

... you can get anywhere in the world in 24 hours. Trying to prevent infectious disease crossing international borders or any borders is a nonstarter in this day and age. It cannot be done. You need another strategy.¹

Screening, surveillance and control of infectious disease

- 3.1 As international travel to and from Australia increases, Australia has a number of screening, surveillance and control measures in place to manage the risk of infectious diseases being imported into the country.
- 3.2 Ms Rona Mellor, of the Department of Agriculture, Fisheries and Forestry (DAFF), told the Committee that government agencies must prioritise the risks that require management at the border:

The community demand for keeping everything out of the country is quite high. When you are processing 15 million passengers and you are processing several million containers and different arrivals in different ways, you really need to be able to narrow down to the things that matter most. So, there needs to be a continuation of priority setting in the things that matter most both in the broad biosecurity imports side and in the human health side, because we are a trading nation and we need to facilitate it as well as manage it.²

- 3.3 Dr Paul Douglas, of the Department of Immigration and Citizenship (DIAC), advised:

1 Dr Richard Gair, Public Health Medical Officer, Queensland Health, *Official Committee Hansard*, Cairns, 2 August 2012, p. 5.

2 Ms Rona Mellor, Deputy Secretary, Biosecurity, Department of Agriculture, Fisheries and Forestry, *Official Committee Hansard*, Canberra, 25 May 2012, pp. 22-23.

In terms of determining who has what tests, we have four to five million visitors from overseas every year come through the borders. We cannot screen all of them, otherwise we would not have a visitor or business program going on.³

- 3.4 This chapter examines the policies and procedures in place to prevent the importation of infectious disease into Australia.

Screening

- 3.5 The Department of Health and Ageing (DoHA), DAFF and DIAC, in partnership with other Commonwealth agencies, play significant roles in developing and implementing health screening measures at Australia's borders. These roles are outlined in more detail in Chapter 2 of this report.

- 3.6 Dr Gary Lum, of DoHA, told the Committee that DoHA worked closely with other Commonwealth 'border' agencies such as the Australian Customs and Border Protection Service (Customs) and DAFF (through the Australian Quarantine and Inspection Service (AQIS)) to screen people for potential public health risks at the border:

Those border agencies are really important for the work that we do at the border, particularly at airports and seaports. We work very closely with them so that they ask relevant questions of any passenger who volunteers information that they are unwell.⁴

- 3.7 There are a number of measures implemented by these Commonwealth agencies, in conjunction with state and territory agencies, to protect Australians. These measures include:
- entry requirements for visitors or Australians arriving in Australia from overseas, including:
 - ⇒ the completion of an incoming passenger card and arrival screening measures; and
 - ⇒ further questioning and checks if required, based on a health matrix.⁵

3 Dr Paul Douglas, Chief Medical Officer and Global Manager Health, Department of Immigration and Citizenship, *Official Committee Hansard*, Canberra, 25 May 2012, p. 20.

4 Dr Gary Lum, Assistant Secretary, Department of Health and Ageing, *Official Committee Hansard*, Canberra, 25 May 2012, p. 44.

5 Dr Paul Douglas, Chief Medical Officer and Global Manager Health, Department of Immigration and Citizenship, *Official Committee Hansard*, Canberra, 25 May 2012, p. 20. The health matrix assesses the level of TB risk associated with the country that a visa holder is coming from, the duration of their intended stay in Australia and intended activities while in Australia.

- entry requirements for people entering Australia as migrants, refugees and asylum seekers, including:
 - ⇒ health requirements such as pre-migration and pre-departure checks; and
 - ⇒ health screening for irregular maritime arrivals.⁶
- 3.8 In addition to health screening, there are a number of biosecurity processes operating at the border which may also lead to the identification of potential health risks. Biosecurity measures are overseen by DAFF and AQIS and include managing all passenger, vessel⁷ and cargo movements in and out of Australia, overseeing the Imported Food Inspection Scheme and screening imports and exports.⁸
- 3.9 In this report, the Committee has focussed on the health screening measures undertaken for travellers, migrants, refugees and asylum seekers in Australia.
- 3.10 From a health perspective, there are stark differences between the entry requirements in place for the travelling public, and those for migrants, refugees and asylum seekers. These are discussed further below.

Entry requirements for travellers

- 3.11 Health screening measures in place for travellers entering or re-entering Australia consists predominantly of the requirement to complete a passenger card upon entry into and departure from Australia.
- 3.12 Travellers to and from Australia are required to identify themselves and provide certain information to the Commonwealth by completing an incoming or outgoing passenger card.⁹ Samples of the incoming and outgoing passenger cards are shown at Figures 3.1 and 3.2.

6 Dr Paul Douglas, Chief Medical Officer and Global Manager Health, Department of Immigration and Citizenship, *Official Committee Hansard*, Canberra, 25 May 2012, p. 20.

7 In this report, *vessel* is taken to have the definition contained in the *Quarantine Act 1908* (Cth), s.5: (a) a ship, boat or other description of vessel used in navigation by sea; or (b) an aircraft; or (c) an air cushion vehicle; or (d) an off-shore industry mobile unit (being an overseas installation) that is bound for, or is at, a port; and includes a part of any of the above.

8 Ms Rona Mellor, Deputy Secretary, Biosecurity, Department of Agriculture, Fisheries and Forestry, *Official Committee Hansard*, Canberra, 25 May 2012, p. 21.

9 Department of Immigration and Citizenship, *Passenger Cards*, 18 January 2013, <http://www.immi.gov.au/managing-australias-borders/border-security/travel/passenger-cards/>, viewed on 18 January 2013.

Figure 3.1: Incoming passenger card

Incoming passenger card • Australia

PLEASE COMPLETE IN ENGLISH WITH A BLUE OR BLACK PEN

▶ Family/surname

▶ Given names

▶ Passport number

◆ Flight number or name of ship

▶ Intended address in Australia

State

▶ Do you intend to live in Australia for the next 12 months? Yes No

▶ If you are **NOT an Australian citizen**:

Do you have tuberculosis? Yes No

Do you have any criminal conviction/s? Yes No

DECLARATION
The information I have given is true, correct and complete. I understand failure to answer any questions may have serious consequences.

YOUR SIGNATURE _____ Day Month Year

TURN OVER THE CARD English

YOUR CONTACT DETAILS IN AUSTRALIA

Phone ()

E-mail OR

Address OR State

EMERGENCY CONTACT DETAILS (FAMILY OR FRIEND)

Name

E-mail, Phone OR Mail address

PLEASE COMPLETE IN ENGLISH

▶ In which country did you board this flight or ship?

◆ What is your usual occupation?

▶ Nationality as shown on passport

▶ Date of birth Day Month Year

PLEASE X AND ANSWER A OR B OR C

A Migrating permanently to Australia

B Visitor or temporary entrant

Your intended length of stay in Australia Years Months Days OR

▶ Your country of residence

▶ Your main reason for coming to Australia (X one only)

Convention/conference 1 Employment 4 Holiday 7
Business 2 Education 5 Other 8
Visiting friends or relatives 3 Exhibition 6

C Resident returning to Australia

▶ Country where you spent most time abroad

MAKE SURE YOU HAVE COMPLETED BOTH SIDES OF THIS CARD. PRESENT THIS CARD ON ARRIVAL WITH YOUR PASSPORT.

Information sought on this form is required to administer immigration, customs, quarantine, statistical, health, wildlife and currency laws of Australia and its collection is authorised by legislation. It will be disclosed only to agencies administering these areas and those entitled to receive it under Australian law. The leaflet *Safeguarding your personal information* is available at Australian ports and airports.

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Source: Provided by the Department of Immigration and Citizenship

Figure 3.2: Outgoing passenger card

Outgoing passenger card • Australia

PLEASE COMPLETE IN ENGLISH WITH A BLUE OR BLACK PEN

PLEASE **X** AND ANSWER D OR E OR F

D Visitor or temporary entrant departing

E Australian resident departing temporarily

F Australian resident departing permanently

▶ Family/surname

▶ Given names

▶ Passport number

▶ Flight number or name of ship

▶ Country where you will get off this flight

▶ What is your usual occupation?

▶ Nationally as shown on passport

▶ Date of birth

▶ State where you spent most time

NSW Vic
Qld SA
WA Tas
NT ACT Other

▶ Country of Residence

▶ In which State do you live?

NSW Vic Qld
SA WA Tas
NT ACT Other

Years Months Days

▶ Intended length of stay overseas

▶ Country where you will spend most time abroad

▶ Main reason for overseas travel (X one only):

Convention/conference 1 Employment 5
Business 2 Education 6
Visiting friends or relatives 3 Exhibition 7
Holiday 4 Other 8

▶ What is your country of future residence?

NSW Vic
Qld SA
WA Tas
NT ACT Other

DECLARATION The information I have given is true, correct and complete.

YOUR SIGNATURE _____ Day _____ Month _____ Year _____

TURN OVER THE CARD English

▶ Are you taking out of Australia AUD\$10,000 or more in Australian or foreign currency equivalent? If answered 'Yes' you must complete a Cross Border Movement – Physical Cash (AUD\$10,000 or more) Report to present with this card.

Note: If a customs or police officer asks, you must report travellers cheques, cheques, money orders or other bearer negotiable instruments of any amount.

Yes No

Did you know?

You can find any lost superannuation accounts you may have by visiting www.ato.gov.au/superseeker

You will need to provide your Australian tax file number, address and date of birth to access the system.

If you worked in Australia on a temporary resident visa you can claim your superannuation money back. For more information on how to apply visit www.ato.gov.au/departaustralia

Information sought on this form is required to administer immigration, customs, quarantine, statistical, health, wildlife and currency laws of Australia and its collection is authorised by legislation. It will be disclosed only to agencies administering these areas and those entitled to receive it under Australian law. The leaflet *Safeguarding your personal information* is available at Australian ports and airports.

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MAKE SURE YOU HAVE COMPLETED BOTH SIDES OF THIS CARD. PRESENT THIS CARD, ON DEPARTURE WITH YOUR BOARDING PASS AND PASSPORT.

Source: Provided by the Department of Immigration and Citizenship

3.13 Passenger cards are used to assist in a range of issues at the border, relating to immigration, customs and quarantine matters.¹⁰

3.14 Mr Tim Chapman, of DAFF, outlined how the Commonwealth used the information obtained through passenger cards:

As far as the card is concerned, there are essentially two purposes with it. The range of questions on there for immigration, customs and biosecurity purposes, and also for human health purposes, really assists the border agencies in assessing the risk and taking the necessary action. One of the things that occurred as a result – I think it started with SARS and then there were the various influenza concerns – was the additional detail on the back, which

10 Ms Rona Mellor, Deputy Secretary, Biosecurity, Department of Agriculture, Fisheries and Forestry, *Official Committee Hansard*, Canberra, 25 May 2012, p. 22.

is the contact details so that, for example, if somebody arrives and they are quite fine and do not report being sick but they get sick later, we or the department of health can identify what flight they came in on, who they should contact and so forth.¹¹

- 3.15 Ms Mellor advised that DAFF worked with DoHA to determine how the passenger cards could be useful from a health perspective:

In the screening through the passenger process, the card is used to determine how much intervention a passenger will get – for example, further questioning or inspection et cetera. Some of the countries that we are interested in clearly are ones where there are very infectious diseases that will mostly infect the animal population. But certainly, if we are guided by our colleagues at the Department of Health and Ageing to look for other things, we will do that as a matter of priority.¹²

- 3.16 Dr Rodney Givney, of the University of Newcastle, told the Committee that the ability to trace a person post arrival through the passenger card was vital, because a person may not feel unwell until after arriving in Australia:

The important thing about those cards is that we get people's contact addresses. The interest arises when one of them gets ill ... Border protection for infectious diseases does not work. We have actually known that since the 1890s. You have to be able to find cases when they appear in your community and then you have to be able to trace back their contacts. So the cards will work in that way.¹³

- 3.17 DIAC advised that passenger cards are currently processed in the following way:

- The cards are batched into flights at the airport and sent to Canberra for scanning by an outsourced provider;
- The contents of the cards are scanned and the images are made available for DIAC and other authorised agencies;
- Cards are stored for a maximum of 8 weeks depending on receipt date, and destroyed once the ABS publishes their monthly data on overseas arrivals and departures;

11 Mr Tim Chapman, First Assistant Secretary, Quarantine Operations, *Official Committee Hansard*, Canberra, 25 May 2012, p. 22.

12 Ms Rona Mellor, Deputy Secretary, Biosecurity, Department of Agriculture, Fisheries and Forestry, *Official Committee Hansard*, Canberra, 25 May 2012, p. 22.

13 Dr Rodney Givney, Infectious Diseases Physician and Microbiologist, University of Newcastle, *Official Committee Hansard*, Canberra, 12 May 2012, p. 15.

- Typically, the data from the passenger cards is available for retrieval within 24 hours of receipt of the cards. However, the time taken to process cards depends on a number of factors, including the location of the airport where the cards were produced; and
 - Sea arrivals are dealt with in a different manner and there can be a longer delay in processing given the time taken to batch and send the cards through. Once the cards are received, scanning usually takes place within 24 hours.¹⁴
- 3.18 The Committee was told that while there were issues in the past regarding the timely processing of passenger cards, this process had improved over time, and the information from the cards was now available very quickly and urgently if required.¹⁵
- 3.19 During the 2009 influenza pandemic, people entering Australia were required to complete a health declaration card if they were feeling unwell, in addition to completing an incoming passenger card:
- In 2009 we put in place a process of health declaration cards so that, when any aeroplane was descending into Australia or any ship was coming into Australia, the master of that particular vessel would have to ask all of the passengers, through a public address system, whether any of them were declaring themselves unwell. The health declaration card needed to be distributed and handed to all of the passengers that needed to complete them. That is distinct from the incoming passenger card, which is a routine process that the Department of Immigration and Citizenship manage for themselves at the moment.¹⁶
- 3.20 Heat screening was another tool used during the SARS outbreak of 2003 with the aim of assisting authorities to identify people who had a temperature at the border. Dr Givney told the Committee of one of the limitations of heat scanners:
- ... The final limitation of those heat screens is that people with flu are infectious before they have a temperature and before they feel sick at all ...¹⁷

14 Sourced from correspondence provided to the Committee secretariat from the Department of Immigration and Citizenship, in an e-mail dated 29 May 2012 from Mr Miles Henderson, Acting Assistant Secretary, Border Security Policy Branch.

15 See evidence from Mr Gregory Saphin, Director, Business Continuity and Incident Response Section, Department of Immigration, *Official Committee Hansard*, Canberra, 25 May 2012, p. 21.

16 Dr Gary Lum, Assistant Secretary, Department of Health and Ageing, *Official Committee Hansard*, Canberra, 25 May 2012, p. 44.

17 Dr Rodney Givney, Infectious Diseases Physician and Microbiologist, University of Newcastle, *Official Committee Hansard*, Canberra, 12 May 2012, p. 15.

- 3.21 With regard to the SARS outbreak, Professor Adrian Sleight, of the Australian National University, noted that data from Hong Kong airport indicated that heat scanners had only detected one case:

There were statistics kept at Hong Kong when they did the thermal imaging. Something like 36 million people were checked, 1,000 people were detained, 100 people were investigated and maybe one case of SARS was found.¹⁸

- 3.22 Professor Tania Sorrell, of the Sydney Institute of Emerging Infectious Diseases and Biosecurity, advised the Committee that heat scanners were more successful in reassuring the public than providing useful information to the medical profession:

It is true that if someone newly develops a fever it is most likely to be due to infection, but there are other causes of fever, which might be due to disease or a drug reaction. The issue with the scanners in airports is that they are not reliable – they offer more reassurance to the public than they actually do information to the medical profession.¹⁹

- 3.23 Dr Gary Lum, of DoHA, agreed that from a scientific perspective, thermal scanners were not useful. However, Dr Lum suggested that the scanners played a useful role in boosting public confidence when they were used at airports:

There were also the issues at the border where AQIS, as well as state and territory staff, were looking after things such as the thermal scanners. We all recognise that, from a scientific perspective, they were not very useful. From a public confidence perspective, we got a lot of letters from well qualified health professionals telling us that we were wasting money. However, at the same time we were also getting letters from Australians who were saying 'This is fantastic, you should buy more,' or 'Why don't we have one at every gate and in shopping centres?' You can see that, from a public confidence perspective, they really had a role to play.²⁰

- 3.24 The master of any aircraft or ship entering Australia is legally obliged to report any illness on board. AQIS must grant permission (known as 'pratique') for passengers and crew to disembark in Australia from an
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18 Professor Adrian Sleight, Professor of Epidemiology and Population Health, Australian National University, *Official Committee Hansard*, Canberra, 25 May 2012, p. 14.

19 Professor Tania Sorrell, Director, Sydney Institute for Emerging Infectious Diseases and Biosecurity, *Official Committee Hansard*, Canberra, 25 May 2012, p. 14.

20 Dr Gary Lum, Assistant Secretary, Department of Health and Ageing, *Official Committee Hansard*, Canberra, 25 May 2012, p. 44.

overseas vessel. Permission is only granted if the vessel is free from any quarantinable disease. The vessel and people on board remain subject to quarantine until such time as pratique is granted.²¹

3.25 Mr Chapman explained the pratique process:

In the times of the heightened pandemic awareness, there was a positive obligation on aircraft captains to report for every arrival, but the standard process is that they advise us only in circumstances where they have identified an ill passenger on board. When that occurs, there is a 'traveller with illness' checklist that we go through. We use that to then advise the department of health of the outcomes, and they provide advice back to us. In 2011 there were only 16 such events at international airports around Australia – that is with more than 14 million arriving international passengers.²²

Committee comment

3.26 The Committee has been reminded throughout this inquiry that infectious diseases do not respect international borders. As international travel becomes more frequent and more accessible it is clear that the transmission of infectious diseases across international borders cannot be totally eliminated.

3.27 The Committee is reassured by the continued efforts of a number of Commonwealth agencies working in collaboration, and with the relevant state and territory authorities, to implement a range of health screening measures to identify infectious disease before it spreads to the Australian population.

3.28 The Committee understands that an incoming passenger card will not necessarily enable detection of an infectious disease at the border. As the Committee heard, a person may have an infectious disease when travelling into Australia, however may not feel ill or show any obvious symptoms until later.

3.29 However, based on evidence the Committee considers that the incoming passenger card is an effective tool for providing the contact information

21 Mr Tim Chapman, First Assistant Secretary, Quarantine Operations, *Official Committee Hansard*, Canberra, 25 May 2012, p. 22. See also Department of Agriculture, Fisheries and Forestry, *Vessel Pratique*, http://www.daff.gov.au/aqis/avm/vessels/quarantine_concerns/human_health/pratique, viewed on 5 December 2012.

22 Mr Tim Chapman, First Assistant Secretary, Quarantine Operations, *Official Committee Hansard*, Canberra, 25 May 2012, p. 22.

necessary to track the spread of infectious disease from that person, if they become ill after entering Australia.

- 3.30 It is evident that lessons have been learned in recent times as the Commonwealth, states and territories have responded to the risks associated with infectious disease outbreaks such as SARS and pandemic influenza. The Committee has been told that in response to increased risk, more stringent measures of infectious disease control were put in place. The Committee is reassured that the relevant Commonwealth, state and territory agencies have the ability to adapt and respond to increased risk when required.
- 3.31 While heat scanners and thermal imaging appear to be an attractive option for mass population screening at ports of entry, the Committee notes the observations of infectious disease experts and DoHA regarding the limitations of this technology. Although the technology is clearly able to detect elevated body temperature, the Committee is aware that a significant limitation is that elevated temperature is not a symptom of all infectious diseases. Even when fever is a common symptom, it may not present at all stages of infection. Fever may be absent during the incubation period where infected individuals are often asymptomatic.
- 3.32 Despite these limitations and data indicating that heat scanners were of little value in detecting SARS during the 2003 outbreak, the Committee was told how the public was reassured by the use of such scanners.
- 3.33 In the Committee's view, this highlights the need for the public to be better informed and educated about the measures in place at the border to mitigate the risk of infectious disease importation, and what practical measures they can take to protect themselves and their families against infectious diseases. The issue of consumer awareness and education is discussed below.
- 3.34 The limitations of heat scanners also calls into question the cost-effectiveness of the widespread deployment of heat scanners at border entry points for mass screening of incoming travellers. While not dismissing outright the potential for heat scanners to contribute to the suite of measures to reduce importation of infectious disease, the Committee believes that cost-effectiveness must be assessed and considered.

Recommendation 2

- 3.35 **The Department of Health and Ageing review the existing evidence base to evaluate the cost-effectiveness of its policy to use heat scanners at ports of entry as a measure to mitigate the risk of infectious disease importation.**

Entry requirements for migrants, refugees and asylum seekers

- 3.36 Migrants, refugees and asylum seekers undergo stringent health screening before being allowed to reside in the wider Australian community. This screening contrasts to the entry requirements for the travelling public.
- 3.37 Migrants who choose to come and live in Australia for economic or other reasons will generally have time to prepare for their relocation. In contrast, refugees and asylum seekers are usually forced to leave their countries of origin with little or no warning.
- 3.38 The vast majority of migrants, refugees and asylum seekers travel to Australia by air with valid visas. With regard to asylum seekers specifically, recent data indicates that although the numbers arriving by boat have increased over recent years, in 2011-12 boat arrivals were about half of Australia's onshore asylum seekers.²³
- 3.39 Noting the differences in pre-travel planning, means of arrival and varying levels of contact with the wider community, a number of policies and practices have been implemented (both pre and/or post entry) to protect the Australian public from risks of infectious disease entering the country via these population groups.
- 3.40 The health requirements for people wishing to migrate to Australia, or who are seeking asylum in Australia as refugees, are set out in Chapter 2. These requirements aim to ensure that those people do not pose a public health risk to the Australian community. Currently, the health requirements focus on ensuring that people with tuberculosis (TB) are identified and treated before entering into Australia or into the wider community.²⁴

23 Parliamentary Library, *Asylum seekers and refugees: what are the facts?* February 2013.

24 Dr Paul Douglas, Chief Medical Officer and Global Manager Health, Department of Immigration and Citizenship, *Official Committee Hansard*, Canberra, 25 May 2012, p. 20.

- 3.41 A waiver of the health requirement is available for certain visa applicants, however this is not available to people considered to be a 'public health risk'.²⁵
- 3.42 As noted earlier, a relatively small population of asylum seekers arrive without valid visas, usually by boat. The Committee visited Christmas Island in November 2012 to learn more about the health screening practices undertaken for so called Irregular Maritime Arrivals (IMAs)²⁶ in immigration detention on the island.
- 3.43 During the visit the Committee inspected the facilities used for health screening at the various detention centres on the island. Following these inspections, the Committee held a roundtable discussion, hearing from representatives of DIAC, International Health and Medical Services (IHMS – DIAC's contracted health services provider), Indian Ocean Territories Health Service (Christmas Island Hospital) and the Shire of Christmas Island.
- 3.44 Health screening on Christmas Island falls under the jurisdiction of the Indian Ocean Territories Health Service and its public health policy is determined by the Western Australian government.²⁷
- 3.45 Depending on how a person arrives on Christmas Island²⁸, initial health screening for IMAs proceeds as follows:
- a public-health-screening assessment for communicable diseases is conducted by a Customs medical officer or health professional from IHMS, before or upon a person's arrival on Christmas Island;
 - a full health induction assessment is conducted within 72 hours of a person entering into immigration detention;
 - new arrivals are separated from the rest of the immigration detention population until the health induction assessment process is complete; and

25 Dr Paul Douglas, Chief Medical Officer and Global Manager Health, Department of Immigration and Citizenship, *Official Committee Hansard*, Canberra, 25 May 2012, p. 20.

26 For further information on IMAs see <http://www.immi.gov.au/ima/>, viewed on 24 January 2013.

27 Dr Paul Douglas, Chief Medical Officer and Global Manager Health, Department of Immigration and Citizenship, *Official Committee Hansard*, Canberra, 25 May 2012, p. 20. See also Mr Paul Windsor, Assistant Secretary, Detention Health Services, Department of Immigration and Citizenship, *Official Committee Hansard*, Canberra, 24 August 2012, p. 2.

28 The Committee was told that some IMAs arrive on the Cocos Islands, and these people were usually processed on Christmas Island. Some IMAs arrived in Darwin, and these people were either screened in Darwin or moved to Christmas Island for screening. Anyone arriving in immigration detention through other means still undergoes similar health screening. See Dr Mark Parrish, Medical Director, Health Services, International Health and Medical Services, *Official Committee Hansard*, Canberra, 24 August 2012, p. 3.

- health-screening relating to infectious disease issues for irregular maritime arrivals includes:
 - ⇒ a medical examination by a GP;
 - ⇒ documentation of the client's full medical history;
 - ⇒ medical observations;
 - ⇒ urinalysis;
 - ⇒ pathology tests including testing for HIV, hepatitis B and syphilis; and
 - ⇒ a public health screen including a TB-screening questionnaire and a chest X-ray, which is reviewed by a radiologist and a GP.²⁹
- 3.46 Mr Paul Windsor, of DIAC, advised the Committee that most communicable diseases identified in immigration detention were pre-existing conditions identified during the health induction assessment.³⁰
- 3.47 Mrs Julie McCaughan, of IHMS, explained the health screening process once people arrived on Christmas Island:
- When the clients arrive on the jetty we attend for observation and clinical assessment of the clients. We are generally looking for clinical signs that the client has a diagnosis or an issue that we need to address acutely and quickly. Following that, they are transported up to the induction centre where we conduct a public health consent. We have a set questionnaire that we ask the clients through interpretation and then we get their consent to be able to deliver their healthcare needs. That is the whole gamut from induction right through the system while they are in detention.³¹
- 3.48 If a person showed symptoms during the initial assessment that required further investigation, that person may be isolated or have to undergo further tests. Mrs McCaughan said that necessary precautions were taken to ensure people were quarantined until testing was complete:
- Should the client through our public health assessment require any additional treatment such as isolation or should we determine that they may have symptoms that we want to investigate further, we may isolate them or start additional investigations of them. Should a client also present clinically, we can also fast-track them

29 Mr Paul Windsor, Assistant Secretary, Detention Health Services, Department of Immigration and Citizenship, *Official Committee Hansard*, Canberra, 24 August 2012, p. 2.

30 Mr Paul Windsor, Assistant Secretary, Detention Health Services, Department of Immigration and Citizenship, *Official Committee Hansard*, Canberra, 24 August 2012, p. 2.

31 Mrs Julie McCaughan, Health Services Manager, International Health and Medical Services, *Official Committee Hansard*, Christmas Island, 21 November 2012, p. 2.

to have a chest X-ray, as an example, and take additional specimens there so that we can send them off and get the results as quickly as possible. Until we get a diagnosis, it is quite difficult for us to determine whether a client needs hospitalisation or full isolation, but we do take the necessary steps to ensure that they are quarantined if need be.³²

- 3.49 Dr Parbodh Gogna, of IHMS, told the Committee that on Christmas Island, IHMS and DIAC worked with the Western Australian Department of Health and the Christmas Island Hospital when infectious disease was identified:

Where we identify infectious diseases we work very closely with the Communicable Disease Control Directorate of Western Australia, as well as the Christmas Island hospital. To manage the care of these patients, we do contact tracing and additional screening when required. These arrangements depend on the cooperation of all parties, which has worked well to date.³³

- 3.50 Mr Windsor explained the process of treating a patient for an infectious disease while in immigration detention more broadly:

In accordance with guidelines established by the relevant centre for disease control, if a client is suspected to be affected by a communicable disease, they are placed into isolation until that condition is confirmed and a treatment plan is established. In these cases IHMS liaises with local public health authorities to ensure that appropriate measures are in place, such as quarantining and treatment to prevent other people from being affected, including in the broader Australian community.³⁴

- 3.51 Where a person is to be transferred from Christmas Island to another detention facility, such as a regional processing centre, that person must have undergone a public health assessment and have been deemed as 'fit to travel'.³⁵

- 3.52 Dr Gogna outlined the health screening process undertaken before a person was transferred to a regional processing centre on Manus Island or Nauru:

32 Mrs Julie McCaughan, Health Services Manager, International Health and Medical Services, *Official Committee Hansard*, Christmas Island, 21 November 2012, p. 2.

33 Dr Parbodh Chandar Gogna, Area Medical Director, Christmas Island, International Health and Medical Services, *Official Committee Hansard*, Christmas Island, 21 November 2012, p. 1.

34 Mr Paul Windsor, Assistant Secretary, Detention Health Services, Department of Immigration and Citizenship, *Official Committee Hansard*, Canberra, 24 August 2012, p. 2.

35 Mr Paul Windsor, Assistant Secretary, Detention Health Services, Department of Immigration and Citizenship, *Official Committee Hansard*, Canberra, 24 August 2012, p. 2.

For the Manus and Nauru transfers, obviously the authorities in Manus and Nauru do not want to have any communicable diseases sent to them, so we have to carefully screen them with dipstick urine you saw at the induction shed this morning, and we will not send carriers of hepatitis B or people infected with hepatitis C. They need specialist intervention and they are given first-world care on the mainland. Patients with HIV we are unable to send. We will not send people with active tuberculosis.³⁶

- 3.53 Mr Windsor told the Committee that there was a minimal risk of infectious disease being transferred into the general Australian population from people living in immigration detention:

There is minimal risk posed to the community by these diseases, as the department ensures that clients adhere strictly to the treatment procedures advised by the relevant state or territory communicable diseases control authority.³⁷

- 3.54 Dr Gogna and Dr Graham confirmed to the Committee that there had been no known instances of transmission of infectious disease from people living in immigration detention to the wider population of Christmas Island.³⁸
- 3.55 DIAC provided the Committee with a table of selected communicable and/or notifiable diseases identified in immigration detention for the period July 2010 until August 2012 (Table 3.1).

36 Dr Parbodh Chandar Gogna, Area Medical Director, Christmas Island, International Health and Medical Services, *Official Committee Hansard*, Christmas Island, 21 November 2012, p. 8.

37 Mr Paul Windsor, Assistant Secretary, Detention Health Services, Department of Immigration and Citizenship, *Official Committee Hansard*, Canberra, 24 August 2012, p. 2.

38 Dr Parbodh Chandar Gogna, Area Medical Director, Christmas Island, International Health and Medical Services, *Official Committee Hansard*, Christmas Island, 21 November 2012, p. 1. See also Dr Julie Leanne Graham, Director of Public Health and Medicine, Indian Ocean Territories Health Service, *Official Committee Hansard*, Christmas Island, 21 November 2012, p. 2.

Table 3.1: Selected communicable and/or notifiable diseases new cases identified in Immigration Detention Facilities

Disease	Jul 2010 - Jun 2011		Jul 2011 - Jun 2012		Jul - Aug 2012	
	All Detention Types	IMAs	All Detention Types	IMAs	All Detention Types	IMAs
Chickenpox	1	1	2	2	1	1
Chlamydia	13	12	29	27	7	7
Gonorrhoea	5	2	16	15	2	2
Hepatitis A	2	2	3	3	1	1
Hepatitis B (incl active and carrier states)	111	30	171	159	45	43
Hepatitis C	13	9	15	12	11	10
HIV/AIDS*	0	0	1	1	3	1
Leprosy	1	1	0	0	0	0
Malaria	1	1	1	1	2	2
Mumps	0	0	1	1	0	0
Pertussis (Whooping Cough)	18	3	1	1	0	0
Syphilis	63	31	40	37	15	13
Tuberculosis - Active	2	2	31	27	10	9
Typhoid	0	0	3	3	0	0
Total	230	94	314	289	97	89

* 2 clients (non-IMA) were known to be HIV+ on arrival in detention (July-Aug 2012).

Source: Provided by the Department of Immigration and Citizenship

3.56 Mr Windsor commented on the number of infectious diseases identified in immigration detention:

I think the numbers that we are seeing are small in light of the overall numbers arriving. My understanding is that, with conditions like TB, we believe that the levels we are seeing are broadly comparable with the source countries from which the people have originated. So, if they are clients who have made the journey ex-Indonesia, then they are broadly comparable with levels in Indonesia. Similarly, if they are coming directly from Sri Lanka, then they are comparable with the levels found there.³⁹

39 Mr Paul Windsor, Assistant Secretary, Detention Health Services, Department of Immigration and Citizenship, *Official Committee Hansard*, Canberra, 24 August 2012, p. 6.

Committee comment

- 3.57 Visiting Christmas Island gave the Committee a valuable opportunity to hear from a number of medical practitioners working on the island, both within the immigration detention network, and in the wider community.
- 3.58 The Committee witnessed firsthand the challenges that DIAC staff, IHMS staff and health workers from the Indian Ocean Territories Health Service face on a daily basis in providing health care services in a remote and largely isolated community.
- 3.59 Adding to this challenge, health service-providers on the island are required to meet the often complex medical needs of IMAs, while protecting the community within immigration detention and the wider community from the risk of spread of infectious disease.
- 3.60 The Committee considers the evidence obtained at Christmas Island within the context of evidence received from a range of infectious disease experts and public health officers throughout the Committee's wider roundtable program.
- 3.61 It is the Committee's view that there are robust screening processes in place to protect Australians from the importation of infectious disease from migrants, refugees and asylum seekers.
- 3.62 On the evidence before the Committee, there are clear protocols in place for pre-arrival health screening of migrants and refugees before they leave for Australia. When deemed necessary by the assessing Medical Officer, people are required to enter into a Health Undertaking, to ensure they adhere to specific treatment or actions regarding their health, while in Australia. There is also a stringent health screening protocol that applies to IMAs once they arrive in Australia and enter the immigration detention network (noting the usual entry point is Christmas Island).
- 3.63 It is evident that the risk of infectious disease spreading to the Australian community from migrants, refugees and IMAs who undergo pre-arrival and/or post-arrival health screening is small.
- 3.64 In stark contrast, an Australian resident or visitor entering Australia via an international airport does not have to undergo this same stringent health screening.
- 3.65 Accordingly, it seems more likely that an infectious disease would be imported into Australia by returning residents or through travellers who are visiting Australia, and who enter the country through one of the international airports or seaports.

Surveillance

- 3.66 How the Commonwealth, state and territory governments identify infectious diseases once they have entered Australia is an important element in protecting Australians from the risk of imported infectious disease.
- 3.67 Surveillance activities are undertaken primarily at a state and territory level, whereby specific diseases are reported by GPs or treating physicians, to the relevant state and territory authority. The Commonwealth is tasked with coordinating surveillance at a national level. These surveillance activities are discussed below.

National Notifiable Diseases Surveillance System

- 3.68 The Commonwealth Government identifies risks of infectious disease outbreak at a national level through the National Notifiable Diseases Surveillance System (NNDSS). The NNDSS is detailed further in Chapter 2.
- 3.69 There are also enhanced surveillance systems in place for particular diseases. For example, comprehensive data is collected on influenza by recording symptoms and other information when a person presents to a GP or hospital.⁴⁰
- 3.70 Dr Firman advised that the surveillance data obtained through the NNDSS and other surveillance processes was reported in annual reports and in a medical journal called *Communicable Disease Intelligence*, which was published quarterly.⁴¹
- 3.71 Professor John McBride, of the James Cook University, said the *Communicable Diseases Intelligence* (CDI) journal was an important source of information regarding communicable disease issues, however it had at one stage been defunded:

It should not have to be about scrimping and begging for resources to maintain what everyone thought was a fantastic idea:

40 Dr Jennifer Ruth Firman, Principal Medical Adviser, Office of Health Protection, Department of Health and Ageing, *Official Committee Hansard*, Canberra, 20 March 2012, p. 45.

41 Dr Jennifer Ruth Firman, Principal Medical Adviser, Office of Health Protection, Department of Health and Ageing,, *Official Committee Hansard*, Canberra, 25 May 2012, p. 45. See also Department of Health and Ageing, *Communicable Disease Intelligence* (CDI), <http://www.health.gov.au/internet/main/publishing.nsf/content/cda-pubs-cdi-cdiintro.htm>, viewed 7 March 2013.

to have a journal of the communicable diseases in Australia. It is great that that is continuing, but it is clearly under threat.⁴²

- 3.72 Dr Paul Armstrong, of the Western Australia Department of Health agreed that the CDI should not have been downgraded, as it is a way of canvassing infectious disease issues of national concern:

There is a journal called Communicable diseases intelligence – CDI, it is called. It is run by the Commonwealth. In recent times it was markedly downgraded in its importance by having its peer reviewed status taken away. This was not done in consultation with the states and territories. It has been reversed now and they are starting to build it up again, but it is really important to have a mouthpiece where communicable disease issues can be voiced. Countries around the world that have very strong communicable disease control systems do have a strong mouthpiece. The classic example is the journal called the [Morbidity and Mortality Weekly Report], which is produced by the CDC in America. That is an internationally renowned journal for communicable disease issues. We need to have a good journal like that here.⁴³

- 3.73 Regarding the surveillance data collected, Dr Firman said that the CDNA met fortnightly to discuss the data:

They look at all the data nationally that is reported for a fortnight and they look at what states have reported. They notify of interesting cases or particular cases from these states. That is discussed further and that is all reported back. Once that data is agreed as valid and correct, that is then posted on a website for public consumption.⁴⁴

- 3.74 Dr Richard Gair, of Queensland Health, told the Committee that effective surveillance allowed authorities to detect and control a disease outbreak before it became widespread:

We need to be able to become aware early of cases coming in. I have to stress the importance of surveillance is becoming aware early because the spread of anything whether it be pertussis or dengue is exponential. One case causes two, which causes four,

42 Professor William John Hannan McBride, Professor of Medicine, Infectious Diseases Physician, School of Medicine and Dentistry, James Cook University, *Official Committee Hansard*, 2 August 2012, p. 17.

43 Dr Paul Armstrong, Director, Communicable Disease Control Directorate, Department of Health, Western Australia, *Official Committee Hansard*, Perth, 8 August 2012, p. 20.

44 Dr Jennifer Ruth Firman, Principal Medical Adviser, Office of Health Protection, Department of Health and Ageing, *Official Committee Hansard*, Canberra, 20 March 2012, p. 45.

and before very long your chances of controlling it diminish rapidly, so you need early detection.⁴⁵

- 3.75 The Committee heard, however, that the success of infectious disease surveillance in Australia was predicated on doctors not only being aware of the notifiable diseases list, but also having the skills necessary to recognise the symptoms of these diseases, including diseases that may be rarely seen in their location.
- 3.76 Dr Armstrong told the Committee that there was strong communication between the Western Australian Government and general practitioners, who are usually a person's first point of call when they are feeling sick:
- From the Western Australian point of view, we have an ability to communicate quite rapidly with general practitioners – by fax, by media release and by, in some cases, email. I think we do have a fairly good system for communicating with GPs.⁴⁶
- 3.77 Dr Armstrong said that clinicians in Western Australia were required to inform the WA Communicable Disease Control Directorate if they considered that a patient had a disease on the notifiable list. However, he noted that the system wasn't perfect:
- Not every case is notified to us by the clinician. However, we have quite a good fall-back position, where in this state it is also mandatory for laboratories to report to us when they have notifiable diseases if they diagnose them from a laboratory point of view. That fall-back position works well. We think we would hear about all notifiable diseases that are tested for and for which there is a laboratory result.⁴⁷
- 3.78 In immigration detention centres around Australia, IHMS is required to report notifiable communicable diseases identified within the immigration detention network to the applicable state or territory health department.⁴⁸
- 3.79 Dr Mark Parrish, of IHMS, told the Committee that each state and territory had different protocols for detection and treatment of infectious disease:
- There are differences in how the states screen, diagnose and, sometimes, treat – less so in the treatment – so we work closely
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45 Dr Richard Gair, Public Health Medical Officer, Queensland Health, *Official Committee Hansard*, Cairns, 2 August 2012, p. 11.

46 Dr Paul Armstrong, Director, Communicable Disease Control Directorate, Department of Health, Western Australia, *Official Committee Hansard*, Perth, 8 August 2012, p. 8.

47 Dr Paul Armstrong, Director, Communicable Disease Control Directorate, Department of Health, Western Australia, *Official Committee Hansard*, Perth, 8 August 2012, p. 8.

48 Mr Paul Windsor, Assistant Secretary, Detention Health Services, Department of Immigration and Citizenship, *Official Committee Hansard*, Canberra, 24 August 2012, p. 2.

with the relevant state or territory health authority and communicable disease centre to ensure we put in the appropriate methods.⁴⁹

- 3.80 Dr Gogna, of IHMS, argued that as infectious disease could be easily transported across state borders, there was a need for a nationalised approach to infectious disease control:

We need to have a single body that is giving consistent advice. IHMS as an organisation and DIAC as an organisation have 22 plus immigration detention centres across the whole nation, and we are trying to have protocols and guidelines for our staff that are consistent. It is very hard to do that when a CDC [the state or territory based communicable disease control directorate] in a different state or territory gives you a differing opinion. For example, with latent TB in the Northern Territory the CDC there will ask for sputum to be collected, looked at under a microscope and cultured. That is not what Western Australia is currently advising us to do.⁵⁰

- 3.81 Dr Gogna considered that the creation of a national centre for communicable disease control would assist in the consistent treatment of people with a communicable disease.⁵¹ This concept is discussed further in Chapter 6.

Committee comment

- 3.82 The Committee notes that a national surveillance system for infectious diseases has been created in Australia in an effort to coordinate surveillance at a national level.
- 3.83 The Committee commends the Commonwealth Department of Health and Ageing for supporting national surveillance initiatives such as the publication of a national peer-reviewed journal, *Communicable Disease Intelligence*, to raise the profile of emerging infectious disease issues of national concern. The Committee notes the importance placed on this publication by infectious disease experts, and encourages the Commonwealth to continue supporting its ongoing publication.

49 Dr Mark Parrish, Medical Director, Health Services, International Health and Medical Services, *Official Committee Hansard*, Canberra, 24 August 2012, p. 7.

50 Dr Parbodh Chandar Gogna, Area Medical Director, Christmas Island, International Health and Medical Services, *Official Committee Hansard*, Christmas Island, 21 November 2012, pp. 13-14.

51 Dr Parbodh Chandar Gogna, Area Medical Director, Christmas Island, International Health and Medical Services, *Official Committee Hansard*, Christmas Island, 21 November 2012, pp. 13-14.

- 3.84 However, the Committee has heard that the creation of a national surveillance system for infectious diseases has not translated into uniformity or consistency of surveillance among the states and territories. IHMS, which delivers health services in all of the immigration detention centres across the country, demonstrates this clearly, given they must comply with different reporting requirements in each state and territory.
- 3.85 The Committee is of the view that a national, consistent approach to infectious disease surveillance would greatly assist in the timely and effective detection of relevant infectious diseases across Australia.
- 3.86 Accordingly, the Committee recommends that DoHA work with the state and territory governments to implement a uniform notifiable diseases list across Australia, with consistent reporting requirements across each state and territory.
- 3.87 The Committee views this discussion in the context of considering the national coordination of infectious disease screening, surveillance and control measures in Australia. The concept of national coordination is discussed in more detail in Chapter 6.

Recommendation 3

- 3.88 **The Australian Department of Health and Ageing work with the states and territories to provide a uniform notifiable diseases list across Australia, with consistent reporting requirements across each state and territory and consistent public health information on infectious diseases disseminated to the public. This work should be a priority of Australian Health Ministers' Advisory Council (AHMAC).**

Health follow-up processes for migrants, refugees and asylum seekers

- 3.89 The ability to prevent the spread of imported infectious disease throughout Australia is influenced by the correct and timely reporting of notifiable diseases to the relevant health authority.
- 3.90 However, it is also dependent on whether there are adequate health follow-up processes for migrants, and for refugees and individuals

seeking asylum as they transition through the immigration detention network and move into the community.⁵²

- 3.91 Further, it is dependent on medical practitioners across Australia being equipped to identify infectious diseases, particularly those diseases that may not be endemic in Australia, but may be prevalent in countries of origin for many refugees and migrants who settle in Australia.
- 3.92 Dr Peter Markey, of the Northern Territory Department of Health, told the Committee that health screening for refugees who arrived on the Australian mainland was conducted by state and territory jurisdictions on an ad hoc basis:

Postarrival checks for refugees are only done by jurisdictions on an ad hoc basis. The guidelines have been established just by non-government organisations such as the Australasian Society for Infectious Diseases⁵³. Informal refugee networks have been involved in screening refugees and there has not been an overall coordinated policy approach to postarrival refugee screening.⁵⁴

- 3.93 Dr Markey expanded on this issue further to the Committee:

There is a need for refugees to be checked in the postarrival phase, simply because they have a high prevalence of a lot of other tropical diseases which may affect their health in the future, but also there might be ramifications for the public as well. The other issue is with immunisation; they are often behind in their immunisation, so they have to catch up ... GPs just do not have the time, the inclination, the knowledge or the skills, in a way, to be able to do it. I am aware now that things are better, that there is a Medicare [item] number, which encourages GPs to take on the role of screening. But they are still reluctant to do it and it is probably not enough to cover the amount of time that it takes, because it is a time-consuming thing. Most jurisdictions have used state government money to support clinics, sometimes also assisted with Medicare money.⁵⁵

52 Dr Julie Leanne Graham, Director of Public Health and Medicine, Indian Ocean Territories Health Service, *Official Committee Hansard*, Christmas Island, 21 November 2012, p. 10.

53 See Australasian Society for Infectious Diseases, *Diagnosis, Management and prevention of infections in recently arrived refugees*, <http://www.asid.net.au/Clinical-Guidelines>, viewed 7 March 2013.

54 Dr Peter Gregory Markey, Head of Surveillance Section, Centre for Disease Control, Northern Territory Department of Health, *Official Committee Hansard*, Cairns, 2 August 2012, p. 2.

55 Dr Peter Gregory Markey, Head of Surveillance Section, Centre for Disease Control, Northern Territory Department of Health, *Official Committee Hansard*, Cairns, 2 August 2012, pp. 10-11.

- 3.94 Dr Parrish advised that IHMS, as the contracted health service provider for DIAC, had a number of processes in place for conducting follow-up health checks for people as they transitioned through the immigration detention network:

The process that we have in place is that, once clients have had that initial health screening, we can then identify those that have particular conditions which might need following up. I would put those conditions in three broad categories. They are: the communicable diseases that we are discussing today; all of the diseases and issues that you and I and the general population get that anybody gets; and then there are those, say, mental health issues that we identify in clients. We have a centrally based, electronic medical record which allows us track those clients as they move through the detention system and we can flag clients requiring review in that. For instance, in the case of clients with a communicable disease, we can put flags in our record to say that the individual needs a check-up and a repeat X-ray. Then when patients move from the detention centre into the community, we pass that information on in conjunction with the local GP and the communicable disease centre to make sure that those contacts are continually followed up.⁵⁶

- 3.95 Dr Gogna advised that IHMS undertook a health discharge assessment for people who moved from an immigration detention centre to live in the community. He noted however, that this follow-up system could fail:

We are contracted to provide a level of health discharge assessment information for the community, but there is a richness there that cannot be transposed in a small document and it is more important to provide that richness ...

... If we have them on a recall register, by law we have to make two phone calls and then send a letter to be able to say that we have discharged our medical legal responsibility. There are lots of reasons why that could fail: addresses change, people move, they get lost to follow-up. Your melanoma that you had excised that you should have regular checks on gets missed over a period of time. It requires robust systems in place for recall and, obviously, resources to maintain those registers.⁵⁷

56 Dr Mark Parrish, Medical Director, Health Services, International Health and Medical Services, *Official Committee Hansard*, Canberra, 24 August 2012, p. 3.

57 Dr Parbodh Chandar Gogna, Area Medical Director, Christmas Island, International Health and Medical Services, *Official Committee Hansard*, Christmas Island, 21 November 2012, pp. 10-15.

- 3.96 Ms Joanna Fagan, of the Western Australian Department of Health, told the Committee that Western Australia had a centralised refugee health-screening health service:

Anyone released from detention into WA is linked into our services. We have a relatively good, but not perfect, turnout. We do try to increase the numbers coming to use our services, but it is difficult because they are young men who are very mobile and move from state to state. So it is not perfect. We have also improved our linkages with the health providers within the detention centres to try and identify individuals at risk. We maintain that people cannot be released from detention centres until they have completed their tuberculosis treatment. They remain in detention until completion of therapy or until offshore screening occurs.⁵⁸

- 3.97 Ms Fagan told the Committee that the service would not see about 25 per cent of people in immigration detention in WA who move into the community, as the majority of those people moved interstate. Ms Fagan commented:

WA is one of the only states which have a centralised service. Most refugee screening is done in primary care within the rest of Australia. We have a dedicated service to try and capture these people...

... We provide a holistic service in that we are not only looking for infectious diseases but also doing mental health. We do very thorough health checks – HIV, all the different forms of hepatitis, latent tuberculosis as well as active tuberculosis, chlamydia, gonorrhoea, syphilis and all sorts of general health checks as well.⁵⁹

- 3.98 Dr Graham told the Committee that educating GPs about lesser-known infectious disease issues facing refugees and migrants was an important part of managing the spread of disease, once people moved into the community:

... These are diseases that are not common in Australia, and so symptom recognition by a GP in urban Melbourne may be a prolonged process. By that stage this person may have been sick

58 Ms Joanna Fagan, Clinical Nurse Manager, Public Health and Ambulatory Care, Department of Health, Western Australia, and Western Australian Tuberculosis Control Program, Humanitarian Entrant Health Service, *Official Committee Hansard*, Perth, 8 August 2012, p. 6.

59 Ms Joanna Fagan, Clinical Nurse Manager, Public Health and Ambulatory Care, Department of Health, Western Australia, and Western Australian Tuberculosis Control Program, Humanitarian Entrant Health Service, *Official Committee Hansard*, Perth, 8 August 2012, p. 6.

for quite a while and may have been through several health facilities. Those with lowered immunity are at risk, and so the chance of spread there is an option.⁶⁰

- 3.99 Professor Scott Ritchie, of James Cook University, argued that ongoing training of doctors was necessary to ensure they were equipped to recognise and test for certain infectious diseases:

... quite often we will have a locum doctor from overseas who has never seen dengue before – they have not been trained for dengue. If it comes in, even though it is a notifiable disease, they will not test for it, despite the person maybe even having a travel history. So I would hope in the future that, with computers and stuff, there may be a way, once these symptoms go in, and if someone has a travel history or something, there could be a reminder brought up – 'Query dengue'.⁶¹

- 3.100 Dr Gogna argued that specialist refugee training would assist in ensuring that effective diagnosis and treatment of disease took place:

My advice would be to work with the professional colleges. There are elements of the Royal Australian College of GPs which are devising specific refugee training programs: being able to engage, cultural awareness and culture specific issues. We have had to put a doctors' handbook together to make sure people understand what languages people speak. How does Farsi relate to Hazaragi? How does it relate to Urdu? People's knowledge of these areas needs to be built up. We do not want to be immersed completely in one culture but be able to do enough to ensure that how we approach a situation is construed clearly...⁶²

Committee comment

- 3.101 The Committee considers that for the most part, there are rigorous processes in place to ensure that people being transferred from immigration detention do not pose a public health risk before they are moved into the Australian community.
- 3.102 However, the Committee is concerned to have heard that despite the stringent processes in place to screen and treat people in immigration

60 Dr Julie Leanne Graham, Director of Public Health and Medicine, Indian Ocean Territories Health Service, *Official Committee Hansard*, Christmas Island, 21 November 2012, p. 11.

61 Professor Scott Ritchie, Professorial Research Fellow, James Cook University, *Official Committee Hansard*, Cairns, 2 August 2012, p. 21.

62 Dr Parbodh Chandar Gogna, Area Medical Director, Christmas Island, International Health and Medical Services, *Official Committee Hansard*, Christmas Island, 21 November 2012, pp. 10-16.

detention for infectious disease, the system could fail once individuals were moved into the community, due to a lack of follow-up health services.

- 3.103 Further, the Committee was told that some infectious diseases may not be identified by a medical practitioner in the general community, for instance where someone has contracted an infectious disease overseas that is not prevalent in Australia, and therefore the medical practitioner is not aware of the relevant symptoms of the disease.
- 3.104 The Committee believes there is a need to facilitate a more uniform, national approach to the health screening, follow-up and treatment of migrants and refugees, including individuals moving from immigration detention centres around Australia (and from regional processing centres) into the wider community.
- 3.105 The Committee heard evidence of a successful centralised refugee health program in Western Australia, where people were linked in with the service upon moving into the community from a WA immigration detention centre. However, it does not appear that this is a uniform approach across all states and territories.
- 3.106 In addition, the Committee is of the view that medical practitioners, who are on the front line of identifying infectious disease, should be better educated on the complex health needs of migrants and refugees, and the symptoms of notifiable diseases and diseases of concern that are not endemic in Australia.

Recommendation 4

- 3.107 **The Australian Government work with the state and territory governments to assess the viability of providing a centralised refugee and migrant health service in each state and territory, which would automatically refer people who move from immigration detention into the wider Australian community.**

Recommendation 5

- 3.108 **The Royal Australian College of General Practitioners provide resources and training to general practitioners on the complex health needs of migrants and refugees, with a focus on identifying infectious diseases which are notifiable in Australia, or diseases which are of specific concern to refugee and migrant communities.**

Control

- 3.109 There are two primary approaches used to control the spread of infectious disease within Australia. One is prophylactic or preventive, which aims to reduce the spread of disease by preventing infection in the first place, for example by immunisation. Where immunisation is not compulsory, national levels of immunisation are influenced by factors including public awareness of infectious disease risks and protective factors (including behavioural risk avoidance), accessibility and cost of undertaking measures to prevent infection. This is particularly the case for international travellers.
- 3.110 The second method of control relates to the broader way in which the Commonwealth, state and territory governments mobilise to respond to disease outbreaks, and reduce the spread and impact on the population. This second facet of control is discussed in Chapter 5.
- 3.111 Immunisation and consumer engagement as methods of controlling the spread of infectious disease are discussed below.

Immunisation

- 3.112 Maintaining strong immunisation among the general Australian population builds on Australia's capacity and ability to control outbreaks of infectious disease.
- 3.113 The Committee was told that Australia maintains good vaccination coverage compared to other countries in the world, despite some groups or individuals holding objections to immunisation:

In Australia, we have very good vaccination coverage compared to many other countries in the world. Compared to when we were children, in fact it is probably better than it was then. But we do have some pockets where people, yes, for whatever reasons have some objections to childhood immunisation, but they are relatively small, they are visible and certainly there are other activities to try and improve vaccination rates. I suspect that with the internet we potentially have greater visibility of those pockets of people who have objections to it. But in Australia, because of some of the initiatives involving the Childhood Immunisation Register, we actually have very good coverage.⁶³

- 3.114 Dr Firman explained developing a 'herd immunity' was key to ensuring that a disease doesn't circulate through the population:

63 Dr Jennifer Ruth Firman, Principal Medical Adviser, Office of Health Protection, Department of Health and Ageing, *Official Committee Hansard*, Canberra, 20 March 2012, p. 9.

With respect to herd immunity, depending on how infectious the disease is, that means you have to vaccinate a greater and greater number of people to achieve a herd immunity, where everybody is vaccinated and the disease will not circulate. For instance, with something like measles, ... but I think around 95 per cent is what you would require to actually develop that herd immunity because it is a very infectious disease. With something like the flu, you can achieve herd immunity with around 30 per cent because it is not as infectious.⁶⁴

- 3.115 Professor Peter McIntyre, of the National Centre for Immunisation Research and Surveillance of Vaccine-Preventable Diseases, explained that Australia leads the world in its national immunisation program:

The areas where Australia is a world leader include the fact that we are the only place, still, that has a national immunisation register that includes all children. This gives us tremendous capacity to track what we are doing. We have also developed over the last 20 years or so a national program, which means that, once a vaccine is on the national program, the delivery of the vaccine right to the point of administration and so on is all covered, and is not at cost to parents or others who might be receiving the vaccine, including the elderly – it is not just children anymore. That means that Australia achieves a very high uptake of vaccines very quickly and that our regional neighbours – and, more broadly, internationally – often look to Australia for early evidence of what is happening with vaccines that are introduced. Recent examples of that include the pneumococcal vaccine and the HPV vaccine.⁶⁵

- 3.116 Dr Peter Markey, from the Northern Territory Department of Health, told the Committee that having a national immunisation program has led to low rates of vaccine preventable diseases. He noted that more could be done regarding adult immunisation:

We have a very low rate of vaccine preventable diseases, with the possible exception of pertussis. This was really a result of when the immunisation program went national in the late nineties. The fact that we had national data collection systems, a national immunisation register and a national approach to immunisation is why we really got on top of things.

64 Dr Jennifer Ruth Firman, Principal Medical Adviser, Office of Health Protection, Department of Health and Ageing,, *Official Committee Hansard*, Canberra, 20 March 2012, p. 9.

65 Professor Peter McIntyre, Director, National Centre for Immunisation Research and Surveillance of Vaccine-Preventable Diseases, *Official Committee Hansard*, Canberra, 25 March 2012, p. 5.

Where we are short now is in fact in adult immunisation – because that program concentrated on childhood immunisation. Now we are short at the adult level because we do not have a national program for adult immunisation...

... That is an example of something where we have done really well at when we have approached it nationally but we can do better by having a national approach to policy and data collection and surveillance.⁶⁶

Committee comment

- 3.117 Australia is a world leader in the area of immunisation, evidenced by the high rates of immunisation of children in Australia, and the eradication of vaccine preventable diseases such as endemic measles and polio in Australia.
- 3.118 It is clear that Australia has achieved its low rates of vaccine preventable diseases through its internationally-recognised national system of immunisation.
- 3.119 The Committee is of the view that while there may currently be a low risk of spread of vaccine preventable diseases in Australia, there is a need for governments, non-government entities and individuals such as medical practitioners, health service providers, and individual consumers to remain vigilant about the ongoing success of immunisation in Australia.
- 3.120 The Committee views the national immunisation program and Australia's ability to maintain nationally low levels of vaccine preventable disease in Australia as an example of strong national coordination between the Commonwealth and state and territory governments.
- 3.121 The Committee considers that the national coordination of immunisation issues should be considered by the Commonwealth as a model for national coordination on infectious disease issues more broadly. This issue is discussed in more detail in Chapter 6.

Informing and engaging the general public

- 3.122 Informing and engaging the general public, and specifically the travelling public, about the risks of infectious disease is seen as an important step in preventing and controlling the importation and spread of infectious disease across international borders.

66 Dr Peter Gregory Markey, Head of Surveillance Section, Centre for Disease Control, Northern Territory Department of Health, *Official Committee Hansard*, Cairns, 2 August 2012, p. 16.

- 3.123 The Committee was told that across the population, many Australians did not have an adequate understanding of health issues, including how to prevent infection:

The latest available data, including the Australian Institute of Health and Welfare's Australia's health 2012 report, showed that only 41 per cent of Australians aged 15 to 74 had a level of health literacy that was adequate or above. That means that almost 60 per cent of Australians do not have adequate health literacy, and the levels of health literacy are much worse for people living in the most disadvantaged areas, those outside of major cities and people with poorer self-assessed health status.⁶⁷

- 3.124 Consumers Health Forum of Australia (CHF) told the Committee that engaging with consumers was key to controlling the spread of infectious disease, observing:

If there is a major threat to health coming across international borders to Australia, it is people, the health consumers, who will be affected. You can have all the strategies you like in place for preventing diseases from entering Australia and preventing diseases from spreading, but ultimately it is consumers and how they act that will have a major impact on the severity of the outbreak and how well that outbreak is controlled.⁶⁸

- 3.125 Ms Carol Bennett, of CHF, told the Committee:

If we want consumers to be active participants in reducing the risks of the spread of infection and the outbreak of disease, we need to inform them about the challenges we face and empower them to be involved and make the right decisions that protect their health and ultimately the health of all Australians.⁶⁹

- 3.126 In correspondence to the Committee CHF commented:

... consumers can be active participants in reducing the risks of the spread of infection and the outbreak of disease, but only if they are

67 Ms Carol Bennett, Chief Executive Officer, Consumers Health Forum of Australia, *Official Committee Hansard*, Canberra, 24 August 2012, p. 9. See also Australian Institute of Health and Welfare, *Australia's health 2012*, Australia's health series no.13, Chapter 5.1 *Health literacy*, <http://www.aihw.gov.au/publication-detail/?id=10737422172>, viewed on 12 December 2012. *Health literacy* is defined at p. 183 of the report as 'the knowledge and skills required to understand and use information relating to health issues such as drugs and alcohol, disease prevention and treatment, safety and accident prevention, first aid, emergencies and staying healthy.

68 Ms Carol Bennett, Chief Executive Officer, Consumers Health Forum of Australia, *Official Committee Hansard*, Canberra, 24 August 2012, p. 9.

69 Ms Carol Bennett, Chief Executive Officer, Consumers Health Forum of Australia, *Official Committee Hansard*, Canberra, 24 August 2012, p. 10.

informed about the challenges Australia faces and empowered to be involved in making decisions that will protect their health, and the health of all Australians.⁷⁰

- 3.127 Dr Armstrong argued that a person's risk of contracting an infectious disease while travelling overseas was largely dependent on the steps that person took to prevent infection. He told the Committee:

People do tend to have an attitude when they go to Bali or other countries that they are on holidays and they let their guard down. They have unsafe sex more often. They wear singlets, T-shirts and thongs without putting mosquito avoidance spray on. Raising the awareness of the public is something we work hard on in this state because 40 per cent to 50 per cent of all people going to Bali from Australia come from Perth or leave from Perth. So we are overrepresented in Bali travellers. One way we can improve things is for governments at the state and federal level to improve the information that is imparted to the public.⁷¹

- 3.128 Dr Armstrong stated that some people did not recognise that travelling to overseas destinations such as Bali held different infectious disease risks than travelling within Australia.⁷²

- 3.129 Ms Bennett argued that people needed to be properly informed about the implications of risky behaviour, so they could make the right choices.⁷³

- 3.130 Ms Bennett said that a challenge to government was to provide consumers with good access to information about the risks of infectious disease:

There are websites like Smartraveller, for instance, that provide some good information, but it is not particularly proactive advice and it is not necessarily consumer friendly. I do not know if it is even tested with consumers and on consumers. But it is about making sure that people know what actually happens, when do people get tested and for what purposes, what happens to them when that happens, what people should be aware of, what are the

70 Ms Carol Bennett, Chief Executive Officer, Consumers Health Forum of Australia, correspondence to the Committee dated 6 September 2012.

71 Dr Paul Armstrong, Director, Communicable Disease Control Directorate, Department of Health, Western Australia, *Official Committee Hansard*, Perth, 8 August 2012, p. 12.

72 Dr Paul Armstrong, Director, Communicable Disease Control Directorate, Department of Health, Western Australia, *Official Committee Hansard*, Perth, 8 August 2012, p. 12.

73 Ms Carol Bennett, Chief Executive Officer, Consumers Health Forum of Australia, *Official Committee Hansard*, Canberra, 24 August 2012, p. 10.

deterrents, when something does happen what are the controls in place? It is all those sorts of things.⁷⁴

- 3.131 The Committee heard that there was not enough information about infectious disease risks for Australians travelling overseas and that people had to proactively seek out the information that was available:

The feedback we get predominantly is that there is not enough information at hand and people have to proactively search it out. Unless you are vaguely aware that there are particular issues in the country you are going to, you may not even be aware that you need to find the information. So I think there need to be more proactive strategies that alert people to the point at which they need to both get the information and then provide quality information access.⁷⁵

- 3.132 The cost of immunisations and other health services was also seen as a potential barrier to people taking preventative steps to reduce the risk of infectious disease. Ms Anna Greenwood of CHF told the Committee that precautionary measures and travel immunisations were expensive:

Travel is much cheaper and more accessible for all sorts of people but they may not be factoring the medical costs into their travel.⁷⁶

- 3.133 While in some circumstances the lack of public information and engagement resulted in an underestimation of risk, under others the perception of risk was elevated.

- 3.134 For example, Councillor Kelvin Kok Bin Lee, of the Shire of Christmas Island, told the Committee that some Christmas Island residents were concerned that boats arriving on Christmas Island could lead to the spread of infectious diseases to the wider population:

Definitely, when the boatloads of people come in here and when they have the tuberculosis detected, it does create some situations where people are fearful. In our community it has been the case for a long time that we have not come across this sort of disease, so it is a bit frightening for a majority of them. Also, in the early days,

74 Ms Carol Bennett, Chief Executive Officer, Consumers Health Forum of Australia, *Official Committee Hansard*, Canberra, 24 August 2012, p. 13.

75 Ms Anna Greenwood, Consumers Health Forum of Australia, *Official Committee Hansard*, Canberra, 24 August 2012, p. 13.

76 Ms Anna Greenwood, Consumers Health Forum of Australia, *Official Committee Hansard*, Canberra, 24 August 2012, p. 13. See also Ms Joanna Fagan, Clinical Nurse Manager, Public Health and Ambulatory Care, Department of Health, Western Australia, and Western Australian Tuberculosis Control Program, Humanitarian Entrant Health Service, *Official Committee Hansard*, Perth, 8 August 2012, p. 12.

when the boat people went to school and they mixed with our kids, they were fearful that it might just carry over to them.⁷⁷

- 3.135 However, Councillor Lee could only recall one instance where a local resident was actually diagnosed with TB, and was unaware of how the disease was contracted. Councillor Lee advised that Dr Graham, on behalf of the Indian Ocean Territories Health Service, usually circulated information to the community regarding infectious disease on the island. Councillor Lee said that it would be helpful if DIAC also communicated more with the community about infectious disease issues, to lessen the fear of the community:

To me it would help if the communicators from the detention centre, especially from those people who are in charge on the other end, could work together with our local doctor in order to provide more information to the community at large; it would lessen the fear.⁷⁸

- 3.136 Mr Troy Sokoloff of DIAC responded to Councillor Lee by stating that DIAC had a very strong program of engagement and inclusion with the Christmas Island community:

We have a community reference group which meets monthly. We also have representatives from the council and shire invited to our daily morning meetings where we discuss issues. We also have regular bulletins that we put out ...

... Certainly on the part of the department we have a very strong sense of working with the community and we are always open to hearing any feedback or responding to any concerns people have. We have a dedicated officer within our team whose primary responsibility is dealing with that. She does a very capable job.⁷⁹

Committee comment

- 3.137 The Committee is of the view that the general public, including the travelling public, could be better informed about infectious disease issues. Such issues include the purpose of screening processes at the border, preventative steps that could be taken to minimise the risk of infection while overseas, and general information about infectious disease issues of concern to the community.

⁷⁷ Councillor Kelvin Kok Bin Lee, Shire of Christmas Island, *Official Committee Hansard*, Christmas Island, 21 November 2012, p. 15.

⁷⁸ Councillor Kelvin Kok Bin Lee, Shire of Christmas Island, *Official Committee Hansard*, Christmas Island, 21 November 2012, p. 15.

⁷⁹ Mr Troy Sokoloff, Deputy Regional Manager, Department of Immigration and Citizenship, *Official Committee Hansard*, Christmas Island, 19 November 2012, p. 17.

- 3.138 The Committee acknowledges that some information is already available for consumers in the public domain. For example, the Commonwealth website 'Smartraveller' provides a range of health advice for Australians travelling overseas.
- 3.139 The Committee considers that a wider public awareness campaign regarding infectious disease issues is necessary to better inform the general public. For travellers, this campaign could link in with the information already provided on the Smartraveller website. Information should be easy to access and user-friendly.
- 3.140 The public awareness campaign proposed should be developed in consultation with the general public, and could include (subject to consumer consultation and feedback) such features as:
- videos which could be published via YouTube, Smartraveller, international flights and/or other relevant access points, providing general advice to consumers about the general health risks for travellers, including infectious disease issues, and actions which could be taken to reduce these risks;
 - reading material such as brochures which can be provided at travel agencies, passport offices, on international flights and other relevant access points, covering issues such as keeping well overseas and preventive measures to take against infectious disease; and
 - targeted ongoing engagement with consumers via social media and on travel websites.
- 3.141 The Committee notes the evidence from the Shire of Christmas Island suggesting that some Christmas Island residents considered that DIAC did not provide enough information regarding infectious disease risks stemming from the immigration detention processes on the island. The Committee also notes DIAC's response that they engaged regularly with the residents of Christmas Island on these issues.
- 3.142 The Committee encourages DIAC to consult further with the Christmas Island community to ascertain where gaps in information and awareness exist, and how these gaps could be filled.

Recommendation 6

- 3.143 **The Australian Government, coordinated by the Department of Health and Ageing and in consultation with the wider Australian community, develop a national public awareness campaign to better inform and engage the travelling public about infectious disease issues.**

This campaign should cover the risks associated with travelling overseas, preventative measures that can be undertaken to minimise these risks, and screening measures used at the border to prevent the importation of infectious disease.

Subject to consumer input and feedback, this campaign could include a range of materials and platforms, including:

- **videos, which could be published via YouTube, Smartraveller, international flights and/or other relevant access points;**
- **reading material such as brochures which can be provided at travel agencies, passport offices, on international flights and other relevant access points; and**
- **targeted ongoing engagement with consumers via social media and on travel websites.**