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RESPONSES AND DIALOGUE

Being There: A Commentary on Göran Hermerén's "A Future for Migrants with Acute Heart Problems Seeking Asylum?" (CQ 30 (2))

Inez de Beaufort

Erasmus Medical Center, University of Rotterdam, Rotterdam, The Netherlands
Corresponding author: Email. profideep@gmail.com
Professor Inez de Beaufort is retired.

"Ensure healthy lives and promote well-being for all at all ages" (Goal 3 of the Sustainable Development Goals UN)[1]

"Health consequences and challenges 12. Many refugees and migrants lack access to health care services, including health promotion, mental health services (in particular those for post-traumatic disorders, which affect many refugees and migrants), disease prevention, treatment and care, as well as financial protection. 13. Nationality should never be a basis for determining access to health care; legal status (often) determines the level of access, as appropriate within national insurance schemes and health systems, without revoking the principle of universal health coverage as set in international agreements. Refugees and migrants may, in some circumstances, fear detection, detention or deportation and may be subject to trafficking or slavery."[2]

"It remains clear that collectively we as humanitarians are leaving millions of people behind. For all the good we undoubtedly do, we are not doing anything like enough, for anything like enough people. We should pay heed to the statistics – but we should also pay heed to the stories behind the statistics. Who are these millions of people left behind? Every human being has a name, a story – and a beating heart – but names and stories are so often subsumed by the words we use to try to present the challenges of our times. The missing millions become 'crisis-affected populations', 'migrants', 'refugees', 'beneficiaries' – or just the neglected, the dispossessed, the dead."[3]

Introduction

Hermerén's rich, systematic, and thought-provoking article raises many questions on many levels on policies, politics, and people, both practical and theoretical, both moral and political, most, I fear, with many differing and controversial answers; some are maybe even unanswerable. His article plunges the readers into the depth of (medical) ethics, their personal conscience and political responsibilities. What does human dignity call for and are there limits to solidarity? I wonder whether many readers may have a first intuitive reaction of doubt, may be thinking providing heart transplants to persons who are not citizens of a country where the transplants are provided, is a bridge, or probably several bridges, too far. That is probably the reason why Hermerén chose this example. (It is, but the situation also actually happened in his country.)

I can only respond with more questions and some comments to a few issues, regarding the who, the what, the why and the how. I will try to relate some of his arguments to other examples.

I agree with his conclusions on the intricate relation between ethics and politics, the importance of the context of a debate.

Who? Being There, Going There, Fleeing There, and Staying There

Who are we talking about? And does that matter? Hermerén uses the notion migrants, and in the title mentions it is about those who seek asylum. Does he want to encompass both migrants and refugees and people seeking asylum, people who have been denied asylum but stay in the country and others who travel to a country and are undocumented people? This is relevant as different legal regimens apply in a global perspective.[4]

Very roughly: refugees cannot return to their country of origin without risk of persecution or death, migrants can. (At least in theory.) Obviously, this is a very complex question as of course all (may) need medical care and some may need a heart transplant. The moral appeal however may be different, and therefore the question is important: who is included? (I presume that those who were granted citizenship and permission to permanently stay, have the same entitlements to the healthcare package/system, including a heart transplant, of a country as every other citizen. I am sure this is a rather optimistic presupposition, as this may not always be the case.)

Hermerén distinguishes two countries Y and X. In Y, there is a war and persecution. This implies that the people from Y travelling to X are indeed refugees. He invites us to assume the following: "young migrants with acute heart problems escape from their country Y to country X hoping to get a heart transplant. They move in order to access what they cannot obtain at home." This concerns hypothetically persons who escape (!) from the dire circumstances in country Y to the "better" country X. Of course, the fact that they need to flee country Y and the fact that they are young appeals to people's moral feelings and ideas.

Country Z

The question we have to ask is: do the arguments Hermerén brings forward to help a person *only* hold for refugees coming from country Y or do they hold for *every person* coming to X because in his/her own country heart transplants are not available (in general, or for him or her). They also "move in order to access what they cannot obtain at home." Imagine people coming from country Z, where there is no war, but the healthcare available for all is very basic, because of general economic reasons and the ensuing priorities in healthcare, or because of the structure of the healthcare system, which provides such treatments only for those who can afford it, or because high technological treatments such as heart transplants are not available. Hermerén brings forward the *"The dignity argument.* All persons have the same human dignity, and the same entitlement to have their rights respected. Thus, they should be judged by the same criteria. Healthcare resources should be distributed on the basis of the treatment needs of the patient and the efficacy of the proposed medical intervention. Ethnic classification, birthplace, political views, the color of the patient's skin, and the patient's economic or social position are irrelevant." He adds that "Human dignity is an ambiguous concept that has been both criticized and defended. The particular understanding of it applied here centers on nondiscrimination. Persons have equal rights, and the same entitlement to have their rights respected, regardless of their political views, ethnic origin, political or religious convictions, age, and social or economic position.(…) But one particular problem needs to be addressed. What does (A 1) entail in its most radical form? Does it mean that anyone from anywhere is entitled to healthcare in any given country? If the argument is interpreted as implying a universal right, this certainly seems to be the implication." The dignity argument in its most "radical form" seems to hold for all. Yes, radical indeed, but is there another defensible interpretation?[5] I think modest interpretations are indefensible, precisely because it is about human dignity. So that also holds for persons like in country Z. A consequence would be that in that case many more people may try to get a heart transplant in X.

In other words: does it make if a difference if one has *fled* to country X or if one has *traveled* there? Does it make a difference if one already has fled to X for other reasons than to seek medical help and then there discovers one suffers from a serious heart condition requiring a transplant, or if one specifically

goes to country X in order to have the heart transplant? To put it simply: is it the being there and the medical condition that are crucial regardless of the reasons and the history of why one is there?

If these considerations matter, is that on legal grounds or on moral grounds? The inclusion criteria for the dignity argument and the radical interpretation make a big difference. This has to do with the question whether the heart transplant is not available elsewhere is the only issue, and the direct moral appeal comes from that fact, or whether different aspects of the *why* the person came to country x are relevant.

We all Want to be Good Samaritans?

The example as formulated by Hermerén appeals to Good Samaritan considerations. It has all the ingredients: young people, innocent people, victims of bad luck and of dire circumstances, and the radical and non-discriminatory interpretation of dignity. A Perfect or Good Samaritan[6] would probably think she ought to help each person on the basis of need regardless of the underlying reasons. But Perfect or Good Samaritans do run into trouble. That may have to do with the fact that they may not worry, care or think about the consequences, such as what if the robbers strike again the next day and there are 10 victims lying on the side of the road. For a Samaritan, this is not a reason not to help the one person she is attending to now. But it is a consideration that may make country X more inclined to be very careful and strict with admission and acceptance because of fear that the healthcare system will be overburdened or even collapse. A more Selective Samaritan maybe would help some persons, for example, the refugees but not others. And, of course, one can wonder whether the notion of Samaritan will then be diluted. I use it because I think it may matter to people to be taken care of by Samaritans or act as Samaritans and tell the story of dignity, compassion and responsibility. (Well to many people, not to all, some rather pretend they are Good Samaritans whereas they are not, some ridicule Good Samaritans and find pride in only helping people who can help themselves, and people who can help themselves by definition do not need help, so…).

Does "simply" giving people what they are entitled to as human beings on the basis of a radical interpretation of dignity mean they should receive *any help* they may require?

What: Heart Transplants

Why heart transplants? It is dramatic, obviously terrible if you die if you are young, the treatment is not available in many countries so one cannot tell people to have the treatment in their own country, and there is the additional problem of the scarcity of organs. Indeed, it is not likely that many, many patients will apply for a heart transplant in X, although one does not know for certain. And the small numbers may support the argument: we can afford to do this, it will not disrupt our whole system. That is also the problem of the example. If you would know beforehand that country X would be flooded with patients seeking help, it would be different. The demand for other forms of care may be bigger, even huge. Also, heart transplants may distract from other forms of care that may be very much needed. Providing a small number of heart transplants will probably not require us to turn our own system in X upside down to fulfill obligations to noncitizens. That may be a comforting thought. But that is a false comfort, as it does set a precedent and confronts us with the question: what is really necessary care and what does that imply for what we can provide to migrants and for our own system. I understand the example as a rather exceptional situation as philosophers sometimes use as such examples are helpful in order to illustrate and to test different moral positions. Why exceptional? It has it all: scarcity, life and death, heroism, and high technology. The scarcity of organs—a scarcity one cannot solve through investing more in a healthcare system, which is always a nice solution in affluent societies—certainly adds to the moral pressure on both patients, doctors, citizens, and society. It puts our solidarity to the test. So, I understand the choice of the example. And it has actually happened. On the other hand, one has to point out the unlikely-nesses, such as the travel[7]: one cannot simply hop on a plane from country Y; the hardships

when travelling from country Y are maybe too demanding for patients in need of a heart transplant. Also, one will usually have to be on a waiting list for quite some time.

The example particularly confronts us with the kind of scarcity that cannot be resolved. People on the waiting lists are all in a very bad condition, and they all had to wait and some die whilst on the list. This is another kind of scarcity than the scarcity that can be solved or at least mitigated by investing in the healthcare system, either by making it more efficient, or employing more healthcare workers and increasing the number of beds, and so forth. If the need increases, then facilities should be increased. With donor scarcity for hearts, that is not possible. Ought implies can. Of course, one could argue that it is mainly about having *equal chances* to receive a heart by being on the waiting list, but in that case, the chances of the citizens of X to be the recipient of an organ if on the waiting list still do become smaller. And that may negatively influence public opinion. This has to do with what Hermerén calls "*the confidence argument.* The confidence of citizens in their healthcare system is likely to be undermined if heart transplants for migrants without permanent permission to remain displace domestic citizens who then find it harder to access adequate healthcare, including heart transplantations if and when they need them." This is countered by the "*The contra-confidence argument.* So far, the problem raised by migrants with acute heart problems seeking asylum is not a big one in terms of numbers. Only a few cases have been discussed in the media, and only in a small number of the relevant countries. So, there is little risk of displacement of the sort envisaged. The likelihood that the healthcare system of the country receiving migrants will be drained of organs and other healthcare resources, such as operating rooms and the time of transplantation surgeons, is actually rather small." Of course, even if the numbers are small, the moral impact may be big. Even helping a few (or even only one) does set a precedent, and precedents attract others who would also need the treatment or other treatments that are not available to them. What holds for heart transplant, holds for cancer treatments or eye surgery, or treatment of other heart conditions, particularly as the arguments in favor of providing other treatments may be stronger. One cannot decide about the heart transplant without deciding about other treatments as well.

First Things First?

Hence, the example is interesting, but the problem is also that in real life this may not the situation we ought to be solving, or at least not in the first place. I admit: realism is overrated, but I do wonder which arguments will hold and how to weigh different arguments if we would not be discussing heart transplants but other treatments, for example, HIV/AIDS-treatment, care surrounding childbearing and giving birth, care for psychological trauma. Situations that are (more or) also acute, more numerous and in a way of a different scarcity. Someone already in X with an acute appendicitis would immediately be helped I presume. So would a woman from country Y about to give birth on the doorstep of the hospital in country X, be helped. People with broken limbs, people suffering from Covid-19, suffering acute heart attacks? Hermerén also quotes that "anyone, even migrants from outside the EU, is entitled to healthcare services that cannot be postponed"[8]—a phrase which presumably means that if the requested healthcare service is delayed, or not provided at all, this will cause serious harm to the patient requesting help.[9] These are in a way no-choice situations. There is no time, and no time for discussion, which also makes the appeal to and pressure on medical professionals stronger. This certainly would include more patients. This leads to the difficult situation that the "contra-confidence argument" that the likelihood of the risk of displacement of citizens is small, becomes more complicated.

We have to ask: is there a moral difference between a one-time treatment in an acute situation, you have it and then you are cured, or a continuous treatment or a treatment that does require monitoring and medication, or access to a whole system of healthcare as Hermerén describes? It may be very different if it comes to more ordinary or "normal" treatments.

Imagine a very rich, even extremely rich Benefactor person who took it upon himself after reading Hermerén's article to pay for all the heart transplants of people who cannot afford it. (That would not solve the scarcity of hearts of course.) Would we say: Yes, you have to do that, thank you? Or would we

say (I would) please may we kindly invite you to consider to use this money to improve the public health of migrants and refugees and citizens in need in general? For good food, vaccinations, and maternal care. In research for endemic diseases like malaria and cholera. You can save many more lives this way.

In other words: the attraction of the example is clear, the help could in theory be provided without disrupting the whole healthcare system of X. We could help the few young people fleeing from Y for this reason. But morally it is complicated.

The Why

What if we change the example and "resolve" the organ scarcity problem through changing the organ. Suppose, a person travels to X to have a kidney transplant and he brings his own donor (say his very motivated, dedicated, consenting, and loving partner[10]) and he also pays for the surgery and the treatment. After the operation he and his partner will go back to their country. (This kind of "tourism,"[11] situations in which the patients are willing and able to pay for the treatment, occurs.) There is time involved of the doctors and other healthcare workers, but not scarcity in the sense that someone else, say a citizen of country X, is "robbed" of the possibility of having the treatment. Would this not considered to be problematic in many countries as nobody is worse off because of this? Or is that too simple? Might it undermine the confidence of citizens of the country of origin, say Z, (why travel abroad? Because healthcare is much better in X and other countries than in our country?), or increase inequalities (other citizens of Z cannot afford to travel)? It might also lead to huge media influence on the promises and availability of such treatments in X as some who do not themselves have the resources might be able to raise money for example through crowd funding whereas others may not. The saddest story seems to "win," but the saddest story is may be the story of the one who does not even get to tell his or her story.

The evaluation of such "tourism" may depend on the why; why do people sometimes travel to a country in order to get specific treatments? Sometimes people travel, for example, to the Philippines because it is cheaper, to the United States for the newest treatments in the most excellent hospitals, or to seek medical help that is not available in their own country for other, moral, reasons, for example abortion, or to have certain reproductive treatments. It may be because treatments are available *only* in that country, or because treatments are easier or cheaper in that country, or because treatments are not covered by their own national healthcare system, or are experimental (last resort) treatments that are only provided in country X, or treatments that are deemed unacceptable in their country.[12] Whether such "tourism" is morally justified, I would argue, depends very much on the reasons why it is not acceptable or possible in country Z.

There is a lot to be said about such "tourism" that cannot be said here. Does it contribute to the healthcare system of the "receiving" country (e.g., via the income it generates) or does it diminish options for the citizens of that country in a more indirect way? Does it then exacerbate inequalities or not? Might it fit with the difference principle? That such inequalities improve the situation of those worst off, for example, because the health system has more income? I cannot go into that here, but it is important.

So, the why matters. Obviously it is not a reason to ban all travel for healthcare purposes. It mostly concerns people who are desperate. But it does complicate our debate and emphasizes the differences between those who can pay and those who cannot.

How? Changing and Adapting Priorities in Healthcare

The heart transplant for a small number of refugees or other treatments for a number of paying "tourists" may not fundamentally influence the healthcare system in X. But if one would defend that access to fundamental healthcare for others than the original citizens, is a right, with a corresponding moral duty to provide such care, that may imply one does have to change the system. One may have to reconsider the priorities the citizens of the country are also subjected to. Unless the country has

limitless means, which is rather rare (and even then does unfortunately not mean that citizens in such a country are treated equally), one cannot have one's cake and eat it, which means that priorities have to be set. Doctors and other healthcare professionals have to work with and within those priorities. (That is to a certain extent. I cannot go into that here, but of course precisely the extent is much debated, sometimes they do not accept the priorities as that would harm their individual patients, or they consider that it would lead to a healthcare system that is too meagre. On the other hand, they of course are also involved in establishing the priorities and very much aware of the necessity of limits. One cannot expect Sir Tom to keep walking and raise so much money for one's healthcare system.) The priority setting is of course an ethical and a political process. The big questions are: what is an acceptable level of care, and what can we afford as a society? Again, it is about solidarity: what do we consider should be available to all? What level of solidarity do we practice? These are questions about which there often are ongoing debates *within* a certain society as the answers of course depend on affluence and whether one is defending equal access. "We want it all and we want it now," is not an option, though there are of course people who think they are entitled to everything they want. There is host of literature about priorities in healthcare, how to design sustainable healthcare systems, about what human beings as humans beings need, about distinctions between necessary and luxury care. One of the reasons for the debate is that in some countries huge amounts of money are spend on (attempts) to save or prolong a life, with the most up to date treatments, that however are often quite or even expensive when balanced with the advantages they provide. One may wonder whether expensive treatments, for example, some treatments for Pompe's disease or cancer that exceed the amount in the Netherlands used as a rule of thumb (80,000 euros per Qaly) should be part of the "universal" healthcare package. This gives rise to the debate on limits, or limited amounts of dollars or euros to be spend per Qaly, on sensible investments in public health and prevention and in care versus cure, and on the comparison with other societal goals such as education, sports, environment and culture etc. The question this confronts us with in this context is: should citizens in X limit their options and entitlements in order to provide care for other people than their "official" citizens? Morally, I think there is a good case to be made, if one looks at the inequalities from a global perspective and not from a national perspective. I know: this is probably the most resistant world problem, but nonetheless an issue we all have to face, given the fact that general access to basic healthcare for people in many parts of the world is not available, and the global inequalities are huge between countries and within countries. Even apart from the dramatic reports one now receives on the lack of preventive measures or (proper) treatment for Covid-19 patients, in many parts of the world, the death-rates of women childbearing is a lot higher than that in other countries. "Maternal mortality is unacceptably high. About 295,000 women died during and following pregnancy and childbirth in 2017. The vast majority of these deaths (94 percent) occurred in low-resource settings, and most could have been prevented."[13] And this is just one example. Now why is this important for the discussion Hermerén is fueling? If we ought to provide care for many more persons, if we include more persons in our "moral community," we will have to set new priorities for healthcare in country X. The citizens of X may have to settle for less than they have now. Yes indeed, and some might think that morally that is a good thing. (I admit that politicians who defend that in all likelihood do not increase their popularity to say the least.)

Your Hospital or Mine?

Many different reactions are possible from the citizens from X: the first is, why us, why our healthcare system? Hermerén discusses the possibility of the public not wanting to support the heart transplants for the persons from Y, as they fear it might undermine their healthcare: we pay (or paid) for our healthcare, so it is for us. Of course, that is true to a certain point, citizens contribute to the education of health professionals, they pay for healthcare through some sort of insurance scheme, be it private, public or a mix of those. But, some historical perspective is needed: affluence is not only acquired through hard

work, but is also based on good luck and was often acquired at the expense of others. Healthcare systems are also built on past economic flourishing which of course is not only a matter of merit, but also of luck and may be even profiting from wrongdoings and exploitation in the past, which again may not be the fault of present citizens as they are not to blame for what their ancestors did. One should, however, wonder whether they can claim they deserve the good system they have, and even if they do, whether they can claim they do not need to share it (and settle for less) with others who have been less fortunate (through no fault of their own[14]). Do we deserve it more because we happen to find ourselves on the more lucky and affluent side of history?

A complex issue indeed. As a state one may have "build" the healthcare system and as an individual one might contribute, for example, in paying healthcare insurance premiums, but migrants and refugees often have not had the chance to do that, and they might have done the same had they had the chance.

I am not optimistic when it comes to citizens accepting their health system to be curtailed, or optimistic to think they will agree with less. And even less optimistic when such is done to relocate funds to basic care for people who are not "formal" citizens. It is already difficult enough when it is about their own priorities, their own citizens. This can only be accomplished (no, that is far too optimistic: argued for and fought for) on a supranational level.

Different arguments might be added: such a global view is necessary for the survival of all, just as investments in the environment: this is a truly global problem, it will affect all of us. The Covid-19 pandemic is confronting us with consequences of a disease that can afflict everyone all over the world, and may increase the incentives to do something also out of self-interest.[15] Another consideration might be that is in in nobody's interest if inequalities lead to global social unrest. This will again lead to more people having to flee from their countries, and so forth.

The Doctors

What is the role of doctors? Hermerén describes how they may face difficult dilemmas. They may suffer from great moral distress when they have to choose and cannot help everyone. They could of course defy the rules of their country on the basis of professional ethics and disregard regulations, claiming it is their duty to help. (This is particularly strong and convincing in the acute appendicitis or child birth example, but then they would not need to disregard the regulations.) But on the whole, they are in a way also "trapped" in the system in which they function. Hospitals have to be run and be financially feasible, doctors cannot go around and offer free services to everyone who needs it. That does not mean they cannot *sometimes* do that, particularly if they think the system in which they work is unfair, for example, in emergency circumstances. Of course, they can stimulate the societal debate, and demonstrate the dilemmas they are facing, but they are also depending on that system.

They can set an example as for example like Dutch so called street-doctors do, and care for those who fall out of the system[16] (undocumented people and homeless people). They are Samaritan "cowboys" challenging the system. What they do is very important. And it confronts us with the mazes in the social net, and huge injustices. But I fear as individuals the position of healthcare professionals is vulnerable. As a professional group they play an important role in the public national and international debate. But it would be better if the system itself would be changed.

Down the Slippery Slope?

The example is very apt to sketch dramatic slippery slopes as would probably happen in political debates: Everyone will come to country X if it becomes known that they provide heart transplants or other treatments. Well, to be cynical but realistic: certainly not everyone, as most cannot afford the journey, or they are too ill (it is mostly not the ill who are leaving the country) and they could not even manage to travel. They may find themselves in a hostile environment, they may not meet doctors that are

considering to help. So, I doubt very much whether a slippery slope would apply in the case of heart transplants. It may, however, be somewhat more convincing regarding other less complicated, less scarce treatments. For some providing such treatments may be a slippery slope arguing that it will undermine the whole system, others may say: this is not a slippery slope at all, it is a good thing, the system needs to be changed.

An issue Hermerén mentions repeatedly is that he has not found empirical evidence in PUBMed. That does not surprise me. If there is evidence it is of a different nature than the kind of evidence that finds its way to PUBMed. Also, one would suppose that it would be research using hypothetical vignettes and hypothetical cases: "how would you feel if two patients from Y would receive heart transplants," which may lead to socially correct answers. If people would not give socially or politically correct answers but say they would be fundamentally against such treatments as, for example, people in Y have to solve their own problems, what then to do with such evidence? What would it prove? One can find a lot of interesting (and not so interesting) views of the public in the media (there is a lot of "not in our backyard" and "not at our expense"). Not evidence in the PUBMed way, but illuminating (and saddening) as it provides an indication of the considerations people bring forward. I also wonder whether the arguments that Hermerén calls "empirical" are not also moral arguments.

The Unpleasant Truth

One, sometimes, has to face the unpleasant truth: many human persons find themselves in terrible situations, refugees find themselves in camps, under circumstances that certainly lead them to have other priorities than heart transplants. Uninsured citizens in many countries do not have access to basic healthcare. Undocumented persons do not seek care, or go to inadequate quacks because they fear detection and detention or eviction if they seek help in the "official" system. The global inequalities are dramatic. Infectious diseases that could be prevented are raging. Mothers die in childbirth. And so much more misery that strikes the human race.

For those who say: "this is not my problem or my responsibility, I do not want to whole world to be a lifeboat," there is no real point in having a serious moral debate. The only answer to them is: try to imagine it was you or your child. There is no excuse for not imagining it was you. Only arrogant and selfish people lack that kind of imagination. There is also a difference between saying: I cannot help, not as an individual at least, although I wish I could, and I will not help because you do not deserve the treatment. The latter would be adding insult to injury.

Rightly Hermerén states that we need a global ethics. "To resolve many of the conflicts touched upon in this article a global ethics would be needed, and ideally also global regulations. It will not be enough to harmonize the regulatory framework within the European Union (EU), as many migrants come from countries outside of EU. But the problems go deeper than that. Even if the ethical and regulatory frameworks were global, differences in economic and technical development between countries around the globe would still make the future of migrants with acute heart problems somewhat insecure. Here again we are reminded of the political context of the discussion." His approach is very systematic. The problem is that in the real world the situation is very messy.

The question is how realistic, or how naïve is a global ethics? Progress has been made. But, of course, we are nowhere close to fulfilling the sustainable development goals. In the end that is probably where the solution lies. In the meantime: we need to bring treatments and experts to people in need, for the simple reason: they are humans who are in need of help. Not only do we need a global ethics: we need the plans and the power to carry out such global ethical ideas and make them reality.[17] Idealistic, probably, but what is the alternative? Closing one's eyes is not a moral option. Giving up is not an option. Too many are "Out of sight. Out of reach. Out of the loop. Out of money. Out of scope. The people we fail to see. The people we cannot get to. The people we unintentionally exclude. The people we do not prioritize. The people who 'are not our problem'."[18]

Notes

1. UN Sustainable Development Goals 2030.
2. WHO Draft Global Action Plan. *Promoting the health of refugees and migrants* (2019–2023); available at https://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_25-en.pdf (last accessed 21 Mar 2021).
3. *Leaving Millions Behind. World Disasters Report.* IFRC 2018, Foreword Mr Elhadj.
4. See UNHCR Handbook on procedures and criteria for determining refugee status and guidelines on international protection. Geneva 2019. Obviously, the issue of available health care also holds for migrants and irregular migrants.
5. Göran Hermerén, "A Future for Migrants with Acute Heart Problems seeking Asylum, CQ 30 (2), discusses a more modest interpretation "Perhaps the dignity argument and its underlying moral principle should be understood more modestly, so that they apply only to people within a certain geographical area, holding certain passports, or having contacts and resources that make it possible for them to travel to other countries. The objection to this, however, is obvious: it cannot be excluded that those who do not have these qualifications may suffer more, and have stronger needs for health care. Hence, the scope of the argument is obviously important."
6. The notion of perfect and minimally good Samaritans comes from Thomson's classical article on abortion Thomson JJ. A defense of abortion. *Philosophy &Public Affairs* 1971; **1**(1).
7. This is of course different if one already resides in a country.
8. Of course, this is also a rather general and vague concept. And in fact, it might include heart transplants. But though there may be a gray area, I think the appendicitis and the birth situation would certainly qualify.
9. Alas, irregular migrants do not ask for help or too late, also because the systems of healthcare and finding them in order to send them away are often related. It is therefore dangerous to seek help, as it may lead to eviction.
10. The problem is complicated enough, we cannot have more complications regarding possibly pressured or fragile donors.
11. I use the term tourism, but it is more dramatic than that, may be treatment-travel would be better.
12. For example, it is possible to have preimplantation diagnosis which, for example, in my country is regulated strictly on moral grounds, in Cyprus. Advertisements suggest to combine this with a nice holiday.
13. WHO website, accessed 13 July 2020.
14. I realize this is a simplification. I will just not touch upon the problem of holding citizens of Y responsible for accepting bad leaders, civil wars, and so forth.
15. Global Preparedness Monitoring Board. *A world at Risk, Annual Report on global preparedness for Health Emergencies.* Geneva: Global Preparedness Monitoring Board; 2019. Very interesting reading now that we know what has happened since.
16. Irregular migrants in the EU are entitled to around 35 percent of the health services available to nationals, mostly relating to emergency care, for example, Ingleby D, Petrova-Benedit R. *Recommendations on access to health services for migrants in an irregular situation: An expert consensus. Brussels:* International Organization for Migration (IOM) Regional Office, Brussels; 2016. Although some countries waive restrictions for antenatal care and treatment infectious diseases, these measures are ineffective without access to primary healthcare that would provide continued care or detect these diseases, for example, De Vito E, de Waure C, Specchia ML, Ricciardi W. *Public Health Aspects of Migrant Health: a Review of the Evidence on Health Status for Undocumented Migrants in the European Region*. Health Evidence Network Synthesis Report No. 42. Copenhagen: WHO Regional Office for Europe; 2015. In many contexts, all but life-saving assistance requires upfront payment of often-unaffordable fees (Aldridge R et al 2017. Falling through the cracks: The failure of universal healthcare coverage in Europe. *Observatory report, European network to reduce vulnerabilities in health.*). Directly linking immigration control to access to services is increasing.

Healthcare providers in five European Union (EU) countries are legally required to report undocumented migrants to immigration authorities. Confidentiality is only assured in 10 countries. In the UK, this is part of a range of measures where landlords and banks are also required to carry out immigration checks. Such environments deter migrants from seeking healthcare and result in alternative strategies such as self-medication, contacting doctors in social networks and borrowing health insurance and identity cards (Vito E et al. Public health aspects of migrant health. A review of the evidence on health status for undocumented migrants in the European Region. *Health Evidence Network Synthesis Report. no 42*. Copenhagen: WHO Regional Office for Europe; 2015). In the UK, research has indicated that a third of irregular migrants avoid timely healthcare and a quarter of pregnant migrants without status had not accessed antenatal care at 18 weeks (Bulm) *Leaving millions behind. World Disasters Report* 2018, IFRC Geneva.

17. Such plans exist. See apart from the ones already mentioned and developed by the WHO, the IFRD, the UNHCR, for example, WHO Regional Office for Europe. *Environmentally Sustainable Health Systems: A Strategic Document*. Copenhagen: WHO Regional Office for Europe; 2017.
18. IFRC Secretary General. *Leaving Millions behind. World Disasters Report* 2018. *Executive Summary*. Geneva: IFRC Secretary General; 2018.

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