**Review Notes**

# Chapter 21: Vulnerability and Vulnerable Populations: An Overview

I. Vulnerability: Definition and influencing factors

A. Definition: *Vulnerability* is defined as susceptibility to negative events.

B. Vulnerable populations are those groups who have an increased risk to develop adverse health outcomes. Risk is an epidemiologic term that means some people have a higher probability of illness than do others. Vulnerable populations often experience multiple cumulative risks.

C. Resilience is the ability to resist the effects of vulnerability. It is important to learn what factors make some people more resilient than others.

D. Vulnerable population groups include the poor and homeless, pregnant adolescents, migrant workers and immigrants, the severely mentally ill, substance abusers, those who have been abused and victims of violence, people with communicable diseases and those at risk, people with HIV or hepatitis B, and people with sexually transmitted diseases.

II. Health disparities and vulnerable populations. Vulnerable populations are more likely than the general population to suffer from health disparities—the wide variations in health services—and health status among certain population groups.

A. *Healthy People 2010* and *Health People in Healthy Communities* are initiatives that talk about vulnerable population groups and illness prevention and health promotion objectives for them. One of the two overarching goals of *Healthy People 2010* is the reduction of health disparities. It is especially relevant to a discussion of vulnerable populations because these underserved and disadvantaged populations have fewer resources for promoting health and treating illness than does the average person.

B. Examples of areas that show health disparities across population groups are infant mortality, childhood immunization rates, and disease-specific mortality rates. Race and ethnicity are not thought to be the causes of most disparities; instead, poverty and low educational levels are more likely to contribute to social conditions in which disparities develop.

C. Vulnerability results from the combined effects of limited resources. Limitations in physical resources, environmental resources, personal resources (or human capital), and biopsychosocial resources combine to cause vulnerability. Human capital refers to all of the strengths, knowledge, and skills that enable a person to live a productive, happy life. People with little education have less human capital because their choices are more limited than for those with higher levels of education.

D. Vulnerability often comes from a feeling of lack of power, limited control, victimization, disadvantaged status, disenfranchisement, and health risks. Disenfranchisement refers to a feeling of separation from mainstream society. Vulnerable groups are often socially isolated and thus relatively invisible to many. They may have few informal sources of support, such as family, friends, and neighbors. In many ways, vulnerable groups have limited control over potential and actual health needs. Disadvantage also results from lack of resources that others may take for granted. Vulnerable population groups have limited social and economic resources with which to manage their health care.

III. Predisposing factors

A. Social and economic factors predispose people to vulnerability. Poverty is a prime cause of vulnerability, and it is a growing problem in the United States. The federal government sets the official poverty level, which in 2003 was $18,400 for a family of four. Poverty is, in fact, relative to buying power and is more widespread than the federal poverty level would suggest. The near-poor and those who are uninsured and underinsured suffer from the effects of relative poverty. People who do not have the financial resources to pay for medical care are considered medically indigent. They are vulnerable because they are less likely to seek preventive health services because of the expense and are therefore more likely to suffer the consequences of preventable illnesses.

B. Age-related causes. The very young and the very old are more vulnerable than others, in part because they are less able to adapt physiologically to stressors.

C. Health-related causes. Changes in normal physiology can predispose people to vulnerability. This may result from disease processes, such as in someone with single or multiple chronic illnesses.

D. Life experiences. Negative experiences early in life may make people less resilient to health risks. Research suggests that those who have been abused early in life or who have suffered severe trauma are often more vulnerable to later stressors. Those who develop an internal locus of control are better able to cope with such stressors than are people with an external locus of control.

IV. Outcomes of vulnerability

A. Poor health outcome. Vulnerable populations are more likely than others to suffer negative outcomes from health problems.

B. Cycle of vulnerability. Without effective intervention, predisposing factors lead to poor health outcomes, which in turn worsen the predisposing factors. This leads to a cycle of vulnerability that is difficult to break out of without assistance. Vulnerability leads to the presence of chronic stress, adding yet another burden with which these groups must cope. The chronic nature of these problems often leads to feelings of hopelessness. Hopelessness results from an overwhelming sense of powerlessness and social isolation.

V. Public policies affecting vulnerable populations. Three pieces of legislation have provided direct and indirect financial subsidies to certain vulnerable groups.

A. The Social Security Act of 1935 created the largest federal support program for elder and poor Americans in history. It was intended to ensure a minimal level of support for people at risk for problems resulting from inadequate financial resources. This was accomplished by direct payments to individuals.

B. The Social Security Act Amendments of 1965, Medicare, and Medicaid provided for the health care needs of elderly, poor, and disabled people who might be vulnerable to impoverishment resulting from high medical bills or to poor health status from inadequate access to health care. These acts created third-party health care payers at the federal and state levels.

C. Title XXI of the Social Security Act, enacted in 1998, provides for the State Children’s Health Insurance Program (SCHIP) to provide funds to insure currently uninsured children.

D. The Balanced Budget Act of 1997 influenced the use of resources for providing health services. To curb the rapid growth in spending on home health and fraud in that industry, the Health Care Financing Administration moved toward prospective payment for home health services. The goal is to ensure that care is appropriate, rather than limited to access.

VI. Managed care and insurance effects on vulnerable populations

A. In many areas, the growth of public managed care (i.e., Medicaid and Medicare) has reduced the personal health services for individuals. The competition for clients in heavy managed care markets has made it more attractive for private clinics and physicians’ offices to provide the personal care services that public health departments used to provide because they can obtain payment for these services. Many public health departments have eliminated personal services and concentrate on providing population-focused services only, such as communicable disease control.

B. However, not all private heath agencies wish to provide services to vulnerable populations. Vulnerable populations are more expensive to treat because they have multiple, cumulative risks and require special service delivery considerations. Managed care organizations (MCOs) have strong incentives to control costs by keeping their enrollees healthy. Many MCOs prefer to care for the healthiest people rather than those who are the most vulnerable. One approach is to contract their care to specialty organizations (known as “carve-outs”).

C. Lack of insurance is a major contributing factor to limited access to health care for vulnerable populations, who may be uninsured or underinsured. Because eligibility limits for Medicaid are so stringent, many people who cannot afford to purchase private insurance may be uninsured. In other cases, people whose insurance is paid by employers may not be able to pay the deductibles and copayments of their benefit policies.

VII. Nursing intervention with vulnerable populations

A. Comprehensive, family-centered services. There is a trend toward providing more comprehensive, family-centered services when treating vulnerable populations. Providing multiple services during one clinic visit is an example of one-stop services. If social and economic assistance are also provided and included in the treatment plans, this is referred to as “wrap-around services,” which are more responsive to the combined effects of social and economic stressors on the health of special populations. Comprehensive services are those that focus on more than one health problem or concern, such a mobile outreach clinic that provides health promotion, illness prevention, and illness management services to migrant camps, schools, and local communities.

B. Advocacy and social justice. Nurses in community health also focus on advocacy and social justice concerns. Nurses who function in advocacy roles and facilitate change in public policy are intervening to promote social justice.

C. The factors that predispose people to vulnerability create a cycle in which the outcomes reinforce the predisposing factors, leading to more negative outcomes. Nurses can identify areas where they can work with vulnerable populations to break the cycle. The nursing process guides nurses through assessment of the populations, diagnosing their strengths and weaknesses, planning and implementing interventions, and evaluating the effectiveness of the interventions.

D. Assessment issues. Because members of vulnerable populations often experience multiple stressors, assessment must balance the need to be comprehensive while focusing only on information that the nurse needs and that the client is willing to provide.

1. When possible, assessment should include evaluation of clients’ preventive health needs, including age-appropriate screening tests, such as blood pressure, serum cholesterol, mammograms, prostate examinations, and glaucoma screening.

2. Vulnerable populations should be assessed for congenital and genetic predisposition to illness and either receive education and counseling as appropriate or be referred to other health professionals as necessary.

3. The level of stress the person or family is having should be assessed. Does the family have healthy coping skills?

4. The living environment and neighborhood surroundings should be assessed for environmental hazards, such as lead-based paint, asbestos, water and air quality, industrial wastes, and the incidence of crime.

VIII. Planning and implementing care for vulnerable populations. Nurses should incorporate the following actions into their care for vulnerable populations.

A. Create a caring environment.

B. Show respect, compassion, and concern.

C. Don’t make assumptions.

D. Coordinate services and providers.

E. Advocate for accessible health care services.

F. Focus on prevention.

G. Know when to walk beside the client and when to encourage the client to walk ahead.

H. Know what resources are available.

I. Develop a personal support network.