

Editorial

# The Prevention and Treatment of Medical Diseases in Vulnerable Populations

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Vulnerability, as a phenomenon of analysis, has long been the subject of extensive social and economic policy reflections, aimed at planning social welfare interventions to support the areas most exposed to the effects of the economic crisis, especially with reference to the presence of potentially weaker segments of the population.

In the debate on social inequality, the concept has been used more recently to describe the social and economic transformations that, in recent decades, have resulted in a sense of insecurity, affecting even traditionally secured social classes, and introducing a new dimension of inequality that develops across to social stratification. In fact, the spread of income instability, the growth of job temporality, the difficulties in reconciling care and work, and the explosion of non-self-sufficiency touch all social strata, increasing the social vulnerability of all classes. In 2014, the United Nations, with the Human Development Report—*Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience*, provided an analysis of vulnerability, focusing on the most vulnerable groups (the poor, disabled, immigrants, children, the elderly, and youth) and analysed the phenomenon with respect to risk factors related to people's life cycle or those related to individuals' socioeconomic status. The report stresses the importance of reducing vulnerability, understood as the exposure to risk factors that can undermine people's levels of well-being, and promoting resilience, i.e., the capacities that strengthen individuals in coping with adverse risks.

Medical diseases in vulnerable populations, including migrants, ethnical and social minorities, and people experiencing homelessness, are very frequent. Many of those persons are especially fragile, including refugees, children, women, and disabled people, and very little is known about the healthcare needs of these groups.

The number of people with migrant status living in Europe is growing rapidly (1.92 million people immigrated to EU in 2020). According to the United Nations High Commissioner for Refugees (UNCHR), the number of refugees reached a total of 84 million worldwide in 2021. Most of the refugees come from war zones and many of them denounce having been victims of persecutory acts in their country of origin [1]. The reasons that lead people to flee are: conflict, COVID-19, poverty, political instability, and increased globalisation [2,3]. Over the years, it has been observed that migrants from middle- and low-income countries migrate to high-income countries, such as the USA, Canada, Australia, and Europe. A number of factors help to define migrants as vulnerable: health risks before, during, and after migration; a disease profile different from that of the host country population; and barriers to access health services in host countries [4].

People experiencing homelessness frequently require medical, psychological, and social care since their health status is often burdened by chronic diseases; mental disturbances; and drug, alcohol, or smoking addiction [4–10]. Homelessness has several detrimental effects on health, and life expectancy is nearly twenty years lower than in the general population [11]. In addition, access to primary and specialist medical care may be more challenging for homeless persons, with no substantial differences between countries with and without health insurance coverage [12–17].



**Citation:** Palaia, G.; Bruscolini, A.; Ralli, M. The Prevention and Treatment of Medical Diseases in Vulnerable Populations. *Appl. Sci.* **2022**, *12*, 10406. <https://doi.org/10.3390/app122010406>

Received: 28 September 2022

Accepted: 14 October 2022

Published: 15 October 2022

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It is essential to discuss recent findings to improve clinical decision making and care of medical disorders which affect this target population on studies conducted worldwide.

**Author Contributions:** Conceptualization, G.P. and M.R.; methodology, A.B.; resources, M.R.; writing—original draft preparation, G.P.; writing—review and editing, A.B.; visualization, M.R.; supervision, G.P., A.B. and M.R. All authors have read and agreed to the published version of the manuscript.

**Funding:** This research received no external funding.

**Conflicts of Interest:** The authors declare no conflict of interest.

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