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Social Vulnerability and Access to Health Services Ethical Dimension

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Abstract

The problem of social vulnerability emerges with greater presence in everyday life given the depth of the threats that increasingly slow down the conditions of stability of human life. The most recent and complete expression of this issue is the devastating short, medium and long-term effects of COVID-19, which made visible the gaps in the coverage of health systems globally. This work reveals the relationship between social vulnerability, understood as the specific level of exposure and fragility suffered by people in the face of a threat of various natures, with access to health services based on the ethical content of said relationship. The issue is topical because analysts and decision makers have not found effective solutions to inequalities, while actions are sterile in the face of the deep and widespread vulnerabilities that extend to the broadest sectors of the world's population.

Keywords: Social Vulnerability; Access to Health Services; Ethic; Multidimensional Crisis

Abbreviations: WHO: World Health Organization; UNICEF: United Nations International Children's Emergency Fund; WUENIC: WHO/UNICEF Estimates of National Immunization Coverage.

Introduction

Humanity is currently experiencing a profound crisis, a multidimensional crisis of the civilizational pattern as the production and reproduction of life on Earth becomes increasingly problematic. In this dramatic context, the term social vulnerability emerges with greater presence in scientific, academic, political, journalistic, health debates, the mass media and everyday life. The most complete expression of this problem is the devastating short, medium and long-term effects that the COVID-19 pandemic caused to the human species and made visible the gaps in the coverage of health systems at a global level. The concept "vulnerability" is a truly complex term, on which extraordinary development has been achieved in recent years, although it presents ambiguous and sometimes contradictory contents [1,2].

In this work, social vulnerability is understood as the specific level of exposure and fragility suffered by people in the face of some threat of various natures. Currently, the depth of social vulnerability is such that even nations taken, during the last four and a half centuries, as references and patterns of civilizational development, also face the presence

of groups and people with certain vulnerabilities [3-5].

From different positions, analysts and decision makers have been unable to point out directions and options as effective solutions to inequalities, while actions are sterile in the face of the deep and widespread vulnerabilities that extend to the broadest sectors of the population of the planet. As threats accelerate, crises emerge, the impacts of climate collapse, food insecurity spread, and especially, inequalities in access to health and sanitation services deepen; insecurity and uncertainty about the future expands, thus increasing the questioning of the relevance of health systems from the perspective of autonomy, respect and solidarity, which allows for processing fragilities, contradictions, inequities and diversities in access to services of health.

Within the set of factors that impact social vulnerability, access to health services becomes one of the most significant as it allows the achievement of one of the essential rights for each person: the right to life. Despite the efforts of governments, civil society, the International Community and health systems to combat and mitigate inequities in access to health services, this problem is still present in many areas of people's lives. These are multiple threats they face on a daily basis.

In this sense, ethics plays a key role in the processes aimed at promoting universal access to health services to reduce or eliminate discrimination and inequalities that make up social vulnerability. This means assuming fundamental ethical principles, such as: social responsibility, transparency, equity, commitment to others, distributive justice and collaboration, which, taken as a whole, allow the enrichment of social inclusion and empowerment of the most disadvantaged sectors, groups and people who are excluded from the products and services that health systems must offer to them.

Reduction in Direct Expenses in Health Development WHO Region	Total Net Official Development Assistance to Medical Research and Basic Health Sectors per Capita (US$), by Recipient Country	Proportion Of Population Using Safely [1] Managed Drinking [1] Water Services ad (%)	Proportion Of Population Using Safely [1] Managed Sanitation Services ad (%)
	Primary data 2021	Comparable estimates 2020	Comparable estimates 2020
African Region	4.08	32	23
Region of the Americas	2.02	81	52
South-East Asia Region	0.95	-	46
European Region	2.04	92	70
Eastern Mediterranean Region	3.16	56	-
Western Pacific Region	0.64	-	65
Global	-	74	54

Source: Annex 1 Country, area, WHO region and global health statistics of the World Health Statistics 2023.
Table 1: WHO Region and Global Health Statistics Selected.

Table 1 shows that, in the last two years, the countries have not improved the coverage of health services in a homogeneous manner, but rather serious asymmetries are observed in the assistance received for medical research in the basic sectors, which denotes a. At the same time, it is seen that the populations have not managed to receive quality services in water consumption and that official development assistance for medical research and basic health sectors per capita is insufficient.

Regarding the assumption of ethical principles, the transversality of social vulnerability becomes a first-order action and an unavoidable requirement if we intend to achieve, in a concrete way, access to health services and products for all people. In short, the question is not so much about productivity, but about finding a solution to those problems of exclusion, conditions and opportunities that impair the enjoyment of people, groups and sectors, and/or that affect some people differently because they deal with different problems or, simply, what may be a problem for some is not a problem for others.

It is therefore necessary to question and, above all, reconstruct the approach to the formulation and implementation of public policies and social practices of the functions and scope of health services, their products and resources. In this sense, the contributions of distributive justice and equity of traditional assumptions of human rights must play a determining role.

WHO Region	Total Population (000s)			Life Expectancy at Birth (years)		
	Comparable Estimates 2021			Comparable Estimates 2019		
	Male	Female	Both sexes	Male	Female	Both sexes
African Region	579 641	583 017	1 162 658	62.4	66.6	64.5
Region of the Americas	508 298	521 212	1 029 510	74.5	79.8	77.2
South-East Asia Region	1 049 022	1 007 451	2 056 473	69.9	73.1	71.4
European Region	451 859	478 950	930 809	75.1	81.3	78.2
Eastern Mediterranean Region	392 503 374	374 038	766 542	68.3	71.3	69.7
Western Pacific Region	980 226	952 584	1 932 809	74.8	80.8	77.7
Global	3 973 370	3 929 291	7 902 660	70.8	75.9	73.3

Source: Annex 1 Country, Area, WHO Region and Global Health Statistics of the World Health Statistics 2023.
Table 2: WHO Asymmetries by Region With Respect To Life Expectancy at Birth (Years).

As a prior requirement to strengthen this change, it is necessary to rethink a new model of health systems and social systems, sensitive to the gender approach, to the social inclusion of vulnerable groups and people; not only from the structural-functional point of view, but also in the culture of disease treatment, prevention and in the way of working and interacting with people, human groups and of these with their environment, the wealth social and with each other, it is essentially about modifying social relations and, in addition, the relations with the other nature, the non-human one, since biological biodiversity also determines the health problems suffered by the human species and many biopharmaceutical products are obtained thanks to her [6].

Although progress has been made, an important indicator to measure access to health services and their products is the Life expectancy at birth (years); Table 2 reflects that there are still marked gaps between the different regions, which denotes that between countries there is an unequal scope for the enjoyment of a satisfactory life for all people, which has a manifestation within them.

Access to health services and their products, as a social practice, in one way or another is linked to ethics; while the action of enjoying these services and products, by all people, must be understood as an action of such nature. From the social systems and, specifically the health systems, decisions are made where the gradations regarding distribution and consumption are distributed almost permanently; these decisions are ethical in nature. Starting from this principle, ethics has to face one of the great problems that has been present in societies and that today exhibits a turning point: social vulnerability, which contains the asymmetric access of people to health services and the products necessary to achieve effective care against a disease or the risk of contracting it [7].

Whether or not to incorporate the relationship of social vulnerability with access to health services and their products is an ethical question, which affects both the participation of people in the equitable distribution of wealth and the dimension of inclusion in it. Whether or not to contemplate the study of the needs and vulnerabilities of vulnerable people and groups places us directly in assuming or not inclusion as an instrumental category of social justice [8].

Evolving in the possibility and probability of access to health services and their products for all people demands concrete actions in terms of equality policies, where a political and ethical commitment is appreciated to change the situation of vulnerable people who have historically been discriminated against, and continue to be deprived of the enjoyment of their rights. In this sense, it cannot be forgotten that health distribution models function within the framework of the system of political power that pursues and serves, in a synchronic manner, economic interests, and adopt patterns and functions that, in some way, deviate from of the intended and desired search for equal opportunities and the effective participation of people, both in the production of wealth, including those related to bio-pharmaceutical products, and in decision-making positions of distribution, in accordance with the principle of social justice; dysfunctional pretension within the socioeconomic context in which the consumption of health services develops, characterized by the market and privatization.

Figure 1 shows the annual number of girls and boys immunized with zero doses and with doses other than zero worldwide, compared to 2010-2021. These figures are alarming as they are infants who are deprived of receiving vaccination, effective method to eradicate diseases. This exclusion from the different established vaccination

schedules places them in a state of vulnerability to multiple health problems that can be eradicated or prevented.

DTP3 coverage will therefore be dependent on reaching zero-dose children and ensuring they are fully immunized.

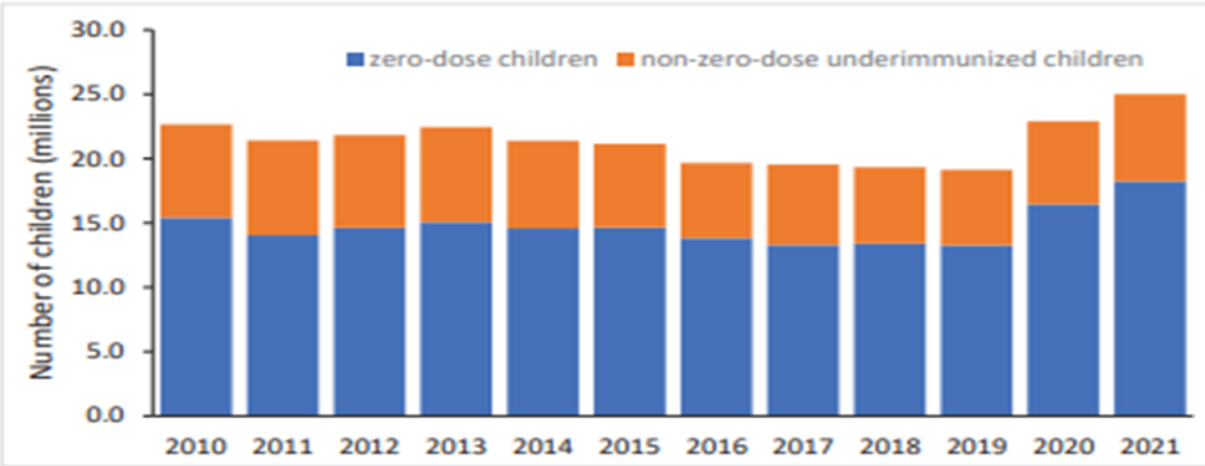

Figure 1: Annual number of zero-dose children and non-zero dose underimmunized children globally, 2010-2021. Data source: WHO/UNICEF Estimates of National Immunization Coverage (WUENIC), July 2022.

Access to health services and their services, whether or not an indicator of social vulnerability, nuanced by ethics indicates that concrete changes must occur, so that advances are translated into empowered people and societies show encouraging indicators that are tangible in reality, since institutions, their structures and organizational mechanisms are transformed based on universal access of people to health services and their products. As long as there is no restructuring and overcoming the asymmetric model of distribution of health goods, it will be impossible to achieve equality, equity and non-discriminatory public and social recognition that allow all people to enjoy the services and products that permit you to receive effective health treatment.

Table 3 reflects that the achievement of universal health coverage in 2030 is essential to realize the promise made in the 2030 Agenda for Sustainable Development and guarantee the basic human right to health; But by region and globally, with respect to Healthy life expectancy at birth (years), there is still much to be done. This prefigures that governments and development partners will invest substantially in the public sector and accelerates the adoption of important measures such as the drastic reorientation of health policies and increased public investment.

WHO Region	Total Population (000s)			Healthy life expectancy at birth (years)		
	Comparable Estimates 2021			Comparable Estimates 2019		
	Male	Female	Both genres	Male	Female	Both genres
African Region	579 641	583 017	1 162 658	55	57.1	56
Region of the Americas	508 298	521 212	1 029 510	64.8	67.5	66.2
South-East Asia Region	1 049 022	1 007 451	2 056 473	61.1	61.9	61.5
European Region	451 859	478 950	930 809	66.6	70	68.3
Eastern Mediterranean Region	392 503 374	374 038	766 542	60.2	60.7	60.4
Western Pacific Region	980 226	952 584	1 932 809	67	70.2	68.6
Global	3 973 370	3 929 291	7 902 660	62.5	64.9	63.7

Source: Annex 1 Country, area, WHO region and global health statistics of the World Health Statistics 2023.
Table 3: WHO Region and Global Healthy Life Expectancy at Birth (Years).

To incorporate the ethical perspective in the relationship between access to health services and their products as a determinant of social vulnerability means keeping in mind that:

1. In the search, detection and analysis of asymmetries in access to health services and their products; it is about identifying inequalities and discrimination that constitute, to a large extent, one of the dimensions of social vulnerability [9].
2. Social vulnerability becomes a transversal category of analysis, which has its expression or not in the consumption and distribution of health services.
3. The recognition of inclusion, opportunities and possibilities based on ethical principles contrary to individualism, selfishness and exclusion in situations and experiences, based on the interaction between access to health services and social vulnerability as a This is how people's lives are manifested and the enjoyment of their rights is specified; therefore, it is about contextualizing.
4. The attention and commitment to vulnerable and disadvantaged groups is qualified by certain ethical principles as they affect the distributive nature and social justice that is part of the social context. In this sense, it is about making health systems work in favor of vulnerable groups and people [10].
5. Practices for implementing inclusion in access to health services and their products, similar to all people, must be aimed at promoting transformation in social institutions, structures and cultures under ethical principles.
6. Access to health services must stop being partial and limited, and be directed towards emancipation and transformation that guarantees universal access. The distribution and consumption of health services contextualized in people is the starting point to achieve realization [11].

Table 4 shows that direct spending on health care that has catastrophic economic consequences, that is, that exceeds 10% and 25% of the family budget continues to increase. More than 13% of the world's population, in the first case and almost 4% of the world's population in the other case were forced to spend at least those amounts out of their pocket, despite the fact that, in absolute terms, even an expense lower income can be devastating for low-income families. Some 1.3 billion people fell into or even worsened poverty due to these payments, including 300 million people who were already suffering from extreme poverty.

Additionally, paying out of pocket for health care can mean that families have to forgo essential services or choose between paying for a doctor's visit, buying food and water, or sending their children to school. This type of dilemma may mean that a family member does not receive early treatment for a preventable disease or that, in a later phase; they suffer more serious or even fatal symptoms. To solve this problem, progressive health financing policies are needed that exempt people with limited spending capacity from paying for services, which has its roots in humanistic ethics.

WHO region	Probability of dying from any of CVD, cancer, diabetes, CRD between age 30 and exact age 70k (%)	Proportion of women of reproductive age who have their need for family planning satisfied with modern methods (%)	UHC: Service coverage index	Population with household expenditures on health > 10% of total household expenditure or income (%)	Population with household expenditures on health > 25% of total household expenditure or income (%)
	Comparable Estimates 2019	Primary data 2022	Comparable Estimates 2021	Primary data 2013–2021	Primary data 2013–2021
African Region	20.8	57.5	44	8.61	2.59
Region of the Americas	14	82.6	80	7.83	1.51
South-East Asia Region	21.6	77.7	62	16.14	5.89
European Region	16.3	76.8	81	7.94	1.3
Eastern Mediterranean Region	24.5	62.3	57	12.11	2.23
Western Pacific Region	15.6	87.3	79	19.8	5.26
Global	17.8	77.5	68	13.46	3.77

Source: Annex 1 Country, area, WHO region and global health statistics of the World Health Statistics 2023.
Table 4: Vulnerabilities Reflected in access to Essential Services by Region.

This entire journey tells us that the fight against social vulnerability based on asymmetries in access to health services and their products demands a broad and participatory model of democracy focused on inclusion and universal access of all people to services, health services and added bio-pharmaceutical products that guarantee a decent quality of life. The economic and social conditions of inclusion require decisive public policies, for example, to avoid the precariousness of working and employment conditions, which inevitably must have a redistributive and synchronous reciprocity component.

The development of vaccines has meant one of the most pertinent scientific advances of humanity in all its history, the accumulated impact of them is the contribution to the safeguarding of one of the most significant human rights: health; since more than contrasting results have been achieved in the eradication and elimination of diseases or their control [12]. But vaccines, like any medicine, are not harmless as countless scientific trials as well as epidemiological data collected over decades confirm, without a shadow of a doubt, that their benefits far outweigh their risks, with these benefits being greater the more they are used. Universalize its implementation.

Despite the proven safety of the effectiveness of vaccines, there are groups of detractors who, for various reasons, do not believe in them or consider that they are not effective and are part of a lucrative deception by the pharmaceutical industry. The big problem with these positions lies not only in endangering the health of their own children by preventing them from being vaccinated, but also the health of everyone, by leaving loopholes in collective immunization against various pathogens (herd effect).

In this context, the World Health Organization (WHO) warns of the risk of diseases that have not been eradicated and whose incidence is increasing due in part to anti-vaccine movements, along with other factors such as migratory movements, low vaccination coverage in certain countries, among other factors. It is unquestionable that the globalization of information, which today the majority has access to through the Internet, multiplies the number of people who have stopped believing in vaccines. Not all published information is scientifically verified, so hoaxes or erroneous information, even intentionally false, give rise to people with little training who may end up making wrong decisions, with much more serious consequences than what, in their ignorance, they can think [13].

For this reason, it is important to fight against the anti-vaccine movement, from which they insist on using social networks and all the means that the Internet makes available to spread their ideas. Around the world, fake news on social media harms vaccination coverage [14,15]. Children represent the most vulnerable group due to their dependence on a legal guardian to receive the vaccine. UNICEF estimates that, between 2019 and 2021, 67 million boys and girls did not receive any or all of the routine vaccines; These children are passing the age at which they should normally be vaccinated [16,17].

Conclusions

Access to health services and products becomes an ethical action that in itself entails the assumption of responsibilities by the actors of each health and social system. Any inclusion practice inevitably involves making decisions, both in the planning and design phase and throughout the distribution and consumption process; decisions that, in one way or another, have an ethical character, and in which access to health services and products defines the form and content of social vulnerability.

The relationship between access to health services and social vulnerability will not find a better channel without the establishment of a more humane and democratic social order, which demands the construction of corresponding values, based on its own and autonomous moral criteria, and on a dialogic and rational basis, and it cannot be otherwise in a context of multiple differences. Confronting and mitigating social vulnerability involves deploying actions within a multiple field of dimensions, where ethics takes on special relevance as there is an urgent need to transcend the formulation and construction of health systems that integrate into a broader perspective: the constitutional legal order, effective justice institutions, the promotion and guarantee of rights, the creation of mechanisms for the resolution of asymmetries, conflicts and the development of transparent action and integration mechanisms in universal access to health and its resources.

References

1. Delor F, Hubert M (2000) Revisiting the concept of `vulnerability'. Soc Sci Med 50(11): 1557-1570.

2. Macpherson I, Roque SM (2019) Ethical analysis of the principle of health vulnerability. Cuad Bioet 30(100): 253-262.

3. Khazanchi R, Beiter ER, Gondi S, Beckman AL, Bilinski A, et al. (2020) County-Level Association of Social Vulnerability with COVID-19 Cases and Deaths in the USA. J Gen Intern Med 35(9): 2784-2787.

4. Kim SJ, Bostwick W (2020) Social Vulnerability and Racial Inequality in COVID 19 Deaths in Chicago. Health

Educ Behav 47(4): 509-513.

5. Emanuel RE, Caretta MA, Rivers IIIL, Vasudevan P (2021) Natural gas gathering and transmission pipelines and social vulnerability in the United States. Geo Health 5(6): e2021GH000442.

6. Murphy DJ, Wyborn C, Yung L, Williams DR (2015) Key concepts and methods in social vulnerability and adaptive capacity. USDA: US Department of Agriculture, pp: 1-30.

7. Cassy J, PenwardenJL, Pott H, Theou O, Andrew MK (2023) Social vulnerability indices: a scoping review. BMC Public Health 23: 1253.

8. Bracken RD, Bell E, Macdonald ME, Racine E (2017) The concept of 'vulnerability' in research ethics: an in-depth analysis of policies and guidelines. Health Res Policy Syst 15(1): 8.

9. Delgado LR, Gomez M, Hinojos S, Dennis L, Grady C (2023) Investigating Social Vulnerability, Exposure, and Transport Network Disruption in the Mid-Atlantic Region. Journal of Infrastructure Systems 29(4): 04023026.

10. Vawter DE, Garrett JE, Gervais KG, Witt A, De Bruin DA (2011) Attending to Social Vulnerability When Rationing Pandemic Resources. J Clin Ethics 22(1): 42-53.

11. Maeckelberghe E (2021) Ethical implications of COVID-19: vulnerabilities in a global perspective. Eur J Public Health 31(S4): iv50-iv53.

12. Galindo BM, Molina N (2020) Vaccination Sustainability and Anti-Vaccine Movements in the Times of the New Coronavirus. Revista Cubana de Salud Publica 46(S1): 1-5.

13. Hotez PJ (2018) The global fight to develop antipoverty vaccines in the anti-vaccine era. Hum Vaccin Immunother 14(9): 2128-2131.

14. Machado HS (2023) The Eradication of Smallpox and the Challenge of Scientific Fake News: Lessons from the Past to the Present. Sulear Interdisciplinary Journal 6(16): 116-123.

15. Bongiorno A (2021) The Battle Between Expertise and Misinformation to Influence Public Opinion: A Focus on the Anti-Vaccination Movement. Undergraduate Honors Theses. William & Mary Paper 1613.

16. UNICEF (2023) The State of the World's Children 2023: For Every Child, Vaccination. Florence, Italy: UNICEF Innocenti - Global Office of Research and Foresigh.

17. Kolawole OT, Akinyemi A, Solanke BL (2023) Household Vulnerability and Childhood Immunization Status in Nigeria. SAGE Open: 13(3):1-22.