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AUDIT OF MEDICAL EVACUATIONS IN THE UNHCR

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EXECUTIVE SUMMARY

In October 2005, OIOS conducted an audit of medical evacuations (MEDEVAC) the purpose of which is to allow staff members and eligible dependents to secure essential medical care or treatment for illness or injury, requiring medical intervention that is locally unavailable or inadequate. The audit focused on the related policy, administrative and financial issues. A draft of the report was shared with the Division of Human Resources Management (DHRM) in December 2005. The comments received in May 2006 are reflected, as appropriate, in this final report.

OIOS was denied access to administrative information relating to MEDEVAC cases, with the UNHCR Medical Service invoking medical confidentiality. This resulted in an audit scope limitation and the inability for OIOS to make an assessment of the reliability of administrative processes. In order to seek clarification on audit access, the UNHCR Legal Affairs Section referred the issue to the UN Office of Legal Affairs (OLA). OLA's legal opinion confirmed OIOS' position and stated that only 'medical information' can be considered confidential and administrative data should have been made available. This opinion came after the audit work had been completed.

Audit Findings and Recommendations

- From January 2002 to December 2005, there were 1,517 medical evacuations at a cost of US\$ 5.35 million. OIOS noted a marked upward trend in this period with the number increasing by 56 per cent, and at the same time, the associated travel and DSA costs rose 124 per cent to US\$ 1.67 million in 2005. On average 32 per cent of MEDEVACs relates to international staff and 68 per cent to national staff.
- OIOS' analysis showed that 50 per cent of the evacuations were from 6 countries, namely Afghanistan, Guinea, Uganda, DRC, Tanzania and Zambia. Evacuations from Guinea alone cost nearly US\$ 1 million, and accounted for 19 per cent of the total costs in the period reviewed. *The Medical Service explained that higher health hazards and medical needs are associated with major refugee situations where medical infrastructure is inadequate.*
- OIOS' review of MEDEVAC procedures at the field level found that crucial documents were either not filed correctly or were not completed and available. For example, control sheets listing vital details of medical evacuations were not maintained in several offices. Important documents were either not submitted to Headquarters or were submitted with considerable delay.
- Although required, all field offices had not developed a Medical Evacuation Plan. This is necessary to ensure all participating units are properly organized, trained and ready to perform

a medical evacuation in an effective and coordinated manner. This issue was already raised in a UNHCR Evaluation Report (EPAU), but no action was taken to ensure appropriate plans were established.

- OIOS noted that the recognised places (locations where persons go on MEDEVAC) differed, in some cases from those of the UN. For example, for West Africa, UNHCR included London and Paris, whereas the UN suggested four countries in the region. OIOS recommended, considering the costs involved in travel to and the medical expenses incurred in certain locations that efforts be made to bring UNHCR in line with those locations recommended by the UN.
- The fundamental principles of medical evacuation were not always applied resulting in unnecessary costs to UNHCR. OIOS noted one case where an office recorded that a staff member was 'planning to evacuate in November 2005'. A planned medical evacuation does not fall under the criteria established. Also, a staff member's dependent was medically evacuated eleven times from 1993 to 2004 to the US for what appeared to be periodic medical examinations. The staff member apparently did not claim MIP reimbursements for medical treatment, but received considerable amounts for travel and DSA. Moreover, OIOS observed that MEDEVACs were authorised for dental treatment, eye conditions, skin disorders and tests.
- The UN restricts payment of DSA on MEDEVAC to 45 days, OIOS noted however that UNHCR did not comply with this, and there were 179 cases exceeding the normal permissible threshold. In one instance, a MEDEVAC to London took place one month before the first appointment with the doctor, and the patient remained in London almost one month after being signed as medically fit to travel. OIOS recommended that the overpayments of US\$ 11,700 relating to DSA payments be recovered.
- DHRM modified the MIP reimbursement guidelines, removing the fundamental principle of 'reasonable and customary cost' in cases of authorised medical evacuations and clarified that the reimbursement will be made according to the prevailing patterns of charges at the place where the services were rendered. OIOS raised concerns regarding lack of clarity in the terms 'recognised place' and 'authorised place'.
- In OIOS' opinion, UNHCR could obtain some cost savings by reviewing the entitlements paid, and harmonizing entitlements with the UN. UNHCR staff members receive DSA and SOLAR (for the first 15 nights), whereas in peacekeeping missions only the accommodation portion of the MSA is paid together with DSA. Moreover, the initial duration of MEDEVAC is usually set at 15 days, thus maximizing staff members' entitlements.
- The rules and procedures governing the payment of DSA on MEDEVAC are complex and OIOS has identified a number of overpayments. The errors found result mainly from the incorrect interpretations of the rules. OIOS recommended they be simplified.

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I. INTRODUCTION

1. From 20 to 28 October 2005, OIOS conducted an audit of the policies and procedures relating to medical evacuations in UNHCR and their implementation in various country operations. The audit was conducted in accordance with the International Standards for the Professional Practice of Internal Auditing.
2. For staff safety and welfare, an issue of paramount importance is medical evacuation facilities. It is essential therefore that UNHCR staff requiring medical intervention in emergency medical conditions have access to an easy and responsive mechanism for medical evacuation. The UNHCR Medical Service, under the Division of Human Resources Management (DHRM), is responsible for managing and processing medical evacuation (MEDEVAC) requests from field locations. The purpose of MEDEVAC is to allow staff members and eligible dependents essential medical care or treatment for illness or injury, requiring medical intervention that is locally not available or is inadequate. The MEDEVAC scheme constitutes official travel for which UNHCR pays for the ticket expenses and subsistence costs. It does not constitute any commitment to meet medical expenses, which is separately governed by the medical insurance schemes of MIP for local staff members and UNSMIS or other schemes for international staff.
3. Issues relating to medical evacuation have been considered and commented on in several previous OIOS reports; however this is the first time it has been comprehensively reviewed by OIOS.
4. Essential administrative information relating to MEDEVAC cases was not available to OIOS, as the Medical Service denied access invoking medical confidentiality. This resulted in an audit scope limitation, as OIOS was unable to examine administrative and procedural information relating to MEDEVACs in order to assess and verify these procedures as well as the financial transactions. On the request of the Medical Service, UNHCR, Legal Affairs Section (LAS) referred the issue of OIOS' access to non-medical administrative and procedural information to the UN Office of Legal Affairs (OLA). OLA, in their legal opinion dated 2 December 2005, confirmed OIOS' position and stated that only 'medical information' can be considered confidential and that generic information such as the names of those evacuated, place of evacuation, cost of evacuation should be made available to OIOS for audit purposes. This opinion however was received after OIOS had completed the field work.
5. The findings and recommendations contained in this report have been discussed with the officials responsible for the audited activities and during the exit conference held on 28 October 2005. A draft of this report was shared with the Director, Division of Human Resources Management in December 2005 and the Director, UNHCR Medical Service. The formal comments, which were received in May 2006, are reflected where appropriate in the report.

II. AUDIT OBJECTIVES

6. The main objectives of the audit were to assess UNHCR's medical evacuations policies and procedures, and more specifically to:

- Evaluate the adequacy, effectiveness and efficiency of internal controls
- Evaluate whether adequate guidance and procedures were in place and consistently applied
- Assess compliance with UNHCR rules and procedures

III. AUDIT SCOPE AND METHODOLOGY

7. OIOS' review covered the period from 1 January 2002 to December 2005. As MEDEVACs have financial, administrative, policy and medical aspects, the planned scope of the audit was to include the first three areas namely financial, administrative and policy. This would include an examination of authorization and approval procedures by the UNHCR Medical Service and policy issues at Personnel Administration Section/DHRM, as well as the implementation of MEDEVAC instructions in the field. However, as noted above, due to the lack of access to certain important records, the review of administrative issues at the Medical Service in Geneva was not possible. This restricted the scope of the audit.

8. In general the audit activities included interviews with staff, analysis of applicable data and a review of available documents and other relevant records.

IV. AUDIT FINDINGS AND RECOMMENDATIONS

A. General aspects relating to medical evacuations

(a) Eligibility for medical evacuations

9. UNHCR's policy on MEDEVAC for international staff is outlined in IOM/85/2001& FOM/83/2001, dated 12 November 2001. It provides for internationally recruited staff members, recognized spouses and dependent children residing at the duty station to be evacuated in case of an acute illness or injury for the purposes of securing essential medical care or treatment that cannot be secured locally because of inadequate medical facilities. Locally recruited staff members, their spouses and dependent children, for whom the organisation has not assumed a responsibility for relocation to or from the duty station, will normally be expected to avail themselves of the facilities available locally. Nonetheless, in case of an acute life-threatening medical emergency, MEDEVAC will be considered when local medical facilities do not offer an adequate response.

10. The UNHCR instructions of November 2001 broadly reflect the guidance contained in ST/AI/2000/10 dated 21 September 2000 (entitled "Administrative Instruction Medical Evacuation"), which establishes the conditions and procedures for the authorisation of travel expenses on medical grounds.

(b) Medical evacuation - an enforceable right?

11. The Medical Service was of the view that staff members, both international and local, have a right or a claim to be medically evacuated in certain circumstances. It was added that UNHCR is operating in unstable situations, such as 'deep field operations' and in situations of civil conflicts and when it sends its staff to these areas, there is an attendant responsibility to extricate its staff, should there be any unforeseen accidents, injury or illness that threaten the health or well being of staff members.

12. OIOS referred to UNAT judgement¹ where the Tribunal observed that 'the *Applicant had a reason to expect that the organisation for which he had volunteered to serve in a dangerous location had a duty to make extreme emergency medical decisions in a manner so as to provide him greatest opportunity to recover fully from an injury to his physical or mental health that resulted from that service. In this regard the respondent has failed*'. While this judgement was rendered in the context of a service-incurred injury, it nonetheless indicates that the organisation has a certain degree of responsibility in ensuring its staff obtains medical intervention when required. OIOS would add that the MEDEVAC scheme is a form of official travel for securing medical treatment and instructions state that 'internationally recruited staff ... may be evacuated' or 'MEDEVAC will be considered' for locally recruited staff members, which makes it clear that medical evacuation is enforceable only subject to the fulfilment of certain essential conditions.

13. Whether or not a staff member should or should not be medically evacuated is in essence a medical question. It is important nonetheless that the fundamental rationale for MEDEVACs (acute illness or injury for international staff and life threatening illness of injury for local staff) is not forgotten while recommending and authorising evacuations. Given that MEDEVAC is not automatically justified in every illness or injury, it is thus important that the correct decision making processes are in place, based upon clinical and logistical criteria to ensure that when the illness or injury is such that evacuation is required to take place, it will be carried out effectively.

B. Analysis of data obtained regarding MEDEVACs(a) Number of MEDEVACs and costs incurred

14. OIOS obtained from the Medical Service and from the Division of Financial and Supply Management data on the number of MEDEVACs and expenditure incurred thereon from 2002 to 2005. Table I shows that 1,517 medical evacuations took place during the period reviewed at a cost of some US\$ 5.35 million for travel costs and DSA.

Table I

Year	2002	2003	2004	2005	Total
Number of MEDEVACs	278	392	413	434	1517
Expenditure in US\$ (travel/DSA)	744,534	1,461,893	1,486,527	1,666,163	5,359,117

¹ AJT 872 dated 31/7/1998

15. Table II presents the breakdown of the medical evacuations by status of staff and shows the overall increase in the medical evacuations. OIOS identified that the steady increase is mainly due to a rise in the evacuations of local staff members, who accounted for some 68 per cent of all evacuations.

Table II

Number of MEDEVACs	2002	%	2003	%	2004	%	2005	%
International Staff	104	37	121	31	129	31	128	29
Local staff	175	63	271	69	284	69	306	71
Total	279	100	392	100	413	100	434	100

(b) Trends of MEDEVACS from major operations/locations

16. Disaggregated data depicted in Table III shows that 50 per cent of the evacuations were from 6 countries, namely Afghanistan, Guinea, Uganda, DRC, Tanzania and Zambia. The first three countries alone accounted for over 32 per cent of all evacuations. *The Medical Service attributed this to the increase in UNHCR's presence and involvement in major refugee programmes in remote locations where adequate medical facilities were not available.*

17. OIOS noted however, that even though there are modern and sophisticated facilities in Geneva, there were 42 evacuations from staff based at Headquarters during the period reviewed. The rationale and justification for MEDEVAC from Geneva was not clear, particularly as UNOG's Medical Service generally does not authorize such evacuations. *The Medical Service explained that the evacuations from Geneva are in the context of a staff member returning to the location of home leave or proceeding to a place where medical experts have previously cared for that condition or in the rare cases where expertise was not available.* OIOS would reiterate that the fundamental purpose of MEDEVAC is to allow eligible beneficiaries essential medical care or treatment for illness or injury that is 'locally unavailable or inadequate'.

Table III

Year/Country	2002	2003	2004	2005	Total
Afghanistan	11	52	61	56	180
Uganda	35	47	38	36	156
Guinea	42	35	44	31	152
Congo DRC	12	33	25	53	123
Tanzania	16	20	24	12	72
Zambia	11	19	20	19	69
Geneva	10	14	15	3	42
Pakistan	11	13	10	9	43
Kenya	5	11	11	11	38
Burundi	2	6	10	13	31
Yemen	3	7	12	6	28
Rest of world	120	135	143	185	583
Total for year	278	392	413	434	1517

18. OIOS appreciates the difficulties and hardship of UNHCR field locations in Guinea. Nonetheless, the number of medical evacuations and in particular the associated cost was high, and a more in-depth review may be warranted. During 2002-2005, MEDEVACs from Guinea exceeded US\$ 986,000; about 19 per cent of the global UNHCR cost for medical evacuations. OIOS' 2005 audit of Guinea showed that 25 per cent of the staff had been medically evacuated at different points in time, and more than 80 per cent of the MEDEVACs were attributed to local staff members. When OIOS interviewed the UN doctor in Conakry, he confirmed that UNHCR had by far the highest number of evacuations among all UN agencies in Guinea. OIOS further observed that 20 staff members resorted to multiple evacuations in 2003 and 2004, with several having three or more MEDEVACs. *Alerted by the significant rise in the evacuations, the Medical Service had undertaken a mission to Guinea in 2004 that resulted in a number of recommendations regarding the procedures to be followed and the destinations to which the evacuations could be undertaken.*

(c) Trends of MEDEVACS - Major destinations for MEDEVACS

19. Data regarding major destinations (table IV) for medical evacuations showed that 776 or nearly 51 per cent of the evacuations were undertaken to five countries, namely South Africa, Kenya, Uganda, Pakistan and Switzerland. Most of the evacuations that took place to Uganda and Tanzania were for in-country evacuations. MEDEVACs to Morocco (Casablanca) increased after the Medical Service decided to refer cases from West Africa (mainly Guinea) to Morocco instead of London or Paris.

Table IV

Year/Country	2002	2003	2004	2005	Total for destination during review period
South Africa	35	36	53	45	169
Kenya	22	40	48	76	186
Uganda	32	45	38	43	158
Pakistan	11	52	54	39	156
Switzerland	23	42	29	13	107
France	14	28	26	27	95
United Kingdom	11	17	18	16	62
Tanzania	12	11	17	7	47
Morocco	1	5	21	16	43
Rest of world	117	116	109	152	494
Total for year	278	392	413	434	1517

C. Medical Evacuation procedures and record management

20. The authority to approve MEDEVAC to the 'recognised place' within the region or to the country of home leave, on the recommendation of the UN designated physician, is delegated to the Heads of Offices, in consultation with the Medical Service. MEDEVAC to any other place requires the prior approval of the Medical Service. OIOS observed that, even where prior approval was not required, most field offices preferred to wait for approval by the Medical Service before authorising the evacuation. In practice, therefore, the decision to grant medical evacuation or not, is taken by the Medical Service. *The Medical Service agreed with*

OIOS comments and stated that they encouraged Heads of Offices to assume responsibility for acting in accordance with guidelines.

21. In view of the limitation in audit scope, OIOS could not assess whether the Medical Service had completed the required administrative and procedural formalities prior to authorising the evacuation and whether the approvals were consistent with guidelines.

(a) Essential documents pertinent to MEDEVACs

22. Prior to a MEDEVAC a number of procedures should be followed. Instructions require specified forms to be part of the records relating to medical evacuations. These include Annex E - MEDEVAC form, Annex F - Information required for MEDEVACs from field offices, Annex G - 'JMS authorisation for MEDEVAC', Annex H - 'Final report on MEDEVAC from field offices to the JMS' and Annex J - MEDEVAC checklist. *The Medical Service stated that in the absence of essential documents from field offices (such as Annex H), administrative recommendations could not be made in a timely manner including the period required for the payment of DSA.* During OIOS' discussions with the Medical Service it emerged that documents (medical and non-medical) have not been filed in a systematic and segregated manner. No consolidated information or statistics were available regarding medical evacuation to enable management to identify and subsequently follow-up on unusual trends.

23. OIOS audits of field operations assessed that many field offices did not adequately comply with the required procedures. The filing systems were found to be less than satisfactory and relevant documents were not properly filed. The following highlights procedures which needed to be improved:

- Approvals from the Medical Service were not always available nor were approvals for extensions of MEDEVAC.
- Annex F that should be completed by the Head of Office recommending MEDEVAC was not consistently available.
- The required certification from the UN designated physician or approval from the Medical Service of the exact number of sick leave days recommended, number of days of hospitalisation and days the patient was required to reside at the place of evacuation was not attached to Travel claims for MEDEVAC.
- Several offices did not maintain and update the MEDEVAC 'control sheet' for compiling information on medical evacuations including the names of staff evacuated, place of evacuation, duration and costs of the evacuation. Also, as part of the audit, OIOS requested eleven country operations to provide the control sheet. Only seven responded (Afghanistan, Burundi, Pakistan, Zambia, DRC, Somalia and Guinea), and in the absence of any communication from the others (Tanzania, Uganda, Sudan and Ethiopia), it was assumed that these operations did not maintain these essential documents.
- One office filed confidential medical information in the staff member's file although this is contrary to MEDEVAC instructions. Concerns were also raised that the medical condition of staff evacuated was not kept confidential.

24. *The Medical Service shared OIOS' concerns about the non-availability of required documentation and would follow up on these issues. The Medical Service added that since they became independent of the Joint Medical Service, action has been launched in consultation*

with DHRM to evaluate existing forms and procedures with a view to refine and improve operational arrangements. The Medical Service also agreed that medical information should never be kept in the staff members file.

Recommendations:

- The UNHCR Division of Human Resources Management should instruct field offices to ensure that all the documents and annexes mentioned in the MEDEVAC instructions (Annexes E, F, G, H and I) are routinely prepared and appropriately filed (Rec. 01).
- The UNHCR Medical Service should maintain medical evacuation files in a manner to ensure medical and non-medical information is segregated. Furthermore, the Medical Service should provide, on a yearly basis, the Division of Human Resources Management with statistics pertaining to medical evacuations (Rec. 02).

25. *DHRM agreed with the recommendations and stated that the existing system of record keeping would be scrutinised to identify the most practical and efficient arrangement for separate record keeping. In this context, DHRM would pursue through the Medical Service and the Personnel Administration Section, the development of a system to ensure that all relevant documents are filed in an easily retrievable manner.*

(b) Medical Evacuation Plans

26. In accordance with paragraph 18, Chapter 23 of the UNHCR 'Handbook for Emergencies', field offices should have a Medical Evacuation Plan to evacuate staff members. A 2004 evaluation of the Medical Service found that 55 per cent of the offices included in a survey indicated that they did not have a Medical Evacuation Plan. The EPAU evaluation observed that "to make the process of medical evacuations more efficient it is recommended that the UNHCR Medical Service and the Emergency Service develop one standard MEDEVAC checklist for each type of situation (regular and emergency), with an action sequence and spelling out of the designated responsibilities and contact numbers. Heads of Offices should become formally responsible for updating the duty station's medical evacuation plan". *The Medical Service informed OIOS that EPAU's recommendation has not been implemented.*

27. In OIOS' opinion, existing arrangements in the field should be reviewed to ensure that when there is a medical evacuation, all participating units (Administration /Human Resources, UN Physician, Logistics) are properly organized, trained and ready to perform in an effective and coordinated manner. OIOS discussions with the UNON Joint Medical Service also highlighted that the absence of clear protocols and procedures was the main obstacle faced in organising MEDEVACs. In an emergency, staff members were unsure of what steps to take. OIOS' review established that as a result of a lack of clear roadmaps on what to do and whom to approach, there is a significant gap in medical evacuation services, and field offices are not in a position to take informed decisions in crisis situations.

28. OIOS requested 11 country operations to submit their medical evacuation plans. These were the countries from where the highest number of evacuations had taken place. Only 4 (Pakistan, Burundi, Somalia and Sudan) submitted them. None were received from those countries where the maximum evacuations took place, such as Guinea, Afghanistan, Uganda, Tanzania and DRC. UNHCR Afghanistan stated that they used United Nations Humanitarian Air Services for evacuations – no other details were provided. This indicates that the level of compliance with the requirement to have medical evacuation plans as prescribed in the UNHCR ‘Handbook for Emergencies’ is still not satisfactory.

Recommendation:

- The UNHCR Division of Human Resources Management and the UNHCR Medical Service should ensure field offices prepare medical evacuation plans detailing the action sequence and the designated responsibilities of personnel for organizing an evacuation. The plans should include specifics of the logistical arrangements planned for evacuations (Rec. 03).

29. *DHRM and the Medical Service agreed with the recommendation and appreciated the usefulness of having advance planning and designated responsibilities. DHRM will further examine the existing procedures within the context of the ongoing evaluation of processes and procedures pertaining to the Medical Service.*

D. Policy issues relating to medical evacuations

30. Policy aspects relating to MEDEVACs are dealt with by DHRM. The UNHCR policy for MEDEVACs is generally in conformity with the United Nations instructions (ST/AI/2000/10 dated 21 September 2000). OIOS however identified certain areas where there was a lack of clarity in the guidelines, leading to inconsistent interpretations. These are detailed in the following paragraphs.

(a) Recognised places for medical evacuations

31. The MEDEVAC instructions contain the list of recognised places designated as regional MEDEVAC centres. These are destinations to where evacuations can take place from different countries. OIOS compared UNHCR’s list of recognised places with those of the UN (as mentioned in ST/IC/2000/70 dated 21 September 2000) and the following differences were noted as outlined in Table V:

Table V

Countries/Regions	Recognised centres per UN ST/IC	Recognised centres per UNHCR instructions
West & Central Africa	Cameroon, Ivory Coast, Gabon, Senegal, South Africa	Johannesburg, London, Paris
Arab states-Central Asia /CASWANAME	Jordan, Lebanon, Egypt, Tunisia, Saudi Arabia, Turkey	Istanbul, London

32. The difference is more marked for West and Central Africa and the only common country/place is South Africa/ Johannesburg. The UN list does not include London and Paris as recognised centres, and designates four other locations in the region. OIOS was of the opinion that UNHCR's recognised centres should be more in line with the UN's, and did not see any justification for the difference. OIOS' audit noted also that there was a tendency to authorise medical evacuation to European and other costly destinations rather than those geographically closer, which according to the UN list have adequate medical facilities. For example, in Guinea from 2002 to 2005 there were 45 medical evacuations to London, Paris, Canada and Geneva.

33. In OIOS' view the inclusion of high cost European locations (London and Paris) for locations in West and Central Africa may not be justified considering that closer locations with adequate medical facilities are available. OIOS must assume that the UN New York list would not have included Cameroon, Ivory Coast, Gabon and Senegal unless these places were deemed suitable for medical evacuations. The inclusion of distant high cost locations has three-fold financial implications for UNHCR, namely (a) higher DSA costs; (b) higher travel costs and most significantly (c) markedly higher medical treatment reimbursement costs.

34. *DHRM stated that while the Medical Service wishes to reconcile its list of medical centres with UN New York, this list was often not up-dated as often as UNHCR's, which was based on more current information.* OIOS concurs that the list of recognised medical centres needs to be revised and updated in tandem with the growth and development of medical infrastructure round the world. Nonetheless, the reasons for deviations from the UN list of recognised places should be explicitly justified and their financial implications properly assessed.

35. The MEDEVAC instructions require that MEDEVAC travel to any place other than the recognised place be documented for audit purposes. This requirement was generally not complied with in field offices and proper justification was not correctly filed when travel was undertaken, for example to the place of choice. At the Medical Service in Headquarters, OIOS could not evidence fulfilment of this requirement due to the denial of access to relevant documentation.

Recommendations:

- The UNHCR Division of Human Resources Management and the UNHCR Medical Service should review and update the list of recognised regional medical evacuation centres to bring it in line with the locations designated in the United Nations information circular ST/IC/2000/70 dated 21 September 2000 on Medical Evacuations. There is a need to take into account the medical facilities currently available in different regions, as well as the financial implications for UNHCR of establishing additional (often more expensive) locations (Rec. 04).
- The UNHCR Division of Human Resources Management and the UNHCR Medical Service should ensure that travel on medical evacuation to any place other than the recognised place is fully documented for audit purposes, both at Headquarters and by field

offices (Rec. 05).

36. *DHRM agreed with OIOS recommendation that travel on medical evacuation to any place other than the recognised place should be fully documented for audit purposes. DHRM will examine the existing procedures jointly with the Medical Service with a view to fill any gaps or inadequacies in the present system.*

(b) Conditions justifying MEDEVACs

37. From some of the information reviewed as part of the audit, OIOS evidenced that one office had recorded in its summary information on MEDEVACs that a staff member was 'planning to evacuate in November 2005'. A planned medical evacuation would not fall under the criteria established. OIOS highlighted that every travel outside the place of duty for medical reasons cannot be treated as a MEDEVAC. For stable non-emergency cases, the staff member should take sick leave or annual leave to obtain medical treatment or care required. It is evident in this case that the staff member could have deferred the medical attention, and it should not have qualified for an evacuation. The existing instructions are already clear on this matter, whereby all elective surgical, medical or dental procedures should be planned in conjunction with home leave or a family visit travel. Routine medical checkups of an existing condition (and planned with the doctors in advance) should also not fall under the category of medical evacuation.

38. OIOS observed instances of repeated evacuations for the same staff member or dependents, and noted a case where a staff member's dependent was medically evacuated (with accompanying parent) eleven times from 1993 to 2004 to their place of choice (United States of America) whereas the recognised place was Nairobi. For the second MEDEVAC, the UN physician had recommended Jordan, but the staff member preferred the United States. It appeared that the repeated evacuations were more in the nature of periodical medical examinations. In this case the staff member apparently did not claim MIP reimbursements for any medical treatment.

39. OIOS would highlight that non-compliance with the MEDEVAC guidelines results in unnecessary and avoidable costs. OIOS appreciates that MEDEVAC decisions are taken by trained medical staff, but would nevertheless urge, in view of the rapidly escalating numbers of evacuations, that the fundamental principles of medical evacuations are applied.

(c) Appendix D of the MEDEVAC instructions

40. Appendix D contains guidelines for physicians advising on evacuations. These comprise a list of chronic conditions with potential for life-threatening outcomes or complications, conditions that are generally not considered for evacuation, as well as conditions that do not qualify. From the data provided by the Medical Service, OIOS observed that several evacuations were authorised for dental treatments, eye conditions, skin disorders, tests and other illnesses, which appeared not to qualify for a MEDEVAC. The absence of adequate facilities, though a *sine qua non* for medical evacuations, does not by itself justify an evacuation; the other essential pre-requisites are 'acute illness/injury' for international staff and 'life threatening medical emergency' for local staff.

(d) Improvements to standard authorisation letter from the Medical Service

41. The standard email approval issued by the Medical Service requires more clarity in certain aspects. Sometimes the MEDEVAC authorisation was unclear about whether the place of the evacuation was the recognised place, place of choice or another place approved by the Medical Service. It is also important that where accompaniment is justified, this should be made apparent in the approval letter. These issues are important to determine DSA eligibility. OIOS suggested that a template be developed for common use.

(e) Medical Evacuations and implications for MIP reimbursement

42. Outlined in a memorandum ref: PAS1/2004/01372 dated 6 September 2004, DHRM had stipulated that where a local staff member is on authorized medical evacuation at the authorized place for medical evacuations, the reimbursement will be made according to the prevailing patterns of charges at the place where the services were rendered. This implies that the ‘reasonable and customary cost’ principle which is fundamental to the MIP rules, no longer applies in case of medical evacuations. Since the number of MEDEVACs has been increasing for local staff, this change could have significant cost implications for the UNHCR.

43. Moreover, the September 2004 circular refers to the ‘authorised’ place for MEDEVACs and it was not clear to OIOS how this will be treated in relation to the ‘recognised’ place mentioned in the MEDEVAC instructions. The MEDEVAC instructions acknowledge only three possible destinations for evacuations, the ‘recognised place’, and the ‘place of home leave/country of recruitment for local staff and ‘place of staff member’s choice’. The use of the phrase ‘authorised place’ in the MIP statutes and September 2004 memorandum is therefore unclear and should be re-examined by DHRM.

44. *DHRM stated that the changes made to the MIP rules were to harmonise them with those of UNDP and UNICEF, and the modifications made have not adversely affected the financial viability of the scheme. DHRM added that the “authorized place” of medical evacuation is the particular place; the Medical Service approves the evacuation to the location where a special treatment is available. The “designated place”, is the place that has been designated by the Medical Service for evacuations. For MIP reimbursement purposes, what is essential is the “authorized place” only, since this is the place where the Medical Service considered that the patient would receive adequate medical care.*

45. In OIOS’ opinion, the instructions still lack some clarity. For instance this would imply that even if MEDEVAC were undertaken to the ‘place of staff member’s choice’ as opposed to the ‘recognised place’, the reimbursement would be done on the basis of costs prevalent at the place chosen by the staff member. To cite a hypothetical example, a local staff member whose recognised place for MEDEVAC is Nairobi chooses to be medically evacuated to London and the Medical Service approves this stipulating that the MEDEVAC is up to the cost to Nairobi. This limits the DSA and travel costs to that of Nairobi, but as the Medical Service had approved the medical evacuation, the MIP reimbursement would be done on the reasonable & customary charge at UK rates. This OIOS’ assumes would be significantly higher than those of Nairobi. OIOS suggests in such cases the reimbursement should be limited to reasonable and customary charges at the ‘recognised place’.

Recommendation:

- The UNHCR Division of Human Resources Management should, in

view of the changes introduced by its 6 September 2004 memorandum and to avoid ambiguity, clearly define the meanings associated with the terms ‘recognised place’ and ‘authorised place’. Where MIP reimbursement is made for treatment obtained at the staff member’s place of choice as opposed to the ‘recognised place.’ DHRM should consider limiting reimbursement to reasonable and customary charges at the ‘recognised place’ (Rec. 06).

(f) Duration for medical evacuations

46. OIOS observed that the initial duration of MEDEVACs was always approved at 15 days, the maximum number of days, for which staff can retain SOLAR or other benefits, while in receipt of DSA for MEDEVAC. OIOS pointed out that the duration should be limited to the period certified by the referring physician. DHRM explained that the duration of 15 days was fixed taking into account the movement from field locations, medical attention required and the return journey back to the duty station. DHRM felt that in view of the remoteness of some of the field locations, such a period is the minimum required. OIOS appreciates that a benchmark may have to be established, but notes that in the years reviewed more than 40 per cent of persons were evacuated for less than 15 days. This benchmark therefore should be reviewed downwards.

47. Table VI presents the data regarding the duration of medical evacuations during the review period:

Table VI

Duration of MEDEVACs	2002	2003	2004	2005 up to (August 2005)
< 15 days	134	140	161	93
15 – 45 days	103	147	149	85
> 45 days	41	55	56	27
Totals	278	342*	366*	205

48. From the data provided by the Medical Service, OIOS observed that there were 179 cases of MEDEVACs in UNHCR exceeding the limit of 45 days mentioned in the instructions. OIOS observed that at UNON the maximum period for which DSA could be paid was fixed at 45 days and beyond this period, the staff member was required to be on sick leave, and no DSA was paid. The UNDP instructions relating to MEDEVAC also stipulate that payment of DSA is permitted for a maximum of 45 days. Also, the UN instruction (ST/AI dated 21 September 2000) states in paragraph 8.5 that DSA can be paid normally only for up to 45 days. As there are several such cases in UNHCR beyond 45 days, which resulted in significant costs, OIOS is of the opinion that practices should be harmonized.

49. OIOS does not question the need for long duration MEDEVACs when medically and clinically justified. Nonetheless, in some cases reviewed, the reason for the extended period was not apparent. In Guinea for instance, OIOS noted a staff member’s son was medically

* Differences with Table I due to inconsistent data provided by the Medical Service. According to the Medical Service, with the impending installation of MediGate Software, such inconsistencies are expected to be sorted out.

evacuated to London (with an accompanying parent) from 12 August to 10 December 2003. The first appointment with the doctor however only took place on 8 September 2003, almost a month later. The patient was signed as fit to travel as of 13 November 2003 yet the evacuee returned only on 10 December 2003. The staff member received DSA amounting to US\$ 47,000. Paragraph 52 of the MEDEVAC instructions provides that “*in non-emergency cases, travel should not commence until the appointment with the pertinent specialist has been made*”. OIOS considered the payment of DSA from 13 August through 7 September and from 13 November to 10 December; estimated at some US\$ 11,700 as inappropriate and recommended recovery. *The Representation agreed to recover the overpaid amounts.*

Recommendation:

- The UNHCR Medical Service when authorising evacuations should
 - (a) ensure that in accordance with UNHCR’s instructions, travel does not commence in non-emergency cases until medical appointments have been properly scheduled to avoid unnecessary stay at the place of evacuation and (b) prolonged evacuations are properly evaluated prior to granting further approvals (Rec. 07).

50. *DHRM accepted that in non-emergency cases, advance travel should not be permitted and lapses if any in the implementation would be addressed through the Medical Service.*

(g) MEDEVAC, official mission and SOLAR payments

51. OIOS observed variances between UN agencies in the instructions regulating SOLAR/MSA on MEDEVAC and official missions outside the Special Operations Area (SOA) or mission area. In UNHCR, both for official missions and MEDEVAC, SOLAR continues to be paid in addition to DSA for the first 15 nights; from the 16th night only DSA would be paid. OIOS noted that in accordance with the United Nations instruction ST/AI/2002/5 dated 7 June 2002 on Mission Subsistence Allowance, during official business outside the mission area including when a staff member is on authorised medical evacuations only the ‘accommodation portion’ of the MSA is paid.

52. As already mentioned, per the current instructions, both SOLAR and DSA can be paid for the first 15 days of the MEDEVAC and from the 16th day SOLAR ceases. If the MEDEVAC is expected to last for more than 15 days from the outset, then SOLAR is discontinued from the date of departure. Under these procedures, it is unlikely that a staff member would state the medical evacuation will be for more than 15 days if the SOLAR is forfeited. Moreover, as the initial authorization given by the Medical Service is normally 15 days it is unlikely that it will be expected to last for more than 15 days from the outset. OIOS does not question the medical assessment in individual cases, but is concerned about a pattern that stretches entitlements to the maximum at a considerable cost to UNHCR.

53. In OIOS’ opinion there was a need for greater clarity on instructions regarding payment of DSA and SOLAR to a staff member who accompanies a spouse or dependent on MEDEVAC. OIOS observed the case of a staff member (posted to an SOA) who accompanied his spouse on two MEDEVACs to Johannesburg lasting 15 days and 22 days respectively. In terms of paragraph 40 of the MEDEVAC instructions, the absence of the staff member was charged to annual leave. The staff member accompanying the spouse was entitled to DSA at

the applicable rates. Additionally as the staff member was on annual leave, he was entitled to SOLAR for the entire duration, even though the absence from the SOA was more than 15 days in the second instance. Thus, OIOS observed a situation where the staff member was on annual leave, while at the same time receiving DSA and SOLAR payments. Given the circumstances, in OIOS' view only one entitlement, i.e. DSA or SOLAR should be paid.

54. Moreover, other arguments can be adduced for questioning the granting of SOLAR to those who have been medically evacuated. The January 2004 SOLAR instructions state that 'SOLAR will be paid during absences on sick leave in the SOA and since by definition MEDEVAC is undertaken to a place outside the SOA, no SOLAR should be paid to staff on medical evacuation, since the absence of the staff member is charged to sick leave. *DHRM did not agree and stated that MEDEVAC was equivalent to official travel and if SOLAR was paid for the first 15 days of mission, the same should apply to absence on MEDEVAC.* OIOS would refer to the instructions applicable to peacekeeping operations, where during official mission outside the mission area, only the accommodation portion of the MSA is payable.

Recommendation:

- The UNHCR Division of Human Resources Management should review the justification for paying SOLAR during official missions and MEDEVAC with the aim to harmonize it with the United Nations where only the accommodation portion of MSA is paid when a staff member is on official travel or medical evacuation (Rec. 08).

55. *DHRM have noted the recommendation and would examine the policy in relation to SOLAR payments during MEDEVACs.*

E. Financial aspects in the field

56. The rate of DSA payable to staff proceeding on medical evacuations depends upon whether the evacuation is to the recognised place, the place of choice or to the place of home leave for international staff or within country for local staff. The rate also changes if the evacuee was hospitalised during the course of the evacuation. In all cases, the payment of subsistence allowance is further subject to the production of hotel/accommodation receipts to determine the appropriate rate. The subsistence allowance payable to the escort also varies depending upon the circumstances. The MEDEVAC instructions governing subsistence allowance are complicated and field offices often make mistakes in its computation. The inconsistent interpretations of the rules often resulted in overpayments and subsequent recoveries. For instance, when local staff are medically evacuated within the country of recruitment, only actual hotel expenses can be reimbursed up to 50 per cent of the standard applicable DSA. Without hotel receipts no subsistence allowance payments can be made. OIOS identified mistakes in Kenya, Chad and Ugandan resulting in overpayments that had to be recovered.

57. The failure to submit hotel/accommodation receipts with MEDEVAC travel claims has been frequently noted. The amounts involved for DSA can be significant, and OIOS noted that field offices proceeded with payment without the appropriate documents in Sudan, Uganda, Guinea, Greece and Yemen. In one county, five medical evacuations were undertaken from

2002 to 2004 and DSA of some US\$ 50,000 was paid. The hotel receipts were subsequently found to be forged – highlighting the importance of scrutinizing supporting documents prior to determining eligibility of payment of entitlements.

58. OIOS also noted errors in the calculation when the MEDEVAC destination is other than the recognised place. The amount reimbursed should be the travel costs only to the recognised place. In Yemen, OIOS found two cases where travel costs were reimbursed without limiting these to the cost up to the recognised place. OIOS also noted that MEDEVAC costs were not charged to the correct accounting codes, making it difficult to obtain an accurate assessment of the expenditures incurred.

Recommendation:

- The UNHCR Division of Human Resources Management should, in view of the numerous errors identified by OIOS, simplify instructions regarding MEDEVAC travel claims including payment of subsistence allowance to assist field offices in complying with the guidelines (Rec. 09).
- The UNHCR Division of Human Resources Management should consider limiting the reimbursement of accommodation for MEDEVAC to the actual accommodation cost up to 50 percent of the applicable DSA rate (Rec. 10).

59. *DHRM have noted the observations and will review the existing procedures with the aim to improve them.*

F. Staffing at the Medical Service

60. The medical and administrative procedures associated with evaluating and approving evacuations are detailed and complex. The Medical Service informed OIOS that they do not possess adequate manpower resources to cope with the constantly increasing numbers of evacuations. An EPAU study also observed in their 2004 evaluation that ‘*To carry out the functions required from the UNHCR Medical Service and to manage the Service itself, the current number of medical staff is insufficient. This leads to a more reactive approach to the work than considered desirable in the interest of staff health and containing health costs*’. The current complement of two doctors, two nurses, three laboratory technicians, three medical secretaries and one administrative secretary was considered by the EPAU as a case of ‘severe understaffing’. Of this staff complement, only a few staff members (not full time) were actually involved in administering medical evacuations and it is evident that additional staffing will improve record keeping and other processes.

61. As a result of the existing heavy workload, higher level planning and coordination of medical evacuations activities by the Medical Service have been minimal, with management generally focused on the day-to-day operations meaning that issues are only dealt with as they arise. OIOS recommended that DHRM conduct an assessment of the additional workload generated by medical evacuations at the UNHCR Medical Service and consider if additional resources are required. *DHRM informed OIOS that under the going a process of reforms and*

restructuring of UNHCR, the concerns expressed by OIOS would factor in to the processes.

V. ACKNOWLEDGEMENT

62. I wish to express my appreciation for the assistance and cooperation extended to the auditors by the staff of the Division of Human Resources Management and the UNHCR Medical Service at the UNHCR Headquarters.

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