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# Rethinking the use of ‘vulnerable’

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There is no doubt that the COVID-19 pandemic has exacerbated existing social, economic and health inequities.

The term ‘vulnerable’ has been used widely across all aspects of COVID-19 including in reference to those potentially more susceptible to infection and morbidity, those most affected by restrictions and lockdowns and those significantly impacted by job losses, school closures and working from home measures. While COVID-19 appears to have amplified its use, the word ‘vulnerable’ has a long history in written and spoken public health discourse. It is typically deployed in shorthand to describe individuals or groups who experience health inequities, a disproportionate burden of poor health or both. Within this journal alone, the term can be found among 50 titles and abstracts published from 1996 to December 2020. The aim of our commentary is to reflect upon this term, prompting further consideration and discussion around the language we use in public health discourse. We share our concern that ethnicity and racialised discourse are powerful examples of the assertion of political power that, without reflective self-consciousness, can be seamlessly rendered through the use of the term ‘vulnerable’.

Widespread, indiscriminate use of the term ‘vulnerable’ is problematic. When used as a term to describe certain individuals or populations in a nondescript and vague manner, the reader ‘fills in the blanks’ of why a certain individual or group is vulnerable.<sup>1</sup> Being vulnerable could be seen as an intrinsic deficit, inferiority or inability to protect the individual’s own best interests. This can in turn reduce both perceived and actual agency of the individual or group, depicting them as ‘others’ who are powerless and in need of protection. This may also result in further stigmatisation and exclusion of these individuals and groups.

We welcome efforts by the National Health and Medical Research Council (NHMRC) to rethink the use of ‘vulnerable’ in their draft National Statement on Ethical Conduct in Human Research.<sup>2</sup> Using a risk-based approach, the NHMRC specifically outlines the characteristics and circumstances that may give rise to vulnerability. This Statement advises researchers to avoid labelling groups as vulnerable and, instead, to consider the characteristics or circumstances that place research participants at increased risk of harm. For example, previous statements implied that pregnancy equated to vulnerability. The new Statement describes ‘participants in life stages that may give rise to vulnerability’. Using this more precise approach, the NHMRC aims to enhance research integrity by employing an inclusionary and explicit approach rather than an exclusionary or implicit one.

Of similar concern, use of the term ‘vulnerable’ can specifically imply an inevitable deficit that will supersede other explanations for the situation under consideration. The use of deficit terms like vulnerable can too easily conceal the wider structural causes that lead to health inequities and obscure accountability of those responsible for generating or perseverating these causes and structural power imbalances. In the recent lockdown of nine public housing towers in Melbourne, Australia, to prevent COVID-19 transmission, David Mejia-Canales tweeted, “I didn’t realise I was poor, hard to engage, and vulnerable until a Victorian Government official told me [so]”.<sup>3</sup> Terms like vulnerable also can be used strategically to attract resources, policy interest and public concern. Prioritising the health of those who are ‘worse off’ in society can be a valid step in securing fair and equitable allocation and distribution of health services or resources.<sup>4</sup> However, using terms like ‘vulnerable’ rather

than providing a deeper explanation of risk impedes more thoughtful analysis about who should be considered ‘worse off’ and why.

Deficit terminology can reduce social and economic determinants of health down to a racial profile, creating racialised narratives, especially when describing health disparities for Aboriginal and Torres Strait Islander communities.<sup>5</sup> Some academics claim that indiscriminate use of the term ‘vulnerable’ represents a form of scientific racism, echoing movements of eugenics, social Darwinism and biological determinism.<sup>1</sup> Many health outcomes are measured and reported against metrics, particularly comparative statistics, which are presumed neutral and unbiased yet this is not the case. Walter and Smith suggest that there is a real need to critique the way health statistics are discussed and reported, especially in regard to Indigenous peoples.<sup>6,7</sup> Globally, Indigenous peoples’ data are consistently described in the deficit, couched in disparity, deprivation, disadvantage, dysfunction and difference.<sup>8</sup> This type of framing draws correlations between social inequities and “racial unfitnes”, using data to further consolidate negative concepts of vulnerable or “problematic people”.<sup>9</sup>

Since 1971, when the first Aboriginal Community Controlled Health Organisation (ACCHO) was established, the Aboriginal and Torres Strait Islander community has had a strong emphasis on changing terminology and shifting the focus from deficit to strengths-based approaches.<sup>10</sup> A self-determining approach to health inequities has seen dramatic improvements in the rates of chronic health diseases as well as social and emotional wellbeing for many communities.<sup>11,12</sup> In regard to the COVID-19 pandemic, Indigenous communities in Australia were quick to recognise the higher risk of acquiring, transmitting and having worse outcomes due to the SARS-CoV-2 coronavirus based predominantly on a nuanced understanding of the impact of the social determinants of health, as well as a higher burden of chronic diseases, particularly of the respiratory system. As Dr Mark Wenitong explained “... the ‘vulnerability’ of our remote communities is much more related to longstanding underinvestment in health infrastructure than our people as individuals”,<sup>13</sup> shifting the focus from the individuals to the overarching

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systems and policies in place. Self-determination approaches and leadership from ACCHOs around the country have not only prevented the spread of the virus into remote communities, but also into urban and regional areas. For example, the Victorian Aboriginal Health Service (VAHS) have implemented programs dedicated to regional and urban areas, recognising that these areas are where the majority (80%) of Aboriginal and Torres Strait Islander peoples live.<sup>13</sup> Like many other Indigenous practices, these types of self-determining approaches can also be effective for other communities.

There is a need for wider recognition that the focus of public health should be on systems and associated policies as driving the conditions in which people live, work and build a society together. This focus affirms a population perspective rather than blaming the victim or impugning individual behaviours and predicaments as inherent vulnerability. It is important that we, as the public health community, challenge ourselves to use accurate and clear language to identify the underlying causes of inequity. If we elect to take on the power and responsibility of designating who is vulnerable, efforts must be made to correctly define and contextualise what makes a group of people vulnerable, to facilitate greater accuracy, and accountability. The transparency such a process entails is further advantageous to public health outcomes. We must challenge ourselves to think about the factors that put the individual or population 'at risk' or that have made their health so inequitable that we reach for the convenient term, 'vulnerable'. It is important instead to ask ourselves, 'Who are the vulnerable and why?'; that is, 'What characteristics and circumstances are responsible for their vulnerability?' If we accept the premise that a vulnerable population exists, does that mean that an invulnerable population also exists? And what makes this population invulnerable? These are questions also worth answering.

We explore this line of thought in the context of the COVID-19 pandemic. Why are residents in aged care facilities vulnerable? Is it due to their reduced ability to act autonomously, policy decisions outside their control, and a high prevalence of physical diseases among this population that place them at increased risk of developing severe forms of COVID-19? Similarly, workers on casual employment contracts or needing to work multiple jobs face economic vulnerability due

to job insecurity and government restrictions aiming to limit employee exposure sites. An even better approach is to extend beyond the individual or group in question and focus on the greater systemic issues at hand, for example, racism, ageism or economic inequity. Public health professionals are well-placed to lead this new expectation in their own practice and the contributions they make to policy decisions.

Other terms similarly used without sufficient explanation include 'marginalised', 'disadvantaged', 'at risk', 'underserved' and 'disenfranchised'. These are similarly problematic. 'Priority population or communities' is sometimes employed as a substitute term. Priority communities are those that need particular attention or focus in the way of investment and resources to create a more equitable health status.<sup>14</sup> Using the term 'priority' rather than 'vulnerable' places an emphasis on the system prioritising communities rather than the community being vulnerable to the system. When this term is used, its meaning should similarly be clearly defined to provide the transparency we recommended earlier. For example, a description of an individual or a group as being a priority should include an explanation of why they are a priority and seek to answer the question of what individual or societal factors are contributing to their need to be prioritised. Using the term priority shifts the focus towards the future, better drawing attention to what resources are needed by whom and why. As editors make room for the additional explication this requires, these conventions we invite should improve descriptions of deficit and risk of harm throughout public health.

Words are powerful and, as public health professionals, we should aim to use language that "affirms instead of questions, benefits instead of oppresses, respects instead of denigrates, values instead of marginalises".<sup>15</sup> We must remain attentive to the needs of individuals and groups experiencing health inequities and allow our language to evolve accordingly. This invites increased transparency within ourselves and advice to use more precise, accurate and clear language throughout our discourse. By using more specific language, we create greater clarity and visibility of the needs of specific groups resulting in their intentional inclusion. This journal's sister publication, the *Canadian Journal of Public Health*, has taken an important step in this regard,

demonstrated by their article 'Unpacking vulnerability: towards language that advances understanding and resolution of social inequities in public health' published in 2020.<sup>16</sup>

The concept of vulnerability in health care has been critiqued for being "centred around disempowerment ... deficits, dependency and passivity, rather than challenges, opportunities, autonomy and self-determination".<sup>17</sup> This shift in framing both theoretically and practically can make a marked difference for priority communities. Looking beyond terms such as 'vulnerable' prompts us to delve further in our understanding of the structural factors that facilitate and perpetuate health inequities such as colonisation, racism, misogyny, imperialism and economic exploitation.<sup>1</sup> In doing so, the individual or community can be distinguished from the true cause of the inequity. This more effectively redirects our focus to solutions to remove structural causes of health inequities. We conclude with a quote from Cree-Anishinaabe Assistant Professor Dr Marcia Anderson, chair of the Indigenous Health Network for the Association of Faculties of Medicine at the University of Manitoba in Canada, "From now on instead of 'vulnerable people' I'm going to use the phrase 'people we oppress through policy choices and discourses of racial inferiority'. It's a bit longer but I think will help us focus on where the problems actually lie".<sup>18</sup>

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