Submission to the Senate Inquiry into Migration Amendment (Repairing Medical Transfer) Bill 2019

Bill to amend the Migration Act 1958 to repeal the medical transfer provisions inserted by the Home Affairs Legislation Amendment (Miscellaneous Measures) Act 2019

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1. Introduction

We are three of the lead doctors implementing the medical transfer provisions of the *Migration Act 1958* (Cth), which provisions were inserted into the Act by the *Home Affairs Legislation Amendment (Miscellaneous Measures) Act 2019* (Cth). We welcome the opportunity to make this submission to the Senate Legal and Constitutional Affairs Committee.

We are a part of a group of independent doctors who have been almost exclusively responsible for medical assessments of a cohort of refugees and asylum seekers currently in offshore processing locations, and the subsequent applications to the Minister for Immigration and the Minister for Home Affairs for medical evacuation on behalf of these patients.

We are qualified and registered Medical Practitioners in Australia. We also hold Fellowship of our respective specialty Colleges, and have worked within our training and expertise to assess individuals and health systems, as we do in our daily practice in Australia.

We are not an organisation or discrete entity, though we are broadly supported by the Medical Evacuation and Response Group consortium. The medical assessments we have undertaken are independent, and absent of any broader advocacy agenda.

As part of our assessments, we and the other doctors volunteering their time alongside us have collected and read hundreds of thousands of pages of medical records, and undertaken direct teleconference health assessments of a large number of individuals. We have conducted individual health assessments on every patient who, to date, has had an application made under the medical transfer provisions.

In undertaking these assessment, we have been able to conduct the first independent audit of the disease prevalence affecting this cohort of refugees and asylum seekers in offshore processing locations (both Papua New Guinea and Nauru), and also the first independent assessment of the health services which have been provided and the access these individuals have had to those health services. All the major Australasian medical Colleges and Societies have been briefed as to the nature and extent of these assessments.

We have obtained patient consent to access their medical histories and undertake these health assessments, but this consent does not extend to exposing their individual medical histories to public scrutiny as part of a Senate inquiry.

We have therefore provided in this written submission only that pooled information which we believe will help you consider medical transfer provisions, in line with our ethical and legal obligations in respect of individual patient confidentiality.

We would be grateful for the opportunity to more extensively discuss our findings, and the finer details of our submission, with the Committee.

2. Recommendation

That the Senate oppose the Migration Amendment (Repairing Medical Transfer) Bill 2019.

3. Summary of health services in Papua New Guinea and Nauru

A snapshot of the health services available in Papua New Guinea and Nauru can be found in the report of the Independent Health Assessment Panel (IHAP) from the first quarter of 2019. In reading the IHAP report, it should be noted the panel was not fully constituted at the time, and the final member of the panel was not inducted until almost the end of the second quarter of the 2019. It is also notable that the second quarter report of the IHAP has not been released, despite an obligation within the legislation that it be prepared and tabled in Parliament.

Nauru is an island in the pacific with a local population of 10,000. There are just over 200 refugees and asylum seekers still in Nauru. These refugees and asylum seekers are served by a combination of health care services. Primary health needs are attended to by medical staff working for International Health and Medical Services (IHMS), a private company which is a branch of International SOS. All emergency care is provided by the Republic of Nauru Hospital. Although the IHAP report suggests there are a large number of health professionals per person, the following matters should be noted. *First*, it is important to note that these health professionals are not subject to any external standards of employment, often being deployed from an international working pool. *Second*, the total number of employees noted in the IHAP report from the first quarter of 2019 does not take into account the division of their labour between shifts, how many employees are on island at any time (taking into account the fly-in-fly-out nature of the contracts), nor provide anything but a brief assessment of expertise. *Finally*, there is no way to reliably tell what quality of care is provided because the emergency care is subcontracted to Nauru (which uses separate medical record management systems and separate systems for recommending transfer) and there is no requirement for external audit by the Department.

The IHAP report notes that specialist services are provided on a 'periodic' basis; most of these assessments seem to be conducted remotely and infrequently. Upgrades to the Republic of Nauru Hospital are noted by the monetary expenditure on them, and not by reference to their quality or suitability for use. It is not clear: whether the panel has been provided with, or asked for, any outcome data from IHMS or the Republic of Nauru Hospital; whether they have been provided with, or asked for, any quality control or governance information the Republic of Nauru Hospital; or whether the panel has engaged any patient groups for feedback about the services provided, which would be the standard of care at an Australian institution were it being evaluated. For these reasons, we consider that caution should be exercised in drawing any firm conclusions about the standard of care in Nauru based on the IHAP report.

A large number of refugees and asylums seekers have been removed from Nauru in 2017-2018 for medical treatment. A majority of these transfers were on the order of an Australian Federal Court judge, with attendant delays in access to appropriate medical care for the patients.

Health care provision on Manus Island has had two distinct phases. From 2013 to October 2017 (some limited extension to March 2018), IHMS was the primary provider, with Pacific International Hospital (PIH) in Port Moresby being the main referral hospital. Subsequent to that, PIH was contracted to provide limited in-hours primary care to the refugees and asylum seekers on Manus Island, while emergency care on Manus is provided by the local government hospital in Lorengau.

The population of Manus Island is approximately 60,000, and is served by only six doctors who work on secondment in this hospital. It is typical of a remote clinic in a resource poor country with limited staff and health care resources, a monthly shipment of limited drugs with ongoing stock issues, very little in the way of diagnostics, and an irregular system of transfer. Containment of mental health patients on Manus is managed at 'Shamrock', a former police barracks that is guarded by non-clinical staff and that at one recent point there were at least 17 mentally unstable men contained in that non-clinical space. Some of these men are eventually transferred to PIH, Port Moresby; some not.

We understand that not many of the Federal Court cases were related to Papua New Guinea, and given that there was an international contractor providing care, relatively little objective information has been publicly available, other than the strident assertions made by each sitting government, and the assessments made by groups such the Red Cross and UNHCR. There has, to date, been no detailed analysis provided of the standards to which the department holds their contractor in PNG.

The first quarter 2019 IHAP assessment and report into health facilities in PNG included a remote assessment of the health services on Manus Island, and a teleconference assessment of the facilities at PIH. The IHAP report noted that on Manus Island, there was a reasonable level of primary care and limited secondary services, with specialist care not reliably available. It is notable that no mention was made of the use of Shamrock as a medical facility for high acuity patients, raising the question as to whether IHAP were aware of its existence or able to evaluate the suitability of an old police barracks in the health care provision of high acuity patients. It is also notable that there is no mention of Lorengau hospital, which provides all after hours and emergency care for the refugees.

IHAP noted that they were impressed with the facilities at PIH, but again it is not clear: whether the panel has been provided with, or asked for, any outcome data from PIH; whether they have been provided with, or asked for, any quality control or governance information for PIH; or whether the panel has engaged any patient groups for feedback about the services provided, which would be the standard of care at an Australian institution were it being evaluated. For these reasons, in our view the IHAP's statement that they were impressed with the PIH facilities should be treated with caution.

It is again notable that only the first quarter 2019 IHAP report is available and the panel was comprised of two doctors employed by the Government, and it was not fully constituted with independent medical professionals at this time. There is no evidence within these reports that evaluation of the health service and health outcome auditing was conducted to Australian standards.

There is no other documentary evidence of independent medical assessment of health facilities in Nauru and Papua New Guinea. Moreover, independent assessment by Australian medical Colleges and the AMA have not been able to be undertaken to date, despite repeated requests to do so.

4. Implementation of the Legislation

While the medical transfer provisions are unique, the idea of recommending transfer for medical care, including recommending the destination best suited to provision of patient care, is an everyday part of health care provision in Australia. Doctors are required by the Australian Health Practitioners Regulation Agency Code of Conduct for Medical Professionals to ensure that patients are referred for appropriate care. Doctors in rural areas routinely make determinations around the level of care required and where they should be provided, and doctors in urban locations routinely accept patients for medical care. Clinicians routinely assess patients remotely using telehealth services, and also provide recommendations for complex care on the basis of assessment of medical records and test results alone. In Australia, the balance is typically in favour of transferring patients where there is an indication that might be required, rather than waiting until a patient is catastrophically unwell before escalating their care provision.

The legislation still requires the Minister of either Immigration or Home Affairs to approve the transfer, and also creates independent medical scrutiny in the form of the IHAP, which is composed of doctors employed by or appointed by the Government.

Although the medical transfer provisions became law in March 2019, it was not implemented in any way by the Government. No funding source or bureaucratic procedure was established. It has thus fallen to a small group of independent doctors to implement this legislation, by creating a pathway by which refugees and asylum seekers in offshore processing locations can access health assessments by independent Australian doctors.

The assessment and application process laid out in the legislation has been utilised in a way which is respectful both to the patients and the Government. Health assessments have been rigorous, undertaken by fully qualified specialist doctors working who assess patients within their areas of medical specialty, and are conducted to Australian health standards. Doctors have fully investigated the capacity of local health services in PNG and Nauru to address the needs of the patient before recommending medical transfer. Assessments have been undertaken in volunteers' spare time, resulting in no negative impact on Australian patients.

It rapidly became clear to those undertaking these assessments that the burden of unmet health need is significant, but the pace of formal assessment has been necessarily slow in order to ensure quality and rigorousness.

As of Thursday August 15, 121 patients have been approved for medical evacuation. This indicates the level of unmet health need among the cohort of refugees and asylum seekers still in PNG and Nauru. A majority of approvals have been given by the either the Minister for Home Affairs or the Minister for Immigration.

Only twenty-two applications were referred to IHAP. Eight of these applications have been approved for medical transfer by IHAP, and fourteen patients were not approved for medical transfer.

5. Disease Prevalence

When making an application for medical assessment, patients are asked to provide details of their most serious and urgent medical complaints. They also provide consent for us to obtain their medical records from relevant health services.

In addition to review of medical files, which contains the findings of the doctors contracted to care for these patients since 2013, telehealth assessments are undertaken where it is legal to do so. If clinical review confirms that the patient does have an unmet health need, a final assessment utilising all available information and a telehealth assessment (where it is legal to do so) is undertaken by two independent specialists. This assessment includes determination of whether the patient has access to appropriate diagnostic and treatment modalities in a time frame which would be considered in line with waiting times in Australia. If, at the end of this process, two independent doctors feel that there is a need for medical transfer, only then is an application prepared.

We present here a summary of the health burden experienced by refugees and asylum seekers remaining in Papua New Guinea and Nauru. These data have been collated from reviews of all the available medical information. All cases have been identified from objective information – direct assessment by doctors or review of the medical records. Nothing that follows has been taken solely from patient applications or their accounts of their own ill-health. Incidentally, we have found that the health information conveyed by the patient vastly under-represents the number and severity of health conditions that they are actually found to have when a formal health assessment is undertaken.

Where a potential diagnosis was unclear or not corroborated by objective evidence, it has not been included. As medical records and test results are not always available, this disease prevalence summary is likely to underestimate the overall burden of disease in this population. It should also be noted that conditions have only been recorded where they are symptomatic and causing significant morbidity. For example, dental problems were only recorded where they are causing significant pain and, in many cases, inability to eat solid food, resulting in

weight loss and malnutrition; gastroenterological issues were only recorded where they are causing severe symptoms such as significant pain and/or gastrointestinal bleeding. The same criteria applied to all organ systems. Minor complaints not requiring further assessment or care by Australian standards have not been recorded.

This is also not an historical review of all the health issues each patient has experienced during their time in Papua New Guinea and Nauru. The purpose is to provide a snapshot of the *current* health needs of these people, pointing towards the continued necessity of the Medevac legislation.

Not all refugees and asylum seekers in Papua New Guinea and Nauru have applied for medical assessment. From a statistical point of view, we have been able to collect high quality data on a statistically adequate sample size. We have been able to provide population corrected 95% confidence intervals. This represents the proportion of the total remaining offshore population we would expect to have each complaint.

Physical Health Problems

The burden of the last six years on the physical health of refugees and asylum seekers is significant. We found that 97% of the people reviewed by our team were found to have a confirmed physical ailment. On average each patient had 4.6 distinct physical ailments, that is, separate problems in distinct areas of the body or bodily systems. The maximum counted in a patient has been 15.

It is worth noting that gynaecological problems have not been included in the results. There are only few refugee and asylum seeking women remaining in Nauru and Papua New Guinea. Of those we have reviewed, 80% presented gynaecological issues. However, with such a small sample it is not possible to estimate the burden among all the remaining women.

The data are presented broadly as affected organ systems, as the number of individual diagnoses is impossible to recount for this context. Where a patient has more than one health problem in the same organ system, it has only been counted once.

	Proportion of patients in this sample	95% Confidence Interval
Any Physical Ailment	97%	96-98%
Gastroenterology	47%	43-52%
Significant Weight-Loss	32%	28-36%
Lower Limb	29%	25-33%
Dental issues	29%	25-33%
Back Pain	28%	24-32%
Headache	26%	23-30%
ENT	23%	20-27%
- Ear	9%	7-12%
- Nose	13%	10-16%
- Throat	6%	4-8%
Visual	23%	19-27%
Urology	22%	19-26%
Upper Limb	21%	18-25%
Cardiovascular	21%	18-28%
Skin Conditions	21%	17-24%
Neurology	17%	14-21%
General Surgical	13%	11-16%
Respiratory	13%	10-16%
Infectious Disease	13%	10-16%
Food Refusal	10%	8-13%
Kidney Stones	9%	7-12%
Endocrinology	6%	4-9%
Nephrology	6%	4-8%
Infection/Sepsis	5%	3-7%
Maxillofacial	$< 5\%$	$< 7\%$
Rheumatology	$< 5\%$	$< 7\%$
Seizures	$< 5\%$	$< 7\%$
Malignancy	$< 5\%$	$< 7\%$
Haematology	$< 5\%$	$< 7\%$
Vascular	$< 5\%$	$< 7\%$

Table 1: Summary of the proportion of patients experiencing each physical ailment.
Proportions are the proportion of the sample population with each complaint
The *95% confidence intervals* represent the proportion of the total remaining offshore population we would expect to have each complaint. The intervals are population corrected to account for the high proportion of the overall population included in our sample.

Psychiatric Health Problems

Psychiatric health problems, despite their prevalence in media coverage, are slightly less common in the population than are physical ailments. Among our sample 91% experienced one or more psychiatric health problems. The full summary appears in Table 2.

At present, 57% of the patients have been actively considering suicide (Suicidal Ideation in Table 2), and 31% have attempted suicide in the last six months. In terms of suicide attempts and self-harm, the reported proportion is the proportion of patients who have self-harmed or attempted suicide; it is not the number of discrete incidents, which is vastly higher, as many patients have self-harmed or attempted suicide on more than one occasion, and some as frequently as daily. It should further be noted that the suicide attempts are all high lethality events such as hanging, drug overdose, and self-immolation.

	Proportion of patients in this sample	95% Confidence Interval
Any Psychiatric Health Problem	91%	88-93%
Depression	82%	78-85%
Ideation	57%	53-62%
Anxiety	45%	41-49%
Self-Harm	38%	34-42%
Suicide Attempt	31%	27-35%
PTSD	28%	25-32%
Psychosis	18%	15-22%

Table 2: Summary of the proportion of people experiencing each psychiatric health problem.
Proportions are the proportion of the sample population with each complaint
The *95% confidence intervals* represent the proportion of the total remaining offshore population we would expect to have each complaint. The intervals are population corrected to account for the high proportion of the overall population included in our sample.

Analysis of Disease Prevalence

We note that in the first quarter 2019 IHAP report, the Panel reaches the view that there were "no patterns of disease that were unusual", but does not provide any evidence of what analysis was undertaken in order to arrive at this conclusion. Using routine auditing methods, we have provided a comprehensive snapshot of disease prevalence amongst this cohort which stands in contradiction to the claim made in the IHAP report.

The same IHAP report also notes that there were a large number of health consultations in both PNG and in Nauru. In the first quarter of 2019, in Nauru there were 5908 consultations to 237 persons, and 73 admissions for 43 individuals. In Manus Island, there were 1981 health consultations for an unmentioned number of individuals, and 21 admissions for 17 individuals

to Lorengau Hospital. Inpatient and outpatient services provided to the population of refugees and asylum seekers in Port Moresby was not reported.

In contradiction to the claim that "no patterns of disease were unusual" in the first quarter 2019 IHAP report, the large number of inpatient and outpatient appointments required points directly to a high burden of disease in this population. In Nauru, this was almost 25 appointments per person in a three month period. The readmission rate to hospital is over half. This points to a health service which is unable to adequately treat and resolve medical issues at presentation, and to a population that has become chronically ill as their health needs have not been met over a long period of time.

The high rate of illness reflects not only the socioeconomic conditions in which this cohort reside, which contribute directly to a number of health conditions that are vastly over-represented (compared even to other disadvantaged populations), but also the lack of resolution to even treatable medical problems which consequently become chronic problems.

Table 3 is a two way table of physical and psychiatric problems. This demonstrates that although the burden of psychiatric disease is often discussed in the media, physical health problems are also endemic. Only 3% of patients were noted to have psychiatric health problems in the absence of physical health problems, whereas 9% have physical health problems without any reported major psychiatric pathology. 88% of patients have evidence of both psychiatric and physical health problems. Notably, over 97% of patients have significant physical health issues. In general terms, it is well known that untreated physical health problems contribute to poor mental health, and poor mental health has an effect on the ability to seek and engage with treatment for physical health complaints.

		Physical health problems		
		Absent	Present	Total
Psychiatric health problems	Absent	0	9%	9%
	Present	3%	88%	91%
	Total	3%	97%	100%

Table 3: Two-way table of the proportion of patients with and without psychiatric and physical health problems

The great majority (88%) of patients are experiencing both physical and psychiatric health problems. Only 3% have psychiatric problems without accompanying physical problems, whereas 9% have physical problems without any current psychiatric ones (see Table 3).

Physical Health Problems Alone			
Number of Health Conditions	Proportion of patients with this number of conditions	95% CI	
0	3%	2-4%	
1	10%	8-13%	
2	12%	10-16%	
3	15%	12-18%	
4	14%	12-17%	Mean 4.6
5	12%	9-15%	
6	11%	8-14%	95% CI
7	9%	7-11%	4.3-4.8
8	7%	5-9%	
9	3%	2-4%	
10	3%	2-4%	
11	2%	1-3%	
12	1%	< 2%	
13	< 1%	< 1%	
15	< 1%	< 1%	
Psychiatric and Physical Health Problems			
Number of Health Conditions	Proportion of patients with this number of conditions	95% CI	
1	2%	1-4%	
2	5%	3-7%	
3	7%	5-10%	
4	10%	8-13%	
5	11%	9-14%	Mean 7.6
6	10%	8-13%	
7	7%	5-9%	95% CI
8	8%	6-11%	7.3-7.9
9	8%	6-10%	
10	8%	6-10%	
11	6%	5-9%	
12	5%	3-7%	
13	6%	4-8%	
14	2%	1-4%	
15	3%	2-4%	
16	1%	< 2%	
17	< 1%	< 2%	
22	< 1%	< 2%	

Table 4: Proportion of patients by number of distinct health complaints.
Proportions are the proportion of our sample found to have that number of distinct health problems.
Mean is the average number of physical and total health problems per person in the sample population
95% CI represents the proportion of the total remaining offshore population we would expect to have this number of complaints or what the average number of complaints would be. The intervals are population corrected to account for the high proportion of the overall population included in our sample.

The health burden on each patient is heavy and complex. The average number of distinct physical health problems per patient was found to be 4.6 (95% confidence interval 4.3 to 4.8). When psychiatric conditions are included this number rises to an average of 7.6 (7.3 to 7.9) distinct health problems *per patient*. The proportions of patients by number of health complaints are displayed in Table 4.

Description of doctors undertaking assessments

Some questions have been raised by the Government regarding the qualifications of the doctors who undertake health assessments, and whose medical opinions form the basis of applications to the Ministers of Immigration and Home Affairs. Accordingly, in this section we provide information in relation to the qualifications and experience of the doctors undertaking the assessments.

All applications have been made on the basis of assessments and reports by specialist doctors who hold full Fellowship of their respective medical College. Many hold additional academic qualifications.

Where patients have a major presenting problem related to a single organ system, then a specialist who is an expert in that organ system is most appropriate to undertake the assessment and provide their medical opinion. Where the patients has a subspecialty medical issue, then a specialist who practices predominantly in that subspecialty area is most appropriate to undertake the assessment and provides their medical opinion.

General Practitioners and Emergency/Critical Care Physicians are experts in multi-system disease and provide comment on the interplay of health problems in patients with more than one discrete health problem, which as can be seen from Table 4, is most patients.

To date, reports have been completed by doctors holding specialist qualifications in the following medical specialties:

- Emergency Medicine and Critical Care including Anaesthesia, Intensive Care and Rural and Remote Medicine
- Psychiatry
- General Practice
- Cardiology
- Respiratory Medicine
- Gastroenterology
- General Medicine
- Dermatology
- Neurology
- Immunology
- Rehabilitation Medicine
- Pain Medicine
- Endocrinology

- Ophthalmology
- General Surgery
- Orthopaedic Surgery
- Plastic and Reconstructive Surgery
- Urology
- Otolaryngology and Head and Neck Surgery
- Maxillofacial Surgery
- Neurosurgery

It is important to note the breadth of required specialties, which reflects again the broad range of health conditions which have not, to date, been adequately treated within the health services provided to refugees and asylum seekers in Papua New Guinea and Nauru.

6. Conclusion

Following a detailed analysis of the disease prevalence affecting this cohort of refugees and asylums seekers in Papua New Guinea and Nauru, two things are clear.

First, the burden of disease is very high, and far exceeds the normal prevalence of disease in the Australian community. Both the rates and patterns of disease are unusual. The 95% confidence intervals are narrow, and suggest that repeated sampling of this population will result in disease prevalence rates very similar to that which has been reported here.

Second, the burden of disease is high as a consequence of their circumstances. Some of the documented health problems result directly from the conditions under which this cohort of refugees and asylum seekers reside. A high rate of kidney stones, for example, relate directly to poor diet and inadequate hydration. Others have been caused by inadequate medical care, with treatable complaints turning into chronic problems through lack of resolution. The high prevalence of surgical pathology, for example is as a result of an accumulation of untreated disease over six years.

It is this health environment which has created a need for the medical transfer provisions. We refer back to our original recommendation:

> That the Senate oppose Migration Amendment (Repairing Medical Transfer) Bill 2019

It is likely that should the Migration Amendment (Repairing Medical Transfer) Bill 2019 succeed, this cohort of individuals will continue to not have access to adequate health care. We should be quite clear that we believe this may lead, in some cases, to serious injury and/or death.