Article

health:

Health
2022, Vol. 26(6) 753–776

DOI: 10.1177/1363459320988879
journals.sagepub.com/home/hea
SAGE

Vulnerability as a palimpsest: Practices and public policy in a Mexican hospital setting

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Abstract
Vulnerability is a concept associated with the effects of social inequities to access health care services. On a hospital level, vulnerable populations must be identified and favored over others. The aims of this study were the analysis of the conceptions and practices of social workers regarding vulnerable patients, and the identification of theoretical elements of vulnerability given by academics. Hospital ethnography and a focus group were implemented. Social workers related vulnerability to the social needs of each patient; however, they state that they have dilemmas to identify a person in a vulnerable condition; these dilemmas are related to social differences and deservingness. Academics indicated that the vulnerability should refer to the lack of access to health services offered by the institution. Academics agree with social workers regarding the importance of considering the overlapped social and individual circumstances in each patient to recognize their vulnerable condition, regardless of belonging to any of the pre-established vulnerable groups. Finally, taking into account the way of conceptualizing vulnerability and how public policy on the identification of vulnerable patients in the hospital has been implemented, these two elements are explained using the palimpsest model, which is a figure of thought that can be applied to analyze the sociocultural significance of this complex issue, as well as other social dynamics.

Keywords
hospital ethnography, Mexico, palimpsest, social work, vulnerability

Introduction

Vulnerability is a multidimensional and dynamic concept (Cabieses, 2016) recognized in several public sectors (e.g. economy, ethics, human geography or engineering) and under different approaches (Adger, 2006; Comisión Económica para América Latina y el Caribe [CEPAL], 2002). It also includes aspects such as risk, threat or resilience (Ruiz, 2012), transforming it into an analytical and pragmatic tool to describe states of susceptibility to damage, impotence, and marginality within a social as well as physical system, and to evaluate the normativity of actions to achieve well-being and reduce risks (Adger, 2006).

From a biomedical perspective, the concept of vulnerability refers to the susceptibility to develop a certain disease or suffer effects from an environmental risk; but it is also referred to as the effects of the inequalities of the population regarding health and care (Grabovschi et al., 2013).

Vulnerable group

The identification of social groups in risk of physical, psychological and social health problems (Aday, 1994) began in the 90s; nevertheless, in the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1978), vulnerability was already recognized from an ethical perspective. This model of vulnerable groups is generalized and, at present, international organizations like the World Health Organization (WHO) promote the creation of public policies to

combat social inequality, taking into account "vulnerable groups" (Larkin, 2009; WHO, 2013, 2015) and the use of this notion in fields of research related to health (Flaskerud and Winslow, 1998). The idea of vulnerability, which can converge into a group classification, precedes identification and assessment of the vulnerable, as the concept itself demands to specify risks and determine the capacity of the affected to answer and adapt actively (Comisión Económica para América Latina y el Caribe [CEPAL], 2002).

Vulnerability as "layers of vulnerabilities"

Vulnerable group classification has been criticized (Kipnis, 2001; Luna, 2009) due to the possibility of stigmatizing and stereotyping groups (Hernández-Rosete et al., 2005; Levine et al., 2004), or granting support to members of socially vulnerable groups who are situated in better social conditions. Other aims are directed toward identifying vulnerable states as a result of diverse types of conditions and not just the consequence of the membership to a certain group, since vulnerability is not a static category or label, but rather a dynamic and relational concept that gives evidence to the accumulation of conditions comparable to layers of situations (Luna, 2009). Vulnerability obeys complexity that involves a variability of social situations, a presence of multiple types of vulnerabilities, difficulties in their assessment (Comisión Económica para América Latina y el Caribe [CEPAL], 2002; Larkin, 2009), and also variabilities in their interpretation depending on the region in the world (Cunha and Garrafa, 2016).

Palimpsest as an explanatory model to analyse vulnerability

The palimpsest is a document on which the older writings have been faded to apply other layers over time. Regardless of the numbers of applications of other writings, the past layers of the palimpsest can be identified. The metaphor of the palimpsest has been used in the analysis of social phenomena as it is characterized by diverse meanings (María, 2013; West, 2019); for example, public policies can be thought of as a palimpsest, emphasizing the complex processes of implementation when there is a lack of clear guidance from those who draft them, and opposing the belief of their linear, unique and socially agreed character (Carter, 2012). In the current research, instead of using it as a metaphor, we consider palimpsest as an explanatory model, as a framework that analyses and creates meanings via narratives and actions regarding the social dynamics. A palimpsest is created when meanings or practices from different times interact, interrelate, enabling the creation of a new meaning or practice with coherent and, at the same time, discordant traces of both interacting processes. We use this explanatory model of overlapping, interrelation and production of a new significant construct to explain vulnerability in a hospital setting. The new meanings also interact in historical, cultural, and social, as well as, power contexts within every day, institutional, or transgressive practices (Vergara, 2018).

This topic of interest in this study was based on a previous research related to Mexican indigenous populations who received medical services in the same public hospital. According to policy, this particular social group is considered vulnerable; however, only 45.9% of the registered indigenous patients at the hospital are vulnerable according to the Department of Social Work (DSW) (Colmenares-Roa et al., 2017), which questioned the institutionally applied norm of identification and care of vulnerable patients. There

was a gap in the revised theoretical proposals on the concept of vulnerability and the practical use of these concepts by social workers (SW). The following question came up: Is this gap between the conceptual and the practice? A dialog between academics working with the concepts of vulnerability and SW that implement such concepts through hospital regulation could answer it.

In order to get a deeper insight into the concept of vulnerability in a hospital context, we decided to conduct the current research.

The aims of this study were to analyse conceptions and practices of the SW regarding the identification and attention of vulnerable patients in a public hospital. Simultaneously, we aimed to identify theoretical and practical elements of vulnerability and its implementation within the hospital context proposed by a group of selected academics (ACAD). Then, applying the explanatory model of palimpsest we explained how the concept of vulnerability is understood and implemented within the hospital.

Methods

The methodological design of this study was qualitative, and divided into two stages. In the first stage, hospital ethnography was applied (van der Geest and Finkler, 2004; Wind, 2008) to understand the conceptualizations and experiences of the SW employed in the hospital. In the second stage, a focus group (Finch and Lewis, 2003) of ACAD was approached to analyse and discuss their perspectives on the concept of vulnerability and the form of its implementation in a public hospital.

First stage. In the hospital ethnography, the researcher observed daily work performed by SW throughout 10 months in 2016 and 2017, in the following hospital's services: geriatrics, gynecology, rehabilitation, external consulting, oncology, and pediatrics. Those medical services were chosen based on feasibility, increased demand for care and the existence of patients who belong to these so-called vulnerable groups. The researcher (TCR) visited social work offices, explained the study objectives, and SW decided whether to consent to the observation of their activities; after that, SW signed an informed consent form. Observations were implemented in order to understand their role in the hospital and the way they interact with patients such as administrative duties, case studies, interventions in hospitalization areas and external consulting, application of socioeconomic questionnaires, and implementation of several mechanisms to support patients in need.

Those observations were complemented with semi-structured interviews with the aim to capture opinions and perspectives from SW, who were invited to share their experiences voluntarily. The researcher (TCR) held interviews in a private space within the hospital. The interviews, with an average duration of an hour and a half, were audio-recorded and later transcribed and analysed. The configuration of the group of 15 participants was based on the saturation and thickness of the gathered data (Martínez-Salgado, 2012) related with the following interview themes: description of all duties and activities on the hospital, description of the population served in the hospital from the SW's point of view, conceptualization of vulnerability and vulnerable person, ways identification and care to vulnerable patient, support provided to these patients, and description of specific cases of vulnerable patients based on their own experience.

Second stage. The focus group consisted of seven ACAD. They were invited due to their academic research experience or public activity regarding some of the vulnerable groups (i.e. indigenous populations, children, elderly persons), human rights, or research ethics. Three of the seven participants are health care providers; they work in public hospitals and distribute their work between researches and care patients. The topics to discuss were: (1) vulnerability concept and its characteristics, a pragmatic concept to the hospital settings; (2) identification of a vulnerable person in the hospital, conditions to be considered vulnerable in the hospital, and (3) actions by SW to the identification. This group discussion took place in a neutral location. It was not necessary to have another face-to-face meeting because all themes were covered. Together with two SW who attended the meeting, the research team wrote and subsequently transcribed in a single document all the discussion that took place during the day. Afterward, the document was sent to each academic participant several times to improve textual interpretation.

Analysis of the findings

A thematic analysis (Nowell et al., 2017) of the data was implemented using the software Atlas.ti (7th version), in order to organize, classify, and guide the interpretation. We identified codes and themes related to the interview guide, as well as others classified as emergent. The codification was applied to all interviews, observations of the SW, and the protocol from the discussion with ACAD. Finally we merged them with theoretical elements in order to create an explanation proposal using the palimpsest framework.

Ethical considerations

All participants signed a letter of informed consent before being included in the study. Due to the presence of patients during the observations, they were also informed about the aims of this study. They agreed to indirect participation by signing a letter of informed consent. The patients were not interviewed. SW and ACAD did not receive any form of payment for their participation.

Ethical approval for this project was given by the research and ethics committees of the Hospital General de México "Dr. Eduardo Liceaga" in Mexico City (DI/16/404-A/04/085).

Results

Context

The Mexican healthcare context was described at three levels: The health-related focalized public policies implemented in the country, the health system, and the hospital organization.

In Mexico, the vulnerable groups model has been used in socially-oriented focalized policies and programs at several public legislation levels, based on the protection of human rights and guided by the democratic frame of the rule of law (Valdés and Lecaros, 2016). The Committee on vulnerable groups of the Mexican Chamber of Deputies

(Comisión de Atención a Grupos Vulnerables, n.d), Ley General de Salud (2018), and the General Direction of Epidemiology of the Health Ministry (SINAVE/DGE/SALUD, 2012) highlight the obligation to give priority on vulnerable groups in terms of health care.

Consequently, these political bodies stipulate that the attention of vulnerable people should be assessed for hospitals' certification throughout the certification process carried out by the General Health Council, which evaluates the quality of care in health institutions based on a patient safety model (Consejo de Salubridad General, 2018).

This perspective of care based on the right to protection needs to be applied mainly in the health system sector that serves the neediest. The Mexican health system has been described as a mixed health insurance type. On the one hand, we have a subsystem of social health insurance or full health care cover, formed by several public health institutions, whose resources come from government, worker, and employee contributions. We also have a partial coverage system, whose resources are provided by the State as well as by the patient. A private subsystem where the patient pays all expenses, either through insurance for major medical expenses or directly out-of-pocket (Gómez-Dantés et al., 2011).

The study was undertaken in a public hospital located in Mexico City, belonging to The Ministry of health. The majority of the population attended has a low socio-economic income level without social security, mainly, and receives any person who seeks care regardless of social security. In this type of general hospital is requested to apply the regulations on care for vulnerable people. This institution has all the medical services and diagnostic aids, conducts training for new doctors, and conducts research activities.

The DSW has 116 professionals distributed in all medical services; the sector with the highest number of SW is the outpatient department where new patients begin the process of care. Regarding the resolution of payment issues, the physicians usually transfer the patients to the DSW. Nevertheless, a small number of patients contact the DSW to request financial aid for the liquidation of their medical bills. To apply for, patients have an interview with the SW who classify them into socio-economic status through application of a Systematized Socioeconomic Questionnaire (SSQ); afterward, a payment rate is set. This questionnaire is used to deliver a social diagnosis, inquiring about relevant information regarding the patient's family situation, as well as their social, economic and work status, their linguistic and cultural background and affiliation, as well as their place of origin.

In in-patient wards, patients must go to the SW office to do the mandatory assessment of the SSQ before receiving medical attention. In addition to the SSQ, patients or relatives seek SW to aid in the execution of administrative processes, and resolve non-medical problems. Therefore, the SW's activities include monitoring economic and social problems and, to a lesser extent, performing the SSQ; interaction with family members is greater, and contact with doctors and nurses makes the work more intense.

People come to SW offices usually because doctors send them to get a payment level to start the care process (doing exams, check-ups, therapies, hospitalization), so during the day, patients come to ask for this procedure. Usually, patients have to stand in line to wait for attention. Waiting rooms and offices are always full, making patients and relatives angry, requiring SW to step into the organization's role. When it is the turn of a patient, the social worker verifies the procedure he/she is requesting and the completion of the SSQ. ~~The time of the interview elapses between questions from the SW and answers from~~

~~the patient~~. It is confusing for many patients to determine their expenses and income since most have informal jobs, and live from daily income, so transforming this to a monthly amount is problematic. Finally, everyone accepts the level of system issues.

During the day, people come to DSW requesting help to pay because they do not have money even though they were classified in socioeconomic level one, which has the lowest prices, for which the SW review the SSQ. Through some procedures, decide whether it can be possible to make discounts on the total debt or forgive the total or partial payment of any exam or surgical material they have needed. Not all patients who request support to pay get a discount. Some patients have such low economic resources that, even with discounts, they do not have enough money, requesting to split payments.

Health policy implemented in 2012 requires that medical institutions set up a procedure to identify and care for vulnerable populations. Consequently, the hospital added the question: "Is the person vulnerable? Yes/No", to the SSQ designed to detect vulnerable patients. Also, it created a standardized protocol that defines the procedures of identification and care of patients who belong to vulnerable groups (Hospital General de México "Dr. Eduardo Liceaga", 2015). This protocol is addressed to the SW, physicians, and nurses in all sectors of the hospital, as well as the paramedics and management. This document is a combination of directive guidelines to (i) disseminate the duty to protect every patient from violence, abuse or negligence, and (ii) protect people who are deprived of their human rights. People who are considered vulnerable in this protocol are: children, disabled persons, "women at risk" (non-specified the risk) pregnant women, and persons exposed to violence, abuse or aggression. Also, people infected with HIV, suffering from mental illnesses, persons who belong to an indigenous group, elderly people, migrants/refugees, homeless persons, and drug consumers.

Since the protocol was implemented, the SW who are applying the SSQ use the compiled information about the socio-economic status, personal and family situation of the patient, as well as the vulnerable groups of the protocol, to decide and choose whether they are vulnerable or not. To this moment, DSW is the only department who assesses social vulnerability in the hospital and in this way, implement the public health policy about vulnerability.

Phase 1. The identification of vulnerability in the hospital. We observed and interviewed 15 SW, most of them women, between 26 and 72 years old, and with different levels of experience in this area (Table 1). In this research phase, we identified two main themes: (a) The concept of vulnerability and its application into the practice of identifying vulnerable patients and, (b) The intervention: support for those in need.

The concept of vulnerability and its application into the practice of identifying vulnerable patients. The term vulnerability is present in conversations among SW themselves to refer to some patients; nevertheless, SW could not provide an exact definition of this concept. During the interviews, the SW defined the concept of vulnerability both thoughtfully and hesitantly. The SW associated "vulnerability" and "vulnerable person" with scarcity, disadvantage or in need of help and support:

> "[People] who can't look after themselves, who depend on others, both, economically, morally, emotionally. Who can't. . . I don't know how to explain it." (D, male, 29 years of age, 5 years of professional experience).

Table 1. Social workers who participated in the research.

	Age	Gender	Level of education	Place of origin	Hospital service	Working experience (years)
A	52	Female	Professionalization*	Mexico City	Pediatrics	1
L	50	Female	Professionalization*	Michoacán	Gynecology	26
E	36	Female	Professionalization*	Mexico City	Oncology	8
S	38	Female	Bachelor's degree	Mexico City	Geriatrics	10
D	29	Male	Technical career	Mexico City	Oncology	5
R	47	Female	Bachelor's degree	Mexico City	External consulting	26
Es	49	Female	Technical career, in the process of professionalization	Mexico City	Oncology	5
Li	29	Female	Technical career, in the process of professionalization	State of Mexico	External consulting	2
M	36	Female	Bachelor's degree	Mexico City	External consulting	14
G	49	Female	Bachelor's degree	Mexico City	Rehabilitation	28
An	52	Female	Professionalization*	Mexico City	Oncology	10
Ma	37	Female	Bachelor's degree	Mexico City	Oncology	14
Do	49	Female	Technical career, in the process of professionalization	Mexico City	External consulting	23
N	26	Female	Bachelor's degree	Mexico City	Pediatrics	6
Ra	72	Female	Technical career	Mexico City	External consulting	27

*The participant studied a technical carrier over 10 years ago while he/she was working in the administrative area of the hospital; subsequently she became a social worker.

The needs perceived by the SW are based on the socioeconomic status and cultural characteristics of patients. Some of them report that they live in houses with lack of basic condition, for example, do not have running water, they do not have a family to support them or reported insufficient intake of protein in their diet

Others visibly do not speak Spanish well or cannot read or write. These situations make SW think that the person has needs in her life and that they will possibly have difficulties within the hospital. However, even if these situations exist if, for example, a patient is a middle-aged man, he may not be recognized as a vulnerable person because he does not belong to a pre-established group.

After each encounter with a patient, the researcher discussed with the SW about how they had decided to classify that person as vulnerable or not. The SW recognized the different needs that exist within a population, but emphasized the economic obstacles people are confronted with when paying their hospital bills. Additionally, they associated vulnerability with the vulnerable groups listed in the standardized protocol (children, disabled person, etc); that is, some patients are automatically considered vulnerable by the SW because they belong to one of those groups:

> "Well, here, the most vulnerable are the children. I work with the most vulnerable, mainly babies. So, they're the most vulnerable and that's why we're stricter with the parents. . ." (A, female, 52 years of age, 1 year 8 months of professional experience).

Some professionals recognize degrees of vulnerability among patients: ones with more issues and in more need of assistance than others:

> "I say all elderly adults aren't vulnerable, because there are some who have a family, who have support networks. So, I consider that those who are abandoned, who have troubles with their families, those may be more vulnerable than others" (S, female, 38 years of age, 10 years of professional experience)

Due to the short time available to perform the SSQ, the SW classify patients quickly without rereading the collected information; in spite of it, the SW expressed dilemmas regarding the identification of vulnerable patients, which we categorized into three groups:

Dilemma 1: Vulnerability cannot necessarily be assessed only based on the patients' group membership

A person who belongs to a vulnerable group according to the perception and norms of the hospital is not necessarily assessed as vulnerable, when this person is in a more favorable living condition compared to other members of the same group.

> "It happened to me that [the patient] has support networks and is then not vulnerable anymore, even though he's an elderly person. . . There are many patients recommended, with a [good] socio-economic status. . . so, they aren't considered with a level of vulnerability" (Ma, female, 37 years of age, 14 years of professional experience).

Also, according to the protocol's standards, the majority of the patients visiting the hospital would have to be classified as vulnerable, since most of them fulfill the criteria of membership to a vulnerable group:

> "The majority of the patients, if we'd follow [the classification of vulnerable groups] as it says, 90% of our patients could be really vulnerable" (Li, female, 29 years of age, 2 years of professional experience).

Dilemma 2: Vulnerability due to illness

Having an illness puts people in a vulnerable position, even more so if the disease is chronic and/or severe. Therefore, the SW should have to classify all patients as vulnerable according to protocol.

> "Well, they let me know that all patients are vulnerable. Since they are in a hospital, they are vulnerable because of their illness. So, they told me that we have to put 'vulnerable' to all of the SSQ." (G, female, 49 years of age, 28 years of professional experience)

Dilemma 3: Vulnerability through changes in the patients' social or economic situation

Some SW think that people can change their status of vulnerability. For example, children grow, women give birth to their children and end their pregnancy, or even because of the momentary assistance they receive. On the other hand, they could become vulnerable due to sudden health issues.

> "I think somebody can be vulnerable depending on the situation because maybe in the asylum where I can take someone, they have all the needs covered. It might be. But at some moment, when he gets out of it, he becomes vulnerable again. So, I think, depending on the situation, he could stop being vulnerable. Or the pregnant lady, after giving birth to her child, well, the vulnerable is taken away from her. Or it wouldn't be that much, or she starts to work. I don't know. . ." (S, female, 38 years of age, 10 years of professional experience).

People can also get into a vulnerable situation caused by economic impact, which can be noticed in patients with oncological diagnosis or in need of organ transplants. A temporary situation of vulnerability due to a weak financial situation caused by high medical costs might be considered by the DSW and lead to an adjustment according to the actual state of solvency of their socio-economic classification.

The intervention: support for those in need. The SW defines "support" as several activities or resources for patients in need (such as foreigners, indigenous persons, elderly people). Some examples of the hospital's support mechanisms are financial, informative, or institutional nature and priority in receiving medical treatment. The participants in this study give assistance (in the form of discounts or monetary donations) to pay for medical bills or clinical material.The hospital has also established collaboration networks with social organizations (such as Nongovernmental Organization or non-profit foundations) through SWs management, which donate medicines, medical supplies, or support the payment of laboratory tests. Some participants also consider that information and emotional assistance or supervision is important for patients during treatment.

> "Giving them warm attention and pretty clear information. Sometimes, they come in like 'horses wearing blinders.' They don't look at the other sides and we have to let them know that they can do a lot of things, but they have to do it. Give them options, but don't mislead them either, give them true and appropriate information. . ." (An, female, 52 years of age, 10 years of professional experience).

Some SW consider that the question about vulnerability does not change their caretaking of the patients. During their daily work, the social diagnosis is aimed to identify the patients' needs to ensure that they are taken care of accordingly; the vulnerability classification is not a factor.

> "A program only for vulnerable patients here, just like that. . .? I personally haven't heard that, but, yes, I've heard that they support different types of patients, so, depending on the problem they have." (An, female, 52 years of age, 10 years of professional experience).

SW is recognized as having empirical knowledge about vulnerability. There is no evidence of training on public policy origins and its sense of social inclusion that seeks care for people in vulnerable conditions. The dilemmas that SW manifest show a practice of exclusion of people who do not meet the requirements to be vulnerable, which contravenes the principle of public policy.

Phase 2. The academic perspective: A paradigm shift is required in patient care. The focus group consisted of seven ACAD, five women and two men (Table 2). At the beginning of the discussion round, the ethnographical findings of this investigation were presented by the researcher (TCR). Then, ACAD discussed the concept of vulnerability and its corresponding institutional actions in the hospital setting. Some issues were discussed without much controversy since ACAD opinions coincided, but other topics generated debate between academic and pragmatic perspectives, depending on the field of professional action and experience.

The concept. Vulnerable patients are at risk in a hospital when they don't have access to healthcare services.

The ACAD discussed the low feasibility of the application of the concept of vulnerability identified in the hospital protocol, which is restricted to only "protection against violence". They also consider that the whole concept should be simpler, have an impact on the care of the patients, and include the aim of identifying this population in the hospital and subsequent contexts.

The principal point of consensus among the experts was the risk of not having access to public health services that the hospital provides to all patients. The risk to which patients are exposed due to a variety of conditions is one of the elements of vulnerability. Those factors and conditions of risk were also discussed among the ACAD:

> "The situation in which people live provides protective factors and risk factors and these create the conditions of vulnerability. What determines vulnerability is a person's condition, not the membership to a group"

> "In the case of indigenous people, for example, we should understand that they are not vulnerable *per se*, but due to their social conditions under which they are living. These limit their access to health services. Thus, we can avoid naturalizing the vulnerability condition as just being indigenous".

It was emphasized that, instead of determining that a patient is vulnerable or not, SW should recognize the multiple conditions that generate the individual's risk of not accessing the hospital service.

For an operationalization of the definition of vulnerability, it is necessary to mention the characteristics or conditions of the persons, but with a certain normative logic, avoiding a simple counting of each one. Since the individual conditions are diverse, one possible form of practice to identify them could be a grouping of these into individual, social, structural, and cultural conditions with a view to organize the variables.

Table 2. Academics who participated in the focus group.

Academic	Gender	Level of education	Working or research area
F	Male	PhD	Philosophy, epistemology, social research ethics
A	Female	PhD	Social psychology, research in public health of vulnerable groups
B	Female	PhD	Social psychology, research in public health of vulnerable groups
K	Female	Bachelor's degree	Social work, administration of health services
M	Female	Specialty	Medicine, educational research, activist in infant rights
I	Female	Master's degree	Pediatrics, bioethics and law
T	Male	Master's degree	Geriatrics, geriatric syndromes, gerontechnology

The interrelation of vulnerability and gender was also discussed. This gender perspective confirmed the idea of having to go beyond a stereotyped conceptualization of vulnerable groups, focusing more on individual conditions:

> "In global terms, it is usually conceived that gender vulnerability is directed collectively toward women, but in particular sectors like health, the causes of death and life expectancy − already relevant topics in hospitals and physicians − are ambivalent in terms of the interpretation of how situations and events are experienced and lived by men."

> "It is assumed that weakness is linked to being a woman and that men are able to resolve their problems without any assistance from outside due to being men. Nevertheless, this gender awareness can result in a denial of seeking support which fragilizes their experiences and makes them vulnerable without falling in victimization."

The institutional measures to face vulnerability. The hospital needs to apply strategies aiming to "diminish the barriers of access and increase the use of resources in health care" with a systematic assessment of the vulnerability condition of each patient, staff training, and access to resources provided by the institution to accomplish the goal of creating social equality."

The proposal was:

> "One sort of checklist with groups of conditions or situations [which could make a person vulnerable] assumes the existence of layers of conditions that cause more or less vulnerability. These conditions in the checklist can be amplified depending on each case. This typology should help the hospital to establish a specified and fixed protocol of interventions, taking into account the limits and the scopes of guaranteeing equal access to health services."

The participants of the focus group proposed to "systematize the institutional collaboration networks and create a support microsystem". This more dynamic approach toward assistance and assessment of deservingness can be used to improve the service, extending the support for longer periods. The temporal duration of assistance should be assessed, taking into account the actual need of the patient and going beyond hospitalization to

promote protective measures in the patient's place of origin or transferring them to other services if required.

Discussion

In the findings of this paper, the perspectives of SW in the hospital and ACAD can be recognized, which correspond to practical experiences and academic proposals, respectively. The SW associated vulnerability with necessity, disadvantage or lack of resources. The ACAD emphasized that vulnerability is characterized by the risk of not having access to services offered by the institution itself.

In practice, the use of pre-established vulnerable groups to identify vulnerable patients is one institutional measurement of assistance. Nevertheless, this sort of measurement causes dilemmas among the SW who focus on the patients' individual living conditions and needs. The ACAD coincide here with the SW as they support the evaluation of each patient, considering their personal and individual circumstances without considering group membership. The SW aid those who need aid, regardless of their classification (vulnerable vs. non-vulnerable).

The results of the two phases suggest that there are frictions of meanings and interpretations on the subject of study, which could be analyzed using the palimpsest model.

The palimpsest of vulnerability

In order to understand and identify vulnerability at the hospital, SW focus on the patients' individual living conditions, needs, disadvantages or lack of resources. This form of interpretation of the concept associated with weakness and helplessness is a tendency (Garrafa and Prado, 2001) that characterizes the use of "vulnerable" in Latin-American countries (Cunha and Garrafa, 2016). Under this perspective, SW are more interested in the individual conditions that make a person vulnerable than in knowing whether they belong to a certain group, even when the institution promotes classification by such membership.

On the other hand, ACAD propose a change to the understanding of vulnerability as "layers of vulnerabilities" conformed by non-hierarchical conditions. In other words, vulnerability could be explained through the accumulation of conditions, which make an individual vulnerable (Luna, 2009; Vergunst et al., 2016). According to both SW and ACAD, in practical situations the concept of vulnerability should be separate from vulnerable group membership because, for example, not all women or indigenous people are automatically vulnerable just because of their gender or cultural background.

However, more than accumulation of conditions, the status of vulnerability is the result of a series of interrelated and overlapping situations that a particular person experiences. The combination or connection of these situations (friction of structural, cultural, economic, social, and individual conditions) creates a new state that re-configures the latent risk each person has of not receiving fair medical attention. Those elements, which might trigger a condition of vulnerability, should be assessed for each patient within a specific context. In other words, beyond the layers of conditions which could be a major or minor risk factor, vulnerability is a process of temporal interactivity that encompasses physical, emotional and cognitive vulnerability at an individual level (Boldt, 2019), as

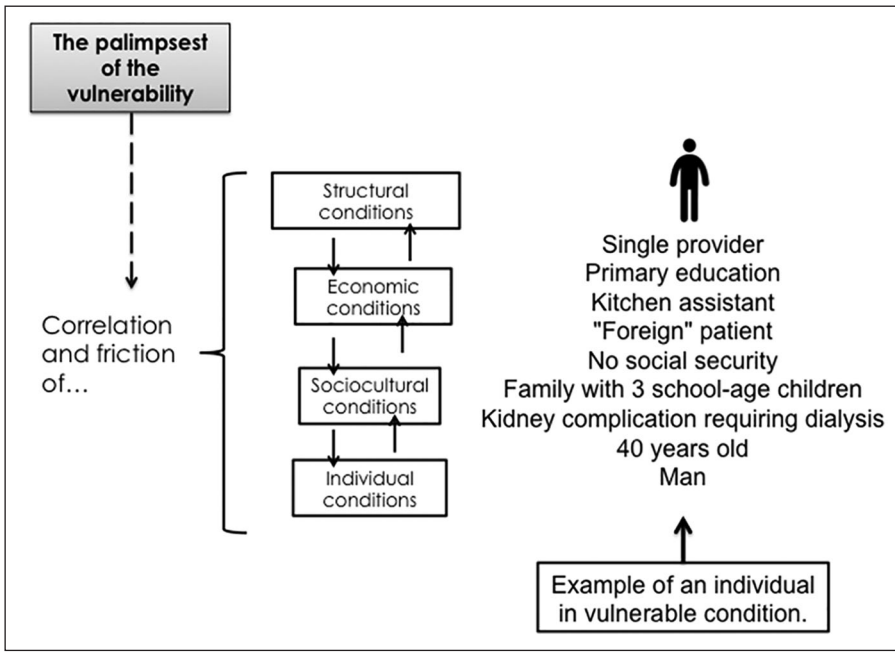

Figure 1. Palimpsest of vulnerability concept.

well as social conditions like poverty, precarious communication, suffering from chronic and/or stigmatized illnesses, among others, which interact to create an experience of vulnerability, and which have to be understood by the SW (see Figure 1).

If all persons who belong to one of the pre-established groups were considered vulnerable, the concept *per se* wouldn't be relevant (Luna, 2009) and would be sparsely convenient in a hospital context. Vulnerability can be understood as particular processes product of the interaction of the available resources (e.g. personal, family and community settings, cultural, economic, and institutional ones), the patient's socio-cultural context (Sánchez-González and Egea-Jiménez, 2011), structural elements, and the risks each one is exposed to.

Although the institution recommends using the vulnerable groups model following the policy to reduce social exclusion, SW carried out contradictory practices that could cause exclusion.

The concept of vulnerability needs to be modified in the hospital context since these institutions' main objective does not refer to achieve the social inclusion of social groups. This hospital aims to provide healthcare to the illness; nevertheless, it requires ensuring that those vulnerable in the social context receive the services offered inside the health context. In other words, the vulnerability concept could be different in hospital settings.

Thus, the pragmatic concept may be created from a dynamic concept of vulnerability, which refers to the exposure to risk situations and the inability to actively respond,

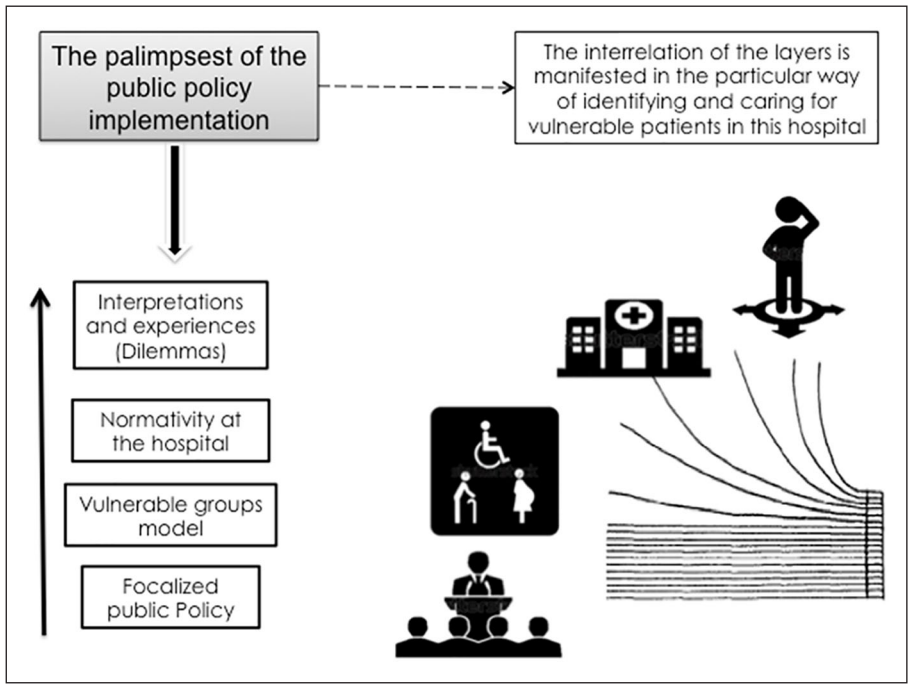

Figure 2. The palimpsest of the public policy implementation related to identification and care of vulnerable patients.

confront, and adapt to the consequences (Comisión Económica para América Latina y el Caribe [CEPAL], 2002). Even though the concept is used daily and is related to a lack of tools necessary to face a challenging situation, it should be conceptualized as a social and individual process considering constitutive, contextual, and causative elements. As Valdés and Lecaros (2016) emphasize, the adoption of an abstract and ahistorical concept of vulnerability might lead to a stiffening of these groups' categories, which would have the paradoxical effect of increasing social segregation and discrimination.

According to the SW, the economical factor is considered to be a significant element leading to vulnerability. This factor has a transversal impact, which aggravates prejudices toward other vulnerable situations (Grabovschi et al., 2013; Valdés and Lecaros, 2016). Therefore, the poverty level of each patient, for example, should be characterized individually to understand the particular manifestation of vulnerability.

The palimpsest of public policy implementation related to identification and care of vulnerable patients

The application of the concept in the hospital can be explained in the same sense of layers or meanings that correlate to each other (see Figure 2); we must begin with the public policy that generated this practice.

Focalized public policy. Human welfare policy offers a variety of focalized aid policies like housing assistance programs, employment assistance for individuals or groups who are exposed to risks within the labor market, or for those who lack the fulfillment of their basic needs (Andrenacci and Repetto, 2006). The interest in focalized policies in Latin America emerged in the 80s with the aim to overcome poverty (Tepichín 2010). Instead of granting legal welfare rights to all citizens, focalized policies aim to provide benefits to at-risk groups (Andrenacci and Repetto, 2006: 94). Therefore, these policies grant socially vulnerable groups goal-orientated benefits with the intention of resolving social exclusion and promoting inclusion (Ingram et al., 2008). Focalized policies have been supported and, at the same time, criticized in terms of lacking efficiency to diminish poverty, and the promotion of stigmatization of the social groups (Ochman, 2016). The enactment of a focalized public policy involves the identification of people belonging to one of the target groups considered in need to receive some kind of benefit.

The model of vulnerable groups. The state must provide unique and specific protection to groups in situations of vulnerability to offer them similar conditions concerning other people. To do so, distinguishing and measuring vulnerability without forgetting the social sphere, risk, and variability which generate social insecurity is essential to achieve an appropriate design of public policies that prevent and avoid it. Determining what help and when to give it is a fundamental ethical issue (Lara, 2015); therefore, policies have been designed based on vulnerable groups historically in vulnerable conditions.

However, through what was observed in the hospital, the sense of the vulnerable group has become static, a list of categories that health professionals have in an informative document used as boxes to include or not a person. For example, it is promoted that in any institutional activity, older adults, people with disabilities, pregnant women, or minors are attended first, as behavior that gives priority to this population due to their obvious disadvantage. However, it is common to hear that in terms of medical care or any other service within the hospital, "everyone should be treated the same", as a slogan that refers to inclusion and equality, but that keeps discrimination against those subject to certain conditions of vulnerability.

Hospital protocol about vulnerable populations. The extent of the general legislation encouraged forms of interpretations, which were converted into guidelines of protection against violence within the procedure protocol of the hospital. It promotes a strict use of the model of vulnerable groups, which has been limited to a list of categories, without a formal justification of why public policy focuses on those specific groups. Social workers, by not receiving information about the nature of the vulnerability and its objective as a form of social inclusion of certain groups or individuals, use the list of vulnerable groups included in the procedure manual as a simplified tool for the complexity of concept and purpose while maintaining recognition of needs among patients without vulnerabilities.

The transformation ranges from the norm based on rights and justice to a categorization of pre-established subgroups, which creates naturalization of the vulnerable condition (Luna, 2009), and thus making it lose its value to promote direct actions. Classification practice is not linked to the social objectives of public policy.

SW experiences. The most outstanding aspect of the experiences of SW is the contrast between the almost immediate classification they carry out when applying the SSQ and some disagreements they manifest about the use of the vulnerable groups model to classify the population; they bring the normativity together with their own attitudes to the policy. This patchwork of norm and perception generates the identified dilemmas in this paper, based on the categorization of the patients as people in need of support. These dilemmas are related to the dilemma of social difference, and the dilemma of deservingness.

The dilemma of social difference: The identified dilemma in the SW narratives is associated with the dilemma of a person's inclusion into or exclusion from one of the vulnerable groups, as it would be unjust if a person of one group in better conditions than others were receiving benefits. It is situated in the question of whether all members of one vulnerable group should be given the same treatment. This decision can stigmatize differences (treating all members of minority groups differently from the majority; Minow, 1990). If a focalized policy includes all the members of a group, who are excluded from society, even though it is a measure to protect human rights, it could re-emphasize this exclusion.

This dilemma has consequences in the protective measures or "support", according to the SW, which can or cannot be granted in accordance to the political idea of "need" which decides if the person requires some sort of benefit in a determined moment and if this benefit will be issued.

The dilemma of deservingness: The states of well-being are orientated, among other aspects, toward a redistributive justice which is centered in a person's deservingness. Feather (2003) defines deservingness as "judgments that are related to outcomes that are earned or achieved as products of a person's actions, where these actions are either directly observed or indirectly inferred from information about a person's qualities" (p. 368). Deservingness is a socially judged and constructed concept due to its cognitive and axiological components (Ochman, 2014); it is expressed in a moral register, and inevitably reckoned in relational terms, so stakeholders' presumptions, which are personal and professionally influenced, can play a powerful role as empirical data (Willen and Cook, 2016). Several criteria to assess a person's need for institutional aid have been depicted (Cook, 1979; De Swaan, 1988). Van Oorschot (2000: 36), for example, identifies five principal criteria of deservingness (control, need, identity, attitude, and reciprocity); other scholars admit the influence of mass media and political discourse in the perception of deservingness (Ochman, 2014); health related-deservingness has been less studied (Willen and Cook, 2016).

The three expressed dilemmas in the results section are related to the deservingness of certain benefits. The question of "who deserves which benefit and why?" is crucial in this decision making, and SW are one of the stakeholders who are influenced by professional and personal values to evaluate health-related deservingness in their daily practice (Willen and Cook, 2016). If a patient has a variety of problems, for example, economic, family-based, communicative, or if a single problem can be perceived as more severe, this patient deserves more assistance than others. One criterium (van Oorschot, 2000) to analyze the perception of deservingness is need: the higher the level of need, the higher the deservingness of benefits issued by the State. Therefore, need is the binding element for the SW to

classify a person as vulnerable and grant assistance. Following Willen and Cook (2016), needs could be the top evaluation criteria, which is based on life circumstances of patients. The support provided by SW is based on need and not on the classification of vulnerability itself, so the use of this tool is only on a discursive and administrative level, but not on a practical one. Vulnerability policy could be understood as a "new tag" as it underlays processes of a normative modernization that cover up old paternalistic social welfare. This new form of social welfare normativity strengthens the role of the SW as a public servant who is in charge of social affairs and diminishes the functions of other health professionals as service providers who also have to operate under the ethical and juridical guidelines of protection about vulnerability while exercising health care.

The idea of vulnerability recognized by SW and, in a certain way related to the ACAD proposal, reinforces the focus on individual conditions moving away from the idea of vulnerability promoted by public policy that reduces the social exclusion of historically discriminated groups. The vulnerability concept to social settings should not be the same in hospital settings. It is necessary to modify the concept that responds to the hospital context's characteristics and needs, taking into account that each hospital serves various populations. In this hospital's case, its character as a public institution with all medical services that care for people without social security, and a historical recognition in the central region communities makes the populations most need care.

Final thoughts

Zarowsky et al. (2013) confirm that the process of "defining" a term or group creates boundaries that tend to become steady and static, and often lead to a concern for measurement rather than understanding, particularly in fields with strong quantitative traditions such as economics or epidemiology. In the hospital, a binary classification (positive or negative) of membership eases a normative measurement of a potential vulnerability in patients but promotes neither a change of paradigm based on social justice, nor a transformation of social structures of inequality. This way of conceptualizing vulnerability stereotypes population groups, without distinguishing between individuals of the same group that may have special characteristics (Levine et al., 2004) or various types of vulnerabilities, since the groups are not homogeneous (Luna, 2009). In the practice, the dilemmas with which SW are confronted, allow breaking the inflexibility of a stiff categorization to lead to an appropriate care based on the patients' needs. Although it does not coincide with the fundamental idea of vulnerability, it executes supportive assistance measures to each patient. Finally, the vulnerability classification is ignored and of little use for SW in most cases. Regarding the analysis of health-related deservingness, we have taken into account the position of SW as stakeholders, as well as the context and the evaluation criteria, to recognize the relational character of deservingness (Willen and Cook, 2016).

On the other hand, the implementation of public policies reflects a series of moments or processes to adopt these policies in a hospital setting, which until now does not transcend directly into the assistance activities related to the classification; in other words, it can be described on a discursive rather than an applicative level.

The palimpsests as an explanatory model to understand vulnerability

The palimpsest as a juxtaposition of meanings produced by the spacial-temporal friction of events and interpretations linked within a context is an analytical strategy to explain social phenomena. The palimpsests of vulnerability and its implementation in a hospital context express the complexity and interaction of individual and social processes, which needs to be understood pragmatically by the SW as intersectionality (Crenshaw, 1991) of interconnected conditions, which would allow specify the supportive interventions to accompany vulnerability and their different modalities. These overlapped conditions should be recognized to activate a mechanism of institutional and interinstitutional actions. Such actions, re-conceptualized as processes of intervention, lead to the necessary step from the identification of vulnerability to the application of a public policy that counteracts it to diminish the gap of inequality in health care.

Although the function of a hospital does not include the elimination of structural factors that cause social vulnerability, it should indeed play a role in the eradication of the limitations that promote it within the institution. The hospital is required to adjust the procedure protocol based on the adaptation of the concept of vulnerability, and to reconsider the procedure to identify vulnerability. Kipnis (2001) and Hurst (2008) suggest listing the situations to identify the individual condition of the vulnerability of each person. Even though this method does not exhaustively assess vulnerability (Luna, 2009), it might be a pragmatic strategy, which could be applied by SW. A new approach is needed that emphasizes the protection of human rights and implements protection measures based on an understanding of the social conditions of each patient. A solid, feasible and inter-institutional procedure for patient assistance measures must be established, through a network of institutional affirmative actions (Rodríguez, 2017) that is recognized as an intervention process and not as isolated supports.

Implementing the operationalization of vulnerability identification is a challenge as respect for human rights, and health equity should not be simplified and enforced. Achieving this involves considering the results of this study in conjunction with SWs and hospital authorities designing strategies such as (1) education for health professionals, cultural competence, for the proper identification of vulnerability (2) An Automated Classification System with the most important elements for vulnerability identification considers academic and practical (results of this study) (3) A change in hospital policy for the implementation of these strategies in conjunction with all health professionals.

Limitations

Patients' voices should be included to capture their experiences with the concept of vulnerability, a category that is attributed to them by the State and "the other" (SW, public policy). Patients' voices should be included to capture their experiences with the concept of vulnerability, a category that is attributed to them by the State and "the other" (SW, public policy). In addition to being able to incorporate patient satisfaction based on the experience in the care provided by health professionals".

Even though in this paper we are not interested in an analysis of the data from a gender perspective, we admit that the information for our research was mostly gathered from female participants. Therefore, we would recommend that subsequent studies take into consideration the participants' gender for a broader analysis of the findings.

Acknowledgements

The authors would like to express their gratitude to the social workers, who participated voluntarily, as well as the patients who accepted the presence of the researcher. We also thank the authorities of the hospital who allowed us to undertake the proposed research. We also want to thank Mario Ruesga for technical assistance, Katharina Antonia Michiko Tremmel for translating the article from Spanish into English and Michelle Guadalupe Miranda Tejeida for its revision, and Amaranta Manrique de Lara for her critical reading and comments.

Declaration of conflicting interest

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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