

# LISBON FORUM 2016

## New vulnerabilities and old social determinants

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Mr Chairman, thank you.

I am supposed to talk about new and old vulnerabilities but talking about “new vulnerabilities” imply we all agree about the definition of the old ones!

In other words, what do we mean when we use the expression “vulnerability”?

From a public health perspective, ‘vulnerable groups’ are those which have high incidence and prevalence rates for certain diseases. However, a static definition does not take into consideration the subjective and contextual dimensions of vulnerabilities, as well as their dynamic nature.<sup>1</sup>

The “European network to reduce vulnerabilities in health” (a network created in 2015 by Médecins du Monde (MdM) bringing together NGOs and academic partners from EU Member States) states the following: “two individuals in the same difficult situation do not necessarily take the same risks, and a given individual does not necessarily have the same vulnerability in different contexts, in different relationships, and at different points of his or her trajectory. In reality, everyone is likely to be ‘vulnerable’ at a given moment in his or her life. Vulnerability can be a transitory situation secondary to particular circumstances, and not a permanent state”. In other words, the transitory status and its dependence on individual or contextual circumstances suggest using the notion of vulnerability rather than vulnerable groups which somehow is more static.

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<sup>1</sup> as described by social scientists such as Delor & Hubert.

**Structural vulnerabilities are responsible of the ill-health of many individuals. As a matter of fact, a number of studies have shown that independent personal lifestyle choices explain at best only 14 to 28% of the level of health inequalities<sup>2</sup>. Indeed, majority of health inequalities are socially determined and do not imply individual responsibility but rather depend on structural factors.**

**What we can say is that vulnerabilities result from two components, one larger which we may define as Structural and one smaller which we may define as Individual. The Structural Vulnerabilities are represented by**

- 1. Legal, administrative, financial and geographical barriers to access to healthcare**
- 2. The degree of Solidity and Resilience of a health system (e.g. when faced with disaster, economic crisis, etc.)**
- 3. The difficulties that specific groups face in accessing education, housing, work & revenues, and justice (as it is the case of asylum seekers, undocumented migrants, Roma, sex workers, drug users, people in detention centers, etc.)**
- 4. The Labor Exploitation**
- 5. Those Migration Policies that criminalize migrants and lead to (structural) violence or trafficking schemes**
- 6. Finally, the degree of social cohesion in a given community**

**The interaction between structural and individual vulnerabilities explain the major and growing impact of some “old” conditions like TB resistance (and more in general antibiotics resistance) but also the appearance of new viruses and the dramatic epidemic of NCDs in high, low and middle income countries.**

**Someone could expect that talking about new vulnerabilities means automatically talking about the immigration phenomenon that**

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<sup>2</sup> **Stronks et al, 1996**

**characterizes Europe today. However, I am convinced that more than a “migrants emergency” we are facing other public health emergencies like the one of NCDs or the one of Child and Adolescents ill-health. These emergencies are determined by growing vulnerabilities among middle and low income communities and they call much less media attention. The migrant emergency, which instead calls an enormous media attention, is too often used by some politicians to promote xenophobic and populist policies while the NCDs epidemic is so interlinked with Multinational Industry interests that enjoys much less media attention and much more hidden political protection.**

**Therefore, let’s talk about the epidemic of NCDs and Mental Disorders. “Recent advances in socioeconomic development and changes in demographics have altered the profile of the major causes of mortality and morbidity. While infectious and parasitic diseases have been historically the main killers in Asia and the Pacific, today they are no longer the major cause of death in most countries of this region”<sup>3</sup> (Amartya Sen). The investment of the GH community has been traditionally directed to Infectious diseases, only recently NCDs have received some attention. The reason of such a lack of attention is probably due to the fact that NCDs have been considered diseases of affluence because they reflect ill-health resulting from improved living standards. NCDs long considered the companion of affluent societies, have shifted places during the past 30 years and are now the leading cause of death in all regions of the world, except Sub-Saharan Africa”. We know today that mega countries with economies in transition and many middle income countries face “a double burden as the increasing prevalence of NCDs coexists with still significant levels of malnutrition and infectious diseases” (Amartya Sen). Countries characterized by a fast economic growth, like China and India,**

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<sup>3</sup> **Amartya Sen, Nobel Prize in Economics 1998**

show how food consumption patterns have changed in favor of a higher protein diet accompanied by a massive increase in *per capita* consumption of salt, sugar and trans-fats, which contribute to the onset of non-communicable diseases. In short, NCDs cause an estimated 36 million deaths every year around the world, 9 million of which occur before the age of 60. Mental Disorders should obviously be part of the NCDs agenda because more than 250 million people suffer from mental disorders. Mental disorders are much more common among the poor and they, in turn, increase poverty. Refugees or displaced persons suffer from a broad range of mental disorders. Rates of mental disorder tend to double after emergencies. People exposed to major economic transitions are at risk for demoralization, alcohol, substance use and suicide. Depression is ranked as the leading cause of disability worldwide. On average about 800 000 people commit suicide every year, 86% of them in low- and middle-income countries. More than half of the people who kill themselves are aged between 15 and 44, in the prime of productive years. Finally, mental health care for depression and substance use disorders is fundamental for decreasing the morbidity and mortality among mothers as well as to prevent short term and long term adverse effects on babies and children. Remember that about half of mental disorders begin before the age of 14. This means that we should strengthen our focus on the increasing new vulnerabilities affecting Children and Adolescents.

Advances in developmental biology are building an increasingly persuasive case for a new way of thinking about health promotion and disease prevention that focuses on morbidity and mortality in the early years of life. Central to this framework is an increasing interest in the extent to which early experiences and exposures are biologically embedded and have lifelong consequences<sup>4</sup>.

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<sup>4</sup> [Barbui & Saraceno, 2016](#)

**In 2008, the American Academy of Pediatrics issued a report to address a “new urgency given the current epidemic of childhood obesity with the subsequent increasing risk of type 2 diabetes mellitus, hypertension, and cardiovascular disease in older children and adults.” The report underscored the need for a more proactive approach in childhood to the prevention of cardiovascular disease through enhanced adherence to dietary guidelines, increasing physical activity, and consideration of pharmacologic treatment of dyslipidemia beginning as early as age 8 years. What the report did not consider is the idea (based on growing evidence of the cardiovascular sequelae of early life adversity) that new interventions to reduce significant stress in early childhood may be a more appropriate strategy for preventing adult heart disease than the off-label administration of statins to school-aged children. Together with my colleagues Itzak Levav and Corrado Barbui<sup>5</sup> we have explored the scientific validity of the proposition that “reducing significant disadvantage early in life may be a powerful strategy for reducing the population-level burden of chronic morbidity and premature death”.**

**A scientific consensus is emerging that the origins of adult disease are often found among developmental and biological disruptions occurring during the early years of life. These early experiences can affect adult health in 2 ways—either by cumulative damage over time or by the biological embedding of adversities during sensitive developmental periods. In both cases, there can be a lag of many years, even decades, before early adverse experiences are expressed in the form of disease. From both basic research and policy perspectives, addressing the origins of disparities in physical and mental health early in life may produce greater effects than attempting to modify health-related behaviors in adulthood.**

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<sup>5</sup> **Levav & Saraceno, 2014 and Barbui & Saraceno, 2016**

**Important research findings, from epidemiology, child development, neurosciences, genetics, converge indicating that modifiable conditions, such as child maltreatment are responsible for many mental disorders. The number of abused children is staggering. Epidemiologic studies have shown that child or adolescent abuse have significant impact on children (generating externalizing or disruptive behavior, conduct and academic problems in school, depressive symptoms), and on adolescents (promoting delinquent behavior, drug use, academic maladjustment, depression). In addition, there are late effects among adults like affective and anxiety disorders, suicide behavior and substance abuse disorders. Also, general health effects have been identified: a recent study found that adjusting for confounders, significant positive relationships emerged between reports of childhood abuse and multisystem health risks.**

**Furthermore, the epigenetic changes caused by abuse may be carried over from one generation to the next, perpetuating a cycle of violence. In sum, while the research findings on the effect of abuse build a case of “toxic stress”, also programs to reduce/eliminate abuse and its “short- and long-term adverse effects” have shown robust effects.**

**As we well know from the WHO Commission on Social Determinants of Health and the WHO/Gulbenkian Report on Social Determinants and Mental Health both reports led by Sir Michael Marmot, Physical and Mental well-being are influenced not only by individual characteristics or attributes, but also by the socioeconomic circumstances in which persons find themselves and the broader environment in which they live” (WHO, 2012). Over the last 25 years, several studies have shown the close links between Low Social Economic Status (SES) namely, exceedingly low income, unemployment and low levels of education AND psychosocial disabilities. Common mental disorders are about**

twice as frequent among low income groups including people exposed to social inequalities and social exclusion.

Low levels of education and unemployment are well-established risk factors for mental ill-health and unemployment is also associated with greater health care use and higher death rates.

Psychosocial disabilities are too often perceived just a medical problem of a given individual and too little is done to prevent those conditions modifying environmental risk factors.

Families, Communities and Public and Private Institutions and Administrations are insufficiently aware of their potential positive role in preventing or mitigating psychosocial disabilities influenced by social and environmental determinants.

Therefore, there is an urgent need to increase the Public and Private Institutions and Administrations literacy about:

- a) the nature of psychosocial disabilities in relation with social inequalities and low socio economic status
- b) the possible cost-effective preventive interventions on  
children exposed to domestic violence  
adolescents with behavioral problems  
single mothers  
unemployed adults  
old people who lost family support
- c) the strategies driven by public and private sectors outside the traditional medical one which could significantly contribute to prevent and or mitigate the effects of psychosocial disabilities

In conclusion, Public and Private sectors including Foundations and NGOs should join hand to:

1. build capacity of public civil servants
2. assist public administrations in designing simple and realistic situation analysis

**concerning the psychosocial problems of given communities**

- 3. assist public administrations in designing interventions addressing the psychosocial problems of given communities**

**It is quite probable that implementing these three rather simple and inexpensive strategies may show a powerful impact on reducing emerging vulnerabilities in our European societies and more in general in middle income countries.**

#### **REFERENCES**

- 1. Barbui C, Saraceno B. (2016). Social and environmental adversities, neurobiological processes and mental disorders. *Epidemiology and Psychiatric Sciences*, Available on CJO 2016 doi: 10.1017/S2045796015001080**
- 2. Delor F., Hubert M. (2000). Revisiting the concept of ‘vulnerability’. *Social Science & Medicine* 50 1557-1570.**
- 3. Levav I, Saraceno B (2014). Primary Prevention Takes a Leading Role in World Mental Health Action. *European J. Psychiat.* 28, 1, 66-70.**
- 4. Stronks K., et al. (1996). Behavioural and structural factors in the explanation of socio-economic inequalities in health: an empirical analysis. *Sociology of health & illness* 18:653-674.**