Admitting non-U.S. Citizens to the United States for Treatment of Ebola Virus Disease

Purpose: Come to an agreed State Department position on the extent to which non-U.S. citizens will be admitted to the United States for treatment of Ebola Virus Disease (EVD). A cleared paper is urgently needed for circulation to the interagency and NSC for a policy decision.

Recommendation: That State and DHS devise a system for expeditious parole of Ebola-infected non-citizens into the United States as long as they are otherwise eligible for medical evacuation from the Ebola affected countries and for entry into the United States.

Issue: The United States needs to show leadership and act as we are asking others to act by admitting certain non-citizens into the country for medical treatment for Ebola Virus Disease (EVD) during the Ebola crisis. The greatest stated impediment to persuading other countries to send medical teams to the Ebola-afflicted countries in West Africa has been the lack of assured medical evacuation and treatment for responders who may be infected with Ebola virus.

State Department contracted evacuation capacity has so far been sufficient to evacuate all Americans and several other international responders with EVD. (Spain, the UK, and Italy have each evacuated one or two of their own citizens.) Of those evacuated, all American citizens have come to the United States for treatment; all others have gone to Europe, where Germany is so far the only country to accept non-citizens with EVD for treatment. Several countries are implicitly or explicitly waiting for medevac assurances for their responders before committing to send medical teams; assurances are also essential to encouraging individuals to volunteer. (The scope of who is eligible for medical evacuation is the subject of another paper.)

There are four essential elements to every medical evacuation:

1. Medical evacuation capacity;
2. Overflight, refueling and landing permission;
3. A hospital able and willing to treat the patient; and
4. Funds to backstop reimbursement, about $200,000 for medevac and $300,000 for treatment per case.

What is at issue here is point 3. As noted, Germany is so far the only country to accept non-citizens for Ebola treatment; Norway has offered to accept EU citizens

in addition to its own. We will be working with the European Commission's Humanitarian Aid and Civil Protection Office (EC ECHO) and with individual countries to impress on them the necessity of opening treatment beds to non-citizens in order to enable and sustain a robust Ebola response. Since it is several hours closer to West Africa by air, Europe is also a preferable treatment destination for medical reasons. We are exploring other destinations as well, and establishment of the Monrovia Medical Unit by the United States and the Kerry Town, Sierra Leone facility by the UK should reduce the need for medevac as they begin to prove themselves effective treatment centers.

There will also be cases where the United States will be the logical treatment destination for non-citizens. For example, we have an obligation to assist non-citizen employees and contractors of U.S. agencies and programs, as well as NGOs and private firms based in the United States. Non-European Ebola response partners (e.g., Australia) consider the U.S. a better destination as well. UN staff permanently employed at headquarters in New York are another category to consider. U.S. legal permanent residents (LPRs) would also expect to come back to the United States. If, as expected, the United States deploys aircraft capable of evacuating more than one patient in the near future, there are likely to be occasions where one patient on a flight is a U.S. citizen and another is not.

U.S. Medevac Capacity: The U.S. Department of State has a contract with a commercial aviation company, Phoenix Aviation, which has the capability to safely transport patients with contagious disease using a specialized aeromedical biocontainment system. A mechanism has been established for the U.S. government to provide reimbursable medical evacuation services to support countries and International Organizations in their efforts to address the Ebola crisis. Because of the specialized air transport and medical precautions required for Ebola Virus Disease (EVD) the Department of State is assisting with evacuations of U.S. citizens infected with Ebola virus from West Africa whenever possible. State has assisted with medevac of several citizens with EVD back to medical facilities in the United States, in keeping with the U.S. government's longstanding role of facilitating emergency medical care for U.S. citizens through the State Department, including bringing them home to receive potentially life-saving treatment for serious illness.

The U.S. government is also working with organizations like the UN Office of Ebola Special Envoy David Nabarro, the World Health Organization, and the European Commission, as well as with several countries, on medevac options for

Ebola victims. In addition to U.S. citizens, we have assisted with the medevacs of four health care workers out of West Africa with confirmed Ebola cases who are citizens of other countries – three were evacuated to Germany and one to France. Any costs associated with evacuations are the responsibility of the patient or their parent organization. They are not funded by U.S. taxpayers – although the financial guarantees required of U.S. citizens are somewhat less stringent than those for non-citizens.

So far all of the Ebola medevacs brought back to U.S. hospitals have been U.S. citizens. But there are many non-citizens working for U.S. government agencies and organizations in the Ebola-affected countries of West Africa. These may be local employees of U.S. Embassies or third country national health care workers who are working for agencies like CDC and USAID. These workers are playing a critical role in the battle against the Ebola outbreak. Many of them are citizens of countries lacking adequate medical care, and if they contract Ebola in the course of their work they would need to be evacuated to medical facilities in the United States or Europe. Thus far Germany is the only country that has accepted citizens of other countries for treatment of EVD in their hospitals.

U.S. Treatment Capacity: Many hospitals in the United States have the technical ability to treat Ebola patients. However, experience with Ebola cases would minimize the risk to health care workers, and the medical community should consider how best to distribute patients. In addition to Emory University Hospital in Atlanta and the University of Nebraska Medical Center, which have both accepted patients, the National Institutes of Health Clinical Center has expressed willingness to do so.

Legal Authorities and Implementation Requirements: State L notes that the legal and procedural constraints outlined below do not determine the policy outcome. If the U.S. government decides to to restrict entry to the United States for non-U.S. citizen Ebola patients, it cannot attribute the outcome to legal and technical issues. At the same time, the mechanism for admission of non-U.S. citizen is not the usual visa process, and normally takes much longer than the time available to an infected Ebola patient, so setting up a mechanism that is ready to move would be essential.

To optimize clinical outcomes and give patients their best possible chance of recovery, air medical transportation of EVD victims should occur in the first five days of illness, with proportionately greater benefit the sooner it can be

accomplished. Operationally, that requires an almost immediate request for medevac and approval for travel to the United States, as the medevac process itself is a two day journey. This presents a challenge, since under INA § 212(a)(1)(A)(i), (implemented by 42 C.F.R. § 34.2(b) and Executive Order No. 13295, as amended) Ebola Virus Disease is a communicable disease of public health significance and grounds for visa ineligibility. In order to permit the travel of such an individual, either an INA § 212(d)(3)(A) waiver of ineligibility or prior approval of parole pursuant to INA § 212(d)(5)(A) would be required from the Department of Homeland Security. (Note: legal permanent residents of the United States would not normally be ineligible to enter because they have an infectious disease, and could enter on their "green cards" in most cases.)

Given the length of time necessary to obtain a waiver of ineligibility, or individual parole, as well as potential difficulties in securing the travel document for an infected individual, issuance of a properly annotated visa/boarding foil pursuant to a waiver request or parole is not a likely option. The Visa Office recommends the development and implementation of a mechanism similar to the one used for the African Leaders Summit (when technical issues precluded the issuance of visas), under which State worked with DHS to arrange expeditious port-of-entry waivers in advance of travel.

A pre-established framework would be essential to guarantee that only authorized individuals would be considered for travel authorization and that all necessary vetting would occur. The precise language and structure would be jointly developed by the Department of Homeland Security and the Bureau of Consular Affairs.