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Understanding vulnerability and deliberations on justice – the case of health care for refugees and asylum seekers in Germany

Abstract
The main concern of this contribution is to further develop an understanding of human vulnerability and what it means for us from an ethical perspective both in general as well as in the particular situation of health care for refugees and asylum seekers. After an introduction to this situation, the next and major part explores the meaning of the term vulnerability as well as the current debate on concepts of vulnerability. Both the term as well as the use of concepts of vulnerability seem inherently ambiguous. Coming from this more abstract and general level of deliberation into concrete questions of health care for refugees and asylum seekers is taken on by testing the taxonomy of vulnerability developed by Mackenzie, Rogers and Dodds. This test confirms that navigating the positive and negative effects of using vulnerability as a guideline for the practical necessity of distributing resources remains a challenging task. Yet, the conclusion is not to forfeit those concepts. The use and usefulness of the taxonomy as a method needs to be tested, reflected, and discussed in more detail but the focus of the last brief part of this paper turns to basic questions of how our understanding of vulnerability is linked to matters of justice.

1. Introduction: The Situation of Refugees and Asylum Seekers concerning Health Care in Germany

The terms »refugee«, »asylum seeker« and »asylum entitlement« are legally strictly defined according to the Geneva Refugee Convention and the German asylum law. Entitlement and access to health care depend on approval according to these legal frameworks. Since the need for health care does not depend on legal status, ethical considerations apply to a wider group here, even if they are not legally approved. So, the terms »refugee« and »asylum seeker« in this text include all people who come seeking protection from war, persecution, natural catastrophe, hunger, poverty, or other for them unbearable situations.

The German Health Care System is a public-private-partnership system based on compulsory membership in mostly statutory but also private health insurances with joint state and expert control over reimbursement of medical services. The sickness funds provide immediate treatment without or with very low out-of-pocket expenses. This means that generally everybody who is part of the system has access to health care provisions. Since membership is compulsory, the cost of the insurance is carried jointly by the employer and the employee. Self-employed persons are obliged to join a private insurance. In case of unemployment the cost of health care is taken on by the social aid according to the Social Code Book XII. So, over all, most people living in Germany are insured.

Yet there are persons or groups of persons who are not absorbed by this system for different reasons e.g. homeless people who do not register anywhere, persons without papers, migrants from European countries or elsewhere whose health insurance is no longer valid and others[1]. Even though emergency care could be provided de jure, de facto there is no public facility taking care of the health needs of persons without papers that does not pose the threat of informing authorities about their undocumented status. This leads to the situation that health care is not accessible for them.

NGOs like Doctors of the World offer very good support but the capacity of voluntary organizations is limited.[2] They cannot fully take on a responsibility of the state. This situation raises serious ethical concerns regarding (public) health care.

Healthcare for refugees and all asylum seekers who are legally registered is not part of the insurance system but regulated by a federal law, the Asylum Seekers' Benefits Act[3] (AsylbLG) and funded by

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[1] Maren Mylius, Andreas Frewer: Zugang zu medizinischer Versorgung von MigrantInnen ohne legalen Aufenthaltsstatus. Zwischen Notfallversorgung, Infektionsschutz und humanitärer Hilfe. In: Zeitschrift für Menschenrechte 9 (2015), pp. 102–120; Maren Mylius: Die medizinische Versorgung von Menschen ohne Papiere in Deutschland. Studien zur Praxis in Gesundheitsämtern und Krankenhäusern. Bielefeld 2016; Zentrale Ethikkommission der Bundesärztekammer: Versorgung von nicht regulär krankenversicherten Patienten mit Migrationshintergrund. Stellungnahme. In: Deutsches Ärzteblatt 110 (2013), pp. A 899–A 903.

[2] Dagna Frydryszak, Anne-Laure Macherey: Legal Report On Access To Healthcare In 17 Countries. MdM International Network 2016. https://mdmeuroblog.files.wordpress.com/2016/11/mdm-2016-legal-report-on-access-to … (accessed 9/24/2019).

[3] Deutscher Bundestag: Asylbewerberleistungsgesetz. AsylbLG 1993; Georg Classen: Stellungnahme zur öffentlichen Anhörung des Gesundheitsausschusses.https://www.

the municipality asylum seekers are attached to, not by the statutory health insurance. So, refugees and asylum seekers are excluded from the common solidarity system of the sickness funds.

This applies for the first 18 months as long as they are in the application process. During this period, according to §4 of the AsylbLG, access to Health Care is restricted to the treatment of acute diseases and pain; maternity care and vaccinations are provided, chronic conditions and assistive appliances e.g. for disabled persons are not covered. According to §6 of the AsylbLG some exceptions could be made so that e.g. victims of violence and torture or children might be granted treatment on a case-by-case level.

Moreover, under the AsylbLG access to healthcare in many communities requires a more complicated administrative procedure.[4] These procedures vary in the different German states and communes since the details of the implementation of the AsylbLG underlie the authority of the states. The initial system requires a so called Behandlungsschein (treatment voucher) granted by the communal administration as well as an approval of the particular treatment. This means that the final decision about a medical intervention is taken by administrative staff with no medical training. In recent years, some states have opted for the so-called Bremer Modell providing asylum applicants with an E-Health-Card (EHIC) which does not change the restrictions nor the difference in financing of the AsylbLG but lowers the administrative work load both for medical practitioners as well as for the patients.

After these 18 months or once the applicant gains a status as refugee according to the Geneva Refugee Convention or asylum according to the German Constitution or subsidiary protection, health care and social aid are regulated according to the Social Code Books (II, V, XII) analog to German citizens. However, according to legal amendments of the AsylbLG[5] (last made 2016, 2017 and 2019) social benefits including health care can be downgraded under specific circumstances, basically as a form of sanction if asylum applicants are

bundestag.de/resource/blob/426800/f496b296a808fe481c3a4285cd22a7f1/ESV-Georg-Classen-data.pdf (accessed 9/24/2019).

[4] Wolfgang Günther, Renate Reiter, Phillip Florian Schmidt: Migration, Integration und Gesundheit. In: Oliver Decker, Steffen Kailitz, Gert Pickel, Antje Röder, Julia Schulze Wessel (Eds.): Handbuch Integration. Wiesbaden 2019, pp. 1–14.

[5] Deutscher Bundestag: Asylbewerberleistungsgesetz (Note 3), § 1a.

judged not to be compliant especially regarding proves of their identity.[6] So, restricted entitlement to health care can be extended beyond 18 months.

Apart from the restrictions in entitlement it is important to note that even once full access to healthcare is granted by law, asylum seekers face many obstacles receiving adequate medical care and treatment due to language problems in the absence of trained and paid interpreters in the system, lack of procedural knowledge concerning the German health care system and (perceived) cultural barriers.

In summary it can be stated that health care for asylum applicants is restricted and impeded on all levels of entitlement to, access to and quality of care.[7]

This seems odd when at the same time refugees and asylum seekers are often described as a vulnerable group. Does this not imply they may need more (health) care rather than less? Indeed, the seemingly neutral description of people as vulnerable is mostly used to make a normative claim and legitimize special interventions and supportive measures for a particular group or population. More or less explicitly and intuitively these normative claims refer somehow to principles of justice. What constitutes the normative basis? What exactly do we mean with vulnerable? What other effects does it have to describe a whole heterogeneous group of people as vulnerable? And how exactly are refugees vulnerable?

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[6] Deutscher Bundestag: Sachstand. Sanktionen im Leistungsrecht für Asylbewerber und Flüchtlinge Asylbewerberleistungsgesetz, Zweites und Zwölftes Buch Sozialgesetzbuch. Wissenschaftliche Dienste WD 6 – 3000 – 053/16. Berlin 2016; Ulrike Davy: Refugee Crisis in Germany and the Right to a Subsistence Minimum: Differences that ought not to be. In: Georgia Journal of International and Comparative Law 7 (2019) pp. 367–450.

[7] Günther, Reiter, Schmidt: Migration, Integration und Gesundheit (Note 4), pp. 1–14; Sylvia Agbih: Gesundheitsversorgung für Flüchtlinge aus ethischer Perspektive: Wo fangen die Fragen an? In: Andreas Frewer, Lutz Bergemann, Caroline Hack, Hans G. Ulrich (Eds.): Die kosmopolitische Klinik. Globalisierung und kultursensible Medizin. Jahrbuch Ethik in der Klinik, Band 10. Würzburg 2017, pp. 41–75; Judith Wenner, Oliver Razum: Die gesundheitliche Versorgung Geflüchteter – von Gleichheit und Ungleichheit. In: Andreas Frewer, Lutz Bergemann, Caroline Hack, Hans G. Ulrich (Eds.): Die kosmopolitische Klinik. Globalisierung und kultursensible Medizin. Jahrbuch Ethik in der Klinik, Band 10. Würzburg 2017, pp. 75–93.

2. Reflecting on Vulnerability

2.1 The term vulnerability – approaching meaning

2.1.1 Vulnerability – term and meaning in every-day language

A first step to understand what we mean with vulnerability and which repercussion, side-effects or implicit consequences it may have to call someone vulnerable, is a reflection of the meaning we generally connect more or less implicitly to the word. Following I do not offer a complete analysis of the term but some initial explorations.

The term vulnerability stemming from the Latin word vulnus meaning wound, expresses that somebody (or something) could be wounded by somebody or something. It expresses a possibility or potential to be harmed and is often defined as susceptibility to harm or as being at higher risk of harm. Yet, vulnerability and risk are not the same. Vulnerability seems to describe a particular relation of risk to resources or something we might want to call resilience (without going into the discussion on the different concepts of resilience, what is meant here is a capacity to cope with adverse events to maintain health and well-being). So, vulnerability as exposure to harm while there is – for different reasons – a lack of resources, protective factors or coping capacity to deal with this exposure. The risk of harm as such is not necessarily special since all human beings and in fact all life is in constant danger of being harmed. The reasons why someone cannot defend or protect herself or himself are manifold and the particular vulnerability seems to be due to these reasons. Vulnerability is not just a higher risk but seems a higher risk or exposure to harm in connection with the lack of means to protect oneself or develop resilience.

2.1.2 Synonyms

The general use of the term vulnerability includes both being susceptible to physical injury as well as to emotional or psychological harm. What exactly harm is would be worth thinking about but is not further explored here due to the scope of this paper. Different situations entail the risk for particular kinds of harm and in what way a person is especially vulnerable depends on the individual circumstances – which is exactly what needs to be figured out when we think of due measures of protection.

Looking at synonymous expressions and exploring the meaning of being vulnerable we find descriptions like being fragile, frail, exposed, naked, defenseless, helpless, weak, unsound, powerless, needy, dependent and therefore at someone's mercy. Literally thinking about vulnerability to the end confronts us with our dependency, our limits and finitude. Therefore, being vulnerable is generally regarded as not desirable and carries a touch of the unwanted and dangerous. Needs and neediness, dependency and vulnerability seem to undermine our autonomy and somehow seem to be a source of shame and maybe even feelings of guilt since we perceive ourselves as indebted to those helping us. We rather like to conceive of ourselves as independent, skillful, competent, and autonomous. Therefore, we might repress feelings of vulnerability although we know how vulnerable we are even as healthy grown-ups. Moreover, as Scully[8] analyses sharply scrutinizing how people with disability are regarded as vulnerable: there are vulnerabilities and dependencies tagged as permitted and normal in contrast to those defined as not normal and not acceptable. According to Scully

> permitted dependencies are naturalized and normalized. They are met and supported without question, and in doing so the vocabulary of vulnerability is never used. Other people, and groups, will have needs that fall outside the normative limit. These are nonpermitted dependencies. They are figured as abnormal and classed as rendering those people as especially vulnerable.[9]

The crucial question is: who defines this? Scully describes the social construction of vulnerability from a feminist perspective as follows:

> Normative dependencies are, tautologically, the dependencies of the normative citizen, and for reasons exhaustively articulated by feminist theorists the normative citizen of moral and political philosophy is likely to be male, white, and heterosexual. He will probably be nondisabled as well[.][10]

And certainly, the normative citizen is not a refugee.

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[8] Jackie L. Scully: Vulnerability and Dependence: On Bodies, Disability and Power. In: Catriona Mackenzie, Wendy Rogers, Susan Dodds (Eds.): Vulnerability. Oxford 2014, pp. 204–222.

[9] Scully: Vulnerability and Dependence (Note 8), pp. 204–222, here p. 217.

[10] Scully: Vulnerability and Dependence (Note 8), pp. 204–222, here p. 217.

2.1.3 Contrasting meaning

Looking at the contrast of vulnerability we find what we attribute to our super heroes and goddesses: being (almost) invulnerable, invincible, powerful, strong, robust, healthy, resilient, well-fortified, independent, unlimited, even endless or everlasting. Interestingly though, the heroes we admire most do struggle with some kind of weak point and vulnerability. Otherwise, it seems there would be no story to tell. As much as we adore strength, invulnerability seems inhuman and we like those heroes who have some human sides, some vulnerable sides, so we can identify with them. In close social relationships like in friendship and partnership one essential feature is trust, so that we can show and share our weaknesses and vulnerability and still feel safe. It seems a relief to have spaces where we can let go of the masks of invulnerability.

So, our evaluation of vulnerability and invulnerability is somewhat ambiguous. We place very high value on independence and since vulnerability is closely related to neediness, dependence and being at someone's mercy, we associate it more with negative experiences, we rather do not have vulnerability. Yet, since we cannot achieve being invulnerable, we build strategies of permitted, normal vulnerabilities and special, abnormal ones. Do we categorize in order to cope with our neediness and not to feel too vulnerable? And at the same time, we somehow value vulnerability as human. Vulnerability might enable us to develop empathy. Zagorac suggests that vulnerability could be a positive force motivating richer personal development as well as richer social contacts – if we accept our vulnerabilities.[11] A similar line is followed by Brené Brown.[12]

The ambiguity remains. Even though there are positive aspects – and for both our theoretical understanding of vulnerability as well as for our self-conception as human beings it seems crucial to look at them more closely – the negativity is not washed away. It is important to recognize this since labelling other people as vulnerable has more than one effect. My thesis here is that vulnerability is not merely descriptive even though it is often attempted to use it as a

[11] Ivana Zagorac in her contribution and discussion during the BMBF Symposium Ulm (3/14/2019); Ivana Zagorac: What Vulnerability? Whose Vulnerability? Conflicts of Understanding in the Debate on Vulnerability. In: Facta Universitatis, Law and Politics 15 (2017), pp. 157–169.

[12] Brené Brown: Verletzlichkeit macht stark. München 2013.

description of e. g. a population or group in social and health sciences. Typically, this goes along with a claim for special protection and interventions for this vulnerable group. But since the term vulnerability in itself carries a normative level more or less explicitly (and I would say a more negative one) it has side-effects. This seems to be at the core of the growing critical discourse on concepts of vulnerability, which we now turn to.

2.2 *Concepts of Vulnerability*

2.2.1 Critical points

Concepts of vulnerability seem to have appeared first in research ethics. The use of the term vulnerable group became popular since the 1980ies through the Belmont Report[13] published in 1979. Since then concepts of vulnerability are being widely used in research ethics as well as in public health practice, health policy documents, and health research.[14] The term and concepts of vulnerability can also be found in other fields like philosophy, theology, social and political science or environmental studies and ecology[15]. Brown, Ecclestone and Emmel call it a buzzword of our time and state that

> the concept of vulnerability has come to play a prominent role in academic, governmental and everyday accounts of the human condition. Policy makers and practitioners are now concerned with addressing vulnerability through an expansive range of interventions.[16]

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[13] The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research: The Belmont Report. Ethical Principles and Guidelines for the Protection of Human Subjects of Research. 1979. https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/read-the-belmont-report/index.html (accessed 9/24/2019).

[14] Verina Wild: Vulnerabilität. In: Christian Lenk, Gunnar Duttge, Heiner Fangerau (Eds.): Handbuch Ethik und Recht der Forschung am Menschen. Heidelberg, Berlin 2014, pp. 297–298; Florencia Luna: Elucidating the Concept of Vulnerability. Layers not Labels. In: International Journal of Feminist Approaches to Bioethics 2 (2009), pp. 120–138.

[15] Daniel Burghardt, Markus Dederich, Nadine Dziabel, Thomas Höhne, Diana Lohwasser, Robert Stöhr, Jörg Zirfas (Eds.): Vulnerabilität. Pädagogische Herausforderungen. Stuttgart 2017.

[16] Kate Brown, Kathryn Ecclestone, Nick Emmel: The Many Faces of Vulnerability. In: Social Policy & Society 16 (2017), pp. 497–510, here p. 497.

The dominant traditional accounts of vulnerability describe certain populations and subpopulations like the elderly, women, children, refugees and others as vulnerable. The proclaimed purpose of this classification is to identify who needs protection and support. At a first glance this may seem laudable. But this labelling of a whole diverse group as generally vulnerable has led to substantial criticism,[17] namely: Labelling populations and subgroups is too simplistic overlooking real complexities. It is in fact stereotyping and has a stigmatizing effect since, as explored earlier on, there are generally mostly negative connotations to vulnerability. Depicting a whole actually diverse group of people as vulnerable leads to overlooking their capacities, their agency, resources and potentials and fosters a common picture of e. g. »the« refugee as a powerless object of our charity. In this way, using vulnerability could give rise to paternalistic practices.

Moreover, labelling some people as vulnerable assumes that there are others who are not vulnerable, who are – normal? There is an implicit assumption of a kind of average baseline of strength or health or resilience and those below are defined as vulnerable.[18] This supports Scully's analysis of permitted and non-permitted vulnerabilities.

Apart from identifying those in need, concepts of vulnerability are used for prioritization: who needs support most and first? These are uncomfortable questions we may be forced to ask in situations when we face limited resources. The search for criteria to make such decisions is a deeply challenging one. The danger here is to deem vulnerability as neutral not reflecting assumptions and pre-conditions of our evaluation. The judgement on who is vulnerable is tied very closely to evaluations of who is worthy and deserving. This again is entangled with unspoken concepts of normal and permitted needs and vulnerabilities.

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[17] Carol Levine, Ruth Faden, Christine Grady, Dale Hammerschmidt, Lisa Eckenwiler, Jeremy Sugarman: The limitations of »vulnerability« as a protection for human research participants. In: The American Journal of Bioethics AJOB 4 (2004), pp. 44–49; Luna: Elucidating the Concept (Note 10), pp. 120–138; Anthony Wrigley, Angus Dawson: Vulnerability and Marginalised Populations. In: Drue H. Barrett, Gail Bolan, Angus Dawson, Leonard Ortmann, Andreas Reis, Carla Saenz (Eds.): Public Health Ethics: Cases Spanning the Globe. Public Health Ethics Analysis. Cham 2016, pp. 203–240; Brown, Ecclestone, Emmel: The many faces (Note 16), pp. 497–510; Florencia Luna: Identifying and evaluating layers of vulnerability – a way forward. In: Developing World Bioethics 19 (2018), pp. 86–95.

[18] Luna: Elucidating the Concept (Note 14), pp. 120–138.

Brown, Ecclestone and Emmel analyze this critically on a socio-political level by looking at what implications the use of vulnerability concepts might have on our understanding of citizenship and the relations between state and citizen.[19] One of their main concerns is an expansion of state-sponsored social control, going along with a diminished view of the human subject, and a paradoxical effect of labelling people as vulnerable since »individuals regulate their own behavior in ways that conform to particular norms about ›correct‹ or ›appropriate‹ behaviors.«[20] This means that people tend to behave more helpless since this is expected of them as vulnerable persons. Finally, this cycle leads to patronizing disempowerment and in fact increased lived vulnerability.

According to the authors challenges and tasks for further research are: a clearer definition of the term, thereby also clarifying differing operationalizations; being aware of implicit normativity bearing the danger of social control as well as psychologisation and individualization of social problems; overcoming imbalance in research since there are more theoretical debates and not enough empirical research into experiences of different stakeholders.

2.2.2 Encompassing two basic conceptions of vulnerability

In the discussion on vulnerability, two main concepts of understanding vulnerability can be discerned: a broad view of vulnerability as universal feature or condition of human life and a more narrow understanding of vulnerability as being tied to concrete circumstances, groups, certain phases in life or other specific attributes.[21] Both views encompass important aspects and both views face some criticism at the same time.

The broad view is said to be simply too broad since according to this understanding all human beings and in fact all life in general is vulnerable. Luna argues: »Whilst it is true that everyone is exposed to suffering, deterioration, and death, this is not the relevant point. (...) It is not the universal human condition that public policies target but

[19] Brown, Ecclestone, Emmel: The many faces (Note 16), pp. 497–510.
[20] Brown, Ecclestone, Emmel: The many faces (Note 16), pp. 497–510, here p. 500.
[21] Wrigley, Dawson: Vulnerability and Marginalised (Note 17), pp. 203–240; Luna: Elucidating the Concept (Note 15), pp. 120–138.

specific persons or groups in need of safeguards, protection or empowerment.«[22]

According to Luna's understanding there could not be specific vulnerabilities if everyone is vulnerable which would make it impossible to use the concept to protect or empower those in need. At the same time though, some form of specific vulnerability could be found for almost every group of human beings so that even in a narrow view we face the problem of an inflationary use of the term vulnerability. This threatens to make the concept useless. Moreover, when the narrow view assumes that some people are vulnerable and others are not, this is what easily leads to the aforementioned processes of stereotyping and stigmatization.

So, is the concept useless? What does it help if no one even knows what it is? Should we forfeit such a concept?

It seems to me that there are good reasons to at least try and rescue vulnerability before discarding it completely. Mainly – to put it very briefly – because we experience and see situations in human life that we can hardly describe and understand otherwise. Moreover, in practical contexts, vulnerability is already established as concept and every concept has and will always have flaws, there is no perfect one. This lies in the nature of conceptualization. Whilst this ought not to be a cheap excuse, the task remains to keep observing and reflecting the effects of the use of such a concept critically. Then, how should we understand and frame vulnerability?

I want to argue that we need both conceptions and need to understand vulnerability as both broad and narrow. Looking at the meaning of the term reflected on before, we can already see elements of both understandings. An encompassing understanding discerns two levels or dimensions of vulnerability rather than two different, separate concepts. To my mind it seems very true or adequate to describe vulnerability as part of our human condition. This human condition the way I understand it is not to be taken as a list of attributes we possess and it is far from trying to define what or who we human beings are as such. It is rather an insight into the conditions we find ourselves living in. An insight we gain through experience.[23] It is in the reflec-

[22] Florencia Luna: ›Vulnerability‹, an Interesting Concept for Public Health: The Case of Older Persons. In: Public Health Ethics 7 (2014), pp. 180–194, here p. 185.

[23] Wilhelm Kamlah: Philosophische Anthropologie. Sprachkritische Grundlegung und Ethik. Mannheim, Wien, Zürich 1972.

tion on our life that we find ourselves fundamentally vulnerable. Which does not mean that we feel vulnerable all the time in our everyday lives (though our life is in fact vulnerable every second). Rather, this fundamental vulnerability manifests itself in certain situations, phases and under specific circumstances. These situations are not the same for every individual and are not uniform across similar situations at different times. I might feel very weak and vulnerable when sick and in pain today, tomorrow the same situation may evoke my resistance, resilience or even anger, which in turn might make me feel and be very strong in the way I cope with the situation. Despite differences, we all know what it means to feel and be vulnerable – this insight into our shared human condition could be a safeguard against stigmatization of those who are in a vulnerable situation.

We are very likely to find many similarities and commonalities looking at when people are vulnerable and how vulnerability manifests. But at the same time these manifestations differ in each individual person and situation. So, (in my view, differing from Luna's analysis) universal vulnerability does not mean that we are all vulnerable in the same way all the time. Therefore, on the basis of an understanding of vulnerability as feature of our human condition, it is not only possible but even called for to develop a pragmatic concept of vulnerability that is more specific and context-bound in order to help us to discern situations that entail a higher risk of exposing people to harm they cannot protect themselves from. In this respect Luna's conception of layers of vulnerability could be very fruitful because it enables us to reflect the complexities of concrete living conditions, the multiple structural determinants and their interfaces and interplay that render people indeed vulnerable.

Acknowledging different sources of vulnerability, namely inherent, dispositional and pathogenic, the taxonomy of vulnerability developed by Mackenzie, Rogers and Dodds[24] takes both universal and specific vulnerability into account. Adding two different states of vulnerability – dispositional and occurrent – discerns more acute risks from dormant ones and therefore offers hints which exacerbations or cascade effects could still be prevented.

[24] Catriona Mackenzie, Wendy Rogers, Susan Dodds: Introduction: What Is Vulnerability and Why Does It Matter for Moral Theory? In: Catriona Mackenzie, Wendy Rogers, Susan Dodds (Eds.): Vulnerability. Oxford 2014, pp. 1–33.

While agreeing with Luna's criticism of taxonomies and categorization[25] because they always bear the danger and disadvantage of illusionary clarity, undue simplification and rigidity, this might at the same time be a necessary risk to run. Without some sort of framework or guideline to disentangle different intersections and layers of vulnerable situations we remain with the vulnerable-group-generalization. The challenge seems to be to keep up the awareness that this taxonomy, like any other categorical system, is not concrete reality but an analytical instrument with its limitations and that we are responsible for the kind of categories we build as well as for the way we use them. With this critical notion in mind a taxonomy could be used as one of the steps or means to gain understanding and necessary differentiation.

2.3 *How are refugees in Germany vulnerable concerning their health?*

2.3.1 Using the taxonomy by Mackenzie et al.

This section shows a first attempt to use the taxonomy of vulnerability by Mackenzie, Rogers and Dodds for assessing health vulnerability of refugees. Considered are health conditions and access to health care for adult refugees/asylum seekers in Germany. Admittedly, this is still a very generalized group and the category refugee/asylum seeker includes very heterogeneous people with very different stories. At the same time the fact of flight itself constitutes specific situational features that affect health and shape the possibilities of access to the German health care system. This does not imply that the whole group is vulnerable the same way. Rather, the purpose is to map out different kinds of situational vulnerabilities. Therefore, it seems useful to start with this categorization and then subsequently analyze more differentiated and finer grained after this first assessment e.g. for accompanied versus unaccompanied minors, people from specific religious, political or sociocultural backgrounds etc. Building up further exploration from there, it would be interesting to see whether and how intersectionality is reflected in the taxonomy.

The taxonomy of vulnerability according to Mackenzie, Rogers and Dodds discerns two states of vulnerability which helps to differ-

[25] Luna: Identifying and evaluating (Note 17), pp. 86–95, here p. 90.

entiate dispositions that are basically there but dormant in the sense of not acute (dispositional state) from those that occur acutely in a specific situation (occurrent state). Both states could stem from different sources: while inherent vulnerabilities are those we find tied to universal conditions of human life (like corporeality, basic physical and psychological needs, aging, and others), the situational sources refer to the context specific features both long- and short term. The pathogenic source aims to capture specific situational factors that exacerbate already existing vulnerabilities by way of paradoxical effects of interventions or structures that are meant to support; or by abuse and dysfunctional personal relationships, social, or political systems.

For the following taxonomy of vulnerability regarding health and health care for refugees and asylum seekers in Germany, influencing factors are grouped into dispositional and occurrent states according to a time-line. The cut-off mark is the entry into Germany. Factors people bring along are taken as acquired dispositions (therefore in the field of dispositional in the table) while influencing factors that occur due to the specific situation in the German health care system are taken as occurrent (therefore titled as »after flight/as asylum seeker«).

States Sources	Dispositional	Occurrent
inherent	Like all human beings: risk of illness, injury, trauma, disability; inherited or acquired	Longstanding, adverse conditions pre-flight that affect health in a long-term like malnourishment, lack of health care, lack of education, etc. >> multiple risks at the same time less chances to develop resources/ resilience;
situational	High exposure to acute risks of infections, accidents, trauma, abuse pre-flight due to acute adverse conditions (war, famine, dysfunctional system etc.) during flight due to unsafe travelling conditions, lack of food, sanitary facilities, health care, protection, privacy	After flight/ as asylum seeker Low social status, lack of social support, social exclusion, adverse living conditions through inadequate housing for a longer period, long waiting times concerning decisions about asylum application, trauma and psychological problems not recognized and/or not treated, language/ cultural barriers exacerbated; lack of interpreters/ mediators

States Sources	Dispositional	Occurrent
	after flight/ as asylum seeker strain of acculturation/ new socialization, loss of family and friends, insecurity of perspective, language and cultural barriers, lack of system-knowledge Undocumented migrants/ refugees: >> no legal access to state support structures, difficulties accessing health care	Undocumented migrants/ refugees: >> no access to legal support structures >> alternative support (NGOs, church groups etc.) not always available
pathogenic	Exposure to violence and human rights violations, asymmetric power-relations and multiple dependencies, lack of protection and of possibilities to claim (human) rights Pre-flight: experience of war, violence, persecution, torture, abuse, dysfunctional systems During flight: exploitation and abuse by smugglers, authorities, care-takers, human trafficking; unsafe vessels and refusal of aid/ rescue; denial of right to asylum exacerbated in case of undocumented migrants/ refugees	After flight: AsylbLG >> restriction of entitlement to health care (for 18 months, in case of sanctions maybe longer), abuse/ denial of rights and entitlements, dependency, hindrance to earn own income, lack of participation in society and decision-making processes, othering, racism, disempowering structures, highly contradictory political and legal frame in Germany and Europe due to ambiguous measures of deterrence Undocumented migrants/ refugees: *De jure* limited access to health care possible (AsylbLG) but *de facto* not given/ not accessible – Care provider obliged to notify immigration authority according to immigration law (§87 Abs. 2 Nr. 1 AufenthaltG) – request for refunding of cost from municipalities not possible without notification

Tab. 1: First attempt to use the taxonomy of vulnerability by Mackenzie et al. regarding health care for refugees and asylum seekers in Germany

Starting with inherent dispositional vulnerability as the first part of the matrix we obviously find that concerning their health all human beings are inherently vulnerable (universal human condition). This disposition turns into an occurrent state in case of adverse conditions which expose people to diverse health risks or even endanger survival. These kinds of situations (lack of means to secure livelihood, war, persecution, natural disasters etc.) are typical causes of migration and flight. Dealing with the situation in Germany these pre-flight conditions are taken into consideration as inherent and occurrent vulnerabilities in the sense that refugees arrive with the (mid- and long term) effects on their health they have already suffered. Moreover, poor health conditions in places already characterized by insufficiencies like weak infrastructure, could turn more adverse due to acute, added problems (renewed outbreak of civil war, breakdown of structures, new waves of persecution, floods). This is taken as situational source of (increased) vulnerability existing pre-flight. During their flight refugees face multiple serious risks to health and life. Maybe it could be assumed that in general there is an acquired dispositional vulnerability through flight? Again, this turns into an occurrent state if the specific circumstances after flight in the receiving country Germany are posing further burdens and stressors like long waiting times, unconducive housing etc.

To my understanding there are multiple sources of (health) vulnerabilities for refugees that have to be placed under pathogenic in the matrix, both due to paradoxical effects as well as due to sociopolitical structures: European and German laws, immigration regulations, restricted health care provision, general lack of adequate protection of Human Rights and of opportunities to participate in society. Refugees without legal papers are specially mentioned since they face particular problems accessing health care (and other support) in Germany.

2.3.2 Brief evaluation

The following remarks are some first, still theoretical reflections on using the taxonomy as a method:[26]

[26] Thanks for the discussion to the participants Anne Kasper, Lea Marie Mohwinkel and Corinna Stoexen of the working group on vulnerability at the FlüGe interdisciplinary graduate school, Bielefeld University.

The use of the taxonomy certainly needs more careful thought and not all critical doubts can be simply thrown overboard. But it proves at this stage its potential to map out and differentiate a situation that is often regarded as vulnerable. This differentiation leads a step away from a generalized view of vulnerability to more specific features of the context and particularly reveals structural determinants of social determinants of health[27] like access to health care systems or other facilities, opportunities for social, cultural, and political participation, strategic housing etc.

Though it is not always salient how to discern dispositional and occurrent states of vulnerability (which the authors acknowledge[28]), this is not necessarily only a flaw since it resonates the real intricacies and complexities. Moreover, the taxonomy is thereby open and flexible enough to take e.g. social determinants of health into account since it offers the possibility to capture developments over time by e.g. taking long-term (situational) threats to health in the past (like malnutrition) as dispositions that can turn into an acute or occurrent state in the presence.

As a taxonomy of vulnerability, the focus does somewhat remain on the deficits. It seems to require a conscious effort to spell out strengths and resources. The taxonomy could be further elaborated and may need additional methodical tools when used for practical purposes to identify necessary interventions in individual cases in such a way that individual resources are taken into account.

Combining it with Luna's approach of layers of vulnerability, with Hurst's[29] definition of vulnerability and the respective questions as guideline (like Durocher does[30]) or with other approaches, is likely to advance the use and development of the taxonomy especially if

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[27] Philippe Bourgois, Seth M. Holmes, Kim Sue, James Quesada: Structural Vulnerability: Operationalizing the Concept to Address Health Disparities in Clinical Care. In: Academic medicine journal of the Association of American Medical Colleges 92 (2017), pp. 299–307.

[28] Mackenzie, Rogers, Dodds: Introduction: What Is Vulnerability (Note 24), pp. 1–33, here p. 8.

[29] Samia A. Hurst: Vulnerability in research and health care; describing the elephant in the room? In: Bioethics 22 (2008), pp. 191–202.

[30] Evelyne Durocher, Ryoa Chung, Christiane Rochon, Matthew Hunt: Understanding and Addressing Vulnerability Following the 2010 Haiti Earthquake: Applying a Feminist Lens to Examine Perspectives of Haitian and Expatriate Health Care Providers and Decision-Makers. In: Journal of human rights practice 8 (2016), pp. 219–238.

adjusted to the setting (clinical trial, clinical care, public health care etc.).

3. Understanding Vulnerability and Justice in Health Care – Questions arising

This first attempt to use the taxonomy of vulnerability as analytical instrument regarding health and health care for refugees in Germany helps to outline different sources and states of vulnerability at different phases in refugee migration. Assessing the current situation in Germany as receiving country shows many pathogenic sources of vulnerability. It makes visible the multiple risk-exposures regarding a wide range of threads and harm to physical, psychological and social health and at the same time diminished opportunities to keep or build up resources and coping capacities. Across the phases pre-, during and after flight vulnerability seems highly increased mostly due to adverse situational conditions, political, legal, and social structures. The restrictions and derogations of health care in Germany for refugees in entitlement, access and quality of care increase vulnerability to an extent that health and well-being are at stake. This is exacerbated dramatically in case of undocumented persons.

More often than not refugees arrive not only with an increased vulnerability but already emotionally wounded or even traumatized. In order to avoid increase of vulnerability or even further harm it seems noteworthy to point out that the taxonomy shows where preventive measures could and ought to be taken[31]: The transformation of some of the dispositional vulnerabilities to the occurrent states could be prevented e.g. by full entitlement and uncomplicated, culturally sensitive access to health care supported by trained interpreters in case of trauma, psychological stress or chronic conditions.

But why does understanding how vulnerable the situation is, lead us to what we ought to do? Or, as phrased by Mackenzie et al: »Why does vulnerability give rise to moral obligations and duties of jus-

[31] Mackenzie, Rogers, Dodds: Introduction: What Is Vulnerability (Note 24), pp. 1–33.

tice?«[32] Moreover, we could ask whether – if vulnerability gives rise to moral obligations – it also constitutes (human) rights.[33]

Realizing how vulnerable other people are in certain situations intuitively appeals to us as a reason to assist. It seems like seeing a person in need – we generally agree that we ought to help to fulfil a need if the person is not able to do so himself or herself, if it is an existential need and if we have the means to do so without considerable danger for our own life. But the number of »ifs« already indicates that things are not as easy as it might seem at first glance. Likewise, we have to ask whether every kind of vulnerability creates a reason to assist or intervene, what kind of vulnerabilities do so, why and to whom exactly they pose a responsibility. Another fundamental question is whether it is vulnerability itself that constitutes a moral obligation or whether it rather points to other sources of such an obligation – like needs.[34] But what are we doing exactly when we try to analyze, categorize and determine different types, forms, levels or layers of vulnerability? Are we not actually trying to determine need? Does being vulnerable not mean being (almost?) in need of support and protection? Certainly, as we saw when analyzing the term in the first section of this paper, there is a strong connection of vulnerability to helplessness, weakness, fragility and so on. Being vulnerable and in need means being dependent and constitutes an asymmetric social power relation. Therefore, vulnerability is often seen as opposite to autonomy. Here, questions arise how we can understand autonomy acknowledging our universal vulnerability at the same time. How vulnerability, dependency, social power hierarchies and autonomy are dynamically related seems to me at the heart of the matter. To disentangle these interconnected phenomena in our lives needs much further thought and to outline the already existing discussion is beyond the scope of this paper. It may be emphasized at least that the role of vulnerability and needs for deliberations on justice touches crucial questions that are still undertheorized and gain

[32] Mackenzie, Rogers, Dodds: Introduction: What Is Vulnerability (Note 24), pp. 1–33, here p. 8.

[33] Lutz Bergemann, Andreas Frewer (Eds.): Autonomie und Vulnerabilität in der Medizin. Menschenrechte – Ethik – Empowerment. Menschenrechte in der Medizin. Volume 6. Bielefeld 2019.

[34] Mackenzie, Rogers, Dodds: Introduction: What Is Vulnerability (Note 24), pp. 1–33, here p. 10.

even more importance in connection with questions of global justice and global health.[35]

4. Further questions and outlook concerning refugee health in Germany

Regarding matters of justice in health care it seems worthwhile to at least point out a few of the central, unsolved questions concerning refugee health. This outlines some of the major tasks we need to urgently face in empirical research, philosophical reflection as well as in practical terms.

Distribution of services in the German health care system claims to consider justice by distributing according to health needs assessed on the basis of medical knowledge and expert judgement. In case of restricting health care for refugees there are no medical reasons rather the common argument in public and political discussion points into a different direction: newcomers should have less entitlement in general including health care services in particular because they have not contributed to the common solidarity system. There is a shift of the principle of justice from need to merit. Why? Moreover, as far as I can see, this shift is not made explicit and (therefore) not debated. At least it has to be questioned whether and how different principles of justice ought to be considered. And what exactly does solidarity entail in the context of health? Health care for refugees is intertwined with wider matters of social justice. If we take the impact of social inclusion and social determinants of health serious then we need to consider participatory justice and we may have to reconsider the protective function of justice. Refugees do not have any other place to turn to than the state, society and health care system of their host country, where they mostly live at the very end of the social hierarchy with little or no means to help themselves in case of illness. Restricting health care (and other forms of social participation) for them seems to equal leaving someone in a helpless situation alone despite the fact that one could assist.

[35] Gillian Brock, David Miller: Needs in Moral and Political Philosophy. Stanford Encyclopaedia of Philosophy. Summer 2019. https://plato.stanford.edu/archives/sum2019/entries/needs/ (accessed 9/24/2019).

Regarding health it is generally accepted that not all health disparities are necessarily unjust but as Norman Daniels argues »health inequalities among different social groups can be considered unjust when they result from unjust distribution in factors that are socially controllable that affect population health.«[36] Since refugees' health vulnerability is less person-bound but rather due to circumstances, political, legal structures, rules, and pathogenic sources, they are principally changeable. So, I would claim, understanding vulnerability informs us about matters of justice.

Under the basic moral and ethical guideline to prevent harm, there is enough evidence already to take up the issue of refugee health seriously. To detect avoidable harm is what working with concepts of vulnerability can help us do. In using them, we need to be aware of and carefully navigate paradoxical effects of our support efforts to keep the direction of empowerment, fostering agency and respecting autonomy.

[36] Norman Daniels: International Health Inequalities and Global Justice: Towards a Middle Ground. In: Solomon R. Benatar, Gillian Brock (Eds.): Global health and global health ethics. Cambridge 2011, pp. 97–107, here p. 101.