a patchwork of contrasting tendencies. The rise of scientific medicine due to Claude Bernard, on the one hand, and the discoveries of Koch and Pasteur (the former focused on disease as imbalance, the latter on disease triggered by an external agent), on the other, show that, despite belonging to opposing paradigms, these two lines of thought would necessarily be integrated in the medical approach. In addition, medicine has ancient traditions that strongly affect its current organization, which is divided between parcellary analytic medicine (which

[1] Here I refer especially to the principle of paradigms' incommensurability and to the disciplinary interpretations of paradigms typical of the so-called paradigm war (see Lincoln & Guba, 1985).

studies different parts of the body separately) and the internal medicine approach (which considers the human body in its entirety) (Nordenfeld, 1995). The field must grapple with this division, let alone the hiatus between medicine and surgery that has emerged due to the evolution of the relationships between crafts and professions.

In this sort of scientific sub-disciplinary federation, one need not wonder why (be it right or wrong) the medical community adopted a self-referential strategy by shielding itself in order to resist external solicitation and by following a typical mechanism of professional closure.

Medicine, however, has been much less impermeable to social factors (including those conceptualised by the social sciences) than is normally admitted. In this light, we should recall the bio-psycho-social model made official by George L. Engel in his famous article published in the journal *Scienc*e in 1977. This proposal was an answer to the external contingency triggered by the stream of discoveries that followed that of DNA (genetics and genomics) and, on the other hand, to the claim that there was a necessary relationship between the biological and the psycho-social aspects of medical science, as well as with professional practice.

Although emblematic, this is only one stage along the path. Nonetheless, it was solidified most by the impact of chronic diseases in the Western world since the early decades of last century. The epidemiological cadre was, therefore, characterised by long-standing pathologies with multi-factorial aetiologies, mostly non-fatal but often cumulative and likely to bring about disabilities in people's functioning in their normal life situations. This brought medicine to search for bridges to link to other disciplines, or, seen from another point of view, to expose itself to contamination from other branches of scientific knowledge.

Sociologists Parsons (1953, with his theory of medicine seen as social control) and Mechanic (Mechanic & Volkart, 1961, with his theory presented in *Illness Behavior*) are examples of such support/intrusion. Nevertheless, not only did epidemiologic change require joint interdisciplinary conceptualization, but also a true shift in medicine's *modus operandi*.

Given that several chronic diseases are difficult to cure, the adoption of preventative methods become a main priority for the related medical branches (i.e., cardiology, rheumatology etc.). Therefore, they felt encouraged to adopt non-medical concepts, such as "lifestyle" and "daily life," with all their adjacent culturally related issues, such as values, personal propensity, attitudes, patient representations, aptitudes, etc. Medicine was obliged to "exit the body", in a sense, by including in its protocols the traditional diagnostic tools alongside by new instruments of detection to evaluate the performance capacity of the person in his/her daily