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Performance Audit

Administration of the Health Requirement of the *Migration Act 1958*

Australian National Audit Office

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Australian National
Audit Office

Canberra ACT
17 May 2007

Dear Mr President
Dear Mr Speaker

The Australian National Audit Office has undertaken a performance audit in the Department of Immigration and Citizenship and Department of Health and Ageing in accordance with the authority contained in the *Auditor-General Act 1997*. Pursuant to Senate Standing Order 166 relating to the presentation of documents when the Senate is not sitting, I present the report of this audit and the accompanying brochure. The report is titled *Administration of the Health Requirement of the Migration Act 1958.*

Following its presentation and receipt, the report will be placed on the Australian National Audit Office's Homepage—http://www.anao.gov.au.

Yours sincerely

Ian McPhee
Auditor-General

The Honourable the President of the Senate
The Honourable the Speaker of the House of Representatives
Parliament House
Canberra ACT

AUDITING FOR AUSTRALIA

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Abbreviations

Act	*Migration Act 1958*
AGHS	Australian Government Health Service
ANAO	Australian National Audit Office
DEWR	Department of Employment and Workplace Relations
DIAC	Department of Immigration and Citizenship (formerly the Department of Immigration and Multicultural Affairs—DIMA)
DIMA	Department of Immigration and Multicultural Affairs
DoHA or DHA	Department of Health and Ageing
ELMA	Electronic Medical Assessments
ETA	Electronic Travel Authority
FaCS	Department of Family and Community Services
FaCSIA	Department of Families, Community Services and Indigenous Affairs
FMA Act	*Financial Management and Accountability Act 1997*
Forum	Migration Health Forum
GMD	Global Medical Director
GMU	Global Medical Unit
HAPR	Health Assessment Permission Request
HAS	Health Assessment Service

HATS	Health Assessment Tracking System
HIV	Human Immunodeficiency Virus
HSA	Health Services Australia Ltd.
HUS	Health Undertaking Service
ICSE	Integrated Client Services Environment
IRIS	Immigration Records Information System
IT	Information Technology
LCU	Local Clearance Unit
MAL	Movement Alert List
Minister	Minister for Immigration and Citizenship
MOC	Medical Officer of the Commonwealth
MOU	Memorandum of Understanding
OPCs	Onshore Processing Centres
Panel Doctor Guidelines	*Instructions for Panel Doctors and Radiologists: medical and radiological examinations of Australian visa applicants*
PAM3	*Procedures Advice Manual: Schedule 4/4005–4007, the health requirement*
PIC	*Migration Regulations 1994, Schedule 4, Public Interest Criteria 4005–4007*
Regulations	*Migration Regulations 1994*
RFT	Request For Tender
RMD	Regional Medical Director
SOW	Statement of Work

TB	Tuberculosis
TRIPS	Travel and Immigration Processing System
WHO	World Health Organisation

Glossary

'A' case	A grading of a health examination which generally indicates that the applicant in question has no significant medical problems.
'B' case	A grading of a health examination which indicates that the applicant in question has a medical condition that requires further investigation by a Medical Officer of the Commonwealth (MOC).
eHealth I	eHealth I commenced in July 2002, and enables visa applicants undergoing x-ray, physical and/or blood tests to download their own medical forms and have their medical results accepted for clearance at the nearest overseas post or Local Clearance Unit in Sydney, as appropriate.
eHealth II	eHealth II commenced in November 2003, and is now available in ten countries. It enables medical and x-ray results to be recorded online using digital images and transmitted to Australia for examination and clearance online by Australian personnel.
ELMA	Electronic system used by Health Services Australia (HSA) to record medical data for visa applicants who undergo health assessments through HSA onshore services, and transfer data to DIAC.
eVISA	Electronic visa application system which allows applicants to complete and submit visa applications electronically.
Front end loading	Front end loading is where a person seeking entry to Australia submits medical results before their visa application.

HAPR	Health Assessment Permission Request. An Integrated Client Server Environment permission request specifically designed to record the result and progress of health assessments.
HATS	Health Assessment Tracking System. The application used to process the health assessment component of visa applications. Results from HATS update the HAPR in ICSE.
ICSE	Integrated Client Services Environment. DIAC's onshore core client processing system, commissioned in 1999. ICSE provides on-line processing and decision recording and integrates the decision process with entry, alert lists and management reporting systems. ICSE enables DIAC staff in State and Territory offices to refuse or grant and evidence over-the-counter visas.
IRIS	Immigration Records Information System. IRIS was introduced as DIAC's offshore processing system in 1989, this system is used to record and support the decision process for visa applications for temporary and permanent entry into Australia. Each overseas post has its own standalone IRIS database with terminals and/or PCs connected.
MAL	Movement Alert List. A system used by DIAC to record applicants with details of concern, including health and character issues. If an applicant has a MAL listing, this will prevent them being granted an electronic visa and will result in a referral to immigration at the border if they attempt to enter Australia.
MOC	Medical Officer of the Commonwealth, appointed by the Minister of Immigration and Citizenship under the *Migration Act 1958*. MOCs are empowered to give opinions on whether or not a visa applicant meets the health requirement.

PAM3	DIAC's *Procedures Advice Manual 3, Schedule 4/4005–4007, the health requirement*. The PAM3 is set based on the *Migration Regulations 1994, Schedule 4, Public Interest Criteria 4005–4007*. It sets out guidelines for implementing the health requirement, including risk assessment tables to assist DIAC assess the health of visa applicants.
RMD	Regional Medical Directors. There were two RMDs, operating out of Bangkok and London. This function was repatriated in December 2004. RMD functions are now carried out by Global Medical Directors (GMDs).
TRIPS	The Travel and Immigration Processing System. The system records a person's travel in and out of Australia.

Summary, Key Findings and Recommendations

Summary

Background to migration health screening

1. Australia operates a universal visa system to manage the movement of non-citizens across its borders. This visa system acts as a screening mechanism to prevent people who pose a security, criminal or health risk from entering Australia. People who wish to migrate permanently to Australia, or to stay temporarily, must apply to the Department of Immigration and Citizenship (DIAC)[1] for an appropriate visa. Currently, there are about 150 visa types for managing applicants in different situations. In 2004–05, DIAC received 4.5 million visa applications and granted 4.3 million visas.

2. Within the visa system, health risks are managed according to the health requirement of the *Migration Act 1958* (the Act) and the *Migration Regulations 1994* (the Regulations).[2] The health requirement (also called the health criteria) is a relatively small but important component of DIAC's broader remit for border control.[3] The intent of the health requirement is to:

- protect the Australian community from public health risks;
- contain public expenditure on health care and community services; and
- safeguard Australians' access to health services in short supply.

3. Diseases such as tuberculosis (TB), Human Immunodeficiency Virus (HIV), malaria and hepatitis B and C are associated with high incidence, morbidity and mortality globally, and may incur high medical costs. Serious health conditions, for example cardiac, pulmonary or renal disease, may also draw heavily on hospital resources or put additional pressure on long waiting lists for organ transplants. Against this backdrop, the health requirement for visa applicants has an important role in contributing to Australia's high standard of health and containing health costs.

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1 As a result of Ministerial changes effective from 30 January 2007, the Department of Immigration and Multicultural Affairs (DIMA) became the Department of Immigration and Citizenship (DIAC).

2 Refer to Appendix 1.

3 The visa system is complemented by other border controls intended to minimise Australia's risk of exposure to diseases of public health significance. These controls include: the completion of passenger cards by travellers landing in Australia from overseas; surveillance of ports by Customs authorities; and human quarantine requirements which may be invoked under the *Quarantine Act 1908*. A quarantinable disease is any disease declared by the Governor-General, by proclamation, to be a quarantinable disease.

4. In line with the health requirement, each visa applicant is required to have their health assessed by DIAC and to satisfy the Public Interest Criteria 4005–4007 (PIC) outlined in the Regulations. The extent of health screening undertaken will vary depending on DIAC's policy requirements and each applicant's situation, particularly their country of origin, length of proposed stay in Australia, and current health status. Some applicants need only to make a health declaration, while others require more extensive health assessments.

Meeting the Health Requirement

5. The health requirement applies to all visa applicants and must be met before a visa can be granted.[4] The foremost components of the health requirement stipulate that the visa applicant:

- is free from tuberculosis;
- is free from a disease or condition that would result in a threat to public health or danger to the Australian community; and
- does not have a disease or condition that is likely to: require health care or community services while in Australia; result in significant costs to the Australian community; or prejudice the access of an Australian citizen or permanent resident to health care or community services.

6. Visa applicants complete a health declaration as part of their visa application and, depending on the applicant's individual circumstances, may be required to undergo further health assessment to establish whether they meet the health criteria. In 2004–05, DIAC processed over 400 000 health assessments, each involving one or more of the following: a medical examination; a chest x-ray; blood tests; and other specialist examinations (see Figure 1).

7. DIAC maintains a panel of more than 3 600 overseas medical doctors and radiologists who perform medical examinations offshore on DIAC's behalf.[5] Each applicant's medical reports are forwarded to DIAC for final assessment and clearance. Where an applicant's medical results indicate a significant disease or condition, a Medical Officer of the Commonwealth (MOC) assesses the medical reports and forms an 'opinion' on whether the visa

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[4] The health requirement is set out in the *Migration Regulations 1994*, *Schedule 4*, *Public Interest Criteria (PIC) 4005–4007*.

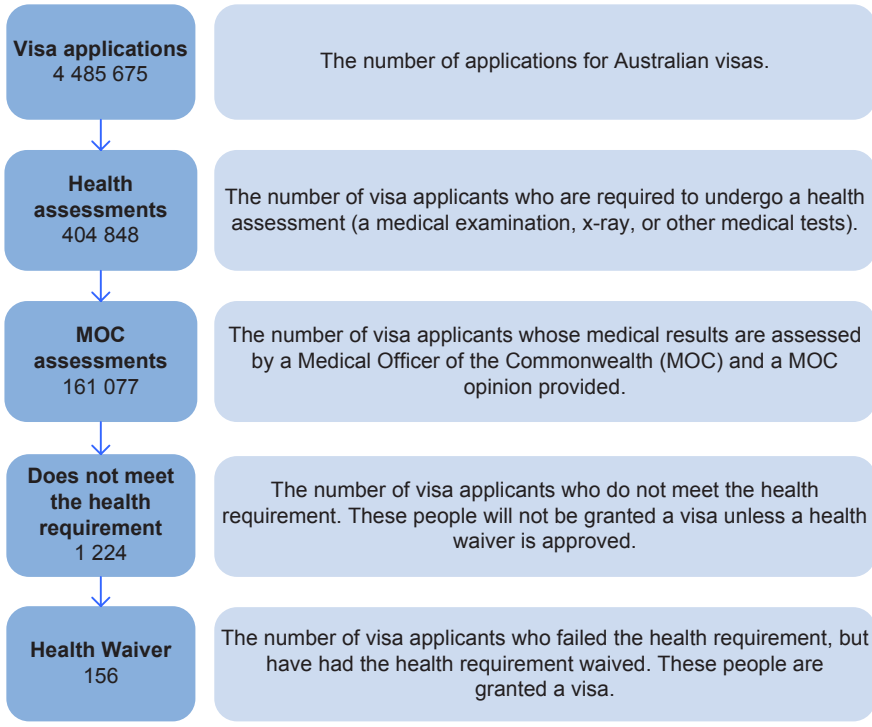
[5] Onshore (within Australia), medicals are performed by Health Services Australia Ltd. (HSA) under contract to DIAC.

applicant: meets or does not meet the health requirement; is eligible for a health waiver; or should be placed on a health undertaking. DIAC's case officers cannot change a MOC opinion and must take the MOC opinion into consideration when making the final decision to grant or reject a visa application.

8. The following figure shows key elements of DIAC's health requirement approval process and the approximate number of visa applications associated with each stage of the process in a one year period.

Figure 1

Visa applications assessed against the health requirement 2004–05



Source: Compiled by the ANAO, based on DIAC's 2004–2005 estimates and procedural documents.

Audit objective

9. The audit objective was to assess the effectiveness of DIAC's administration of the health requirement of the *Migration Act 1958* (the Act). To achieve this objective, the ANAO examined whether DIAC was setting and implementing the health requirement in accordance with the Act, the *Migration Regulations 1994* (the Regulations), and DIAC's own guidelines.

Overall audit conclusion

10. DIAC had established administrative structures, procedures and guidelines to implement the health requirement specified in the *Migration Act 1958* (the Act) and the Public Interest Criteria (PIC). While DIAC complied with the intent of section 60 of the Act, the audit identified several limitations and gaps in DIAC's administrative processes underpinning its implementation of the PIC. These limitations and gaps weakened DIAC's ability to fully assess the appropriateness, consistency, and efficiency of its health screening of visa applicants. This also meant that DIAC could not determine the effectiveness of its implementation of the health requirement in protecting Australia from public health threats, containing health costs and safeguarding access of Australians to health services in short supply—important DIAC objectives under the health requirement.

11. DIAC's primary focus for health screening of visa applicants is to protect Australia from tuberculosis (TB). TB is the only disease specifically identified in the PIC, largely due to the significance and long history of TB as a global public health threat. Concurring with this focus, DIAC's guidelines and procedures for implementing the health requirement for TB were well-established. Notwithstanding these guidelines and procedures, DIAC should strengthen its arrangements to reduce the health risks associated with TB. In particular, DIAC's health risk matrix for assessing temporary visa applicants should be kept up to date, to ensue that visa applicants of highest TB risk were identified.

12. In some cases, individuals identified as having inactive TB (or who have a history of treatment for TB), are allowed entry into Australia providing they sign a 'health undertaking'. DIAC requires a person on a health undertaking to report to a designated health authority in their State or Territory of residence for a follow-up health assessment. This is a precautionary measure to check that their TB has not become active since their last medical examination. DIAC has few mechanisms to monitor or ensure visa

holders' compliance with health undertakings, and thus cannot determine whether health undertakings are effective in terms of meeting the intent of the health requirement. DIAC would improve the effectiveness of health undertakings by establishing arrangements with the States and Territories that enable better monitoring and reporting of compliance.

13. DIAC guidelines and procedures for areas of the PIC concerning health threats other then TB, and to determine significant costs and prejudice to access, were less well established. In particular, DIAC had not determined which diseases or conditions constituted a 'disease or condition that would result in a threat to public health' for immigration purposes. While DIAC included some infectious diseases of global significance within this criterion, the reasons or a firm basis for doing so was often unresolved and undocumented. DIAC did not follow a systematic process for incorporating new or emerging health risks into its guidelines and risk management framework. This weakened DIAC's ability to develop responsive and soundly based migration guidelines and procedures, and to ensure that its guidelines aligned with other national public health policies.

14. To implement the PIC, DIAC requires technical advice from DoHA on public health issues. However, cross-agency collaboration between DIAC and DoHA had not been formalised. This affected the timely development of migration health screening guidelines and procedures. Stronger cross-agency arrangements would be beneficial in: defining roles and responsibilities; supporting the review and updating of DIAC's risk management framework for migration health screening; and in providing a timely and sound basis for the development of guidelines and procedures on immigration health matters, particularly in relation to public health threats and migration health screening.

15. Data management for the purposes of internal management of the health requirement and external reporting were also areas that required strengthening, both in terms of IT system capability and use of data. DIAC's capacity to store and manage information on the health requirement was limited by the differences between its many IT systems and the lack of a central repository for client health data. Gaps in DIAC's client health data was reflected throughout its visa application processes, with consequential weaknesses in monitoring of health undertakings and health waivers undermining DIAC's ability to determine compliance or consistency with its own guidelines.

16. There is a particular need to address these IT limitations, as they weaken DIAC's efficiency in processing and managing visa applications, and diminish its capacity to generate meaningful data to monitor, evaluate and report performance against the health requirement. Under its *Systems for People* initiative, DIAC has outlined preliminary costings and priorities for the redesign of its IT systems for health processing.

17. DIAC's performance framework provided little scope for performance monitoring and reporting of the health requirement. There were no outputs for the health requirement and one effectiveness measure, pertaining solely to TB. DIAC's performance framework needs to include a broader range of performance indicators and measures to provide better accountability and transparency of the health requirement. This will involve DIAC defining the cost and quality of the health requirement services it provides and assessing the overall effectiveness of the PIC.

18. The ANAO has made eight recommendations and a number of suggestions to strengthen DIAC's management of the health requirement.

Key Findings

Governance and coordination (Chapter 2)

19. Under the *Migration Act 1958* (the Act) and the *Migration Regulations 1994* (the Regulations), the Department of Immigration and Citizenship (DIAC) has responsibility and primary carriage for administering the health requirement and assessing the health of visa applicants. DIAC produced guidelines which set out its policies and procedures for managing health assessments (health screening) according to the Public Interest Criteria (PIC) 4005–4007 of the Regulations. DIAC also consulted with other agencies to assist in aligning its guidelines with other government policies. The ANAO considered whether effective cross-agency coordination and consultation arrangements were in place, including documented and agreed roles and responsibilities, to ensure timely advice on migration health matters.

20. Historically, DIAC has relied on the Department of Health and Ageing (DoHA) to provide technical advice on national public health issues, including the setting of health screening requirements for specific diseases (for example, tuberculosis (TB), hepatitis B, and Human Immunodeficiency Virus (HIV)) and other migration matters (for example, health services in short supply in Australia and health screening of refugees). However, there were longstanding difficulties associated with coordination and provision of technical advice for the health requirement. This had delayed updating of DIAC's guidelines for health screening.

21. Two previous reports (a 1992 Parliamentary Committee review of health processing in 1992[6], and an ANAO audit of the Family Migration Program in 2003[7]) recommended that agencies clarify their roles and responsibilities and formalise consultative arrangements for developing migrant and temporary entrant health screening policy.[8] While agreeing to the recommendations, this audit found that DIAC and DoHA had not successfully defined, documented, or formally agreed their roles and responsibilities.

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6 Joint Standing Committee on Migration Regulations, *Conditional migrant entry: the health rules*, Australian Government Publishing Service, Canberra, 1992.

7 ANAO Audit Report No.62, 2002–03, *Management of Selected Aspects of the Family Migration Program*. <www.anao.gov.au>.

8 The recommendations also indicated that the Department of Family, Community Services and Indigenous Affairs (FaCSIA) clarify its roles and responsibilities. However, FaCSIA was not included in this current ANAO performance audit.

22. The ANAO notes that in December 2006, DoHA wrote to DIAC, describing DoHA's role 'in relation to DIAC's administration of the health requirement' and inviting DIAC to discuss this further.

Developing guidelines and procedures (Chapter 3)

23. Information supporting the PIC is in DIAC's procedure manuals and guidelines, particularly *Procedures Advice Manual 3* (PAM3), *Instructions for Panel Doctors and Radiologists: medical and radiological examinations of Australian visa applicants* (Panel Doctor Guidelines), and Medical Officer of the Commonwealth (MOC) *Notes for Guidance.* These documents set out procedures and policies for DIAC officers, doctors and MOCs to guide implementation of health assessments in line with the PIC.[9]

24. The ANAO examined DIAC's progress in developing guidelines to assist MOCs in forming their opinions, and DIAC's ability to develop sound and consistent procedures to support implementation of health screening in line with the intent of the PIC.

MOC Notes for Guidance

25. In 1992, the Parliamentary Committee review on health processing[10] noted that there were 'no official guidelines for assessing health conditions', and recommended that priority be given to producing guidelines to assist MOCs in forming their opinions. The Government agreed to the committee's recommendation.[11] However, subsequent progress in developing the MOC guidelines (now referred to as *Notes for Guidance*) was slow; the process generally characterised by a series of contract difficulties, project delays, and partially completed work. Consequently, DIAC and ANAO audits (in 2002 and 2003 respectively) made similar findings regarding incomplete *Notes for Guidance* (refer to Chapter 3, Table 3.1).

26. DIAC has identified 19 *Notes for Guidance* papers required to support MOC decisions. The ANAO found that the development, updating and review of the *Notes for Guidance* has continued to be problematic, characterised by a

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9 *Migration Regulations 1994*, Schedule 4 Public Interest Criteria (PIC) 4005–4007.

10 Joint Standing Committee on Migration Regulations, *Conditional Migrant Entry: the health rules*, Australian Government Publishing Service, Canberra, 1992.

11 Australian Government, *Response to the report of the Joint Standing Committee on Migration Regulations, Conditional Migrant Entry: The Health Rules*, 1995. The Government accepted the recommendation of the Joint Steering Committee, stating 'it strongly endorses the need for relevant, comprehensive and current medical information to be available to support the medical assessment process'.

lack of priority setting and uncertain mechanisms for their endorsement. Recent work contracted by DoHA to produce five papers resulted in delays and unfinished work. The *General Principles* paper, written in January 2006, has not been endorsed.

27. During the audit, DIAC was progressing towards a new contract to develop 13 *Notes for Guidance*, with identified priorities. It is important that DIAC monitors progress of the development of the *Notes for Guidance*, and establishes appropriate mechanisms for the completion, endorsement, and regular revision of all 19 guidelines.

Guidelines defining the health criteria

28. Consistency of information across guidelines and procedures is important for promoting uniform interpretation and implementation of the PIC and DIAC's health screening policies. This should include clarity and consistency in defining specific terms and processes.

29. Generally, DIAC's guidelines were well targeted to their specific users and provided a useful overview of DIAC's health assessment process. Nonetheless, ANAO's analysis identified several gaps and inconsistency in DIAC's documentation. In particular, the health criterion indicating 'threat to public health,' which must be met by applicants in order to be granted a visa, was not defined in DIAC's guidelines. Guidelines did not clearly explain which diseases constituted a public health threat under the health requirement. In addition, some costings for MOCs to determine 'significant costs' were incomplete or out of date, and there was no systematic decision process for inclusion of items (or services) on DIAC's significant 'prejudice to access' list. Consequently, DIAC was not providing a sound basis for MOCs to make consistent decisions on 'prejudice of access'.

Health assessments (Chapter 4)

30. To a large degree, DIAC's system of health screening relies on the honesty of applicants to disclose health conditions that may put Australians at risk. It also relies on the integrity of panel doctors overseas and their ability to detect significant health issues and report these to DIAC.

31. All visa applicants for permanent entry undergo full health assessments. However, the extent of health assessment a temporary visa applicant undergoes depends on their individual level of risk, determined according to DIAC's multilayered risk management framework. Risk factors

include length of stay, country of origin, intended activities in Australia, and factors of special significance.

32. The ANAO examined the effectiveness of DIAC's health assessment process in terms of DIAC's: risk management framework; management of panel doctors; and clearance of offshore medicals.

33. DIAC's health risk matrix for temporary visa applicants was largely based on the risk level of countries according to their incidence of TB. DIAC stated that it updated its list of countries and corresponding risk levels every two years (based on World Health Organisation data). However, DIAC's process for categorising a country's risk level was not transparent. In particular there was no record of when the countries' risk levels were last reviewed or the process for review. Therefore, DIAC could not verify that the health risk matrix was soundly based or up to date.

34. Risks or threats to Australia's public health may come from newly emerging (or re-emerging) disease or the changing incidence of disease in particular countries. If screening procedures and guidelines are not kept abreast of global trends, this could impact on the effectiveness of DIAC's screening procedures and expose Australia to disease threats, contrary to the intent of the health requirement. Diseases posing potential public health risk other than TB, for example HIV and hepatitis C, were incorporated into DIACs migration health screening risk framework in various ways. However, in general, there was little evidence of a systematic methodology for deciding migration health risks, including new or re-emerging communicable diseases, or for including these into DIAC's migration health risk framework.

Panel doctors

35. DIAC relies on overseas panel doctors to provide medical examinations to visa applicants. To this end, DIAC maintains a list of over 3 600 panel doctors and radiologists that it has approved to undertake medicals. DIAC's Global Medical Unit, (GMU) established in 2004, has implemented several improvements to the management of panel doctors. For example, GMU introduced a risk based model and audit program for panel doctors, mechanisms to monitor complaints, monthly performance reports for monitoring program performance, and newsletters for disseminating information to panel doctors and overseas posts. In addition, Global Medical Directors (GMD) from the GMU conduct overseas inspections of panel doctors and their facilities. This contributes to assessing service quality and to follow up of complaints or reported processing problems.

36. DIAC demonstrated thorough records for removal of doctors from the panel. However, documentation submitted to DIAC to support the approval of panel doctors did not meet DIAC's own standards. A small ANAO sample identified deficiencies in 50 per cent of approved panel doctor applications examined, including: illegible copies, non-certified documents, documents not translated, and photographs too unclear for identity purposes. Further improvements in this area would contribute to a higher level of integrity and reliability in the appointment of panel doctors.

Clearance of health assessments

37. Health assessments are either cleared by DIAC's overseas posts or the Local Clearance Unit (LCU), or referred to a MOC for further assessment and a medical opinion. Since 2004, DIAC has been centralising clearance of health assessments for some visa types within the LCU, to achieve greater efficiency and accuracy in processing. DIAC has established guidelines and procedures manuals for LCU operations and several levels of process controls. An internal quality assurance program had also commenced.

38. DIAC's clearance process for health assessments allows officers in 'gazetted countries'[12] to clear 'A' cases (no significant health findings) and some 'B' cases (significant health findings). DIAC's guidelines lack clarity in these clearance processes, which increases the risk of incorrect processing and/or missed referral of cases to MOCs. In particular, the ANAO found:

- there was no methodology or documentation to explain how DIAC arrived at its list of gazetted countries;
- the gazetted countries had not been revised since 2000;
- DIAC had given local clearance capability to some non-gazetted countries, but not others. However, there was no methodology or records to explain the basis of these decisions; and
- DIAC's procedures[13] did not clearly explain the circumstances in which 'B' cases could be locally cleared by overseas posts.

39. Overall, a lack of transparency and rigour in DIAC's risk management framework for temporary applicants meant that DIAC could not be certain that it was assessing the health of applicants consistently, meeting its objective to

[12] Gazetted countries are those listed by DIAC in the Australian Government Gazette, for the purpose of Regulation 2.25A.

[13] DIAC *Procedures Advice Manual (PAM3)*, 1 July 2006.

'maintain high levels of integrity of health screening', or managing its specified risk 'to identify applicants of concern'.

Health waivers (Chapter 5)

40. In most cases, failure to meet the health criteria results in refusal of the visa application. However, for some visa types, a health waiver is available. In these cases, a MOC provides an opinion to the DIAC decision maker, which includes a calculation of the potential cost for each health waiver. This cost takes into consideration the expected impact of the waiver in terms of health care and community services. All health waiver decisions must be reported to, and monitored by, DIAC's Health Policy Section. Cases with expected costs over $200 000 require consultation with the Health Policy Section prior to the final decision. Health waivers cannot be granted if the applicant fails to satisfy the legislative provisions relating to tuberculosis, public health or health undertakings.

41. The ANAO examined DIAC's ability to ensure consistent waiver decisions in line with DIAC policy, and to accurately monitor and report on health waver decisions.

42. DIAC had documented procedures for administering health waivers, but it did not demonstrate consistent compliance with these. For example, ANAO sampling showed that a significant number of health waiver Minutes (waiver decision records) were incomplete: 22 per cent of reports examined did not include a MOC opinion and 65 per cent of 4006A waivers examined did not include written employer undertakings, contrary to DIAC's requirements.

43. DIAC's electronic records for health waiver decisions were also incomplete, with applicants' records fragmented between two databases. Discrepancies in figures between the two databases indicated that more than two-thirds of the health undertaking decisions were not reported to DIAC's Health Policy Section. This made it difficult for DIAC to obtain a history of waiver applicants or to consolidate data for compliance and reporting purposes.

44. Waiving the health requirement results in the Australian community absorbing the health and welfare costs of the visa applicant, and may increase demand for health and community services which are in short supply. In 2003, the ANAO audit report, *Management of Selected Aspects of the Family Migration Program*, identified deficiencies in health waiver data held by DIAC. The current audit found little improvement in DIAC's data.

45. Due to limitations in DIAC's health waiver process and tracking of decisions, DIAC was not able to show whether it had considered the health waiver for all eligible visa applicants, or accurately report the number of health waivers granted. Due to incomplete records, data on health conditions for waivers were also unreliable. Furthermore, DIAC could be underestimating the annual cost in exercising health waivers, because of its low compliance in reporting of health waiver decisions.

Health undertakings (Chapter 6)

46. Schedule 4 of the Regulations authorises MOCs to request a visa applicant to sign a health undertaking as a prerequisite to the applicant passing the health requirement. A health undertaking is used if the applicant has a medical condition that is not a public health risk, but requires follow-up treatment or examination once the applicant is in Australia.

47. Around 15 000 to 20 000 health undertakings are signed each year, and about 90 per cent of these are for TB follow-up. Other than TB and pregnancy, DIAC's guidelines did not provide comprehensive information on the diseases or conditions for which a health undertaking applied, or the circumstances in which they should or should not apply. This lack of guidelines to support MOC decisions puts DIAC at risk of making decisions or issuing health undertakings inconsistently.

48. Although an applicant signs a health undertaking with DIAC, once in Australia, the applicant's follow-up examination or treatment falls to the State or Territory of residence. DIAC has no formal agreements with States or Territories to administer health undertakings, or to monitor clients' compliance with health undertakings.

49. DIAC did not collect sufficient data to monitor compliance with health undertakings. Data available through DIAC's Health Assessment Tracking System (HATS) and a 2002 DIAC internal audit report were significantly different (604 and 5 535 cases of non-compliance respectively). The internal audit recommended modifications to HATS to allow compliance monitoring, but DIAC took no action in this respect.

50. As DIAC had not established mechanisms to monitor or control compliance with health undertakings, it could not show whether undertakings were effective in terms of protecting Australia's health, or their associated cost to Australia's health system.

Information technology systems (Chapter 7)

51. DIAC does not have a central system for managing the health requirement of visa applications or a central repository of client data. Current information technology (IT) support consists of several unintegrated IT systems that were developed to meet DIAC's business needs over the last 15 years. These systems are dissimilar in design and function. This has led to several difficulties and inefficiency in managing visa applicants' health records, and limits DIAC's ability to generate data for program monitoring and performance purposes.

52. Checking and clearing an applicant's health records usually involved the use of multiple screens across several different systems. This, and double or multiple entering of data into the various systems, increases the risk of errors occurring. Matching an applicant's records for case management or identity purposes can be lengthy or problematic if there are missing or duplicate records (for example, resulting from front end loading[14] or ineffective transfer of data from one IT system to another). Duplicate or incomplete records can lead to serious implications for identification and tracking of cases, as demonstrated by the Cornelia Rau case.[15]

53. DIAC did not monitor systems' down-time and the effects this had on business continuity or processing efficiency, or maintain systems logs to assist in monitoring and prioritising IT problems. Due to a lack of detail in data held within the various systems, DIAC was unable to provide a breakdown of health assessments, for example, to show the number of x-rays, HIV or Hepatitis B tests, or specialist examinations completed. There were also difficulties in producing reports on the total number of visas refused on health grounds. This information would be useful for monitoring trends in testing between different countries, informing policies on future screening needs, and revising DIAC's health screening risk management matrix.

54. Collectively, limitations and weaknesses in DIAC's IT systems prevented DIAC from fully meeting its objective 'DIAC systems to support health assessment processing; allow seamless and effective decision making.' Under the new *Systems for People* initiatives, DIAC is planning major IT reforms

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[14] Front end loading is where a person seeking entry to Australia submits medical results before their visa application. If the person fails to meet the health requirement, they would likely choose not to submit a visa application, and thereby avoid paying the (sometimes large) visa charge.

[15] Mick Palmer AO APM, *Inquiry into the Circumstances of the Immigration Detention of Cornelia Rau*, Commonwealth of Australia, 6 July 2005; and Commonwealth Ombudsman, *Inquiry into the Circumstances of the Vivian Alvarez Matter,* Commonwealth of Australia, 26 September 2005.

which may see changes to the IT environment for health assessments. The changes aim to consolidate DIAC's IT into a more central system.

Monitoring and performance (Chapter 8)

55. As DIAC has primary carriage for the health requirement,[16] its performance information is expected to provide a measure, or indication, of progress against set outcomes, outputs and performance indicators that align to key elements of the health requirement (as defined in PIC 4005–4007).

56. Under DIAC's outcome and output framework, the health requirement has one relevant outcome indicator 'the extent to which public health and safety is protected through immigration screening'. It also has only one effectiveness measure 'the incidence of TB relative to the percentage of overseas born in the Australian population compared to the same ratio for other major developed countries'. Other components of the PIC (other public health diseases of public health threat, significant cost, and prejudice to access) have no effectiveness indicators, and are not systematically monitored, measured, or reported.

57. The health requirement is an integral component of several DIAC programs that report against Output 1.1—non humanitarian entry, and is a legislated requirement for some 150 visa types. However, DIAC has set no outputs or measures specific to the health requirement. Because of the cross-program nature of the health requirement, DIAC also could not provide the full cost of administering the health requirement.

58. DIAC's performance monitoring for the health requirement has focused on internal management (operation level) guided by objectives and key indicators in Branch level business plans, and targets levels of activity, funding and reporting requirements defined in DIAC's *Statements of Work*. However, the *Statements of Work* were draft documents, which had ceased in late 2005. The replacement performance system was not yet in place. The ANAO found that local performance data was used to inform process improvements, but contributed little to broader annual reporting against outputs and outcomes.

59. Overall, DIAC was able to provide only minimal information on the performance of the health requirement, and had little capacity to gauge its own achievements. Essentially, the extent to which public health and safety was protected through immigration screening was not fully measured or reported.

[16] Under Administrative Orders, DIAC has responsibility for the Migration Act.

Agency responses to the audit

60. The ANAO made eight recommendations to assist DIAC in strengthening key aspects of its administration of the health requirement. DIAC agreed to each of the eight recommendations.

61. Recommendations 1 and 3 were also directed to DoHA. DoHA agreed to both of these recommendations.

62. DIAC's and DoHA's overall responses to the audit are provided below. Agency responses to individual recommendations are shown in the body of the report, following each recommendation.

DIAC's response

The department welcomes the report of the ANAO. Australia enjoys some of the best health standards in the world and this department views the protection of public health as a high priority. In order to help maintain these high standards DIAC administers one of the most comprehensive health screening processes in the world.

The ANAO has put forward some constructive findings in relation to the overall governance of the health requirement. DIAC agrees that the implementation of the health requirement would continue to be advanced through a collaborative approach to policy development with DoHA. The department notes and accepts the ANAO suggestions for reviewing current health policies and planning for emerging issues.

The department has made substantial progress in addressing some of the findings of the report. Contractual arrangements have been finalised for the completion of Notes for Guidance papers and the Health Services Project has commenced work on implementing an IT solution to address the processing and reporting issues identified by the ANAO.

DoHA's response

The Department of Health and Ageing (DoHA) acknowledges the need for cross-agency cooperation and supports the ANAO's recommendation to formalise consultative arrangements and roles and responsibilities between DIAC and Health.

DoHA understands that under the Administrative Arrangements Order (AAO), DIAC is responsible for administering the health requirement under the *Migration Act 1958*, with a range of agencies contribute technical advice in accordance with their expertise.

DoHA understands its role in relation to the health requirement is to provide broad public health advice and assistance to DIAC to access appropriate technical input to their development of policy on administering the health requirement under the *Migration Act 1958*. In addition, it is not appropriate for DoHA to endorse specific guidelines for use by DIAC as the professional colleges have the clinical expertise to provide this endorsement.

Provision of public health care in Australia is shared by Commonwealth and State/Territory Governments with each jurisdiction having discrete and separate responsibilities. Most public health issues are managed by State and Territory authorities with each State and Territory having its own Public Health Act, which gives them a legislative basis to implement public health requirements. The States and Territories also provide public hospital and community health services. State and Territory Governments bear significant responsibility for the provision of health services to migrants in Australia and the cost and demand for services is keenly felt by them. States and Territories also have a significant role to play in providing advice on conditions to be included on the 'Prejudice to Access' list.

Another important source of information for DIAC is the Communicable Diseases Network of Australia (CDNA). The CDNA is a subcommittee of the Australian Health Protection Committee (AHPC), established under the Australian Health Minister's Advisory Council (AHMAC) and is made up of representatives of the Australian Government, and States and Territory Governments. CDNA is part of the AHMAC structures and not part of the Commonwealth Department.

Recommendations

Set out below are ANAO's recommendations aimed at improving DIAC's management of the health requirement. Report paragraph references and abbreviated agency responses are also included. Highest priority should be given to recommendations 1, 2, 3, 4 and 7.

Recommendation No.1

Para 2.31

To ensure that health risks to Australia are minimised, the ANAO recommends that DIAC and DoHA develop a protocol, such as a Memorandum of Understanding (MOU), that clearly define the respective roles and responsibilities of each agency in setting and managing the health requirement of the *Migration Act 1958*. The protocols or MOU should document mechanisms to achieve a well-coordinated and timely response to support DIAC in setting and reviewing the health requirement.

DIAC's response: *Agreed*

DoHA's response: *Agreed*

Recommendation No.2

Para 3.10

To provide a sound basis for consistent medical assessments of visa applicants against the health requirement by Medical Officers of the Commonwealth, the ANAO recommends that DIAC:

- ensure an up to date and complete set of guidelines (*Notes for Guidance*); and
- implement a formal process for regular review and appropriate endorsement of these guidelines.

DIAC's response: *Agreed*

Recommendation No.3

Para 3.32

ANAO recommends that DIAC, with assistance from DoHA, formulate comprehensive and current advice on what constitutes a threat to public health for immigration purposes. This advice should be used to inform the development of timely strategies for addressing emerging immigration issues having public health risk.

DIAC's response: *Agreed*

DoHA's response: *Agreed*

Recommendation No.4

Para 4.49

ANAO recommends that DIAC improve its risk management of health assessments by:

- documenting the procedure for categorising countries' risks (low to very high) for the temporary health risk matrix, giving clear indication of the basis on which the risk categories are decided, and a process for regularly reviewing them;
- regularly updating the gazetted list, *Specifications for countries for the purposes of regulation 2.25A;*
- defining the methodology and reasons for selecting countries for the gazetted list, and the basis for allocating authority for local clearance of health assessments to gazetted and non-gazetted countries; and
- evaluating its process for assessing medical reports submitted by visa applicants prior to their visa applications (front end loaded applications) with a view to developing standard procedures and guidelines to manage and monitor this process effectively.

DIAC's response: *Agreed*

Recommendation No.5

Para 5.18

To encourage consistency in health waiver decisions and enable accurate reporting of health waiver outcomes, the ANAO recommends that DIAC:

- in line with the department's requirements, ensure that all health waiver decisions are sent to a designated coordination point, such as the Health Policy Section, for review and recording; and
- ensure that sufficient data is collected to enable accurate monitoring and reporting of the outcome of health waiver decisions, including potential costs to the Government.

DIAC's response: *Agreed*

Recommendation No.6

Para 6.21

To improve the effectiveness of health undertakings, ANAO recommends that DIAC:

- develop guidelines on health undertakings, to provide the basis for more transparent and consistent decisions; and
- consult with the States and Territories with a view to establishing arrangements to assist DIAC in monitoring and reporting of compliance for health undertakings.

DIAC's response: *Agreed*

Recommendation No.7

Para 7.20

The ANAO recommends that DIAC fully scope the IT needs for the health requirement, in consultation with users, and develop a comprehensive strategy and plan for improving management of client records and data collection for purposes of program management, performance and outcome reporting.

DIAC's response: *Agreed*

Recommendation No.8

Para 8.26

DIAC's effectiveness measure for its implementation of the health requirement of the *Migration Act 1958* is the 'extent to which public health and safety is protected through migration screening'. To enable DIAC to monitor and report its progress against this, the ANAO recommends that DIAC:

- develop appropriate effectiveness indicators and effectiveness measures to monitor and report its performance in meeting key elements of the Public Interest Criteria, including: diseases of public health threat other than tuberculosis; significant cost to the Australian community; and prejudice to access; and
- effectively utilise data to set and review the health criteria, procedures and guidelines.

DIAC's response: *Agreed*

Audit Findings and Conclusions

1. Introduction

This chapter provides background to the health requirement. It also outlines the objective and scope of the audit, and the structure of the report.

The health requirement

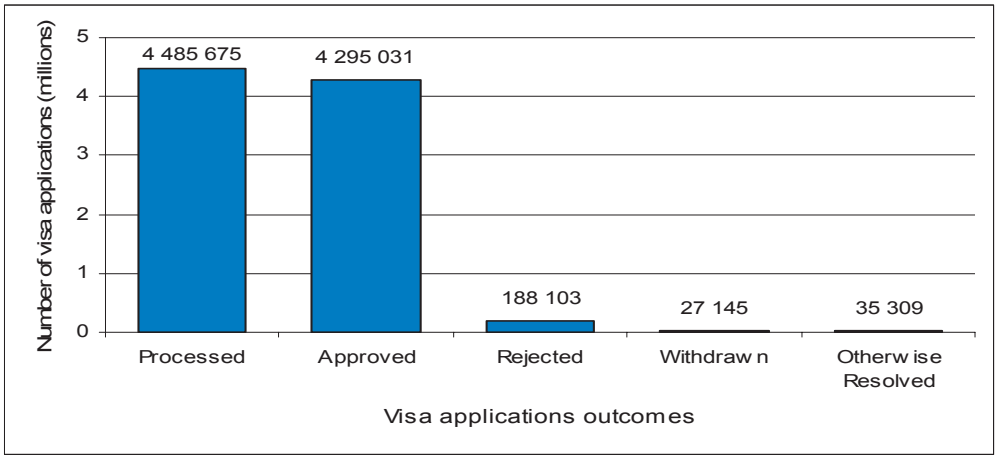
The health requirement is an important component of Australia's visa system

1.1 The Department of Immigration and Citizenship (DIAC) administers entry and stay in Australia for non-citizens under the *Migration Act 1958* (the Act) (see Appendix 1). People, who want to migrate permanently to Australia, or to stay temporarily, must apply to DIAC for an appropriate visa. The visa system operates as a screening mechanism, to prevent the entry of people identified as posing a security, criminal or health risk.

1.2 In 2004–05, DIAC processed almost 4.5 million visa applications and approved 4.3 million visas (Figure 1.1).

Figure 1.1

Visa outcomes for 2004–05



Source: Data estimates provided by DIAC's Data Warehouse.

1.3 DIAC administers around 150 different visa types to cater for a broad range of situations and purposes. Non-citizens entering Australia[17] have to

[17] Foreign diplomats do not require a visa to enter and stay in Australia, therefore, they are not subject to any health requirements regardless of the planned length of stay.

meet the health requirement that is defined in the Public Interest Criteria (PIC) 4005–4007 of the *Migration Regulations 1994* (the Regulations).[18]

1.4 The foremost components of the health requirement stipulate that the visa applicant:

- is free from tuberculosis (TB); [19]
- is free from a disease or condition that would result in a threat to public health or danger to the Australian community; and
- does not have a disease or condition that is likely to: require health care or community services while in Australia; result in significant costs to the Australian community; or prejudice the access of an Australian citizen or permanent resident to health care or community services.[20]

1.5 The intent of the health requirement is to help maintain Australia's high health standards. DIAC states that:

> It is important for Australia and the continuation of many successful visa programs that public health risks and health costs are not unduly increased by visa holders, whether permanent or temporary.[21]

1.6 Concurring with this, DIAC's health processing procedures define the objectives of the health requirement, as shown in Figure 1.2.

Figure 1.2

Objectives of the health requirement

- to protect the Australian community from public health and safety risks;
- to contain public expenditure on health care and community services; and
- to safeguard the access of Australian citizens and permanent residents to health care and community services in short supply.

Source: DIAC Procedures Advice Manual (PAM3), July 2006, p. 13, section 10.1.

1.7 Depending on a visa applicant's individual circumstances, DIAC may require visa applicants to undergo a range of health checks to assess whether

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18 The health requirement is defined in the *Migration Regulations 1994, Schedule 4, Public Interest Criteria (PIC) 4005–4007*. The term 'health requirement' is interchangeable with the term 'health criterion', defined in s5(1) of the Act.

19 TB is the only disease specifically mentioned in the Act.

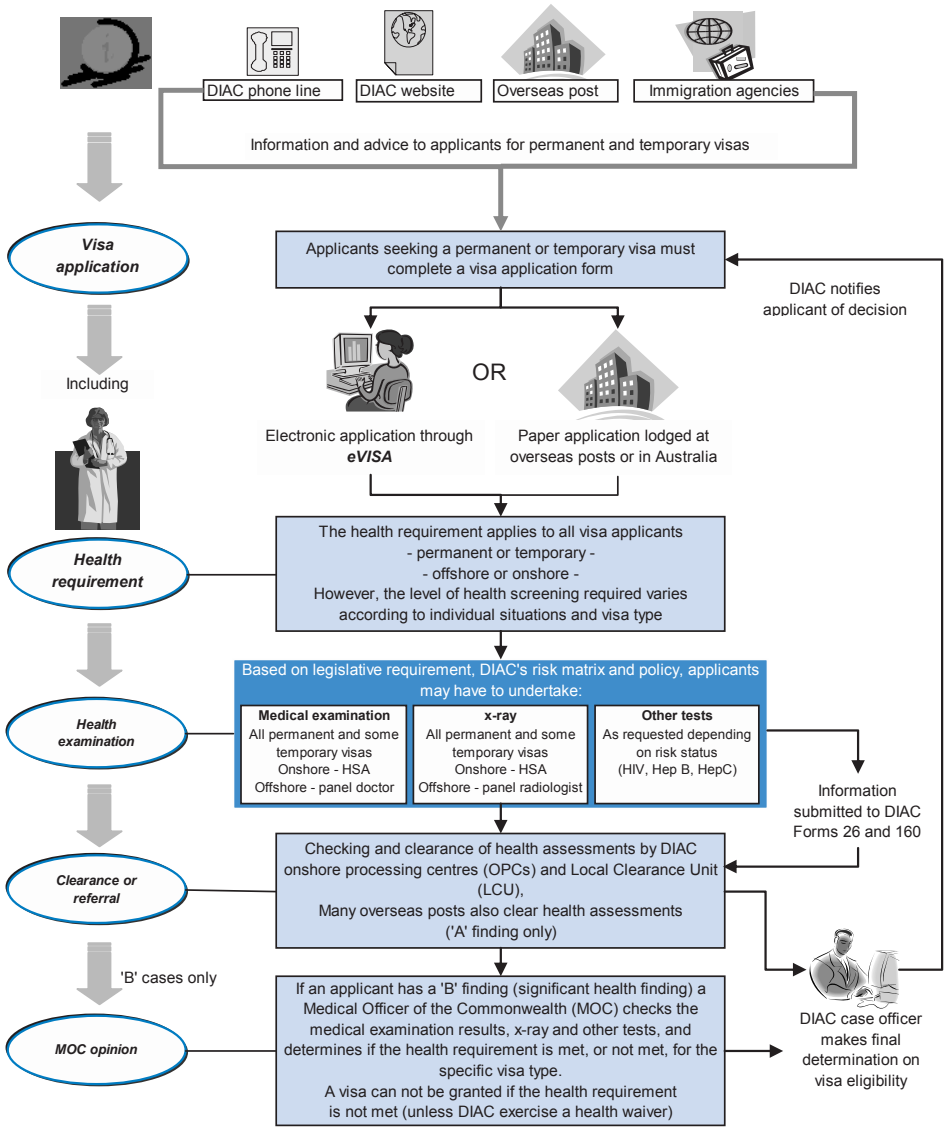
20 *Migration Regulations 1994, Schedule 4, PIC 4005*.

21 DIAC, *Procedures Advice Manual (PAM3)*, 1 July 2006, p. 6, s1.

they meet the health requirement. Figure 1.3 shows key aspects of processing for the health requirement.

Figure 1.3

Main steps in processing the health requirement of visa applications



Source: Compiled by ANAO from DIAC guidelines and interviews.

Notes: HSA (Health Services Australia); Hep (hepatitis); HIV (human immunodeficiency virus).

1.8 A visa applicant must satisfy the health requirement before DIAC can grant them a visa. An exception to this is where the visa type has provision for a health waiver.[22] The waiver provision allows Australia to grant visas in cases where a person has failed the health requirement but:

- can offer an economic benefit;
- is subject to humanitarian considerations; or
- has very close family relationships in Australia.

1.9 Health waivers are assessed on a case by case basis and cannot be exercised if the applicant fails to satisfy the legislative provisions relating to tuberculosis, public health, or health undertakings.[23]

1.10 DIAC estimated that it received almost 4.5 million visa applications in 2004–05. Of these applicants, DIAC estimates that 405 000[24] undertook medical examinations, and approximately 1 per cent of these were refused visas on the grounds that they did not meet the health requirement. Approximately 150 applicants were granted a health waiver.

Whose health is checked?

1.11 Implementing the health requirement is an important and often complex DIAC function. Ineffective implementation has the potential to place Australians at increased risk of exposure to infectious diseases or diminish their access to health services that are in high demand, including nursing homes, dialysis and organ transplants. However, with almost 4.5 million visa applications in 2004–2005, it is not viable for DIAC to check thoroughly the health of every applicant. Australia's policy on who should receive a medical examination is, therefore, based on the level of health risk posed by visa applicants in terms of their country of origin, their expected length of stay in Australia, and their likely activities while they are here.

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22 PIC 4005A and 4007 provide for health waivers for specific visas.

23 Health Waivers and Health undertakings are examined in Chapters 5 and 6 respectively.

24 DIAC can only estimate these figures due to difficulties it has in collating data between different databases. The number of health assessments undertaken in 2004–2005 could be as high as 450 000. (DIAC–ANAO emails and meetings 2006).

1.12 For all visa applicants, DIAC collects information about the applicant's health and requires them to make a health declaration.[25] Further checks may include a medical examination, chest x-ray, blood tests or other screening procedure. The extent of health screening will vary according to each applicant's circumstances and the type of visa sought (see Table 1.1 below and Chapter 4).[26]

Table 1.1

Health checks required for permanent and temporary visa applicants

	Health checks required
Permanent visa applicants	Applicants are asked to undergo: • a medical examination; • an chest x-ray if aged 11 years or older; • a HIV/AIDS test if 15 years or older; and • any additional tests requested by the Medical Officer of the Commonwealth (MOC).
Temporary visa applicants	Applicants may be required to undergo: • a medical examination; • a chest x-ray; • other tests depending on how long they propose to stay in Australia, their intended activities while here, the TB rating of current and previous countries of residence; and • other tests if the applicant identifies factors of significance, including: - likely to enter a hospital or health care area; - likely to enter a classroom; - likely to be engaged in an Australian pre school age child care centre; - is aged 70 years or older; or - if there is an indication that the health requirement may not be met.

Source: DIAC Fact Sheet No.22—*The Health Requirement*, 2006; and DIAC Forms 1071i and 1163i.

[25] This does not apply to non-citizens entering Australia under an Electronic Travel Authority (ETA). These entrants do not make a health declaration. However, they are required to complete a passenger card which includes a TB 'declaration'. ETA's are the subject of another ANAO performance audit currently underway.

[26] 'In line with Australia's non-discriminatory immigration policy, the health requirement applies equally to all applicants from all countries, although the extent of testing will vary according to the circumstances of each applicant.' DIAC Fact Sheet 22: *The health requirement,* 2006.

1.13 For permanent visas, the applicant, spouse and any dependent family members must be assessed against the health requirement.[27] The applicant and any family members must meet the health criterion. This includes applicants for temporary or provisional visas that lead to eligibility for a permanent visa.[28]

1.14 For a temporary visa, only the applicant and family members who are actually travelling to Australia must meet the health requirement. The health assessment requirements for temporary visa applicants are related to the applicant's country of citizenship, country of residence (if the applicant has lived in certain locations for more than three months in the last five years), intended length of stay in Australia, as well as other factors of significance.[29]

Health processing

1.15 Health processing consists of three main components:

(a) the health examination;[30]

(b) assessment and clearance of medicals; and

(c) a decision as to whether the applicant meets the health requirement.

1.16 Medical examinations and x-rays are conducted either offshore (that is, for visa applicants applying from an overseas country of origin or the country they are currently in) or onshore (for visa applicants already in Australia). DIAC contracts Health Services Australia Ltd. (HSA), to conduct onshore medical examinations.[31] Offshore, medical examinations and x-rays are usually conducted by a panel doctor and panel radiologist, appointed by DIAC.

1.17 Visa applicants can access a list of panel doctors and panel radiologists on DIAC's website, or from overseas posts. DIAC's Global Medical Unit

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27 DIAC, *Health requirement for permanent entry into Australia*, Form 1071i.

28 These include temporary or provisional partner visas, prospective marriages visas, temporary parent visas, and the provisional business skills visas.

29 Health examination requirements for temporary visa applicants are set out in more detail in Chapter 4—Health Assessments.

30 Also referred to as health screening or health checks.

31 Formerly the Australian Government Health Service, HSA was established as a Government Business Enterprise in 1997. Its function is to provide an independent health assessment and medical advisory service to Commonwealth and other agencies.

(GMU)[32] arranges the appointment and removal of doctors and radiologists from the panel lists, and monitors the performance of the panel doctors.

1.18 Medical examiners (including panel doctors and panel radiologists) are not responsible for providing an opinion on whether applicants meet the health criteria. They report the results of the health assessment, noting any abnormalities, to DIAC officers. The assessments will include whether the applicant is an 'A' (no significant health problems) or a 'B' case (a medical condition that requires more investigation by a Medical Officer of the Commonwealth (MOC)).

1.19 Many overseas DIAC offices and overseas posts are permitted to clear 'A' cases. In circumstances where overseas DIAC offices do not have the authority or facilities to approve health assessments, panel doctors send the health reports and x-rays to DIAC's Local Clearance Unit (LCU) located in Sydney.

1.20 Offshore 'B' cases are sent to a MOC within DIAC's Health Assessment Service (HAS).[33] Only MOCs have the authority to provide an opinion on these cases. DIAC case officers must accept the MOC's opinion as correct, and can not override that opinion.[34]

1.21 Visa applicants who have a history of TB or who have a known medical condition that does not represent a public health risk can be required to sign a Health Undertaking (discussed in Chapter 6). The applicant must contact DIAC's Health Undertakings Service (HUS)[35] upon arrival in Australia and seek follow-up medical treatment or monitoring in their State or Territory of intended residence. DIAC advised that it issues about 15 000 Health Undertakings each year.

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[32] DIAC's GMU was established in Sydney in December 2004. Its functions include appointment, removal and management of DIAC's network of overseas panel doctors and radiologists.

[33] The HAS is located in Sydney. Its main function is to provide medical opinions, as per the department's legislative requirements and policy guidelines. HAS is discussed in Chapter 4.

[34] MOCs are appointed by the Minister under the *Migration Act. Regulation 2.25A* provides for the MOC to give an opinion in respect of an applicant's ability to meet the Schedule 4 health requirement.

[35] The HUS is part of DIAC's Health Assessment Service.

Links to border management

1.22 The health requirement is complemented by other border controls intended (among other things) to minimise Australia's risk of exposure to diseases of public health significance. These controls include: the completion of passenger cards by travellers landing in Australia from overseas; surveillance of ports by Customs authorities; and human quarantine requirements which may be invoked under the *Quarantine Act 1908*.[36]

Previous ANAO performance audits

1.23 No previous ANAO performance audit has dealt solely with DIAC's administration of the health provisions of the Act. Audit Report No.62, 2002–03, *Management of Selected Aspects of the Family Migration Program* addressed aspects of the health requirements of the Act, namely DIAC's administration of the health waiver and associated costs, and cross-agency processes for setting health standards for migrants. The audit included one recommendation related to the health requirement:

> The ANAO recommends that DIMIA, in consultation with DoHA and FaCS, review and formalise the consultative arrangements for setting health policy for migrants to ensure that Migration Regulations reflect current risks, and the roles and responsibilities of each agency.

Other relevant audits and reviews

1.24 A 1992 report from the Joint Standing Committee on Migration Regulations, C*onditional migrant entry: the health rules*, made a recommendation concerning production of background papers to assist Commonwealth medical officers (now called MOCs). This recommendation is still relevant to the current ANAO audit:

> Priority be given to the production of the background briefing papers for Commonwealth medical officers on the assessment of medical and disability conditions. These papers should provide up to date and realistic assistance to the Commonwealth medical officers in forming opinions on whether or not applicants meet the health requirement for entry or stay.

[36] The *Quarantine Act 1908*. A quarantinable disease is any disease declared by the Governor-General, by proclamation, to be a quarantinable disease.

The audit

Audit objective

1.25 The audit objective was to assess the effectiveness of DIAC's administration of the health requirement of the *Migration Act 1958* (the Act). To achieve this, the ANAO examined whether DIAC was setting and implementing the health requirement in accordance with the Act, the Regulations, and DIAC guidelines. More specifically, the audit examined:

- governance and coordination, including roles and responsibilities in setting the health requirement (Chapter 2);
- the development of guidelines and procedures for implementing the health requirement (Chapter 3);
- arrangements for assessing the health (health screening) of offshore visa applicants, managing risks, and clearing medical assessments (Chapter 4);
- the exercising of health waivers (Chapter 5);
- administrative arrangements for health undertakings (Chapter 6);
- the effectiveness of IT systems in supporting health assessment processing (Chapter 7); and
- monitoring of performance against program objectives, outputs and outcomes (Chapter 8).

Audit scope

1.26 The audit scope included aspects of DIAC's administration of the health requirement across all visa application types submitted to DIAC offshore and onshore. ANAO assessed DIAC's approach to governance and coordination, management of risks, quality control and information management. It also examined DIAC's arrangements for: appointing and managing panel doctors; providing MOC opinions; clearing medical assessments; and managing health waivers and health undertakings.

1.27 The audit included coordination arrangements between DIAC and the Department of Health and Ageing (DoHA), given DoHA's role in providing technical advice to DIAC on public health issues, to assist DIAC in developing the health requirement procedures and guidelines. The Department of Workplace Relations (DEWR) and the Department of Families, Community

Services and Indigenous Affairs (FaCSIA) have relatively minor roles in matters concerning administration of the health requirement. Therefore, they were not included in the scope of the audit except in the context of previous audit/review findings or recommendations.

1.28 The audit scope did not include: on-site evaluation of overseas posts; assessment of the conduct of medical examinations by overseas doctors; new contract negotiations for DIAC's onshore medical services; detention centres; specific coverage of refugee health assessments; Electronic Travel Authorities (ETAs);[37] or the *Quarantine Act 1908*.

Audit methodology

1.29 The audit was conducted in accordance with the ANAO Auditing Standards and completed for a total cost of $439 000.

1.30 The ANAO conducted fieldwork primarily in DIAC's Canberra office and in the Local Clearance Unit (LCU), Health Assessment Service (HAS), and Global Management Unit (GMU) all located in Sydney. The ANAO interviewed program managers and other staff, and examined legislation, guidelines, operational documents, on-screen processing, files and electronic records, to determine consistency and compliance with the health requirements of the Act, DIAC's policies and guidelines, and better practice. Other fieldwork and consultation involved DoHA's Canberra office, Health Services Australia in Canberra, and the NSW Health Department.

Structure of the report

Chapter 1	***Introduction***
Chapter 2	***Governance and Cross-Agency Coordination***
Chapter 3	***Developing Guidelines and Procedures***
Chapter 4	***Health Assessments***
Chapter 5	***Health Waivers***
Chapter 6	***Health Undertakings***
Chapter 7	***Information Technology Systems***
Chapter 8	***Monitoring and Performance***

[37] The current audit does not evaluate ETAs. ETAs are the subject of another ANAO performance audit, currently underway. Applicants for an ETA are deemed to meet the health requirement and complete only the health declaration on the passenger card on arrival in Australia. DIMA review, *Analysis and Review of Medical-Examination and Health–Related Services Provided to the Department of Immigration and Multicultural and Indigenous Affairs: Part 1 Scoping Study*, December 2002, p. 19. Also confirmed with DIAC during the audit.

2. Governance and Cross-Agency Coordination

This chapter considers agency roles and responsibilities in administering the health requirement, and cross-agency coordination for providing technical advice to DIAC.

Management of health risks at the Australian border

2.1 The health requirement is a relatively small but important component of DIAC's broader remit to protect Australia's borders from security, criminal or health risks. Operating within the visa system, the health requirement was designed to provide a safety net to detect visa applicants who pose a public health risk to Australians or lead to undue burden on Australia's health system.

2.2 Procedures and guidance underpinning the health requirement are extensive and complex, and should be kept up to date in response to: global situations; changing Australian immigration policies; different groups of migrants and visitors to Australia; and emerging technology or security needs. In this environment, a coordinated approach is required to ensure that the implementation of the health requirement by DIAC is consistent with Australia's national health strategies. Inter-agency coordination is particularly necessary for DIAC and the Department of Health and Ageing (DoHA), given DoHA's role in 'providing technical advice on public health issues to assist DIAC in its development of policy on health related issues'.[38]

2.3 The ANAO examined:

- the roles and responsibilities of DIAC and DoHA in setting, implementing and providing technical advice for the health requirement; and in particular
- the effectiveness of cross-agency coordination between DIAC and DoHA.

[38] Comments from DoHA in its response to this audit's Issues Papers, December 2006.

Roles and responsibilities

Department of Immigration and Citizenship

2.4 Under the *Migration Act 1958* (the Act), DIAC has responsibility for preventing the entry or stay in Australia of non-citizens who pose a risk to Australians.[39] Within this broader role, DIAC has primary carriage and responsibility for administering the health requirement and assessing the health of visa applicants in accordance with the Public Interest Criteria (PIC) (Figure 2.1).[40]

Figure 2.1

Public Interest Criteria – 4005

The applicant:
(a) is free from tuberculosis; and
(b) is free from a disease or condition that is, or may result in the applicant being, a threat to public health in Australia or a danger to the Australian community; and
(c) is not a person who has a disease or condition to which the following subparagraphs apply:
(i) the disease or condition is such that a person who has it would be likely to
(A) require health care or community services; or
(B) meet the medical criteria for the provision of a community service during the period of the applicant's proposed stay in Australia
(ii) provision of the health care or community services relating to the disease or condition would be likely to:
(A) result in a significant cost to the Australian community in the areas of health care and community services; or
(B) prejudice the access of an Australian citizen or permanent resident to health care or community services;
regardless of whether the health care or community services will actually be used in connection with the applicant; and
(d) if the applicant is a person from whom a Medical Officer of the Commonwealth has requested a signed undertaking to present himself or herself to a health authority in the State or Territory of intended residence in Australia for a follow-up medical assessment, the applicant has provided such an undertaking.

Source: *Migration Regulations 1994,* PIC 4005.

2.5 In order to effectively undertake its role, DIAC also has to ensure that appropriate procedures and guidelines are in place to support implementation of the PIC. Matters relevant to the PIC are outlined in DIAC's *Procedures Advice Manual* (PAM3). Other DIAC guidelines complement the PAM3 by explaining in more detail the functions and procedures that underpin implementation of the health requirement.

2.6 DIAC seeks information and technical advice from other departments, particularly DoHA, to inform its policy and procedures on migration health.

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[39] Administrative Orders 2005. The schedule is as amended by an Order in Council dated 21 July 2005 and 27 January 2006.

[40] Migration Regulations 1994, Schedule 4, Public Interest Criteria 4005–4007.

Other agencies

2.7 DIAC works in an environment where immigration policy is expected to complement government policies administered by other government agencies such as DoHA, the Department of Families, Community Services and Indigenous Affairs (FaCSIA) and the Department of Workplace Relations (DEWR).[41] Due to the health requirement's focus on protecting Australia's public health, collaboration between DoHA and DIAC on public health matters is particularly important.

2.8 On 10 December 2006, DoHA defined its role as:

> DoHA understands its role in relation to the health requirement is to provide technical advice on public health issues to assist DIAC in their development of policy on health related issues. This is against the backdrop of DoHA's portfolio agency role as primarily in health financing and broader public health policy, rather than providing advice on individual medical decisions.
>
> DoHA is one source of technical advice to DIAC and can have an advisory role on formulating health criteria as expressed in the Migration Regulations 1994 and associated procedures and guidelines. [42]

2.9 In its PAM3, DIAC described DoHA's role as:

> The health requirement—prescribed in Regulations Schedule 4—is set by DIAC on advice from the Australian Department of Health and Ageing….
>
> DoHA Central Office provides high-level advice to DIAC and has an advisory role to DIAC on formulating health requirements as expressed in the Regulations and associated procedures and guidelines.[43]

2.10 The roles of FaCSIA and DEWR in relation to the health requirement are relatively minor. These agencies provide expert advice on issues relating to access to disability and community services. This includes advice on eligibility for services and benefits. Centrelink, which delivers payments on behalf of FaCSIA and DEWR, supplies quarterly updates on such benefits to DIAC.[44]

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41 These agencies each have a role in providing timely technical advice to DIAC when setting health screening procedures upon request.

42 DoHA response to the ANAO Issues Papers for the current performance audit, *Administration of the Health Provisions of the Migration Act 1958*, received 10 December 2006.

43 DIAC, PAM3 1 July 2006, p. 6, paragraph 1 and p. 10, paragraph 6.6.

44 DIAC, Draft MOU between DIAC, DoHA, and FaCSIA, August 2005; DIAC, DoHA and FaCSIA, Migration Health Forum Minutes, 26 October 2005. DIAC advised ANAO that it was considering the need to involve DEWR in the task of developing migration health policy. This was because of the transfer of income support payments, programmes and services for working aged job seekers from FaCSIA to DEWR, following machinery of government changes announced in October 2004.

2.11 With the exception of quarantine,[45] the delivery of health services is largely a State and Territory responsibility. Thus, the State and Territory Governments and health service providers are major stakeholders, as changes to health screening policy can impact on demand for health services.

2.12 DIAC's interpretation and administration of the health requirement has implications for these agencies, in as much as they may have to deal with the downstream impacts of DIAC's decisions. In turn, implementing the advice of these agencies may have resource or other implications for DIAC. Given the ongoing and important role of DoHA in advising DIAC on public health issues relevant to the migration health requirement, the ANAO examined the effectiveness of cross-agency coordination arrangements between these two departments.

Coordination arrangements between DIAC and DoHA

2.13 The information required by DIAC to administer migration health screening includes technical advice and data on: Medicare; diseases and medical conditions; current treatment and costs; and information on specific communicable disease strategies (for example: tuberculosis (TB); Human Immunodeficiency Virus (HIV); and hepatitis B). These are areas that DoHA may be and has been consulted on. The need for such exchange of information and advice underlines the importance of cross-agency coordination between DIAC and DoHA.

Documenting roles and responsibilities

2.14 Historically, the roles and responsibilities of the two agencies in migration health screening have not been clearly documented or agreed. The 1992 Parliamentary Committee report on Australia's migration health regulation observed:

> Given the confusion which appears to exist in the official documentation and the regulations concerning the respective roles of [the then] DHHCS/AGHS and DILGEA in health decision making, the Committee in addition to recommendations 1 and 2, sees the need to define these roles more clearly in relation to processing of the health requirement for entry….[46]

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[45] Quarantine is a Commonwealth responsibility under the Australian Constitution and the *Quarantine Act 1908*. The Act and subordinate legislation cover human, plant and animal quarantine activities. Human quarantine is administered by DoHA.

[46] Joint Standing Committee on Migration Regulations 1992, p. 52.

2.15 In 1997, responsibility for migration health screening was transferred from DoHA to DIAC.[47] However, at that time, DoHA and DIAC did not clearly define or document their respective responsibilities for providing technical or policy advice on health screening matters.

2.16 Thus, in 2003, the ANAO report on the Family Migration Program concluded that the need to improve arrangements between the agencies remained relevant, and recommended:

> That DIMA, in consultation with DoHA, and FaCSIA, review and formalise the consultative arrangements for developing health policy for migrants to ensure that Migration Regulations reflect current risks, and the roles and responsibilities of each agency.[48]

2.17 The current audit found little sustained progress against either of the above recommendations (discussed below).

Day-to-day coordination between DIAC and DoHA

2.18 There were several attempts between 2001 and 2006 to establish coordination arrangements between DIAC and DoHA; some more effective than others.

2.19 A central interdepartmental arrangement was the Interdepartmental Migration Health Forum (the Forum).[49] The forum was managed by DIAC and had existed in various forms since the late 1990s. DIAC had established the Forum to formalise consultative arrangements between DIAC, DoHA and FaCSIA on broader migration health issues, and monitor progress of cross-agency matters.

2.20 The ANAO evaluated the management of the Forum against criteria for good practice.[50] Table 2.1 shows the criteria and the results of ANAO's analysis.

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[47] In 1997, the AGHS became a Government Business Enterprise (now Health Services Australia Ltd, managed through a contract with DIAC). As part of the new arrangements, responsibility for migration health screening was transferred from DoHA to DIAC. However, under the new arrangements, the two agencies did not document or agree their respective responsibilities for providing technical or policy advice on health screening matters, a function previously performed by the AGHS. Agency roles for providing advice have remained undocumented and uncertain since this time.

[48] ANAO, Audit Report No.62, 2002–03, *Management of Selected Aspects of the Family Migration Program*, Recommendation 5.

[49] Forum meetings were held six monthly, although DIAC's intention was to hold them quarterly. No forum meetings occurred in 2006.

[50] The criteria in Table 2.1 were derived from the Management Advisory Committee 4, *Connecting Government: Whole of Government Responses to Australia's Priority Challenges*, 2004.

Table 2.1

The Migration Health Forum

Criteria	Criteria met	ANAO comments.
Clearly documented terms of reference, including roles and objectives	Not met	The Forum had no documented terms of reference, objectives or roles for the respective agencies.
Regular meetings scheduled	Not met	The Forum was intended to be a quarterly meeting between agencies. However, it has rarely met this frequently, and the timing of meetings was irregular. The Forum has not met since October 2005.
Documented membership and recorded attendance	Met	Forum membership includes Assistant Secretaries and Directors from DIAC, DoHA and FaCSIA. The last Forum meeting (October 2005) was attended by nine DIAC, eight DoHA and two FaCSIA representatives.
Clearly stated agenda items and minutes	Met	Each forum had documented agenda items and minutes were completed. DoHA commented that 'some Fora had agreed agenda items'.
Agenda items monitored	Not met	There was little evidence of prioritising or monitoring of agenda items. Some items had been ongoing or outstanding for several years. For example, HIV issues concerning the Sub-Saharan pilot study, HIV testing for health care worker entrants. Appendix 2 provides other examples.
Minutes and other documents circulated to specified people and timeframes defined	Partially met	Forum Minutes were usually circulated to participating agencies. However, DIAC confirmed that Minutes from the last meeting (October 2005), though prepared, were never circulated to participants. There was no evidence of any agreed timeframes for circulation of Minutes or other documents.
Clearly documented outcomes	Not met	DIAC and DoHA documentation did not provide identified outcomes for the Forum, and there were no performance indicators.
Review and renewal	Not met	There was no planned approach to review the Forum. The Forum had lapsed, with little attempt by DIAC or other agencies to re-convene.

Source: ANAO assessment of DIAC Immigration Health Forum Minutes and Agenda items, 2001 to 2005. The above criteria were derived from the Management Advisory Committee 4, *Connecting Government: Whole of Government Responses to Australia's Priority Challenges*, 2004.

2.21 The ANAO found that management of the Forum did not meet several of the criteria and had not been well structured (see Table 2.1). In particular, the Forum had no Terms of Reference, and lacked monitoring, follow-up and resolution of agenda items. Overall, consultation and collaboration through this avenue had not been used to full advantage by agencies. A DoHA internal minute stated:

> Although the Interdepartmental Forum on Migration Health can, in theory, be an effective avenue for discussion and decision making, this opportunity has not been fully realised for a number of reasons. To date Forum meetings have been somewhat infrequent and there has not always been enough time prior to

> these meetings to fully consider the issues. The situation is compounded by the sensitive nature of the issues, and the lack of a formal mechanism through which the Department can develop and endorse policy positions.[51]

2.22 In October 2006, DIAC indicated to the ANAO that the Forum was likely to be discontinued, and that DIAC would be pursuing other means of collaboration and coordination with DoHA. As at February 2007, no other mechanism had been decided.

Draft Memorandum of Understanding

2.23 Cross-agency arrangements are becoming more common as agencies seek to address increasingly complex and/or operational activities that cut across organisational boundaries. While these arrangements may take other forms, they can be negotiated and formalised through Protocols or a Memorandum of Understanding (MOU) between the participating agencies. These arrangements are equally useful where a more structured approach to cross-agency coordination or collaboration is needed in order for an agency to meet its responsibilities.

2.24 Through the Forum, DIAC approached agencies to develop a MOU to help address matters raised by ANAO's 2003 audit and recommendation. At the October 2005 Forum, DIAC presented agencies with a draft MOU (Appendix 3), which included a list of general undertakings by DIAC, DoHA and FaCSIA. However, the participating agencies queried whether a MOU was the correct mechanism for formalising cross-agency roles and responsibilities, and the MOU has not progressed.

2.25 In January 2006, an internal DIAC Minute described the status of the ANAO's 2003 recommendation as follows:

> As a result of the ANAO recommendation, at the committee's [the Forum] October 2005 meeting, DIMIA submitted a draft Memorandum of Understanding for consideration by the remaining Forum committee members with request that responses be made prior to 10 December 2005….To date there has been nil response from DoHA or FaCSIA.

[51] DoHA internal Minute (unsigned), Targeted Prevention Program's Branch, entitled 'Processes for the provision of advice to the Department of Immigration and Multicultural and Indigenous Affairs, 28 September 2004.

Overall effectiveness of cross-agency arrangements

2.26 Efficient setting and implementation of the health requirement requires coordination between departments, based on defined roles and responsibilities. It is important that such arrangements meet accepted standards of governance. In particular, they should have clear lines of consultation and the responsibilities of the parties should be agreed and understood. It is also important that risks and opportunities are identified and managed in accordance with each agency's contribution and level of responsibility or area of expertise.

2.27 A recurrent message of government in recent years has been for agencies to work together in a 'whole of government fashion'.[52] In 2002, the Management Advisory Committee published a report in responses to Australia's priority challenges.[53] The report emphasised:

> A vital issue for the APS in delivering quality advice, programs and services is ensuring work is effective across organisational boundaries. Making whole of government approaches work better for ministers and government is now a key priority for the APS. There is a need to achieve more effective policy coordination and more timely and effective implementation of government policy decisions, in line with the statutory requirement for the APS to be responsive to the elected government. Ministers and government expect the APS to work across organisational boundaries to develop well informed, comprehensive policy advice and implement government policies in an integrated way.
>
> Often the real challenge of whole of government work is not the large scale, high-level multi-lateral exercise so much as the day-to-day realities of trying to work across boundaries to make sure that outcomes are achieved.[54]

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[52] Australian Government, *Working together: Principles and practices guide to the Australian Public Service*, 2005, p. 1.

[53] Management Advisory Committee (MAC) 4, *Connecting Government: Whole of Government Responses to Australia's Priority Challenges*, 2004.

[54] Management Advisory Committee (MAC) 4, *Connecting Government: Whole of Government Responses to Australia's Priority Challenges*, 2004, pp. 2 and 9.

2.28 The report was supplemented with 'Good Practice Guides' to assist in cross-agency activity. The ANAO used this good practice model to develop criteria for cross-agency management. Table 2.2 illustrates ANAO's assessment of the strategic relationship between DIAC and DoHA to implement the health requirement against these criteria.[55]

Table 2.2

ANAO assessment of the strategic relationship between DIAC and DoHA

Criteria for cross-agency management	Criteria met	ANAO comments
Agreed cross-agency approach	Not met	• Administrative Orders give DIAC responsibility for the health requirement, under the *Migration Act 1958.* However, when coordination on migration health issues is necessary, there are currently no agreed cross-agency protocols or MOU to formalise consultative arrangements between DIAC and DoHA. • The Forum and the draft MOU were two attempts to formalise across-agency collaboration. The Forum has not met since October 2005 and the draft MOU has not been endorsed and has no status.
Documented roles and responsibilities of government departments, along with reporting arrangements	Partially met	• The absence of clearly documented roles and responsibilities for provision of technical advice for health screening has been a long-standing weakness of the agencies' strategic relationship for the health requirement. • Recommendations by a parliamentary review of health processing in 1992, and an ANAO audit of the Family Migration Program in 2003 raised the need to clarify roles and responsibilities. These recommendations were not adequately addressed. • Transfer of screening services from DoHA to DIAC in 1997 was not followed up with documented roles regarding provision of technical advice to inform health screening policy and procedures.
Coordination of organisational effort in developing national immigration health screening guidelines and procedures	Partially met	• DIAC has established interagency coordination and liaison through the Health Policy Unit of the Temporary Entry Branch.[56] In DoHA, the migration health function is coordinated by its International Strategies Branch.[57] • Arrangements were partially successful, but have not provided a reliable mechanism for timely or complete resolution of issues (see below).

[55] The Criteria are based on Management Advisory Committee 4, 2004 (above); National Institute for Governance, *Proposed Better Practice Guide: Public Sector Governance,* 2003*;* and ANAO, *Better Practice Guide: Cross-Agency Governance, Guidance Paper No.7*, 2003.

[56] DIAC, PAM3 section 6.2.

[57] DoHA, internal Minute November 2004, and interviews.

Criteria for cross-agency management	Criteria met	ANAO comments
Risk management, protocols for prioritisation and defined timelines and targets for managing queries	Not met	• There was no standard approach to prioritising policy review and queries, or for risk management. In general, there were few protocols for prioritising and monitoring queries from DIAC, and no set targets or timelines for responding. • A more organised approach to coordination would ensure that matters concerning the health requirement are not overlooked or delayed.[58]
Timely and accurate technical/policy advice	Not met	• Advice from DoHA has not been timely, which impacts on DIAC's ability to develop immigration health policy that reflects current health trends, and national strategies. • Significant issues had not been fully addressed some years after DIAC's initial request for information. For example, for almost three years DIAC has been seeking definitive advice to enable the review of HIV and hepatitis screening policy for temporary stay visa applicants intending to work in the health care industry while in Australia.
Cross-agency Coordination activities with defined liaison contacts	Partially met	• Currently, DIAC and DoHA each has a designated liaison area for coordinating responses to questions and interagency meetings. • It would benefit both agencies to regularly provide each other with up to date lists of contacts and relevant policy areas. This would assist more efficient communication between officers and better understanding of respective agency roles. • There were examples of good collaborative procedures, such as development of Refugee Health Protocols through the Multijurisdictional Working Group for Refugees and Humanitarian Entrants, in collaboration with DoHA and the Communicable Diseases Network Australia. However, in many other circumstances collaboration had not been timely and effective. This is illustrated in Appendix 2, which provides examples of outstanding agenda items from the Forum.
Review and renewal	Not met	• DIAC and DoHA had no documentation or agreed approach to formally review the success or otherwise of their cross-agency collaboration.

Source: ANAO analysis of DIAC files and interviews.

[58] In a DoHA interview, DoHA confirmed that HIV issues had not been given the priority that they should have been. DoHA said that it was now addressing this situation.

2.29 A lack of formalised mechanisms for progressing migration health matters had affected collaboration between DIAC and DoHA and the timely resolution of migration health issues. While, at times, there had been progress in addressing previous recommendations of the Parliamentary Committee in 1992 and the ANAO Family Migration Audit in 2003, neither recommendation was fully met.

2.30 Protecting Australia's borders is of national importance. Within this environment, the health requirement and health screening of visa applicants provide mechanisms for protecting Australia from public health threats. Optimising the benefits of these mechanisms requires reliable cross-agency collaboration. To provide an effective basis for coordinated action in this critical area, it is highly desirable that DIAC and DoHA agree on their respective roles and responsibilities and document them. An agreed protocol or MOU would inform staff of both organisations of their responsibilities and expectations, and sustain focus on cross-agency activities.

Recommendation No.1

2.31 To ensure that health risks to Australia are minimised, the ANAO recommends that DIAC and DoHA develop a protocol, such as a Memorandum of Understanding (MOU), that clearly define the respective roles and responsibilities of each agency in setting and managing the health requirement of the *Migration Act 1958*. The protocols or MOU should document mechanisms to achieve a well-coordinated and timely response to support DIAC in setting and reviewing the health requirement.

2.32 Other departments, particularly FaCSIA and DEWR, also provide advice or data to DIAC for the purpose of administering the health requirement. Where this is an essential part of DIAC's business, it will be necessary for DIAC and the respective departments to establish sound mechanisms for coordination of migration health issues, and ensure that the protocols or MOU encompass relevant functions within the respective agencies.

DIAC's response

2.33 Agreed. DIAC is accountable for the administration of the health requirement under the *Migration Act 1958*. The development and review of policies and processes that support the health requirement is dependent on advice from other agencies, primarily DoHA, State and Territory public health authorities and relevant professional bodies.

2.34 DIAC is working on a collaborative approach to policy development with DoHA, State and Territory public health authorities and other relevant bodies. To this end, DIAC will pursue a protocol or a Memorandum of Understanding with DoHA and other agencies, to clarify our respective roles and responsibilities

DoHA's response

2.35 Agreed. DoHA acknowledges the need for cross-agency cooperation and supports the ANAO's recommendation to formalize consultative arrangements and clear roles and responsibilities of DIAC and DoHA. Documents outlining the proposed respective roles and responsibilities have already been circulated between DoHA and DIAC with a view to incorporating agreed elements in a protocol or MOU.

3. Developing Guidelines and Procedures

This chapter examines DIAC's process for developing guidelines and procedures to support implementation of the health requirement.

Background

3.1 Information supporting the Public Interest Criteria (PIC) is contained in DIAC's procedure manuals and guidelines, particularly its *Procedures Advice Manual* (PAM3), *Instructions for Panel Doctors and Radiologists medical and radiological examinations of Australian visa applicants* (Panel Doctor Guidelines), and Medical Officer of the Commonwealth (MOC) *Notes for Guidance.* These documents set out procedures and policies for DIAC officers, doctors and MOCs to guide implementation of health assessments in line with the PIC.[59]

3.2 The ANAO examined DIAC's:

- progress in developing *Notes for Guidance* to support MOCs in forming medical opinions; and
- ability to develop sound and consistent procedures to support implementation of health screening in line with the intent of the PIC.

Guidelines to support medical opinions

3.3 Medical assessments for the purpose of the health requirement are made in a complex legal environment that is subject to change. Migration decisions are subject to appeal through the courts, and court decisions can change the basis for interpretation of the legislation, and the basis of health assessments. Because of this, MOCs need reliable and up to date guidelines (*Notes for Guidance)*[60] to assist them in reaching robust, defensible opinions, and to promote consistency in such opinions.

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[59] *Migration Regulations 1994,* Schedule 4, Public Interest Criteria 4005–4007.

[60] Over time, the MOC guidelines were referred to as *health assessment guidelines*, *background briefing papers* and more recently as *Notes for Guidance.*

3.4 Developing medical guidelines is a complicated process, requiring input from a range of experts. The potential cost of treating a disease or condition, the level of risk a disease may pose to other people, or whether a particular condition will require access to health services in limited supply (prejudice to access), are not easy matters to determine. Influencing factors include the severity or longevity of the condition, the choice of treatment, response to treatment over time, and many other factors. Conflicting medical opinions and changes in diagnosis over time are also complicating factors.

3.5 The development, updating and review of the *Notes for Guidance* has been problematic over a substantial period of time. In 1992, a Parliamentary committee inquiry noted that there were 'no official guidelines for assessing health conditions' (Table 3.1).

Table 3.1

Inquiries into the development of the Notes for Guidance

Investigation	Findings
1992 Joint Standing Committee on Migration Regulations	The Committee found that: ….except for (a) few topics now covered by briefing papers, there are no official guidelines for assessing health conditions. The Committee recommended that: Priority be given to the production of the background briefing papers for Commonwealth medical officers on the assessment of medical and disability conditions. These papers should provide up to date and realistic assistance to the Commonwealth medical officers in forming opinions on whether or no applicants meet the health requirement for entry or stay.[61]
2002 DIMIA (now DIAC) internal audit of health processing	DIMIA internal audit found that: the health assessment guidelines were still only in draft form, were mostly incomplete and required 'significant work.
2003 ANAO Family Migration Program in 2003	The audit reported: Clear, comprehensive and consistent guidance on estimating the likely lifetime community cost of medical conditions of migrants is critical if waiver provisions are to be applied equitably and if appropriate accountability is to be maintained. The ANAO was unable to determine whether current DIMIA guidance provides a sound and sufficient basis for the effective and accountable administration of the health waiver provisions.[62]

Source: Compiled by ANAO.

[61] Joint Standing Committee on Migration Regulations, *Conditional migrant entry: the health rules*, Australian Government Publishing Service, Canberra, 1992, p. 45.

[62] ANAO Audit Report No.62, 2002–03, Management of Selected Aspects of the Family Migration Program, paragraph 5.39.

3.6 The Government agreed to the committee's recommendation.[63] However, subsequent progress in developing the *Notes for Guidance* was slow; the process generally characterised by a series of contract difficulties, project delays, and partially completed work (see historical summary in Appendix 4). Consequently, DIAC and ANAO audits in 2002 and 2003 made similar findings regarding incomplete *Notes for Guidance* (see previous Table 3.1).

3.7 Implementing the Joint Standing Committee recommendation involves the production of 19 *Notes for Guidance* papers. Table 3.2 shows the status of these papers as at April 2006 and January 2007.

[63] Australian Government, *Response to the report of the Joint Standing Committee on Migration Regulations, Conditional Migrant Entry: The Health Rules*, 1995. The Government accepted the recommendation of the Joint Steering Committee, stating 'it strongly endorses the need for relevant, comprehensive and current medical information to be available to support the medical assessment process'.

Table 3.2

Status of Notes for Guidance

Paper	Work required on guidelines (identified by DIAC analysis)	Status of work	
		At May 2006	At January 2007
Nephrology	Review, complete as necessary and update treatments and costings	At review with specialists	DoHA commissioned the writing of these papers in 2005. DIAC advised that of these papers, the General Principles and the Rheumatology papers are completed but are yet to be endorsed by DoHA. DIAC intends to complete these papers in 2007–08 (see note (1) below).
Principles and costings	Extensive rewrite	At review with DoHA	
Rheumatology	Review, complete as necessary and update treatments and costings	Treatment consultation with specialists	
Endocrinology	Review, complete as necessary and update treatments and costings	To commence	
Tuberculosis	Review, complete as necessary and update treatments and costings	Commenced February 2006	
Human Immunodeficiency Virus (HIV)	New paper	To commence	DIAC has engaged a Contractor to complete this paper. It is scheduled for completion by mid-2007.
Cardiology	Extensive rewrite	To commence	A tender for the completion of these papers was released in August 2006. DIAC advised that contract negotiations with the preferred provider are underway and it is anticipated that the contract will be in place by March 2007.
Disability	Extensive rewrite	To commence	
Drugs and Alcohol	New paper	To commence	
Gastroenterology	Extensive rewrite	To commence	
Haematology	Extensive rewrite	To commence	
Hepatitis	Extensive rewrite	To commence	
Neurology	Review, complete as necessary and update treatments and costings	To commence	
Oncology	Extensive rewrite	To commence	
Ophthalmology	Review, complete as necessary and update treatments and costings	To commence	
Psychiatry	New paper	To commence	
Respiratory	Review, complete as necessary and update treatments and costings	To commence	
Supported care	Review, complete as necessary and update treatments and costings	To commence	
Hearing	Review, complete as necessary and update treatments and costings	To commence	

Source: DIAC, Attachment A to the internal Minute entitled Notes for Guidance for Medical Officers of the Commonwealth—Completion of papers, 31 March, 2006; and DIAC advice February 2007.

Note: (1) DIAC advised that at the time of its tender release, the status of these papers was unclear, and as such, the papers were not included as part of the tender process. DIAC will seek to complete these papers during 2007–08. In December 2006, DoHA informed the ANAO that the Nephrology and Rheumatology papers were endorsed by the Royal College of Physicians (RACP) and provided to DIAC; and the final draft General Costings paper and draft Tuberculosis paper were provided to DIAC.

3.8 The ANAO found that past activities had lacked a sound method for prioritising the different *Notes for Guidance.* This had resulted in delays in producing papers urgently required by MOCs, such as the Human Immunodeficiency Virus (HIV) paper, but commencement of some less urgent papers. In 2005, DoHA contracted for the writing of five papers. These were at various stages of completion as at December 2006 (refer to Table 3.2, Note (1)); DIAC re-assuming responsibility for their completion after this point in time.

3.9 In 2006, DIAC had undertaken a further Request for Tender (RFT), to continue the development of the other 14 *Notes for Guidance*. DIAC advised that the priority of papers had been set through the RFT Statements of Requirement, and that DIAC would negotiate with the contractor about the work plan. The ANAO suggests that DIAC's process include a sound methodology and timelines for determining priorities for the development, update and review of the *Notes for Guidance.* These should reflect the immediate and longer term needs of the MOCs in assessing applications, and be informed by current workload trends and changes in national and global health issues. The work plan should also include a firm process for professional endorsement of *Notes for Guidance* to ensure their accuracy and suitability.

Recommendation No.2

3.10 To provide a sound basis for consistent medical assessments of visa applicants against the health requirement by Medical Officers of the Commonwealth, the ANAO recommends that DIAC:

- ensure an up to date and complete set of guidelines (*Notes for Guidance*); and
- implement a formal process for regular review and appropriate endorsement of these guidelines.

DIAC's response

3.11 Agreed. Completion of the *Notes for Guidance* project is a high priority for DIAC. There are contractual arrangements in place to ensure the completion of all 19 papers in a timely manner. It is anticipated that the first set of papers will be ready for use by Medical Officers of the Commonwealth by the end of 2007.

3.12 A feature of the contractual arrangements is that each paper will be reviewed on an annual basis. In addition, should there be a major change in health policy or treatment guidelines for a specific condition, DIAC is able to request an ad-hoc review.

3.13 Endorsement of the clinical aspects of the *Notes for Guidance* papers will be sought from the appropriate medical college. DoHA and other relevant agencies will be consulted during the drafting process.

Procedures to support implementation of health screening

3.14 The PIC 4005 contains three particular areas that all visa applicants must satisfy before a visa can be granted. Namely, the applicant must not pose a risk to Australia in terms of:

- public health threat (a) tuberculosis (TB) and (b) other diseases or conditions that may be a threat or endanger the Australian community; or
- significant costs; or
- prejudice of access to services.[64]

3.15 DIAC's procedures manuals, particularly its PAM3 and Panel Doctor Guidelines,[65] contain information to support panel doctors, MOCs and other DIAC officers in implementing these three components of the health criteria. Visa applicants also have access to information about the health criteria, through DIAC's website, and in the form of information sheets and application forms.

3.16 Consistency of information across guidelines and procedures, and clarity in defining specific terms and processes therein, is important for promoting uniform interpretation and implementation of the PIC and DIAC's health screening policies. The ANAO examined the PAM3 and several other key documents for consistency with the *Migration Act 1958* (the Act), Regulations and DIAC policy, as well as clarity, currency, completeness and accessibility to intended users. Table 3.3 summarises the results of ANAO's analysis.

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64 *Migration Regulations 1994*, Schedule 4, Public Interest Criteria 4005–4007.

65 DIAC, Instructions *for Panel Doctors and Radiologists: medical and radiological examination of Australian visa applicants*, July 2006.

3.17 Generally, DIAC's guidelines were well targeted to their specific users and provided a useful overview of DIAC's health assessment process. Nonetheless, ANAO's analysis identified several gaps and areas of confusion in DIAC's documentation. For example, the PAM3 did not explain the roles and responsibilities of overseas posts in administering health assessments. DIAC reported that it had been negotiating a Memorandum of Understanding (MOU) with overseas posts for some time. However, few formal arrangements were in place at the time of the audit.

3.18 The ANAO suggests that DIAC encourage the establishment of formal protocols or guidelines with its overseas posts, as this may assist both parties in meeting DIAC's requirements more consistently, and decrease the occurrence of processing discrepancies.[66]

[66] The ANAO is aware that DIAC had established some procedural formality with overseas posts through *Statements of Work* (SOWs). These outlined functions and performance indicators for specific areas in DIAC, such as the LCU and GMU. DIAC ceased the SOWs in late 2005. Also see Chapter 8.

Table 3.3

ANAO assessment of DIAC's procedural documents

Guideline/Document	ANAO assessment based on consistency, clarity, currency, completeness and accessibility	Criteria met
DIAC Procedures Advice Manual (PAM3) Users: Not specified in the PAM3, but DIAC advised that the PAM3 was intended for case officers and other DIAC officers involved in administering the health requirement.	Updated regularly, accessible, and provides useful overview, including legal and policy responsibilities and essential information for assessing visa applicants. Some aspects need strengthening: more clarity of roles and responsibilities of overseas posts, case officers, and panel doctors; define and use terminology consistently across guidelines; and align more with the Act and Regulations.	Partially met
Instructions for Panel Doctors and Radiologists: medical and radiological examination of Australian visa applicants Users: Panel doctors and other medical examiners.	Quality has improved since 2002, and current version reflects legislation, health criteria and procedures for conducting medical examinations.	Met
Information sheets 1071i and 1163i Users: Applicants and DIAC staff.	Provides a concise overview of the health assessment process consistent with health criteria and PAM3. Are updated regularly and accessible from DIAC web.	Met
Form 26: Medical examination Users: Applicants to record medical history and health declaration. Panel doctors to record medical results. **Form 160: Radiological report on chest x-ray** Users: Panel radiologists.	Were accessible and updated regularly. Inconsistency in applicant identity information found across the different forms. DIAC would improve the reliability and timeliness of its identity checking process by including key identity information on each form (for example, passport number, previous names). This comment also applies to other health assessment forms.	Partially met
Local Clearance Unit Procedures Manual Users: Local Clearance Unit staff.	Current, accessible, and consistent with PAM3. Use of flow charts and tables aid checking of applicants against health criteria, guidelines and policy requirements.	Met

Source: ANAO analysis of DIAC documents.

Consistent definition and use of terminology

3.19 The terminology used in manuals to support the PIC needs to be: well defined; in line with the Act and Regulations; and consistently adopted across all DIAC documentation, to ensure equitable application of the health requirement.[67]

3.20 In comparing DIAC's key guidelines and procedures, ANAO found several fundamental differences in the terminology between different documents, which could lead to a narrower interpretation of the PIC than intended (see example in Table 3.4).

Table 3.4

Inconsistent wording between guidelines and Public Interest Criteria

Panel Doctors Guidelines	Public Interest Criteria
the applicant is to be free of: • tuberculosis or any other **communicable disease**[68] that is a threat to public health in Australia; and • a disease or condition that is, or may result in the applicant being a danger to the Australian community;….	The PIC does not specify **communicable disease**. It requires that the applicant: • is free from tuberculosis; and • is free from a disease or condition that is, or may result in the applicant being, a threat to **public health** in Australia or a danger to the Australian community….

Source: Panel Doctor Guidelines and PIC 4005–4007.

3.21 There was also variation in the description of the health criteria within the PAM3 itself (see Table 3.5). For example, there were no clear definitions of key terms such as 'safety', 'welfare' or 'community services', as they applied to the PIC. In addition, ANAO noted that in 2005 there was an appeal in the Federal Court of Australia involving the term 'Health Care', as referred to in the PIC 4005(c)(i)(A). Such essential terms need to be well defined to withstand scrutiny and challenge.

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[67] To reduce confusion, consistent terminology should be used in policy documents and IT documentation and databases. Currently there is considerable variation in terms being used.

[68] A communicable disease is an infectious disease transmissible from one source (either an animal or person) to another, directly or indirectly (as via a vector). Blackiston's *Gould's Medical Dictionary*, Fourth edition, McGraw-Hill Publishing Company, 1979.

Table 3.5

Example: variations in wording of the health criteria in DIAC's guidelines

PAM3 section 1 says that the health requirement is designed to ensure that:	PAM3 section 10.1 describes the objectives of the health requirement as:	Panel doctor guidelines give broad objectives of the health requirements as protecting Australia's:
Risks to **public health** in the Australian community are minimised	To protect the Australian community from **public health** and **safety risks**;	Standard of **public health** and **safety**
Public expenditure on health and **community services** is contained	To contain public expenditure on **health care** and **community services**	Expenditure on health and **welfare**
Australian residents have access to **health** and other **community services**	To safeguard the access of Australian citizens and permanent residents to **health care** and **community services in short supply**	Access to **health services**

Source: DIAC's PAM3, March 2006 and Panel Doctor Guidelines March 2006.

Note: Bold text indicates differences in text between different publications.

Threat to public health, significant cost and prejudice to access

3.22 The ANAO's assessment of procedures supporting the health requirement identified several gaps and deficiencies in each of the three afore mentioned elements of the health criteria (see paragraph 3.14. These are discussed below.

Threat to public health

3.23 The 'threat to public health' criterion must be met by each applicant in order to be granted a visa. DIAC therefore has an obligation to define what constitutes a threat to public health, and to ensure that decisions concerning public health matters (for migration health purposes) are soundly based and applied consistently.

3.24 Specific diseases that are global threats to public health are shown in Table 3.6.

Table 3.6

Examples of global threats to public health

Infectious disease	Significance of the disease globally and/or in Australia	ANAO audit comments/findings on DIAC's procedures
Tuberculosis (TB)	There were 1.6 million deaths from TB worldwide in 2002. (1)	There is a National TB Strategy TB is the basis of DIAC's risk management framework for migration screening. DIAC seek advice on TB policy and procedures from the National TB Advisory Committee, managed through DoHA.
HIV/AIDS	In 2006, the number of adults and children living with HIV was estimated at 40 million, with 25 million of these occurring in Sub-Saharan Africa. Deaths from AIDS were estimated at 2.9 million worldwide, with 2.1 million of these in Sub-Saharan Africa.(1)	Australia has a National HIV Strategy. DIAC tests all permanent visa applicants (over 15 years of age) for HIV. Generally, temporary visa applicants do not undergo HIV test, unless there are clinical indications of disease or factors of special significance apply (see Chapter 4). DIAC has a 'pilot study' for HIV testing of Sub-Saharan students. The 'pilot' has been running since 2001. Continuation of the pilot has been under discussion with DoHA since 2002, along with other HIV testing issues.
Hepatitis B	In 2002, 0.1 million deaths were attributed to hepatitis B worldwide. (1) Estimates of people living with chronic hepatitis B in Australia are between 90 000 and 160 000. (4)	Australia does not have a national hepatitis B strategy (unlike HIV and hepatitis C). DIAC includes hepatitis B testing for permanent visa applicants and where 'special significance' applies.
Hepatitis C	Australia has a National Hepatitis C Strategy 2005–08. (2) 80 per cent of current, and 90 per cent of new, infections are due to unsafe injecting practices. (2) 10.9 per cent of all people with hepatitis C in Australia were born in countries with higher rates of hepatitis C. 6.8 per cent of infections are attributed to contaminated blood, unsterile tattooing or body piercing, sharing of toothbrushes and razors, occupational exposure and mother to baby transmission. (3)	DIAC's policy on hepatitis C testing falls under 'special significance'. The PAM3 states that 'whenever an applicant's circumstances give visa officers cause for concern or clinical indications are noted, the applicant will be subject to HIV/hepatitis B/hepatitis C testing. DIAC issues health undertakings for hepatitis C. DIAC's screening requirements for visa applicants with an occupation involving tattooing were unclear.
Malaria	Approximately 40 per cent of the world's population is at risk of malaria. It is found mainly in tropical and sub-tropical regions and causes more than 300 million acute illnesses. Globally, WHO estimated deaths from malaria of 1.3 million in 2002, compared to around 2.0 million in 1993. (4)	No general policy was evident for health screening or risk management purposes, although procedures have been developed (in collaboration with DoHA) for managing malaria in refugees and illegal detainees.

Source: Compiled by the ANAO from (1) World Health Organisation, *The World Health Report* 2004: *changing history*, statistical annex, annex Table 2; (2) Department of Health and Ageing, *National Hepatitis C Strategy 2005–2008*; (3) National Centre in HIV Epidemiology and Clinical Research, *Estimates and Projections of the hepatitis C Virus Epidemic in Australia*, October 2006; (4) Australian Hepatitis Council: Addressing Hepatitis B; and National Centre in HIV Epidemiology and Clinical Research, *Estimates of chronic hepatitis B virus infection in Australia, 2000.*

3.25 TB is a recognised global risk to public health; declared a global epidemic and emergency by the World Health Organisation (WHO). TB was the original basis for DIAC's risk management framework for the health requirement,[69]and is the only health condition specifically prescribed in the health Regulations as precluding the grant of a visa. In 2002, worldwide mortality due to TB was 1.6 million (see Table 3.6).[70] The incidence of TB in Australia is amongst the lowest in the world, 5.4 cases per 100 000 population.[71] However, DIAC states that 'more than 75 per cent of cases in Australia occur in the overseas-born'. Overseas born people therefore represent a high-incidence risk group for Australia.

3.26 DIAC also states that 'of particular importance in the migration context is to prevent the spread of TB to Australians through travel and other contact with infected persons'.[72]

3.27 The PIC specifies that an applicant must be 'free from TB', it does not differentiate between active or inactive TB. Visa applicants with active TB can not be granted a visa until they have undergone treatment and are found to be medically clear of TB. However, DIAC does allow people with inactive TB entry to Australia, providing they sign a health undertaking (discussed further in Chapter 6). This requires the entrant to report to a State or Territory TB clinic to check that their TB has not re-activated since their medical examination and x-rays were done.[73] [74]

3.28 ANAO noted that DIAC's last major review of health screening procedures for TB was in 1998. Given the importance of TB to DIAC's health screening process, DIAC should ensure that its TB polices are reviewed regularly and that guidelines and procedures align with the legislation.

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69 TB still forms the basis of DIAC's health risk matrix for health screening under the health requirement.

70 World Health Report (WHO), 2004, found at http://www.who.int/whr/2004/annex/topic/en/annex_2_en.pdf The WHO report ranked TB as the fourth highest cause of death due to infectious diseases.

71 P Roche *et.al*. Tuberculosis Notifications in Australia Annual Report 2004, *Communicable Diseases Intelligence*, 2006; 30; pp. 93-101.

72 DIAC PAM3, s114.

73 *Analysis and review of medical-examination and health-related services provided to the Department of Immigration and Multicultural and Indigenous Affairs, Part 1:Scoping Study*, 17 December 2002, p. 17.

74 DIAC, PAM3, s114.

Threat to public health: other diseases or conditions

3.29 The PIC states that a visa applicants is to be free from 'other diseases or conditions that may be a threat to public health or a danger to the Australian community'. However, DIAC procedures and records contained little explanation or recent policy guidelines describing what other diseases or conditions actually constituted a threat to public health.[75] One exception to this was DoHA's advice to DIAC that HIV was not a public health risk for immigration purposes. However, the ANAO noted that elements of HIV policy had been under review, awaiting advice from DoHA, for a number of years (see Chapter 2, Table 2.1).

3.30 The risk status of other diseases, for example hepatitis B and C, malaria and influenza, for immigration purposes, was not well explained (see Table 3.6). Like TB, these had not recently undergone review or systematic risk analysis.

3.31 Better definition of terms and conditions of public health risk, and regular review of procedures and policies, is necessary to ensure that decision makers are working consistently within the intent of the health requirement and DIAC's guidelines.

Recommendation No.3

3.32 ANAO recommends that DIAC, with assistance from DoHA, formulate comprehensive and current advice on what constitutes a threat to public health for immigration purposes. This advice should be used to inform the development of timely strategies for addressing emerging immigration issues having public health risk.

DIAC's response

3.33 Agreed. Formulation of advice on public health issues crosses organisational and jurisdictional boundaries. When defining what constitutes a threat to public health, DIAC seeks assistance from DoHA to formulate comprehensive and current advice on public health matters for immigration purposes.

[75] DoHA commented in its 24 April 2007 response to the draft audit report: 'Agree that determining a list (and the criteria for what makes the list) of diseases or conditions which constitutes "disease or condition that would result in a threat to public health" needs attention.

DoHA's response

3.34 Agreed. DoHA can assist DIAC with broad public health advice on particular aspects related to public health for immigration purposes. DoHA can assist DIAC in contacting State and Territory public health authorities and professional bodies such as the Royal Australasian College of Physicians and the Communicable Diseases Network of Australia (CDNA) in the development of guidance in this area.

Significant cost

3.35 Visa applicants can be refused a visa if they have a costly health condition. DIAC's PAM3 states:

> The MOC decides whether the health condition [of a visa applicant] would attract a level of public funding regarded as 'significant'. There is no absolute definition of the level of costs regarded as significant, but the MOC may be guided by a multiple of average annual per capita health and welfare expenditure for Australians.

3.36 MOCs generally apply a threshold value of $20 000 over five years.[76] Applicants over this threshold can be deemed not to meet the criterion for significant cost.[77] In making their assessment, MOCs rely heavily on the examining doctor reports providing accurate information, not only on the medical condition, but on the severity of that condition and its expected progression or deterioration.

3.37 Recent court action has raised the need for MOCs to consider more carefully all information provided on the severity of a condition (see Figure 3.1 below).

[76] This is calculated on the average cumulative health care expenditure per capita over 5 years ($14 000) added to the average cumulative welfare expenditure per capita over 5 years ($3 000) and a 20 per cent loading: giving roughly $20 000. DIAC, *Notes for Guidance for Medical Officers of the Commonwealth of Australia*, January 2006, pp. 9–10.

[77] Also see Chapter 5—Health Waivers. Where health waivers are permissible for a given visa type, health costs are calculated using an upper threshold of $200 000. Applicants whose medical costs are likely to exceed $200 000 may not be granted a health waiver.

Figure 3.1

Recent Federal Court cases

In reviewing a decision of the delegate, the Minister and the Migration Review Tribunal (MRT) are required to take the opinion of the Review MOC (regarding whether an applicant satisfies PIC 4005) to be correct, provided that the opinion is validly made. In making their decision, the Review MOC is required to ascertain the 'form or level of condition suffered by the applicant in question and to apply the statutory criteria (PIC 4005)…to a hypothetical person who suffers from that form or level of condition.'

In the following two cases (of public record), the Federal Court of Australia ruled in favour of the visa applicant, on the basis of unclear decisions by MOCs and/or Review MOCs.[78]

Case 1: Robinson

In the Robinson case, the Robinson family was refused a permanent residence visa on grounds that 'the applicant's 8 year old son….had Down's Syndrome, and, granting him permanent residency would be likely to result in a significant cost to the Australian community'. The MRT affirmed the delegate's decision. The case went to the Federal Court, which found in the Robinson's favour. The Court commented that the 'MOC is not to proceed to make the assessment at a higher level of generality by reference to a generic form of the condition.' The Federal Court recommended that the MRT expressly record in its reasons:

- the MRTs own understanding of the correct test to be applied by the review MOC; and
- whether the MRT considers the RMOC has applied the correct test.

Case 2: Ramlu

PIC 4005 requires that an applicant not be a person who has a disease or condition that is likely to result in a significant cost to the Australian community in the areas of health care and community services. Mr Ramlu, who suffers diabetes and rheumatoid arthritis in both knees, was refused the visa because he did not meet PIC 4005.

The Court found that the opinion of the review MOC, in relation to Mr Ramlu's diabetes, was questionable as it did not identify whether he suffered from Type 1 or 2 diabetes….this was an important consideration in ascertaining the complexity and cost of ongoing management of the disease. Further the Review MOC's opinion that Mr Ramlu had 'probable renal disease' was contrary to the medical evidence before the MOC.' The Court went on to find that the Review MOC opinion was unclear as to which of the two diseases….did not satisfy the PIC 4005.[79]

3.38 These cases led DIAC to improve its documenting of reasons behind MOC opinions. DIAC revised forms to encourage more substantial information and instigated additional training for MOCs, including the legal aspects of providing opinions.

3.39 The ANAO also noted that DoHA and DIAC had significantly progressed development of the *Notes for Guidance—Principles and Costings Paper,* which was intended to assist MOCs in determining significant cost. The ANAO suggests that DIAC give priority to completion and endorsement of the *Principles Paper*. Costings for particular conditions included in individual *Notes*

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[78] DIAC, *Draft Form 884: Opinion of a Medial Officer of the Commonwealth*, 2006; DIAC, Seminar Presentation, *Writing a Lawful 'Does Not' Meet MOC Opinion: Post Robinson,* June *2006;* and Federal Court of Australia, Federal Court of Australia [2005] FCA 1626, *Robinson v Minister for Immigration and Multicultural and Indigenous Affairs and Migration Review Tribunal WAD 293 of November 2004*, <http://www.austlii.edu.au//cgi-bin/disp.pl/au/cases/cth/federal>.

[79] DIAC Minute 16 December 2006, *Migration and Temporary Entry Litigation Fortnightly Report as at 16 December 2005*.

for Guidance should be reviewed and updated regularly to ensure currency of costs (also refer to recommendation 3).

Prejudice to access

3.40 DIAC's PAM3 states that officers:

> should regard prejudice of access as occurring when the treatment, care or community services an applicant requires are in short supply in Australia, and where their utilisation of these resources would result in existing residents having to forego or wait longer for access.

3.41 The ANAO examined DIAC's guidelines for prejudice of access, and identified a number of weaknesses.[80] Health services listed as in short supply, along with ANAO findings, are summarised in Table 3.7.[81]

3.42 DIAC guidelines stated that 'the requirement of any of these products by a potential resident would represent an extreme or significant prejudice to access for the resident Australian community'.[82] Despite this, DIAC's process for compiling the prejudice of access list was not fully explicable. Specifically the ANAO found:

- there were few documented procedures, risk assessments or criteria for including or removing health services items on the list;
- guidelines of costings for many of the listed items were not fully developed;
- there was little evidence of a planned or regular consultation process between DIAC, DoHA (including the MOCs) and other agencies in setting or revising the list; and
- the list was not regularly reviewed.

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[80] DIAC, PAM3, July 2006, pp. 81–82; and *Notes for Guidance for Medical Officers of the Commonwealth: General principles associated with financial implications and consideration of prejudice to access of services*, draft version 19 January 2006.

[81] The PAM3 did not include a full list of 'resources in short supply'.

[82] Notes for Guidance for Medical Officers of the Commonwealth, *General principles associated with financial implications and consideration of prejudice to access of services*, draft version 19 January 2006, p. 19.

Table 3.7

Significant prejudice to access for the Australian community, and ANAO observations and findings

Item appearing on DIAC's Significant Prejudice to Access list	ANAO general observations and findings
Dialysis	DIAC is aware that Australia's dialysis services are on occasion used by temporary entrants. These temporary entrants often do not have dialysis as an option in their home countries. A compounding factor is that many do not apply up-front for a medical treatment visa (subclass 675 or 685), but obtain other visas by not declaring their medical condition (see Figure 3.2)[83]. This indicates a gap in DIAC's ability to detect applicants who do not meet the health requirement through normal migration health screening.
Organ transplants	Costings for renal transplants were prepared as part of the new Nephrology paper. Otherwise, guidelines on costings were still in early stages of development.
Intravenous immunoglobulin (IVG) Factor 8 blood products General blood/blood products	The formal process for determining these items was not defined. MOCs raised some doubts about the need for some items to be on the list. This did not necessarily mean that the list was wrong. However, DoHA needs to validate its advice, and make sure that DIAC officers are aware of the intent or need for the particular items deemed to be in short supply. Broader consultation between DIAC, DoHA and State and Territories is required to ensure the information is correct and current.[84]
Knee and hip joint replacement Nursing home placement for high level dementia (to be confirmed)	DIAC had no evidence to support listing of these items. 'To be confirmed' indicated that DIAC was not certain if the item should be listed, and was awaiting confirmation from DoHA. In its response to the audit's Issues Papers, DoHA commented that it was still finalising the list.
Special education needs (to be confirmed).	'To be confirmed' indicated that DIAC was not certain if the item should be listed. Confirmation to be sought from other agencies.

Source: Notes for Guidance and ANAO interviews with DIAC staff.

3.43 DIAC has difficulty in updating its information on services in short supply. For example, DIAC had sought advice from DoHA on dialysis access issues as early as 2001 (see Figure 3.2).

[83] DIAC Minute 2001.

[84] DIAC may need to consider broader consultation, for example with the National Blood Authority, as the national coordinator of blood products for Australia.

Figure 3.2

Dialysis services

A DIAC-DoHA meeting noted the following issues concerning dialysis services:

DIMIA is aware of a number of instances of temporary visa holders using Australian dialysis services on an unfunded basis. This is of concern as we have been previously advised (by the Department of Health and Ageing and by State and Territory Health Departments) that dialysis services are in short supply. As this is a long-standing issue, which appears to be on the increase, we wish to discuss the following issues:

- confirmation (or otherwise) that dialysis services, in general, are in short supply so that we can clarify the advice we give to our Medical Officers of the Commonwealth (MOCs);
- defining the true scope of the problem; and
- discussion of possible options.

Source: FACS and DoHA meeting agenda 12 December 2001.

3.44 Apart from DoHA confirming that dialysis was in short supply, these issues remained largely unresolved.

3.45 To strengthen the reliability and accountability of the process for prejudice of access, ANAO encourages DIAC, with advice from DoHA and other stakeholders as appropriate, to establish a complete list of service or resources in short supply and a process for regular and systematic review of health services and items.

3.46 The ANAO also noted that DIAC did not have data to enable systematic calculation of the savings to Australia from the refusal of applicants on grounds of prejudice of access and/or significant cost. Given this, DIAC could not substantiate the reliability of its process or the impact of its decisions concerning prejudice of access. To assess its performance against the PIC, ANAO suggests that DIAC examine options for more regular monitoring of the effectiveness of prejudice of access.

4. Health Assessments

This chapter examines DIAC's arrangements for assessing the health of visa applicants.

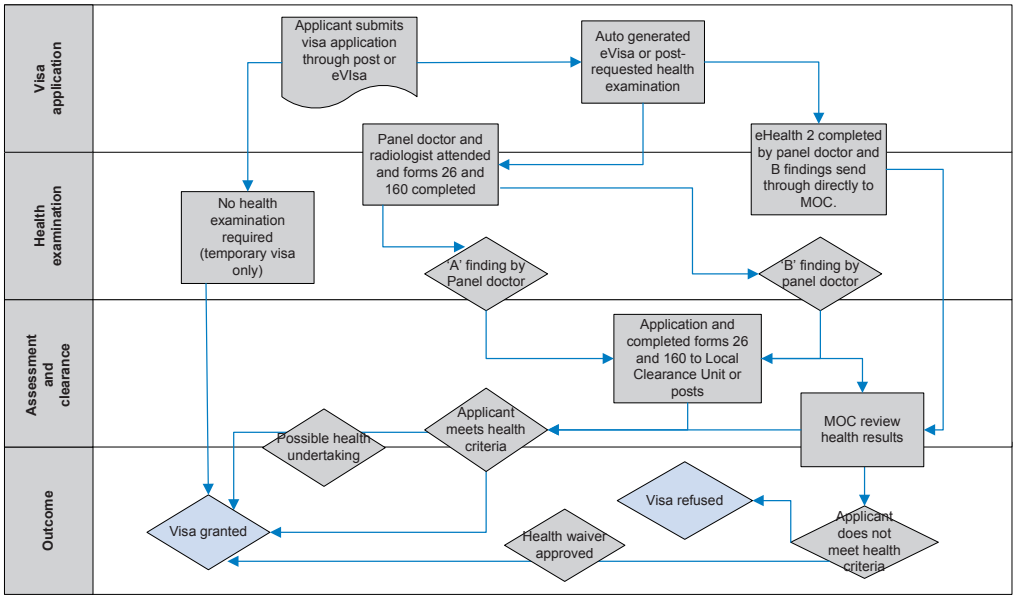
The risk management framework for health assessments

4.1 Effective administration of the health requirement is contingent on DIAC identifying visa applicants who pose undue health risks to Australia (in terms of public health threat, significant cost, or prejudice of access to services), and accurately assessing whether those individuals meet or do not meet the Public Interest Criteria (PIC) 4005–4007. DIAC's decision-makers are required by law to ensure that the health criteria are met before a visa can be granted.[85]

4.2 To meet these obligations, DIAC has developed a system of health assessment which aims to identify applicants of highest health risk using set criteria, guidelines and health screening methods. Administration of health assessments follows a complex, multi-layered process (Figure 4.1).

Figure 4.1

Key steps in processing health assessments



Source: ANAO analysis, compiled from DIAC documents and interviews.

[85] *Migration Act 1958*, s65(1)(a)(ii); the *Migration Regulations 1994; Schedule 4, Public Interest Criteria 4005–4007*; and DIAC *Procedures Advice Manual 3 (PAM3)*, July 2006, s10.2.

4.3 Assessing the health of visa applicants involves many entities, located onshore and offshore, each carrying out specific functions under DIAC's guidance (Figure 4.2). Some of these entities are part of DIAC, and others (such as panel doctors) are outside of DIAC's direct control.

Figure 4.2

Agency and officer functions

Entity	Location and type	Key Functions
Health Policy Section	Within DIMA Canberra	> Formulate policy, regulations, instructions and procedures concerning health criteria > DIMA's first point of contact for all matters concerning the health requirement > Coordinate enquiries and liaison on health requirement matters (including cross-agency) > Monitors health waivers and checks those over $200 000
Global Medical Unit	Based in DIMA office Sydney	> Manage panel doctors: appointment, monitoring and removal of doctors from the panel > Information and support to the panel, communicating changes in process and policy > Visits to panel doctors and clinics overseas, and audit the work of panel doctors > Answer medical questions on migration health
Panel doctors	3000 overseas doctors (non-contract) approved and listed by DIMA	> Examining doctors conduct medical examinations > Confirm identity of applicant attending for medical examination or tests > Oversee completion of all tests, x-rays, and arrange additional specialist evaluation > Submit completed forms 26, 160 and additional reports to DIMA, with 'A' and 'B' rating
Local Clearance Unit	Within NSW health processing Sydney	> Processing and local clearance of medical results sent from panel doctors > Process 'A' cases within one day of receipt > Referral of health assessment 'B' cases to Health Assessment Service (HAS) > Respond to client enquiries > Quality assurance
Onshore Processing Centres	DIMA centres at several locations in Australia	> Process visa applications > Centralised processing of specific visa types at centres in Perth, Adelaide, and Hobart > Check and clear health assessments and refer 'B' cases to HAS > Case officer issues visa or rejects application, and informs applicant of visa outcome
Health Services Australia	Contracted medical service provider with several locations around Australia	> Provides medical opinions for onshore visa applicants > Medical advisors do medical and x-ray examination, and complete forms 26 and 160 > MOCs provide DIMA with opinions on health assessments, and liaise with HAS > Maintains IT system ELMA for electronic lodgement of Medical Assessments
Health Assessment Service	Within NSW health processing Sydney	> MOCs give medical opinions on offshore visa applications > Advise on medical and radiological examinations and panel doctor guidelines > Provides telephone enquiry service for health assessments to applicants and sponsors > Operates the Health Undertaking Service

Source: ANAO, compiled from DIAC PAM3 July 2006, other guidelines and interviews.

4.4 This chapter focuses on the Health Policy Section, panel doctors, Global Medical Unit (GMU), Local Clearance Unit (LCU) and Health Assessment Service (HAS). The ANAO examined how effectively these areas functioned to minimise risks, provide an effective health assessment program, and meet its objectives. DIAC has identified the following objectives and key risks for health assessments (Table 4.1).[86]

Table 4.1

Objectives and key risks identified by DIAC for health assessments

(1) Objective: Maintain high levels of integrity of health screening processes	(2) Objective: Medical opinions and decisions in accordance with legislation and policy
Risk: Failure to identify applicants of concern *Risk: Failure to detect health fraud*	*Risk: Inefficient or ineffective decision making or errors in relation to health requirements*

Source: Extract from Health Policy and Processing Risk Management Plan 2006–07 (draft).

4.5 The ANAO examined three main aspects of health assessments:

- DIAC's risk management for health screening;
- medical examinations; and
- clearance of offshore health assessments.

DIAC's risk framework for health screening

4.6 To manage its identified risk of 'failure to identify applicants of concern', DIAC must ensure that each applicant undergoes the required level of health checks according to the individual's particular risk status and DIAC's health assessment guidelines. DIAC's *Procedures Advice Manual* (PAM3) outlines the basic components of DIAC's risk management framework for health screening. The ANAO examined DIAC's risk management framework to determine if its procedures were: clearly stated; based on sound, risk-based selection of applicants; and applied consistently.[87]

[86] DIAC, *Health Policy Section Risk Management Plan 2006–07* (draft), 2006.

[87] The assessment was based around the risk framework for health screening of temporary visa applicants set out in DIAC's PAM3, July 2006 (and previous PAM3 versions).

Health declarations

4.7 The first element of health screening is the health declaration. As part of their application, each visa applicant answers a set of questions about their medical history and current health status, and sign a health declaration.[88] The answers given to these questions affect the combination of health checks (if any) the applicant will be required to undergo. To a large degree, this means that DIAC relies on the honesty of visa applicants in its determination of who needs a health assessment. As a result, DIAC cannot be certain of detecting all people who pose health risks.

4.8 DIAC had not instigated systematic auditing (random or selective) to check the accuracy or reliability of health declarations. Therefore, DIAC could not estimate compliance in this aspect of health screening, or demonstrate the overall effectiveness of health declarations in identifying applicants of high health risk. ANAO suggests that DIAC consider options for developing quality assurance measures for temporary visa applicants who do not undergo medical examinations, to determine the reliability of the health declaration process.

Health screening requirements for permanent entry visas

4.9 All applicants for permanent visas, and their families, undergo a health assessment[89] consisting of: a medical examination; a chest x-ray examination if aged 11 years or older;[90] and an HIV test if aged 15 years or older.[91] Panel doctors performing the medical examination, or a Medical Officer of the Commonwealth (MOC), also request applicants to undertake further medical assessment to establish their health status.

4.10 DIAC does not require a MOC assessment on all applications for permanent entry visas, and is therefore largely reliant on overseas panel

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88 An exception to this is Electronic Travel Authority (ETA) applications. DIAC does not seek a health declaration for ETAs, although travellers on ETA make a TB declaration on the passenger card, on arrival in Australia. Also refer to Chapter 1, paragraph 1.28.

89 DIAC, PAM3, July 2006, s75. Family members are required to undergo health examinations and assessments regardless of whether they are visa applicants or intending to accompany the applicant to Australia.

90 DIAC, PAM3, July 2006, s.13. Applicants must complete the appropriate DIAC forms: form 26 *Medical examination for an Australian visa*; and/or form 160 *Radiological report on chest x-ray of an applicant for an Australian visa.*

91 DIAC, PAM3, July 2006, pp. 67–75. Also see Chapter 1.

doctors and DIAC case officers to ensure that health examinations and tests are conducted in line with DIAC requirements.

Health screening requirements for temporary entry visas

4.11 DIAC's risk management framework for screening temporary visa applicants is more complicated than for permanent visas applicants.

> Health examination requirements vary according to the proposed length of stay and/or whether the applicant falls under special significance provisions or answers 'yes' to any question in the health declaration that forms part of the visa application form.[92]

4.12 This means that for many short-stay visitors the health requirement only involves completing a health declaration (see paragraph 4.7), while for others it entails a medical examination and/or x-ray and possibly other tests before a decision to grant or refuse a visa can be made (see Figure 4.1).

4.13 Doctors and case officers work through a series of policies, risk tables, and special situations presented in DIAC's PAM3 and other guidelines, to determine the right computation of health checks for a given applicant.[93] The process is often quite complex, and guidelines can change from time to time. Collectively these factors increase the level of risk associated with implementing the health requirement correctly.[94]

The health risk matrix for temporary visa health screening

4.14 The DIAC's health risk matrix[95] summarises DIAC's health examination requirements for temporary visa applicants according to the risk level of the applicant's country of origin and their proposed period of stay (Table 4.2).

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92 DIAC, PAM3, July 2006 s35.

93 The risk framework for temporary applicant health screening is presented in DIAC's PAM3, July 2006, pp. 30–31, 38–53. It is also supported by various other guidelines to assist panel doctors and MOCs.

94 For example, the minimum age for x-rays changed from 15 to 11 years in 2002; the risk rating of a country can change depending on the incidence of TB or other diseases; and some visa sub-types may be made exempt from medical examinations or be made eligible for health waivers. ANAO noted that the requirement for tattooists to undergo blood tests was removed from the July 2006 PAM3. No reason for this was provided, contrary to DIAC processes, which require changes to the PAM3 to be listed on its front cover.

95 DIAC, Form 1163i-Health Examination Requirements by Country and Period of Stay, also referred to as the 'health risk matrix', is included in the PAM3, p. 38.

4.15 DIAC advised the ANAO that it sets countries' risk level on the basis of its incidence of tuberculosis (TB), and reviews them every two years.[96] However, DIAC's process for categorising countries in the matrix as low, medium, high or very high risk was poorly defined. There were also no records showing when the countries' risk levels were last reviewed, or the process for review. Therefore, DIAC could not confirm that the matrix was soundly based or current.

[96] DIAC internal review, *Review of health screening procedures with regard to tuberculosis*, 18 September 1998, pp. 33–34 indicates that TB rates are monitored internationally by the World Health Organisation (WHO). DIAC sets risk ratings based on TB data published every two years by the WHO. A country's level of risk may change if its incidence of TB rises or falls.

Table 4.2

DIAC Health Risk Matrix for Temporary Visa Applicants (Form 1163i)

Country – Level of Risk (citizenship or 3 months stay in last 5 years) Highest risk applies	Stay of up to and including 3 months	Stay of greater than 3 months, up to and including 12 months	Stay of greater than 12 months
Low Iceland, Monaco, Norway, San Marino, Sweden, (Australia)	• no formal health examination required unless special significance* applies.	• no formal health examination required unless special significance* applies.	• no formal health examination required unless special significance* applies; • health insurance for your period of stay.
Medium Austria, Belgium, Canada, Cyprus, Denmark, Finland, France, Germany, Greece, Ireland, Israel, Italy, Liechtenstein, Luxembourg, Malta, Netherlands, New Zealand, Puerto Rico, Switzerland, United Kingdom, United States of America, Vatican City	• no formal health examination required unless special significance* applies.	• no formal health examination required unless special significance* applies.	You will be required to undergo: • a medical examination; and • an x-ray. Note: If you are an applicant for a 457 visa, you will be required to undergo a chest x-ray only, unless your health is of special significance*, or you are likely to enter a classroom situation for a stay of greater than 12 months, in which case, a medical examination will also be required.
High Andorra, Bahrain, Czech Republic, Egypt, Fiji, Hungary, Iran, Japan, Jordan, Kuwait, Lebanon, Libya, Mauritius, Oman, Palestinian Territories, Poland, Qatar, Saudi Arabia, Seychelles, Slovakia, Spain, Syria, Tunisia, Turkey, United Arab Emirates	• no formal health examination required unless special significance* applies.	• no formal health examination required unless special significance* applies; OR • if you are likely to enter a classroom situation for more than 3 months, in which case, a medical examination and chest x-ray will be required.	You will be required to undergo: • a medical examination; and • an x-ray. Note: As per 457 'Note' above, however, entry to a classroom situation will require a chest x-ray and a medical examination for a stay of greater than 3 months.
Very high All countries not listed above including: Algeria, Argentina, Bangladesh, Brazil, Chile, China, India, Indonesia, Korea, Malaysia, Pakistan, Papua New Guinea, Philippines, Portugal, Russia, Serbia and Montenegro, Singapore, Sri Lanka, South Africa, South Africa, Vietnam, Zimbabwe Countries not listed are very high risk	• no formal health examination required unless special significance* applies; OR • if you are likely to enter a classroom situation for more than 4 weeks, in which case, a medical examination and chest x-ray will be required.	• you will be required to undergo a chest x-ray; • a medical examination and chest x-ray will be required if you are likely to enter a classroom situation for more than 4 weeks, in which case, a medical examination and chest x-ray will be required; • any special significance* requirements must be met.	You will be required to undergo: • a medical examination; and • an x-ray. Note: As per 457 'Note' above, unless likely to enter a classroom situation for more than 4 weeks, in which case, you require a chest x-ray and a medical examination.

Source: DIAC, Form 1163i, 2006.

Note: Factors of special significance are provided in DIAC's PAM3. Table 4.3 lists these.

Factors of special significance

4.16 Where a person's health is considered to be of 'special significance' (regardless of their length of stay), DIAC requires additional health checks to those outlined in the health matrix (Form 1163i) (see Table 4.3).[97]

Table 4.3

Factors of special significance for temporary visas

Special significance factor	Level of health check required (as at March 2006)
Likely to enter a hospital or health care area (including nursing homes) for any reason (PAM3 s59).	X-ray is a minimum requirement. Visa applicants intending to be involved in medical procedures (for example, doctors, dentists, nurses) also must undergo HIV/AIDS, Hepatitis B and hepatitis C tests.
Likely to be engaged at an Australian childcare centre (including preschools and crèches) either as an employee or trainee (s60).	X-ray is a minimum requirement.
Aged 70 years of age or older (s61).	Medical examination required.
Parent with a 'queued' migration application (s62).	Medical examination and x-ray is required for a stay greater than 6 months.
There is an indication that the health requirement may not be met (existing medical condition), regardless of length of stay (s63).	Medical examination required.
Pregnant women (s64 and s115.1).	If TB status is not confirmed (no x-ray), and the application is not deferred, applicant may be required to sign a health undertaking before a visa is granted.
Intending to work in an occupation where blood contact may occur, such as tattooing, body piercing, acupuncture (s59). **	HIV/HepB/HepC testing is required **

Source: ANAO, compiled from DIAC PAM3, March 2006, sections 50–53 and 58, and July 2006, sections 38 and 58.

Note: ** DIAC's PAM3 March 2006 did not specify if an x-ray was required in these cases. PAM3 July 2006 did not specify this factor of special significance.

4.17 Recognising factors of special significance in applications is a significant step in DIAC's health risk management, so it is important that this information is both consistent and complete throughout the PAM3, health risk matrix and other documentation. The ANAO found areas of inconsistency across documents and within DIAC's PAM3. DIAC needs to maintain consistency of information when updating its guidelines and procedures, as this will facilitate correct interpretation of DIAC's requirements by clients, medical examiners and clearance officers.

[97] 'Special significance' appears in tables in DIAC's PAM3, July 2006, pp. 37 and 50–5.

4.18 Risks associated with applying factors of significance also stem from DIAC's dependence on disclosure of correct information by applicants, and detection of pre-existing diseases/conditions by panel doctors. Both risks were largely outside of DIAC's control. DIAC officers check whether factors of special significance apply to applicants for temporary visas (from information contained in the visa the application form, medical forms 26 and 160, and other attached documentation), and ensure that the correct combination of examinations and tests are performed prior to processing the visa application.

4.19 DIAC records indicated that internal quality assurance, including auditing of processing by GMU and LCU, assisted DIAC in maintaining the integrity of this process.[98] However, ANAO noted that DIAC's case management IT systems record limited information on applicants' factors of significance, which affects the completeness of client records, and DIAC's ability to monitor cases (see Chapter 7).

ANAO assessment of DIAC's risk framework

4.20 A summary of the ANAO's analysis of DIAC's risk framework for temporary visas is shown in Table 4.4.

4.21 The ANAO found that, notwithstanding its limitations, DIAC was implementing the risk framework for temporary visa applicants as specified in the PAM3. However, aspects of the risk framework lacked transparency and consistency, were not regularly reviewed and, in some instances, did not have a firm policy basis. As a result, DIAC could not be certain of the extent to which it was:

- meeting its objective to 'maintain high levels of integrity of health screening processes'; or
- managing the specific risk 'to identify applicants of concern'; or
- assessing the health of temporary visa applicants consistently.

4.22 To improve the transparency and accountability of DIAC's health screening for temporary visa cases, ANAO recommends that DIAC review the risk management framework with particular consideration of current evidence and health trends, and fully document the basis of the framework to support decision making (see Recommendation 4, paragraph 4.49).

[98] Various DIAC reports, including monthly reports prepared by GMU, LCU and HAS.

Table 4.4

ANAO assessment of DIAC's risk framework for temporary visa applicants

Criteria	Criteria met	ANAO comments/findings
Risks are identified and documented	Partially met	• DIAC produced a (draft) risk management plan for health assessments for 2006–07, but there was no evidence of previous year's risk management planning. • Categorising of countries' risk levels (low to very high) in the health risk matrix did not demonstrate a firm policy basis. • Evidence/risk base of including specific factors of special significance was not always evident. • The PIC makes provision for other diseases or conditions of public health risk. DIAC does not specifically denote these in its guidelines. • The basis for not including diseases such as HIV, hepatitis B, or malaria as public health risks was not clearly identified or documented.
Information is up to date	Partially met	• DIAC had not systematically or regularly reviewed countries' risk levels, and had no procedures or timeline in place for such revision. • There was no process in place for reviewing the risk levels in response to urgent global situations. • Occurrence of disease outbreaks was not visibly linked to updating of guidelines for risk management, or for informing screening policy change.
There is a consistent approach to risk assessment of applicants	Partially met	• People entering Australia on ETAs or temporary visas (or those on bridging visas) were not subject to the same level of health assessment as those on long term stay or permanent visas. Problems can arise if the person becomes unfit to travel home. DIAC advised that it cannot produce data to estimate the extent or impact of these occurrences on Australia's health system, but was developing new protocols for 'unfit to depart' persons. • Aspects of the risk framework were not portrayed consistently throughout DIAC's guidelines. The PAM3 lists many exemptions and variations to the health assessment requirements. This increases the complexity of DIAC's assessment process, and heightens the risk of inconsistent assessment of applicants.[99]
There are clear processes for reviewing and incorporating new risks into DIAC's risk framework.	Partially met	• DIAC reviewed health screening procedures with regard to TB in 1999, health processing of temporary entrants in 2000, and screening for older persons in 2003. • However, DIAC did not have a planned or systematic approach to reviewing or incorporating new risks into its risk framework or guidelines. It also had few mechanisms in place for determining the impact on Australia of changes to health screening procedures.

Source: ANAO analysis.

[99] For example, sections 41 and 42 concerning students and students from Africa; and the health risk matrix itself.

Medical examinations

4.23 Responsibility for organising the medical appointment and the costs of the medical examination are borne by the applicant, and paid directly to the doctor or clinics performing the examination. Information sheets and application forms outlining DIAC's requirements are available to clients through DIAC's website.[100]

4.24 Visa applicants can access panel doctor lists through the DIAC website or from local Consulates and overseas posts. Panel radiologists are also listed on the website, although DIAC advised that this list did not contain all radiologists used by DIAC.

4.25 The examining doctors are responsible for: verifying the identity of the applicant; conducting the medical examination; arranging for examining radiologists to complete x-rays and related forms; and requesting additional tests or specialist reports to ensure that the most comprehensive information is available to assess the applicant's health.[101] Doctors assess the applicant's health according to the processes set out in the panel doctor guidelines[102] and records an 'A' or 'B' rating (see paragraph 4.30). The medical information is reported to DIAC on Forms 26 (for medical examination) and 160 (for radiology), with any additional specialist reports, test results, or additional information attached.

Confirming an applicant's identity

4.26 To manage the risk 'failure to detect health fraud', examining doctors must establish the identity of a person presenting for a medical or test, in accordance with Panel Doctor Guidelines (section 5).

> Security in the medical examination process is of paramount importance. It is essential to ascertain that the person who presents for an examination is the actual applicant. A passport is the preferred means of identification.

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[100] DIAC forms: *Form 1071i, Health Requirement for Permanent Entry into Australia*; and *Form 1163i, Health Requirement for Temporary Entry into Australia*; *Form 26 Medical examination for an Australian visa*; and *Form 160, Radiological report on chest x-ray of an applicant for an Australian visa.* Commonwealth of Australia, 2006.

[101] DIAC, *Health Requirement for Permanent Entry into Australia*, Form 1071i, 2006.

[102] DIAC, *Instructions for panel doctors and radiologists: medical and radiological examination of Australian visa applicants,* July 2006.

This requirement applies to all examinations: clinical, radiological, HIV testing, and special referrals. Applicants have been known to send substitutes to examinations in the belief that they would experience difficulty in meeting required medical standards. [103]

4.27 Once an application reaches the Local Clearance Unit (LCU) for processing, [104] the LCU will attempt to resolve identity problems, or return the application to the overseas post. Further identity checks are performed at the level of case officers and MOCs. It is usually the MOCs who are able to detect substitution of medical results, such as x-rays. DIAC has processes for reporting and following up these cases, and its Global Medical Unit (GMU) maintains a database for monitoring purposes. The database includes cases where substitution of medical results has occurred (see examples in Table 4.5).

Table 4.5

Examples of identity discrepancies

Example 1: Mislabelling of x-ray or possible substitution of test results – from complaints database

A female applicant's x-ray was labelled with the applicant's name and date of birth. However, the shape of the chest suggests that x-ray is that of a male. The x-ray has been mislabelled or there has been substitution. This is the second case today. There also has been a third similar case which has already gone into the system in HAS and we are unable to identify the applicant.

Example 2: DIAC complaint file—picked up through Global Medical Directors' (GMD) audits

Panel doctor has not signed across the photograph on form 26 or form 160 or the LCU identity declaration. The radiographer's section of form 160 is not completed. The x-ray is so black it is unreadable. The radiologist has reported abnormalities on the chest x-ray on his separate typewritten report, but completed the form 160 as normal. The panel doctor has ticked normal to question 19 and marked the case 'A'. The applicant has also listed breast surgery in her declaration but the doctor has not written anything about this.

Example 3: Panel doctor not carrying out proper identity check

LCU reported: 'A panel doctor recently processed numerous clients who had not provided their passports at the time of the examination. This creates an extra workload for both the LCU and the client as we have to follow up such results with another ID declaration. Is there any way we can reinforce the importance of proper identification of clients at the time of medical examinations?'

Example 4: Identity not established and use of non-approved radiologist

An applicant had his application for a temporary visa subclass 457 refused, because the x-ray provided had not been performed by a HAS/DIAC approved radiology provider. No form 160 was provided, so identity could not be established.

Source: From DIAC file records and databases.

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[103] DIAC *Guidelines for panel doctors and radiologists: medical and radiological examination of Australian visa applicants*, March 2006, p. 8, s5.

[104] The overseas posts send forms 26 and 160 to the LCU for clearance, or forward them to a MOC for a medical opinion.

4.28 Administrative errors or departure from DIAC processes by panel doctors or overseas posts, and IT system problems, were more often causes of confusion over an applicant's identity (see Table 4.6).

Table 4.6

Administrative errors causing difficulty in identifying applicants

Some frequent administrative problems encountered by DIAC staff included:

- LCU officers had difficulty in matching x-rays to other medical records as a result of medical documents being separated from applications and not properly labelled or identified;
- delays in matching records due to inconsistency in recording of applicant names on different forms;
- multiple HAPRs (Health Assessment Permission Request) and multiple electronic records lead to confusion of identity and medical records; and
- IT system failure to copy data from ICSE to HATS lead to 'missing' records.[105]

Source: Compiled by ANAO from observations, DIAC files and interviews.

4.29 DIAC did not routinely collect data on the incidence of such administrative errors, so could not monitor their impact on processing efficiency or performance. However, DIAC's internal quality assurance audits of LCU's normal case checking processes showed low rates of serious processing errors passing undetected through DIAC's checking regime.

'A' and 'B' cases

4.30 DIAC estimates that medical examiners conduct around 400 000 medical examinations for immigration purposes each year. Most of these examinations were reported to DIAC as 'A' cases—no significant history or abnormal findings. About 160 000 (35 per cent) of medical examinations were 'B' cases, which meant that the medical examiner found significant medical history or abnormal findings, or for another reason the application needed to be assessed by a MOC. The panel doctor guidelines assist doctors in grading applications, and include criteria which must be met for an 'A' recommendation.[106]

[105] During the audit, the LCU provided data on down-time due to IT outages. These figures are provided in Appendix 6.

[106] The *Guidelines for Specific Conditions* indicate whether an A or B rating should be given, depending on the condition listed and whether the application is for a temporary or permanent visa. *Instructions for Panel Doctors and Radiologists: medical and radiological examination of Australian visa applicants,* July 2006, pp. 50-52.

4.31 The grading of cases as 'A' or 'B' is essentially a risk management strategy which helps DIAC focus attention on higher risk applicants. 'A' cases do not receive further assessment by a MOC and are 'locally cleared' either by an overseas post or LCU.[107]

4.32 DIAC's methodology for grading applications was essentially soundly based, although aspects were open to interpretation by panel doctors.[108] However, DIAC should clarify its guidelines (PAM3) for clearance of 'A' and 'B' rated cases, to minimise risks at the point of clearing health assessments. This is discussed later under clearance of health assessments (see paragraph 4.39).

Ensuring the integrity and performance of panel doctors

4.33 DIAC's GMU manages the appointment, auditing and removal of panel doctors. Panel doctors sign an undertaking to follow DIAC's guidelines and policies. However, they are not under contract to DIAC. ANAO examined GMU's management of panel doctors.

4.34 The GMU was established in 2004, and since this time has made considerable progress in establishing standard methods for appointment, removal, retirement and monitoring of panel doctors. Table 4.7 shows some of the GMU's activities to date. [109]

[107] Or by Health Services Australia if the application was made onshore and the medical was done onshore.

[108] For example, the severity (or significance) of a medical condition may involve more subjective consideration by a panel doctor.

[109] The GMU function was previously operated by two Regional Medical Directors, who operated out of Bangkok and London with little program or operational support. This function was repatriated in December 2004 in an effort to develop a more strategic approach (achieve efficiencies), and consolidate knowledge. This was necessary, as the panel has grown from 1500 to 3200 members in the last few years.

Table 4.7

Monitoring of the integrity and performance of panel doctors

Activities undertaken by the GMU since its establishment in 2004.	ANAO comments
Strengthened processes for appointment of panel doctors, including more stringent requirements for curriculum vitae, medical credentials, and certification of documents.	• There were improvements in DIAC's appointment/removal process over the period April 2005 to May 2006 (see comments paragraph 4.34). • However, the ANAO found that compliance with DIAC standards for documentation of appointments was only 50 per cent. DIAC needs to improve this given the significant role that panel doctors play in health screening. • Audit findings included: documents not translated; documents not certified; copies of documents not legible; and photographs not clear enough for identity purposes.
Engages overseas posts to conduct inspections of panel doctors' premises, procedures, and laboratories performing tests for DIAC health assessments.	• GMU provides checklists of standard questions. However, qualifications of overseas post staff conducting inspections are unclear, giving process some uncertainty of quality and rigour. • There were no formal arrangements with overseas posts. DIAC should investigate more formal arrangements, inclusive of performance indicators.
Has established desk audits of cases (up to 650 cases per month).	• ANAO acknowledges this is a new process, still being refined.
Integrity and quality of panel doctors and laboratories is investigated by Global Medical Directors (GMDs) located in GMU. GMDs conduct overseas site visits.	• GMU selects sites based on its risk model. • GMD inspections are done according to set methodology, and are well organised. • Where GMD's reports showed sub-standard medical practice or laboratory procedures, GMU records incidents, and follows these up within its resource limits.
Established a complaints database for monitoring panel doctors complaints and audit findings. GMU advised that a more comprehensive database was under development.	• At the time of audit the database contained some 600 entries (cases), most of which were followed up and progress/resolution recorded. • Some cases had missing data. DIAC should ensure completeness of data for each case.
Disseminates information (frequently asked question sheets, and GMU Newsletter) to panel doctors and radiologists.	• Overall, useful documents. • ANAO suggests that Newsletters should be cleared by the Head of Health Policy Section and a Medical Officer, to ensure accuracy and clarity of information.
Reports results of audits to overseas posts, to inform service improvements through lessons learned.	• This is reinforced by the site visits, which provide opportunity for panel doctors to ask questions about the health assessment process and improvements required.

Source: ANAO analysis of GMU, based on interviews, databases and hard copy files, and reports.

4.35 Appointment of panel doctors and monitoring of their performance is important, because DIAC is relying on their judgement and integrity in providing medical examinations and reports. Documentation of panel doctors appointments had improved over the period 2005–2006. However, the ANAO's analysis showed that around 50 per cent of applications approved by GMU had documentation that did not meet DIAC's standards.[110] This included documents that were: not translated; not certified; not legible; and photographs not clear enough for identity purposes.

4.36 Appointment of panel doctors based on non-compliant documentation diminishes DIAC's ability to ensure the integrity and qualifications of the panel doctors, and the reliability of health examinations. This is inconsistent with DIAC's objectives and identified risks for health assessments (see Table 4.1).

Use of non-panel doctors

4.37 In most instances, DIAC does not accept a medical examination if performed by a non-panel member. However, some exceptions are allowed on the premise of 'fair and reasonable' treatment of applicants. Figure 4.3 provides examples.

Figure 4.3

Use of non-panel doctors

- Some overseas posts maintain their own panel doctor lists, which may differ from the GMU listing[111]. DIAC documents indicated that this can, at times, lead to a health assessment being conducted by a non-panel doctor.[112] In these cases the GMU advises 'under the "fair and reasonable' test we will accept medicals, as it is a Departmental responsibility to provide clients with correct information.'
- In countries where DIAC had no panel doctors, DIAC will accept a medical examination from a non-panel doctor.
- The USA has only 1 panel radiologist, so GMU accepts form 160 for temporary or permanent visas by non-panel radiologists on fair and reasonable grounds.

4.38 The ANAO acknowledges the difficulty in appointing panel doctors in some countries, and the need for flexibility in DIAC's system. However, these exceptions carry additional risk, as non-panel doctors have not gone through the same integrity checks as DIAC appointed panel doctors. Therefore, the ANAO suggests that DIAC ensure that it has additional risk management strategies identified for these cases, and incorporates these additional

[110] Based on ANAO's sampling of panel doctor applications from two months in 2005 and two months in 2006.

[111] For example, if a panel doctor is removed from the GMU list and the overseas post has not updated its list.

[112] DIAC information attached to mail dated 3 July 2006.

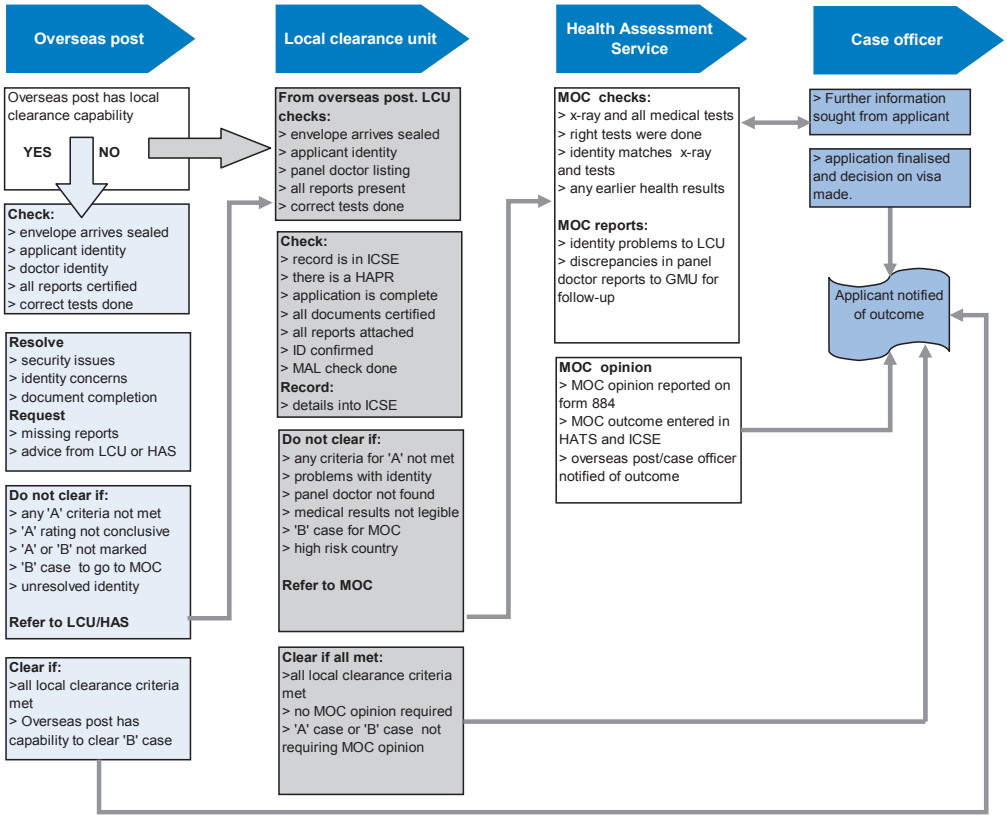
measures into its risk management plans, process guidelines, and audit methodologies.

Clearance of offshore health assessments

4.39 DIAC's PAM3 and LCU Procedures Manual document the processes for clearance of health assessments performed offshore (by panel doctors).[113] The ANAO examined the effectiveness of these procedures, including the mechanisms DIAC employs to ensure the integrity of the clearance process. Figure 4.4 illustrates the main steps involved in clearing medical results.

Figure 4.4

Clearance of a health assessment for an offshore application



Source: ANAO analysis based on DIAC documents, interviews and ANAO observations during fieldwork.

Legend: HAS (Health Assessment Service); MOC (Medical Officer of the Commonwealth); ICSE (Integrated Client Services Environment); HAPR (Health Assessment Permission Request); HATS (Health Assessment Tracking System); GMU (Global Medical Unit).

[113] PAM3 July 2006, paragraphs 97-101; and DIAC, *The Local Clearance Manual*. 2006.

4.40 The ANAO assessed DIAC's clearance processes, with particular attention on LCU and HAS functions. ANAO's findings against specific audit criteria are given in Table 4.8. The assessment was predominately based on paper-based medical reports. Analysis of specific issues follows the table.[114]

Table 4.8

ANAO's assessment of clearance of health assessments by DIAC's Local Clearance Unit and Health Assessment Service

LCU/HAS demonstrated that:	Criteria met		ANAO comments/findings
	LCU	HAS	
Processes are documented and up to date.	Yes	Partial	• Most processes were documented and regularly updated. • However, lack of HAS MOC guidelines increases risk of inconsistent opinions and health costings. A previous ANAO audit finding emphasised the need for guidelines, but this was not successfully addressed (see Chapter 3).
Processes are consistent with DIAC PAM3 and LCU guidelines.	Partial	Partial	• This criterion was met in as far as there were specific documented procedures in place. • DIAC had no policy or consistent procedures for managing front end loaded applications. • There were no defined lines of responsibility for LCU or onshore processing centres (OPCs) officers to create ICSE records when front loading or faults with transferring of records occurs. • Policy and procedures for use of health undertakings for diseases/conditions other than TB, Hepatitis, and pregnancy were not defined or documented.
Processes comply with legislation, regulations and DIAC policy.	Yes	Partial	• In general, DIAC's processes were in line with the intent of the PIC and relevant parts of the Migration Act. • However, the Regulations make no distinction between active and inactive TB, although these are managed differently by DIAC. • Front end loaded health assessments were processed without a visa application form (see paragraph 4.46). • More comprehensive and current documentation of policies underpinning guidelines would ensure better alignment with the legislation and improve transparency of the health assessment process.
Assessments are based on DIAC's risk management framework.	Yes	Yes	• Assessments are generally carried out according to DIAC's risk management framework. However, there was little evidence that DIAC had recently reviewed key aspects of the framework, which undermines confidence in its applicability or relevance. • Inconsistencies across DIAC documents should be amended to ensure consistent interpretation and application of the framework.

[114] DIAC receives medical reports (mainly as forms 26 and 106) for the most part as hard-copy.

LCU/HAS demonstrated that:	Criteria met LCU	HAS	ANAO comments/findings
Applications are tracked and progress/outcomes recorded.	Partial	Partial	• ICSE and HATS are used to track information, although both have limitations as comprehensive case management systems and data repositories (see Chapter 7) • Outcomes are recorded mainly as 'meets' and 'does not meet'. Little detail of actual test results is recorded in the Information Client Services Environment (ICSE), the central onshore case management system. • HAS recently drafted a new form for recording 'does not meet' decisions, which should improve transparency and accountability of the MOC opinions.
Suspected cases of substitution or fraud are recorded and followed up/resolved.	Yes	Yes	• LCU and HAS report cases into GMU complaints database. Cases are followed up and outcomes recorded in database. GMU site visits and overseas posts also investigate incidence of substitution or suspected fraud.
There is a system for reporting of problems and detecting non-compliance.	Yes	Yes	• GMU maintains central database for complaints relating to panel doctors and their processing of applications. • Non-compliance cases reported by HAS and GMU audits are recorded, and follow up is monitored.
There are set performance targets and indicators and progress against service standards is monitored.	Yes	Yes	• Some processing service standards and targets were set and monitored through Statements of Work (SOWs). However, were discontinued in late 2005 and DIAC has yet to introduced a replacement system. • Applications are for the most part processed within service standards. Both areas report monthly to management against service standards.
Quality Assurance (QA) process in place to check consistency and integrity of decisions.	Yes	Partial	• Some processes are in place. However, in HAS these need further development to ensure a more transparent and structured approach, inclusive of regular independent auditing of MOC opinions for consistency and compliance with regulations and policy.

Source: ANAO analysis.

Local clearance in gazetted and non-gazetted countries

4.41 The Regulations indicate that a visa application requires a MOC opinion unless:

- **the application is for a temporary visa** and there is no information to suggest that the applicant will not meet the health requirement; or

- **the application is for a permanent visa made from a gazetted country** and there is no information to suggest that the applicant will not meet the health requirement.[115]

4.42 DIAC's list of gazetted countries is found in the *Specifications of countries for purposes of regulation 2.25A* (required under Regulation 2.25A). DIAC advised that gazetted countries were:

> 'intended to represent countries where standards of medical practice—that is, in the context of tuberculosis, the ability accurately to report chest x-ray films—are equivalent to those in Australia….'[116]

4.43 DIAC advised that the list was reviewed every two years. However, evidence indicated that DIAC had not reviewed or updated its *Specifications of countries for purposes of regulation 2.25A* since 2000. Based on its list of gazetted countries, DIAC produces a *List of Locally Clearable Countries*[117] which specifies those countries that DIAC allows to locally clear health assessments for permanent and/or temporary visa applicants. The ANAO found that:

- countries on the gazetted list did not match those on the local clearance list specified to clear permanent visas (as they should have);
- there was no documentation to explain how DIAC had arrived at the list of gazetted countries in 2000. DIAC had not defined criteria for assessing countries, and had no record of the decision process which led to the existing list; and
- some non-gazetted countries, but not others, were given local clearance capability for temporary visas. The ANAO found there was no methodology, risk analysis, or other record of the basis of these decisions.

4.44 Overall, DIAC's guidelines on local clearance by gazetted countries were confusing and, therefore, could be open to interpretation and application.

4.45 There was also some confusion (lack of clarity) in the PAM3 concerning clearance of 'B' cases. To minimise risk of incorrect processing and referral to MOCs, ANAO suggests that DIAC:

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[115] *Regulation 2.25A(1) Referral to Medical Officers of the Commonwealth;* and PAM3, July 2006, sections 98 to 101.

[116] Internal DIAC report, *Review of health screening procedures with regard to tuberculosis,* 1998. The report also states: 'This list is not meant to relate to the incidence tuberculosis in those countries….'

[117] List of Locally Clearable Countries *s8.8 Local Clearance Unit Procedures Manual*, May 2006.

- amend the PAM3 to more clearly explain the circumstances where a 'B' case can be cleared locally, and whether this clearance capacity applies to both gazetted posts and LCU; and
- ensure that newly appointed clearance officers undergo sufficient training. Clearing of 'B' cases can be quite complicated, and places considerable responsibility on clearance officers, who are not medically trained. This is a risk area for DIAC.

Front end loading

4.46 DIAC form 1071i (information for permanent entry) states that:

> If you are overseas–do not complete your health examination before you lodge your visa application. The department will provide applicants with details of the medical examination required for your circumstances.

4.47 DIAC did not implement this policy universally, accepting front end loaded applications for processing in many instances.[118] However, DIAC had not developed consistent procedures or guidelines to manage front end loaded cases. Furthermore, the impact of front end loading on DIAC's business efficiency was generally not known. In particular, the ANAO found that DIAC could not confirm:

- the number of front end loaded cases, because it did not monitor them;
- what impact on processing efficiency and costs (such as additional workload for HAS and LCU) front end loading had, or the benefits that it may be delivering;
- the effect of front end loaded cases on the integrity of DIAC's data;
- the risks front end loading posed for identity verification, or possible fraud, as medical assessments are done in the absence of an official application; and
- the legal implications for DIAC in tracking these applicants and inclusion of failed medicals in DIAC's Movements Alert List (MAL), or of managing health data for these individuals in the absence of a visa application.

[118] Front end loading is where a person seeking entry to Australia submits medical results before their visa application. If the person fails to meet the health requirement, they would likely choose not to submit a visa application, and thereby avoid paying the (sometimes large) visa charge.

4.48 ANAO recommends that DIAC evaluate its practices with a view to developing appropriate processes and policies to manage front end loading effectively.

Recommendation No.4

4.49 ANAO recommends that DIAC improve its risk management of health assessments by:

- documenting the procedure for categorising countries' risks (low to very high) for the temporary health risk matrix, giving clear indication of the basis on which the risk categories are decided, and a process for regularly reviewing them;
- regularly updating the gazetted list, *Specifications for countries for the purposes of regulation 2.25A;*
- defining the methodology and reasons for selecting countries for the gazetted list, and the basis for allocating authority for local clearance of health assessments to gazetted and non-gazetted countries; and
- evaluating its process for assessing medical reports submitted by visa applicants prior to their visa applications (front end loaded applications) with a view to developing standard procedures and guidelines to manage and monitor this process effectively.

DIAC's response

ANAO recommends that DIAC improve its risk management of health assessments by:

- *documenting the procedure for categorising countries' risks (low to very high) for the temporary health risk matrix, giving clear indication of the basis on which the risk categories are decided, and a process for regularly reviewing them;*

4.50 Agreed. The current basis for the determination of countries' risks for intending temporary residents is established on the basis of the latest tuberculosis rates reported by countries to WHO, the latest TB rates reported by the National Tuberculosis Advisory Committee and other information on tuberculosis contradictory to the rates reported to WHO.

4.51 DIAC has recently commenced a review of the 1163i health risk matrix. The review will explore the potential to take account of a range of variables other than tuberculosis in order to more fully inform and simplify the risk-assessment matrix. Such identified indicators may include: use of resources in

Australia by other than permanent residents; HIV rates for countries estimated by WHO; and, patterns by country of conditions noted by the Health Assessment Service in persons found not to meet the health requirement, broken down by country and medical condition.

4.52 As the review progresses DIAC will engage representatives from the Communicable Diseases Network of Australia, the National Tuberculosis Advisory Committee and other health stakeholders. This group will oversee the development of a documented health matrix rationale and criteria, as well as implementing an agreed review timetable.

- *regularly updating the gazetted list, Specifications for countries for the purposes of regulation 2.25A;*
- *defining the methodology and reasons for selecting countries for the gazetted list, and the basis for allocating authority for local clearance of health assessments to gazetted and non-gazetted countries; and*

4.53 Agreed. DIAC has commenced a review of the list of gazetted countries for the purposes of regulation 2.25A. The review aims to develop appropriate criteria and procedures for inclusion and review of countries on the gazetted list. The same process will also establish a consistent methodology for the allocation of local clearance to gazetted and non-gazetted countries.

- *evaluating its process for assessing medical reports submitted by visa applicants prior to their visa applications (front end loaded applications) with a view to developing standard procedures and guidelines to manage and monitor this process effectively.*

4.54 Agreed. DIAC has commenced a review into pre-visa application health assessments. In summary, DIAC is considering the administrative, procedural and legal complexities posed by medical reports that are not linked to a visa application. The review will also consider the practice in terms of providing a fair and reasonable service to clients.

4.55 Once the review is completed, the Procedures Advice Manual will be updated to reflect policy as it relates to pre-visa application health assessments. The Health Services Project will investigate whether a systems solution can address the administrative and procedural issues.

5. Health Waivers

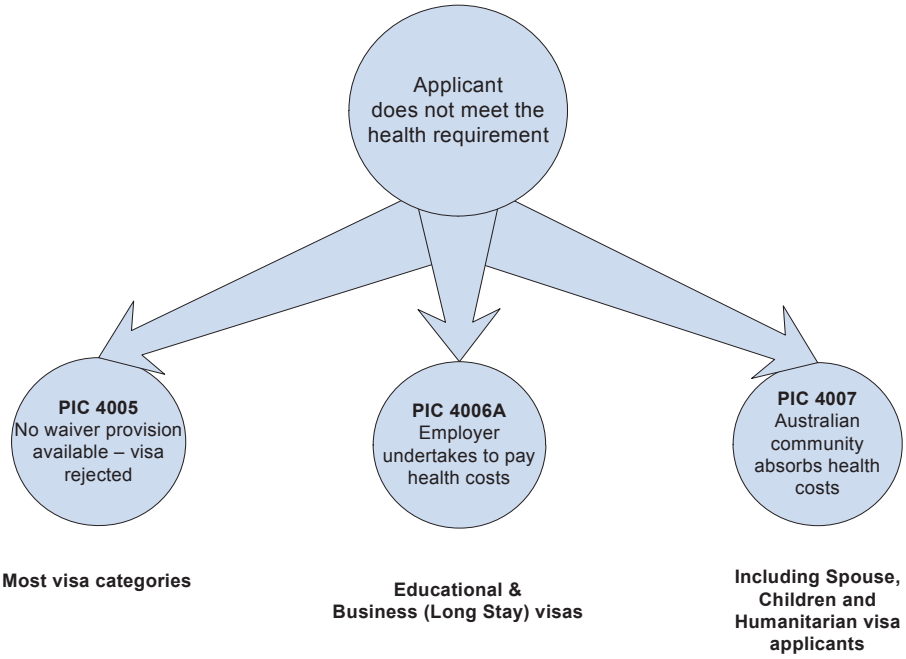
This chapter examines whether DIAC is effectively administering Public Interest Criteria (PIC) 4006A and 4007 health waivers.

Background

5.1 Most visa applicants are assessed against the health requirement, Schedule 4 Public Interest Criteria (PIC) 4005. Failure to meet this results in refusal of the visa application. However, for some visa subclasses, applicants may be eligible for a health waiver under PIC 4006A or 4007(1)(c) (see Figure 5.1 and Appendix 5). These provisions allow DIAC to grant a visa where it considers that the applicant can offer an economic benefit, is subject to humanitarian considerations, or has very close family relationships in Australia.

Figure 5.1

Regulatory provisions for waiving the health requirement



Source: ANAO, compiled from DIAC PAM3, Schedule 4 Public Interest Criteria (PIC) 4005–4007, sections 66–73 and 88–96.

5.2 DIAC's Procedures Advice Manual (PAM3) outlines DIAC's policy and procedures for administering health waivers. Against these, the ANAO assessed DIAC's ability to: ensure waiver decisions are consistent and in line with DIAC procedures; and accurately monitor and report on the outcome of health waiver decisions.

5.3 ANAO's assessment also included following up a previous ANAO recommendation on health waivers (see paragraph 5.15).

Waiving the health requirement

5.4 Under DIAC's policy, DIAC must consider waiving the health requirement for all cases where the health waiver option is available 'even though the power to exercise the health waiver is not compellable'.[119] Consideration is on a case by case basis and takes into account undue cost or undue prejudice to the access of Australians to medical and support services should a visa be granted. Notwithstanding this, the health requirement cannot be waived if the applicant fails to satisfy the legislative provisions relating to tuberculosis (TB), public health or health undertakings.[120]

The health waiver process

5.5 Figure 5.2 shows the decision process for health waivers 4006A and 4007. Important steps in this process include the assessment of the visa application by a Medical Officer of the Commonwealth (MOC), determination of the health waiver cost by the MOC,[121] and provision of the MOC opinion to the DIAC case officer.

5.6 Responsibility for assessing and making a decision on health waiver applications lies with DIAC case officers (onshore and offshore). DIAC's PAM3 specifies the factors that case officers must consider when making their decision. DIAC advised that in 2004 it delegated the granting of health waivers to authorised DIAC overseas post officials. DIAC had been operating on this basis since that time. However, DIAC had no record of Ministerial approval for the transfer of delegations to the overseas posts, and[122] should take steps to affirm compliance with the *Migration Act 1958* (the Act).

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[119] DIAC PAM3, July 2006, sections 67.1 and 89.1.

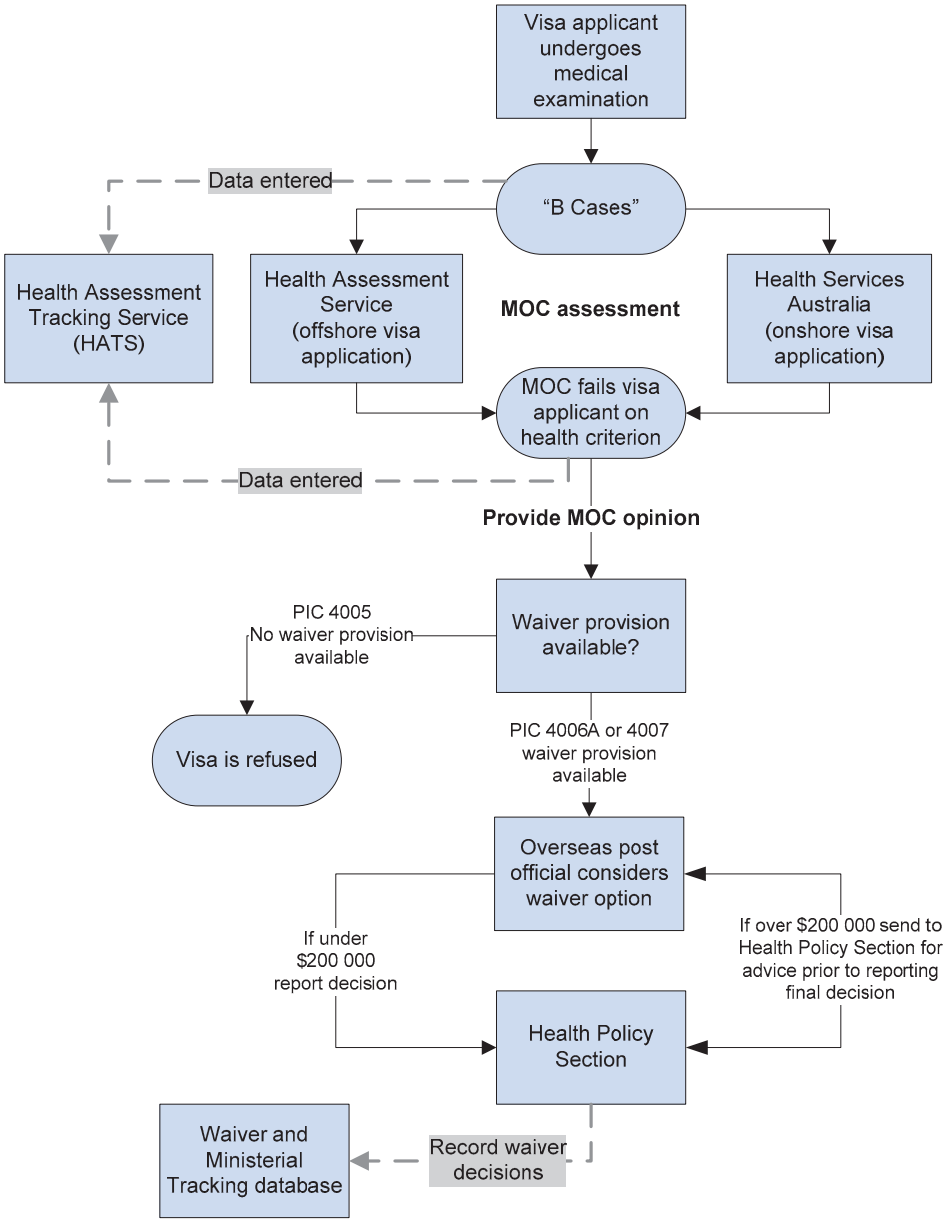
[120] DIAC PAM3, July 2006, sections 66.5 and 88.1.

[121] The MOC's costing of health and welfare costs of different medical conditions is discussed in Chapter 3.

[122] Draft Minute to Minister for Immigration and Multicultural and Indigenous Affairs, *Administration - Health Waivers*, 4 February 2004. DIAC could not locate the final approved Minute authorising this delegation.

Figure 5.2

Key steps in processing health waivers



Source: ANAO, compiled from DIAC PAM3 July 2006, and other DIAC documents and interviews.

5.7 DIAC's PAM3 states that all waiver decisions must be reported to DIAC's Health Policy Section. Reports should include MOC decisions and, where applicable, employer undertakings. This provides DIAC with a mechanism to monitor the number and consistency of waiver decisions. As an

additional process check, in cases where the MOC has determined costs greater than $200 000 or significant prejudice to access is indicated, the DIAC delegate with the authority to approve waivers must refer the case to DIAC's Health Policy Section for advice before a final decision is made.[123]

5.8 The ANAO examined a sample of health waiver decisions, and found that a significant proportion of records were incomplete; 22 per cent of cases did not include a MOC opinion and 65 per cent showed no employer undertakings.[124] DIAC's electronic records for health waiver decisions were also incomplete, with applicants' records fragmented between two databases, the Health Assessment Tracking System (HATS) and the Waiver and Ministerial Tracking database.

5.9 HATS automatically recorded if an applicant was eligible for a health waiver, but it contained no record of whether the waiver option was considered or the decision outcome. DIAC recorded waiver decisions in its Waiver and Ministerial Tracking database when they were reported to DIAC's Health Policy Section. However, discrepancies in figures between DIAC's two databases indicated that more than two thirds of waiver decisions were not reported, contrary to DIAC's health waiver policy (see Table 5.1).

Table 5.1

Applications for health waivers

	2000–01	2001–02	2002–03	2003–04	2004–05
HATS *Number of applicants eligible for health waivers*	348	371	465	542	536
Waiver and Ministerial Tracking database *Records waiver decisions*	124	111	152	159	156
Per cent difference	**64**	**70**	**67**	**71**	**71**

Source: Ministerial and Health Waiver Tracking database and the Health Assessment Tracking Service

Notes: HATS (Health Assessment Tracking System database).

Data from the Ministerial and Health Waiver Tracking database are from ANAO analysis of DIAC data. The HATS data were provided by DIAC. The per cent difference is rounded to the nearest whole percent.

[123] DIAC PAM3 s.67.

[124] DIAC's PAM3 provides proforma Minutes for PIC 4006A and PIC 4007 health waivers. These specify the information required from overseas posts when referring and reporting health waivers to the Health Policy Section. The PIC 4006A and 4007 Minutes require inclusion of the MOC opinion. PIC 4006A waiver Minutes should also include an Employer Undertaking. ANAO examined 48 cases (where records were held by DIAC's Health Policy Section) for compliance with the PAM3 specifications.

5.10 Given the limitations of DIAC's health waiver process and tracking of decisions, it was difficult for DIAC to determine an accurate history of visa applicants' health waivers. Also, because DIAC could not account for all health waiver decisions, it was unable to demonstrate that the health waiver had been considered for all waiver-eligible visa applicants, or substantiate that health waivers were applied consistently and in line with its policies and procedures.

Waivers involving employer undertakings

5.11 PIC 4006A waivers apply to Educational (418) and Business (Long Stay) (457) temporary work visas. For these waivers, the intended Australian employer must give DIAC a written undertaking to meet all the health costs defined in the MOC opinion.[125] Waiver decision reports must include the MOC opinion and the employer undertaking.

5.12 The ANAO examination of health waiver decisions indicated that this was not occurring, as the employer undertaking reports were absent in 65 per cent of the PIC 4006A health waiver reports examined. DIAC confirmed that compliance of overseas posts in reporting waiver decisions was low. DIAC also confirmed that it had no mechanism in place to follow-up employer undertakings. Overall, this meant:

- that waiver decisions lacked the level of scrutiny set by DIAC;
- DIAC could provide little assurance that the PIC 4006A waivers were applied consistently or according to DIAC procedures; and
- DIAC was not in a position to determine compliance rates or the broader impact of non-compliance on health services and costs.

Improving tracking of waiver decisions

5.13 ANAO noted that DIAC had recently introduced mandatory fields in its Immigration Records Information System (IRIS)[126] to facilitate better reporting of health waivers by overseas posts. However, to ensure that waiver processes meet the intent of the PIC and DIAC procedures, it will be necessary for DIAC to establish more rigorous quality controls to monitor compliance of

[125] PIC 4006A waivers apply to the Educational (418) and Business (Long Stay) (457) temporary work visas. These allow visa applicants to approach their intended Australian employer to cover the health costs for the condition that caused their failure to meet the health requirement. The intended employer needs to meet all costs for the disease or condition that resulted in the visa applicant failing the health requirement.

[126] Chapter 7 includes information about DIAC's IRIS system.

overseas posts with DIAC's waiver process, and to consolidate information on health waivers to ensure that waiver decisions are transparent and accountable, and applicant histories complete.

Monitoring and reporting of health waiver outcomes

5.14 Waiving the health requirement not only results in the Australian community absorbing any health and welfare costs of the visa applicant, but may increase demand for health and community services which are in short supply.

5.15 In 2003, the ANAO audit report, *Management of Selected Aspects of the Family Migration Program*, identified deficiencies in health waiver data held by DIAC. The ANAO suggested that DIAC put in place procedures to ensure accurate collection of data on health waivers so that DIAC could determine:

- the total number of waivers granted;
- the health conditions of the visa applications to whom waivers were granted; and
- the overall cost to government and the community of waiving the health requirement.

5.16 The current audit found little improvement in DIAC's data sets. As demonstrated in Table 5.1, DIAC could not confirm the number of health waivers granted. Due to incomplete records, data on health conditions for waivers was also unreliable. Furthermore, there was evidence that DIAC had underestimated the annual cost in exercising health waivers, because of the low compliance in reporting of health waiver decisions. For example, allowing for under reporting, the ANAO estimates that the annual cost of exercising the health waiver could be $92 million.[127] This is almost 3 times the health waiver costs reported by DIAC to DoHA for 2003–04 and 2004–05.

5.17 Without complete and accurate information on health waiver outcomes, DIAC and other government agencies are unable to monitor and manage the impact of health waiver decisions.

[127] This figure is the ANAO's estimate calculated by multiplying the percentage approved of waiver decisions from the Waiver and Ministerial Tracking database by the HATS estimate for total cost of health waivers in 2004–05.

Recommendation No.5

5.18 To encourage consistency in health waiver decisions and enable accurate reporting of health waiver outcomes, the ANAO recommends that DIAC:

- in line with the department's requirements, ensure that all health waiver decisions are sent to a designated coordination point, such as the Health Policy Section, for review and recording; and
- ensure that sufficient data is collected to enable accurate monitoring and reporting of the outcome of health waiver decisions, including potential costs to the Government.

DIAC's response

5.19 Agreed. The requirement to report health waiver outcomes to Health Policy Section is included in the Procedures Advice Manual as current DIAC policy. However DIAC systems do not support this reporting requirement and it is currently the responsibility of each case officer to manually report on waiver decisions.

5.20 DIAC has recognised its restricted ability to report on the impact of health waivers on the Australian community in terms of health and welfare costs and the demand for services in short supply. Health waiver monitoring and reporting forms part of the scope of the Health Services Project. The project is expected to deliver centralisation of unstructured health records within DIAC's corporate records management system and this will facilitate more effective reporting on the impact of health waivers on the Australian health community.

6. Health Undertakings

This chapter examines DIAC's administrative arrangements for health undertakings.

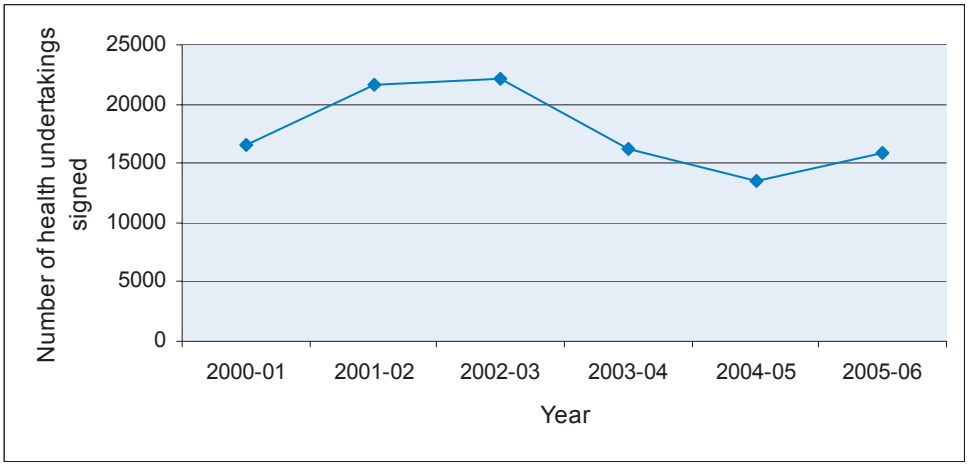
Introduction

6.1 Under the *Migration Regulations 1994* (Regulations) Public Interest Criteria (PIC), a Medical Officer of the Commonwealth (MOC) can request a visa applicant to sign a health undertaking as a prerequisite to satisfying the health requirement.[128] The visa holder, on their arrival in Australia, must then present themselves to the health authority in their intended State or Territory of residence for a follow-up medical assessment.

6.2 Figure 6.1 shows the number of health undertakings signed by visa applicants between 2000–01 and 2005–06.

Figure 6.1

Number of health undertakings signed 2001–02 to 2005–06



Source: DIAC's Health Assessment Tracking System (HATS).

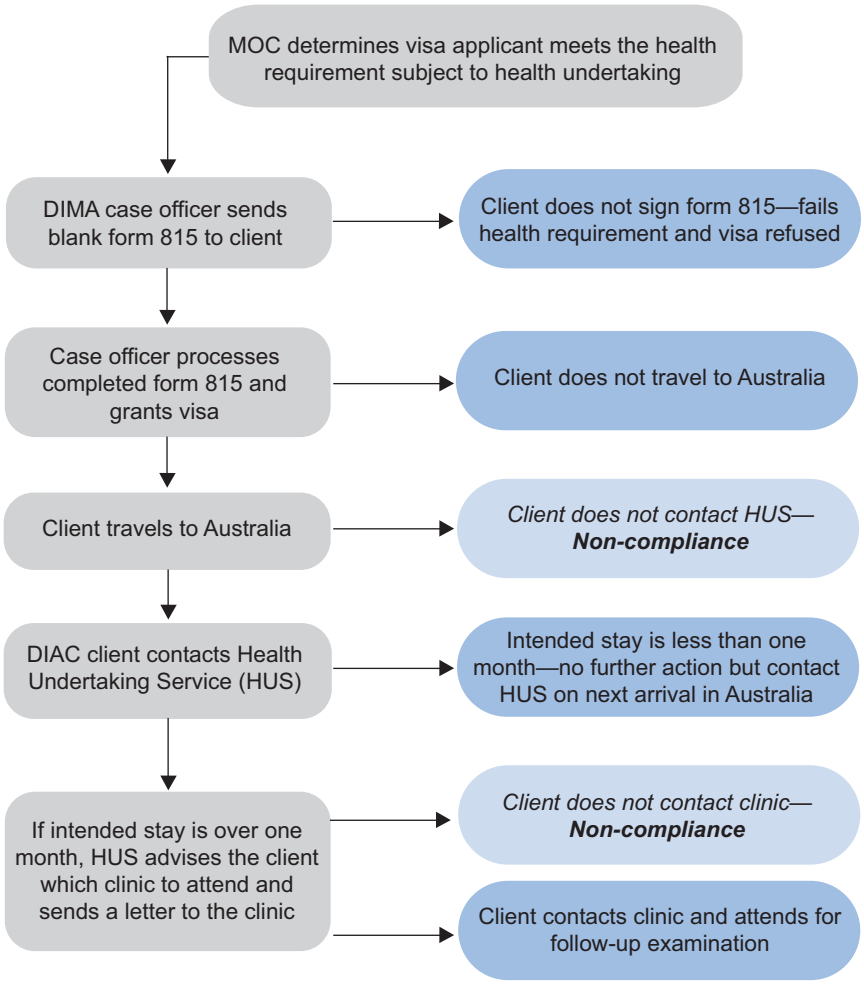
6.3 DIAC's health undertaking process is outlined in Figure 6.2. The ANAO examined:

- whether DIAC's use of health undertakings was consistent with the PIC and DIAC's guidelines; and
- DIAC's capacity to monitor health undertakings.

[128] *Migration Regulations 1994*, Schedule 4, Public Interest Criteria (PIC) 4005(d); 4006A(1)(d); and 4007(1)(d). Also, DIAC *Procedures Advice Manual (PAM3)*, 1 July 2006, pp. 126–129.

Figure 6.2

DIAC's health undertaking process



Source: ANAO, compiled from DIAC, PAM3, July 2006, sections 115–118, other DIAC documents and interviews.

Note: This figure shows the offshore process for health undertakings. The process is similar for onshore cases, except that onshore clients do not have to contact the Health Undertaking Service (HUS); Health Services Australia arranges the appointment with the State or Territory clinic.

DIAC's use of health undertakings

6.4 A visa applicant may be required to sign a health undertaking if they have a disease or condition that the MOC determines to warrant a health undertaking.[129] In particular, health undertakings are used if an applicant:

- has a history of treatment for diagnosed or suspected tuberculosis (TB) (or other chest condition) but is now inactive or disease-free; or
- is pregnant and has not had the chest x-ray examination that is part of the standard health examination[130].

6.5 DIAC's procedures states that health undertakings are not issued if the status of TB or other diseases is unknown, nor to facilitate treatment in Australia.[131] Table 6.1 shows the number of health undertakings signed for 2004–05. Over 90 per cent were attributed to TB.

Table 6.1

Health undertakings signed by disease type

YEAR	Tuberculosis	Hepatitis C	Hepatitis B	Leprosy	TB and Hepatitis B	Other	Total
2000–01	16018	0	337	0	65	75	16495
2001–02	21250	0	292	0	52	39	21633
2002–03	21613	17	404	3	85	17	22139
2003–04	15342	59	690	0	63	3	16157
2004–05	12521	111	786	3	86	9	13516
2005–06	14724	137	925	3	98	25	15912

Source: DIAC data from the Health Assessment Tracking System (HATS).

Other diseases/conditions

6.6 DIAC's PAM3, states 'in a few instances, health undertakings are used for diseases/conditions other than TB (for example, hepatitis B)'. DIAC's data confirms this, with less than 10 per cent of total health undertakings issued for hepatitis B or C, Leprosy and 'other' conditions (see Table 6.2).

6.7 Even though the number is relatively small, DIAC's guidelines provided little information on the use of health undertakings other than for TB and pregnancy.[132] The ANAO found that DIAC had not specified:

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[129] DIAC, PAM3, July 2006, s115.1–115.2

[130] PAM3 states that this is not normally extended to persons from high risk countries.

[131] DIAC, PAM3, July 2006, s115.1

[132] Note that use of health undertakings for pregnancy was not indicated in the data provided by DIAC (Table 6.1).

- agreed 'other diseases or conditions' for which health undertakings should or should not be used; and
- whether the health undertaking should be applied to every case of these diseases/conditions, or in specific circumstances.

6.8 The lack of clarity in DIAC's PAM3 and few guidelines to inform DIAC in its use of health undertakings, increases DIAC's risk of issuing health undertakings inconsistently or having its decisions challenged.

6.9 The ANAO suggests that DIAC ensure its guidelines on health undertakings contain explicit explanation of the diseases and circumstances where health requirements should or should not be used.[133] This will assist the MOCs in making consistent decisions, and ensure that health undertakings are appropriately used (refer to Recommendation 6, paragraph 6.21).

Monitoring compliance

6.10 ANAO assessed DIAC's health undertaking process, particularly DIAC's ability to monitor compliance with signed health undertakings. A summary of ANAO's analysis is shown in Table 6.2. Detailed comments follow the table.

[133] This is also important for maintaining business continuity, given DIAC's recent turnover of key staff.

Table 6.2

ANAO's analysis of DIAC's health undertaking process.[134]

DIAC's process	ANAO comments/findings
When a person signs a health undertaking, but has not yet entered Australia, they agree to:	
• contact DIAC's Health Undertaking Service (HUS) within a specified time of arriving in Australia;	DIAC sends out standard letters explaining the conditions and details of the health undertaking.
• contact, within the required time limit, the State or Territory health authority; and	DIAC has specified times for a health undertaking recipient to contact the HUS: either one or four weeks set by the MOC at the time of the health assessment.
• place themselves under the supervision of that State or Territory health authority.	DIAC maintains location and contact details for clinics in each State and Territory, to inform clients.
Once the health undertaking recipient (the client) is onshore, DIAC's HUS:	
• registers that the client has contacted the HUS;	DIAC (HUS) maintains data on referral of client to State and Territory clinics.
• advises the client which State or Territory clinic to attend; and	Information will vary for different States and Territories, according to the way that their clinics operate.
• assists in the monitoring of compliance with health undertakings.[135]	DIAC collects data on compliance, although this becomes incomplete and unreliable once the client has registered with HUS and is referred to a clinic.
Follow-up examinations are provided by the States and Territories.	
• all cases are to be followed up; and	DIAC relies on States and Territories to provide services. DIAC advised that clinic waiting lists were often long. Therefore most urgent cases are often seen first. Less urgent cases may leave the country before appointment time. DIAC cannot confirm that all cases that receive or do not receive follow-up assessments.
• examinations are free, as indicated on form 815 *Health Undertaking*.	There was evidence that some clients did not receive free treatment, for example, in regional Australia. This could have implications for compliance rates (see paragraph 6.11).

Access to free medical treatment

6.11 To encourage compliance for health undertakings, DIAC advises clients that they have access to free medical treatment:

> The Australian Government provides free health checks to minimise the risk of spread of tuberculosis and hepatitis B to close family, friends and the

[134] Process shown is for offshore visa applicants. DIAC, PAM3, July 2006, p. 126.

[135] DIAC, Health Undertaking Service – Functions and Procedures Manual.

community. If the doctor thinks it necessary, treatment for tuberculosis or vaccination for hepatitis will be arranged.[136]

6.12 The HUS functions and procedures manual also states that, 'the follow-up is free'. However, a DIAC review of the health undertaking process underway during the audit commented:[137]

> Clinics are not located in regional areas. Because of this clients in regional areas are referred to local clinics whereby they may be expected to pay. This may discourage clients to attend follow up examinations, especially refugees who are in rural areas and will have difficulty meeting the cost.

6.13 Providing accurate information to clients about the availability of follow-up assessments and any associated costs, may improve compliance with health undertakings.

Relationship with the State and Territory health authorities

6.14 Health undertakings are largely administered by the State and Territory health authorities. Therefore, it is important that DIAC has formal protocols with these health authorities, including for monitoring and compliance purposes.

6.15 DIAC has some informal arrangement with States and Territories, but these did not provide comprehensive data on compliance with health undertakings or outcomes. DIAC has no formal or standard agreements with the States and Territories for health undertakings, although this need was highlighted in DIAC's Health Policy Section 2006–07 draft risk management plan:

> Develop and maintain formal protocols with State and Territory health bodies for chest x-rays and health undertakings.

6.16 DIAC advised that this initiative was scheduled to be implemented, subject to availability of resources, by late 2006. However, the development of formal protocols had not commenced by January 2007.

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[136] DIAC, Form 815 *Health Undertaking 2006*.

[137] DIAC emails May and August 2006.

Non-compliance data

6.17 The ANAO found that DIAC did not collect sufficient or reliable information to measure non-compliance with health undertakings. This is demonstrated in the following comparison of data from DIAC's Health Assessment Tracking System (HATS) and a DIAC internal audit report (see Table 6.3).

Table 6.3

Compliance with health undertakings 2002–03

	Number of people non-compliant	Percentage non-compliant
HATS data	604	0.03
Internal audit report data	5535	25

Source: DIAC, 2002: HATS data provided to ANAO in July 2006; and data from DIAC's internal audit report September 2002.

6.18 DIAC reported that it had difficulty calculating compliance with health undertakings for the following reasons:

- DIAC considers that after the health undertakings service has referred a health undertaking recipient to a State or Territory health authority, the health undertaking recipient is no longer its responsibility;
- DIAC receives irregular feedback from State or Territory health authorities on compliance with health undertakings; and
- after two years, if the client has not contacted DIAC's HUS, their status in HATS is changed to 'no further action'. However, visa holders who have complied with their health undertaking also have a 'no further action' status. Therefore, visa holders who did not comply with their health undertaking cannot be identified.[138]

6.19 The ANAO noted that DIAC's 2002 internal audit report recommended that HATS be modified to allow collection and reporting of data on compliance with health undertakings. However, no action was taken, and HATS is still unable to provide accurate compliance reports.

6.20 DIAC advised the ANAO that visa holders who are non-compliant with their health undertakings, do not have their visa cancelled. Furthermore,

[138] Meeting with Health Assessment Service, July 2006.

no entry on the Movement Alert List (MAL) is made for future reference.[139] The ANAO recommends that DIAC examine these practices and assess their potential risks, with a view to improving monitoring and follow-up of non-compliance.

Recommendation No.6

6.21 To ensure the effectiveness of health undertakings, ANAO recommends that DIAC:

- develop guidelines on health undertakings, to provide the basis for more transparent and consistent decisions; and
- consult with the States and Territories with a view to establishing arrangements to assist DIAC in monitoring and reporting of compliance for health undertakings.

DIAC's response

6.22 Agreed. DIAC has commenced a review of its administrative and systems-based procedures for Health Undertakings. Health Undertakings play an important role in facilitating the entry of visa applicants with identified health concerns, particularly tuberculosis. Without the option of a health undertaking a significant number of visa applicants would not meet the health requirement and would be denied entry into Australia.

6.23 One aspect of the review will focus on the Department's ability to build on existing relationships with State/Territory health authorities with a view to establishing and formalising arrangements to practically monitor compliance with Health Undertakings.

[139] The Movement Alert List (MAL) is a database that records people whose presence in Australia may constitute a risk to the Australian community and people who may not enter Australia as they are subject to exclusion periods prescribed by migration legislation, including health concerns. <http://www.immi.gov.au/media/fact-sheets/77mal.htm>. DIAC's health requirement processes require that a visa applicant is included on MAL if the visa applicant fails the health requirement. PAM3 s112.

7. Information Technology Systems

This chapter examines DIAC's Information Technology (IT) systems support for health assessment processing and decision making.

IT systems supporting the health requirement

7.1 Currently, DIAC's IT support for the health requirement consists of several, unintegrated IT systems that have been developed to meet DIAC's business needs over the last 15 years. These systems are dissimilar in design and function, and limited DIAC's capacity to manage data for tracking clients, process visa applications efficiently, and generate reports for performance purposes.

7.2 DIAC was aware of limitations in its IT systems. Under new *Systems for People* initiatives, DIAC is working towards major IT reform, which may see changes to the agency's IT environment (discussed later). DIAC advised the ANAO that these changes aim to consolidate DIAC's IT into a more central system with several entry portals,[140] and thereby, over time, improve client data management, data storage and retrieval, search capacity and performance reporting.[141]

7.3 The ANAO examined whether the current IT systems supported DIAC in processing applications efficiently and correctly (according to DIAC's guidelines and policies). The ANAO also considered whether DIAC was successfully meeting its objective and managing the identified risk:

Objective: DIAC systems to support health assessment processing allow seamless and effective decision making
Risk: Ineffective and inefficient infrastructure, particularly IT systems

Source: Extract from DIAC's Health Policy and Processing Risk Management Plan 2006–07 (draft).

7.4 ANAO's assessment focused on DIAC's main systems for managing health assessment (shown in Figure 7.1). These are:

- **ICSE:** Integrated Client Services Environment;
- **IRIS:** Immigration Records Information System;
- **ELMA:** Electronic Medical Assessments;

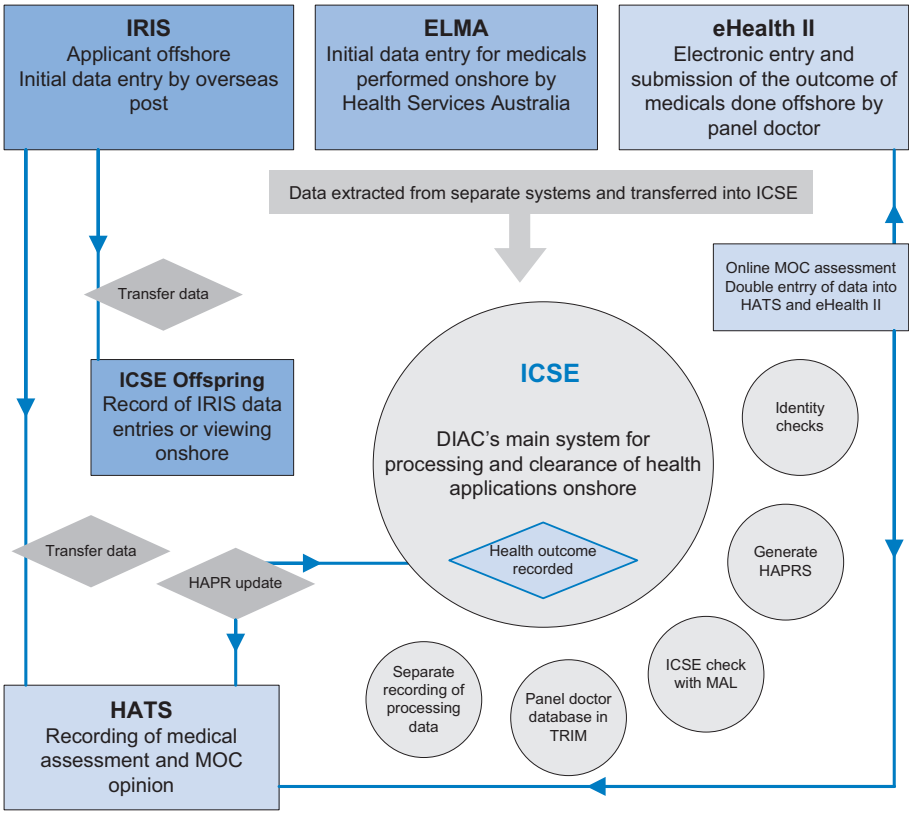
[140] DIAC advised that there would be a health portal, although this was not included in original IT plans.

[141] ANAO meetings with DIAC officials and DIAC documents.

- **HATS:** Health Assessment Tracking System; and
- **eHealth II:** DIAC's system for electronic submission and processing of medical reports.

Figure 7.1

DIAC's main IT systems supporting health assessment processing



Source: ANAO, compiled from DIAC documentation and interviews.

Tracking and recording health assessments

7.5 DIAC's case officers receive health applications as hard-copy information and/or as electronic files[142] for each applicant. However, regardless of its form, at several steps in the process, an applicant's information and finally the outcome of the health assessment is recorded into one or more of DIAC's health databases/systems (Figure 7.1).

[142] These are usually ELMA (for Health Services Australia medical assessments); ICSE offspring (from offshore IRIS records); HATS (cases seen by MOCs in DIAC's Health Assessment Service (HAS)).

7.6 The ANAO's analysis of the IT systems and health assessment processing is summarised in Table 7.1.

Table 7.1

IT support for the health requirement—summary of general findings[143]

ANAO criteria	Criteria met	ANAO comment/finding
DIAC schedules training, and has training documentation available	Largely met	In DIAC's Local Clearance Unit (LCU), training is scheduled and there is a Procedures Manual and training materials. Regular staff meetings enable discussion of processing and IT issues. However, there were instances where availability of documentation on system changes was not timely.
Prompt and efficient access to client records	Partially met	Variable. Case officers work in ICSE while MOCs put medical results into HATS. Multiple systems complicate access to records, and increase risk of unreliable data. DIAC officers access up to eight systems, and in some instances in excess of 100 different screens, for the purpose of checking identity, entering health information, and referring an application to a MOC.
Client records are complete	Partially met	Front end loaded cases (see paragraph 4.46) and failed transfer of data between systems can lead to missing records and mismatched records in ICSE or HATS. Duplicate and multiple records also increase the risk of overlooking information.
Reliable transfer of data between systems	Partially met	Variable. Errors in transferring of data often occur, and are problematic because they may take several days or longer to resolve, and can cause processing delays.
Systems are reliable	Partially met	Variable. Down-time is frequently encountered, which affects availability of ICSE, HATS and eHealth II. There were some instances where processing of hundreds of applications was delayed due to system failures.
Problem/fault logs are available	Not met	DIAC advised that there were no logs for error or fault reporting, including for ICSE and HATS (the main systems for medical data and health assessment records).
System down-time monitored and impacts on productivity considered	Not met	LCU logged down-time to determine its loss of productivity. However, generally DIAC did not monitor down-time and there was no formal mechanism for determining its impact on business efficiency.
Timely response to system faults or problems	Partially met	Response times varied. DIAC did not set response times or targets, or report the effect of down-time on business continuity, costs, or risk.
Prioritises problems	Partially met	Some problems were given high priority. However, a systematic or risk-based approach to prioritising tasks was not in place.
Maintains business continuity	Partially met	There was no business continuity plan for health assessment. ANAO observed down-time in LCU which resulted in near closure of processing. LCU data indicated significant loss of productivity and disruption to business continuity.

Source: ANAO, compiled from DIAC documents and interviews.

[143] ANAO's assessment included: observing use of IT systems for processing visa applications; examination of IT documentation; meetings and discussions with IT staff, management and system users; emails and file evidence. Also see Table 7.2 for more detailed analysis of: ICSE, IRIS, HATS and ELMA.

7.7 The above analysis identified numerous limitations in existing systems, which led to inefficiency in DIAC's tracking of health assessments, incomplete applicant health data, and difficulties in data analysis for monitoring and performance purposes.

7.8 Over the last few years, DIAC has sought to develop ICSE as the main repository of client information. However, the limitations of system processes make it necessary for DIAC to rely on other systems such as ELMA, IRIS and HATS to: manage client health information; track key actions and decisions; and produce data for monitoring and performance purposes for the health requirement. The functionality and design differences between these systems have limited DIAC's capacity for system integration or consolidation of data. As a result there is no central repository of data for managing applicant's medical information, or for broader program monitoring and performance purposes.

7.9 Errors in data transfer between systems[144] frequently occur resulting in missing, duplicate or multiple records. Front end loaded applications (see paragraph 4.46) can also result in missing or mismatched records in ICSE and HATS. Compounding this, processing of applications involves double and multiple entry of data, and checks across several different systems.[145] [146]

7.10 Cumulatively, these limitations and weaknesses prevent DIAC from fully meeting its objective 'DIAC systems to support health assessment processing; allow seamless and effective decision making'.

Specific IT system findings

7.11 Table 7.2 provides ANAO's more detailed observations for four of the main systems used by DIAC to manage health assessments: ICSE, IRIS, ELMA and HATS. The ANAO's findings demonstrate the difficulties encountered with current systems limitations and weaknesses, and the impact these have on business continuity, processing efficiency, and DIAC's overall monitoring and reporting capacity.

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[144] For example, transfer of client information from one system into another is done mainly through daily data transfer in and out of DIAC's mainframe system.

[145] Internal DIAC data showed that processing of a Working Holiday Maker visa application can sometimes involve working across as many as 107 screens, with processing time of up to 25 minutes.

[146] DIAC, internal document June 2006, indicated that as many as '20 different systems or elements of systems supporting health processing'.

Table 7.2

ANAO findings for health processing in specific IT systems

System	ANAO comment
The Integrated Client Services Environment ICSE ICSE was commissioned in 1999 as DIAC's core onshore processing system. It is the main system used by DIAC case officers, LCU and Help Desk for recording health assessment outcomes.	• **Information on health outcome not complete:** ICSE is the main system for DIAC officers recording information on applicants. However, only the decision of the health assessment is recorded (meet or does not meet), not details of the medical results or details of the MOC opinion. • **Limited reporting capacity for health:** ICSE does not record when a visa rejection is due to a 'does not meet health requirement' or for some other reason. Therefore, DIAC cannot accurately report how many people are refused visas as a result of a failure to meet the health requirement. • **Duplicate records**: Created when health assessments loaded into ICSE do not match with existing client record in TRIPS or ICSE. Correcting records is very time consuming. DIAC was considering a project to investigate this issue.[147] • **Untimely system support:** For example, failed transfer of MOC decisions from HATS into ICSE, and slow response to rectifying the problem, has, on occasion, resulted in delayed processing of large numbers of applications. • **System down-time:** DIAC was not monitoring down-time and the affect this had on work output (for example loss of productivity in LCU) or operational performance targets. • **Front end loaded cases:** This leads to mismatching or duplicate records. DIAC could not determine how many applications were front end loaded, or the impact this had on processing load, efficiency or cost (see Chapter 4).
The Immigration Records Information System (IRIS) IRIS has been the overseas visa processing system used by overseas posts since 1989. There are 66 IRIS systems offshore (41 in DIAC managed posts and 25 in DFAT posts) and 7 onshore. Each night, DIAC's Remote Access File Transfer System (DRAFTS) connects to each IRIS post, and extracts IRIS data on visas granted, processed or amended for the day. DRAFTS transfers IRIS data to other DIAC systems, including TRIPS, ICSE Offspring, HATS, and DIAC's Data Warehouse.	• **Non-reporting of waivers not auditable:** DIAC could not determine from IRIS records the number of health waivers approved, or whether waivers were being correctly processed, by overseas posts. In November 2005, DIAC introduced additional fields into IRIS to enable capture of more information on health waivers. For example, a mandatory field for waiver cost was added. This should enable DIAC to monitor waivers better in the future. • DIAC overseas posts became responsible for health waiver approval in 2004. It was not until November 2005 that IRIS fields were updated to include the name of the delegate approving the waiver and date of approval. • **No unique identifier**: IRIS does not have a unique identifier for people, thus a person may have several records in IRIS. The country of birth also defaults to local country. These factors contribute to inaccurate, duplicate or multiple records.

[147] DIAC Draft Report, *One Person: One PID: A scoping study into the causes and solutions to multiple PIDS,* 9 August 2005.

System	ANAO comment
The Health Assessment Tracking System (HATS)	• **Incomplete health record:** Information entered into HATS is limited and does not constitute a 'complete' record of the applicant's health information. HATS is primarily for recording the result of the assessment—meets or does not meet the health requirement. For example, HATS does not record factors of significance or information to explain why DIAC requests particular test for an applicant. HATS records contain little information about the reasons behind MOC decisions. • **Limited reporting capacity:** Incompleteness of data makes monitoring of trends for planning, performance, and policy purposes difficult.
HATS was introduced in 2000, for use by the Health Assessment Service (HAS) and MOCs to record individual health assessments and MOC opinions. Medical Assessments have risen from around 70,000-80,000 per year in 1997 to around 130,000–140,000 in 2005.	
Electronic Medical Assessments (ELMA)	• **Transfer of data:** Transfer of data from ELMA into ICSE and other DIAC databases occurs throughout the day. ELMA transfers ensure that data held externally by HSA is transferred to, and managed by, DIAC. If this transfer fails, records will not appear in ICSE. Data mismatches can also cause duplicate or multiple records. • **No reconciliation:** There was no reconciliation of the data sent by HSA with that received by DIAC. Therefore, DIAC had no record of frequency of missed data events or the impact these had on business efficiency or data accuracy.
ELMA is the core case management tool for Health Services Australia (HSA). ELMA was established in 2002.	

Source: ANAO, compiled from DIAC documentation, emails, and interviews.

Capacity of IT systems to monitor performance

7.12 One of the limitations of DIAC's IT systems is the difficulty in extracting accurate data for monitoring outputs and performance.

7.13 Table 7.3 shows DIAC's estimated number of health assessments (cases) entered into the various databases used by overseas posts (IRIS), HSA (ELMA), onshore processing units including LCU (ICSE), and HAS (HATS). DIAC advised that it was not possible to determine the exact number of health assessments performed each year. This is largely due to unreliable ICSE data, and overlap of data between ELMA and ICSE. DIAC stated that estimating health assessments 'does take some time'. [148]

[148] Email and data provided by DIAC 9 June 2006.

Table 7.3

Health assessments, 2004–05

Health assessments	Data source	Number
Health examinations cleared directly by DIAC overseas posts (Offshore 'A' findings from 'gazetted' countries)	IRIS	94 387
Health examinations cleared by Health Services Australia (Onshore 'A' findings)	ELMA	95 928
Health examinations cleared by DIAC onshore processing units* [149] ('Locally clearable' results)	ICSE	53 456
Health examinations assessed by medical officers of the Commonwealth		
- Health Services Australia Commonwealth medical officers	HATS	25 569
- DIAC HAS Commonwealth medical officers	HATS	135 508
Total		**404 848**

Source: DIAC and ANAO, rough estimates.

7.14 Due to the lack of detail of data held within the various data systems, DIAC was unable to provide a breakdown of health assessments, for example, to show the number of x-rays, HIV or hepatitis B tests, or specialist examinations completed. This information would be useful for monitoring trends in testing between different countries, informing policies on future screening needs, and revising the health risk matrix for temporary visas.

Improving DIAC's IT capacity for the health requirement

7.15 DIAC was aware of the limitations of its IT systems and record keeping and, at the time of the audit, was planning significant IT reform to address this. The ANAO noted that DIAC's IT reform agenda was to a large degree prompted by previous government inquiries into the Cornelia Rau and Vivian Alvarez cases,[150] which led to recommendations for DIAC to improve its immigration processes, including IT systems.

7.16 DIAC was provided $458 million in 2006 to improve IT under the umbrella of *Systems for People*. The ANAO noted that the health requirement was not a prominent feature of DIAC's initial planning under this initiative. However, after the audit fieldwork, DIAC advised that it would adopt a staged approach to IT system development to improve support for the health

[149] LCU assessment worksheets and report for 2004–05. 20 137 cases were referred to HAS by LCU and should have been accounted for in the HATS MOC assessment report.

[150] Mick Palmer AO APM, *Inquiry into the Circumstances of the Immigration Detention of Cornelia Rau*, Commonwealth of Australia, 6 July 2005; and Commonwealth Ombudsman, *Inquiry into the Circumstances of the Vivian Alvarez Matter,* Commonwealth of Australlia, 26 September 2005.

requirement. DIAC subsequently provided the ANAO with a draft plan outlining its preliminary costings and priorities for redesign of IT systems for health processing. This specified funding of $2.16 million[151] to cover a first stage release and planning exercise for future system releases.

7.17 The ANAO acknowledges DIAC's progress in planning for systems reform, but emphasises that DIAC undertake comprehensive forward planning and stakeholder consultation to ensure that IT developments for the health requirement are well aligned with business needs. The ANAO notes that past IT developments for the health requirement had not always involved purposeful consultation with line managers and staff.[152] This had resulted in some IT products which were difficult to use, or not matched to user requirements or business needs.[153]

7.18 DIAC could avoid problems of this kind by including the following in its stakeholder consultation and IT planning to support the health requirements:

- forward estimates of costs, which cover all essential redesign components;
- a comprehensive plan indicating timelines for stakeholder consultation, development activities, adequate pilot testing and feedback by users;[154]
- a business continuity plan for health assessments, including identification of major risks to DIAC's business, and strategies to reduce the impact of current system issues on productivity and performance while system improvements are undertaken; and
- suitable targets and standards to ensure that DIAC moves towards a single system which overcomes current problems and risks (particularly multiple records, cumbersome transfer of data between systems, and matching of client data for identity and health assessment purposes), and meets legislative requirements.

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151 DIAC advised this sum covered a first release and planning exercise for future releases.

152 Control Objectives Management Guidelines Maturity Models (COBIT) 4.0, IT Governance Institute, USA. <www.itgi.org>.

153 An example was the July 2006 release of eHealth II, which involved an auto-clear facility that was not usable in the health assessment business process. ICSE had also not fully met DIAC's business needs for health assessment processing (also see Table 7.2).

154 The ANAO noted that DIAC was making progress in this area.

7.19 Consideration of these matters early in DIAC's planning process will ensure that its system developments meet business needs, and that adequate funding can be made available to complete the necessary development of new support systems for the health requirement.

Recommendation No.7

7.20 The ANAO recommends that DIAC fully scope the IT needs for the health requirement, in consultation with users, and develop a comprehensive strategy and plan for improving management of client records and data collection for purposes of program management, performance and outcome reporting.

7.21 The strategy should include costs and timelines for implementing IT improvements to ensure that DIAC can meet its legislative and policy obligations for the health requirement into the future.

DIAC's response

7.22 Agreed. DIAC has initiated the Health Services Project as part of its Systems for People initiative. The aim of the Health Services Project is to provide an integrated health processing environment which provides a robust and comprehensive health solution for visa processing and to address the significant number of issues and gaps in health processing and reporting.

7.23 The Health Services Project Directions paper outlines the strategic directions of the project and its aim of an integrated health environment. It provides the context and framework in which the project activities, in alignment with business process change, can deliver an end to end process and program support across all departmental health activities. It is currently being revised to take account of recent changes to the Systems for People timetable and architectural impacts. The Directions paper will continue to be updated to take into account major changes.

7.24 The Health Services Project has established a Health Working Group comprised of health stakeholders within DIAC to progress the advancement of the Health Services Project. The Working Group meets monthly to participate in the development of business directions and requirements, agree and endorse those directions, provide business acceptance of the project deliverables, provide advice and make recommendations to the project team.

8. Monitoring and Performance

This chapter examines DIAC's monitoring of the health requirement for the purposes of improving its performance and managing external reporting.

Background

8.1 Each Australian Government agency is expected to monitor and report its performance using comprehensive and balanced performance information. This performance information should demonstrate agency effectiveness against pre-set outcomes, and efficiency in managing outputs, key tasks and services.

8.2 The assessment, measurement and reporting of performance is relevant to internal managers, as it assists them to manage core business, monitor trends and inform business improvements. External performance reporting conveys an agency's progress to the Parliament, stakeholders and broader community.

8.3 To assess DIAC's arrangements for performance management and reporting for the health requirement, the ANAO examined:

- the appropriateness of DIAC's performance management framework for measuring the effectiveness of the health requirement; and
- DIAC's collection and use of data for internal management and reporting purposes.

Measuring the effectiveness of health assessments

8.4 As DIAC has primary carriage for the health requirement[155], its performance information is expected to provide a measure, or indication, of progress against pre-set outcomes, outputs and key performance indicators that reflected DIAC's performance for key elements of the health requirement.

8.5 The performance framework established by DIAC to assess and report on its implementation of the health requirement is illustrated in Figure 8.1.[156]

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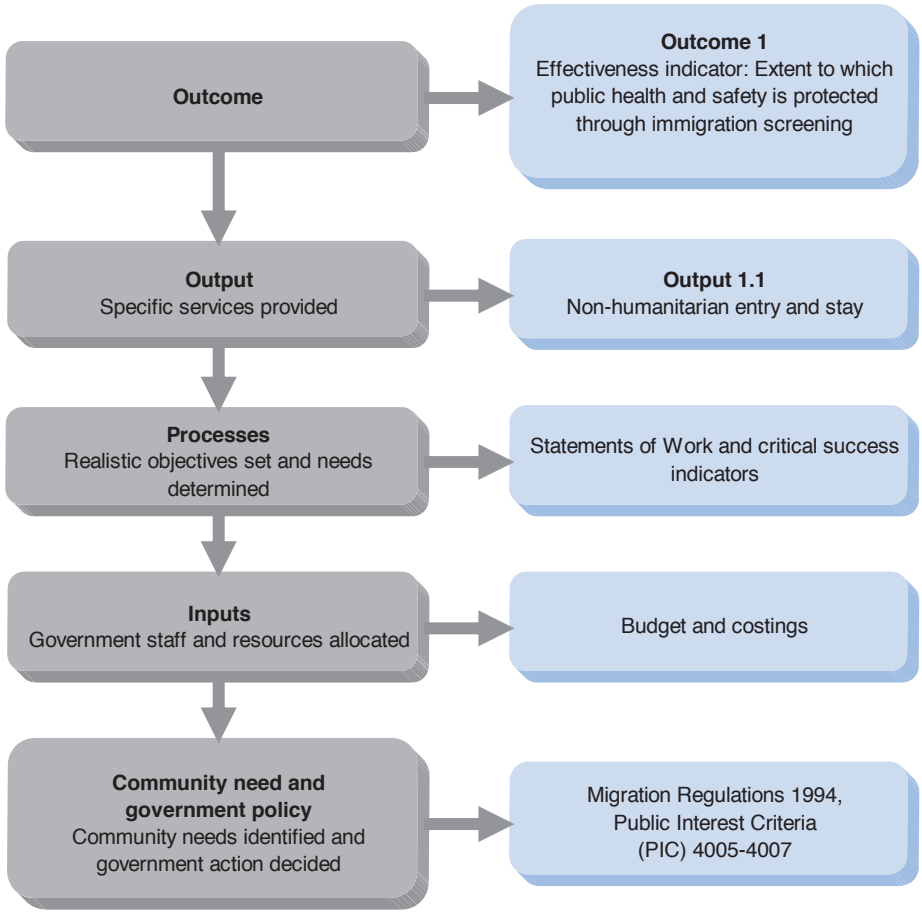
[155] Under Administrative Orders, DIAC has responsibility for the *Migration Act 1958*.

[156] The Department of Immigration and Multicultural Affairs (DIMA) Portfolio Budget Statement 2006–2007, p. 20, specifies that one of the services provided by the portfolio overseas and in Australia is 'assessing the character, health and bona fides of applicants applying for entry into Australia'.

Figure 8.1

DIAC's Performance Hierarchy



Source: ANAO, compiled from ANAO Better Practice Guide: Performance Information Principles 2002; and DIAC, Migration and Temporary Entry Business Plan 2005–2006.

8.6 Agency Portfolio Budget Statements should identify indicators that cover both:

- the effectiveness of outputs in contributing to desired outcomes; and
- the efficiency of outputs—their quality, quantity and price. [157]

An agency's effectiveness indicators should identify the contribution of outputs and administered items to the achievement of the stated outcome. [158]

[157] ANAO, *Performance Information in Portfolio Budget Statements*, May 2002; and ANAO, *Better Practice in Annual Performance Reporting*, April 2004. <http://www.anao.gov.au/WebSite.nsf/Publications/>

[158] ANAO, *Better Practice Guide: Performance Information Principles*, 1996. <www.anao.gov.au>.

8.7 The health requirement sits within DIAC's Outcome 1:

> **Outcome 1**: Contributing to Australia's society and its economic advancement through the lawful and orderly entry of people.[159]

8.8 The outcome lists twelve strategic priorities, providing a broad overview of DIAC's programs. However, none of these strategic priorities contain information specific to the health requirement.

8.9 DIAC has one outcome (effectiveness) indicator relevant to the implementation of the health requirement, and specifies one measure of this.

> **Effectiveness indicator:** The extent to which public health and safety is protected through immigration screening.
>
> **Effectiveness measure:** The incidence of tuberculosis (TB) relative to the percentage of overseas-born in the Australian population compared to the same ratio for other major developed countries.[160]

8.10 DIAC reports data on the incidence of TB in its Annual report each year (Table 8.1). These data indicate a low incidence of TB in Australia's overseas-born population, but provided little information on DIAC's performance in TB screening of visa applicants. For example, DIAC did not report: the number of visa applicants screened for TB; the number refused entry due to active TB; or how many applicants granted visas (with or without health undertakings) subsequently received treatment for TB while in Australia.

Table 8.1

Incidences of Tuberculosis: as a percentage of overseas born in the Australian population

Financial Year	2003–04	2004–05	2005–06
Australia	0.022	0.021	0.023
Canada	0.027	0.026	0.025
France	0.171	0.106	0.091
Germany	0.094	0.069	0.063
Sweden	0.087	0.038	0.042
United Kingdom	0.283	0.148	0.152
United States	0.045	0.041	0.040

Source: Compiled by ANAO from DIAC Annual Reports 2003–04 to 2005–06.

[159] DIMA Portfolio, *Portfolio Budget Statements,* 2004–05 to 2006–07, Commonwealth of Australia, Canberra.

[160] DIMA, 2003–04 Annual Report, p. 24; and 2004–05 Annual Report, p. 29.

8.11 Furthermore, the ANAO found that:

- DIAC had no definition or standards for 'extent' of public health;
- measurement of effectiveness for the health requirement was limited to one aspect of the Public Interest Criteria (PIC)—TB.
- DIAC had not identified effectiveness measures to cover other key elements of the PIC, namely: threat to public health from other diseases or conditions, significant cost; or prejudice to access; and
- as DIAC's effectiveness measures were not representative of the key elements of the PIC, DIAC could not provide an adequate measure of 'the extent to which public health and safety is protected through immigration screening'.

Measuring outputs

8.12 Performance information should include data on the efficiency of outputs in terms of their quality, quantity and price.

8.13 The health requirements is an essential component of several DIAC programs that report against Output 1.1—non humanitarian entry and stay,[161] and is a legislated requirement for some 150 visa types. However, DIAC has no defined output, or specific quality or quantity indicators relating to the health requirement for output 1.1. Also, because the health requirement applies across programs, DIAC could not provide an accurate estimate of the total cost of administering the health requirement.

Overall outcome-output reporting

8.14 Due to the limitations in DIAC's performance reporting framework, DIAC was not in a position to report its performance in implementing key elements of the health requirement to the Parliament and the public.

8.15 To provide greater accountability of DIAC's responsibilities under the health requirement of the *Migration Act 1958* and the PIC, the ANAO recommends that DIAC develop appropriate effectiveness indicators and effectiveness measures to monitor and report its performance in meeting key elements of the PIC, that is, that entrants into Australia are:

- free from tuberculosis (TB); [162]

[161] DIMA, Portfolio Budget Statements for 2004–05, 2005–06 and 2006–07; and Annual Reports.

[162] TB is the only disease specifically mentioned in the Act.

- free from a disease or condition that would result in a threat to public health or danger to the Australian community; and
- do not have a disease or condition that is likely to: require health care or community services while in Australia; result in significant costs to the Australian community; or prejudice the access of an Australian citizen or permanent resident to health care or community services.[163]

Data and reporting for internal management

8.16 The ANAO examined DIAC's mechanisms for setting health requirement performance targets and performance monitoring and reporting for internal management purposes (at the operational level).

8.17 DIAC's Statements of Work (SOWs) document the roles of the business units (for example the Local clearance Unit (LCU), Global Medical Unit (GMU), and the New South Wales State Office), establish a price for units of work, and encourage good practice by providing guidance on processes and quality of work required.[164]

8.18 DIAC has a range of monitoring and audit processes in place for health assessments, to provide quantitative and qualitative data for process monitoring and management purposes. The GMU, LCU and Health Assessment Service (HAS) combine monthly reporting on processing of applications. These reports show monitoring of core activities against targets and standards specified in the SOWs, to assist management of workload fluctuations, resource planning, and refinement of health assessment processes. Table 8.2 illustrates aspects of DIAC's health assessment processing data for 2005–06.[165] Other data are presented in Appendix 6.

8.19 The GMU reports monthly on Global Medical Director site audits, risk management and quality assurance, improvement to record management procedures, trends, staffing, medical issues and complaints.

8.20 The LCU reports monthly on performance and trends, staffing, training and other issues. LCU performance information is mainly a quantitative measure of the number of applications processed in each visa category, the

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[163] *Migration Regulations 1994, Schedule 4, PIC 4005*.

[164] The ANAO noted that the SOWs were draft documents that DIAC had intended to replace (either with new SOWs or different arrangement) from August 2005. However, DIAC advised that a date for implementing the new arrangements had been delayed, and that business units were still working to the old SOWs.

[165] Appendix 6 contains further examples of DIAC's data and performance reporting.

number of referrals to MOCs and target timeframes. This data is mainly for local monitoring, including process improvement. It is not reported in DIAC's Annual Report.

Table 8.2

Health processing statistics July 2005 to June 2006

2005–06	Medical results processed	Adherence to processing service standards (per cent)	Cases locally cleared (per cent)	Cases referred to MOC (per cent)	Email Inquiries received
July	10622	76.50	69.06	30.94	1697
August	11040	88.50	74.10	25.90	1521
September	11046	81.60	72.18	27.82	1842
October	10886	80.94	70.68	29.32	948
November	12344	89.63	72.03	27.97	1186
December	11657	55.22	70.60	29.40	1070
January	15573	48.88	74.95	25.05	1474
February	13747	80.94	73.75	26.25	1046
March	14243	85.35	70.38	29.62	1406
April	10841	57.50	68.92	31.08	850
May	18031	60.00	72.30	27.70	827
June	16181	94.00	72.00	28.00	1491
TOTAL	**156211**	**74.92**	**71.75**	**28.25**	**15358**

Source: DIAC combined LCU, GMU and HAS monthly reports for May and June 2005–6.

Data available for performance management and monitoring

8.21 While DIAC generates data for internal management purposes, it is limited in its ability to consolidate this data in a number of fundamental areas.

8.22 In particular, DIAC was not able to accurately state: the number of health assessments completed annually; the number of people not granted a visa as a result of not meeting (failing) the health requirement; or the number of people who did not fulfil the requirements of their health undertaking. DIAC's difficulty in providing such data stems, in part, from the disaggregation and incompatibility of data stored in DIAC's different IT systems (see Chapter 7).

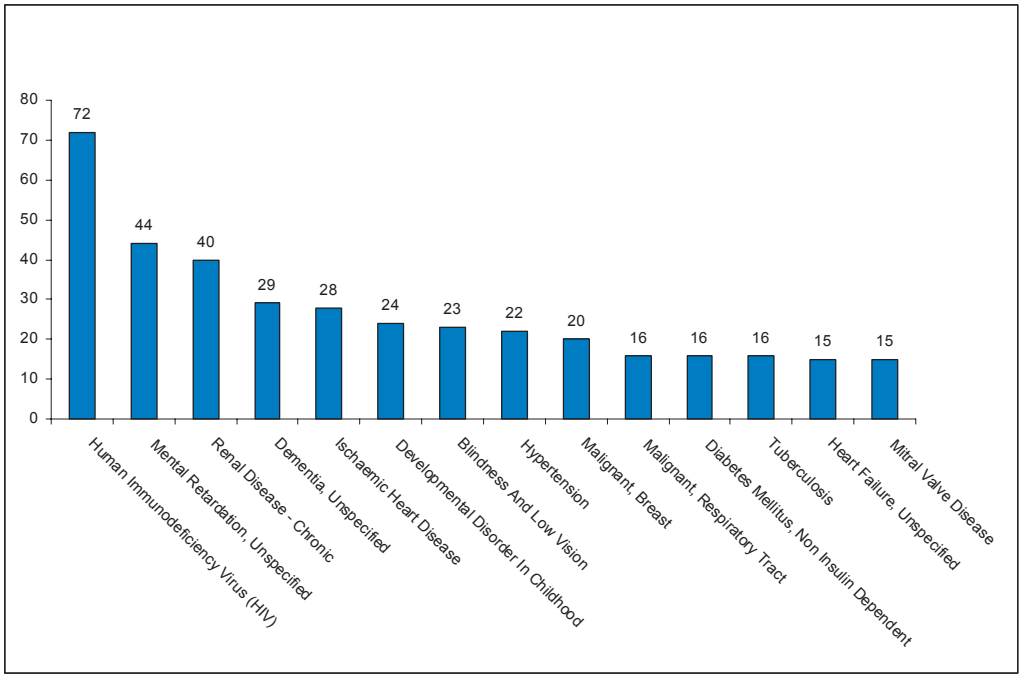
8.23 By increasing its capacity to generate more encompassing data (for example, showing trends and linkages between elements of the health requirement and visa outcomes) DIAC would be in a better position to assess

its performance against outputs and outcomes, and to assess the overall effectiveness of health screening.

8.24 DIAC was able to provide the ANAO with data on the number of visa applicants that did not meet the health requirement broken down by disease or condition. An extract of this data is illustrated in Figure 8.2. While such data is collected by DIAC, there was little evidence of its systematic use for refining or reviewing the health criteria.

Figure 8.2

Did not meet by disease or condition: July 2005 to February 2006



Source: DIAC, Integrated Client Server Environment.

Note: The data period is from 01 July 2005 to 28 February 2006. The graph displays only diseases/conditions in which 15 or more people did not meet the health requirement as a result of the disease/condition. These data represent 380 of the 800 people that did not meet the health requirement. The full range of diseases or conditions shown by DIAC's data was 104.

8.25 Appendix 6 provides other examples of data DIAC generates for internal management purposes.

Recommendation No.8

8.26 DIAC's effectiveness measure for its implementation of the health requirement of the *Migration Act 1958* is the 'extent to which public health and safety is protected through migration screening'. To enable DIAC to monitor and report its progress against this, the ANAO recommends that DIAC:

- develop appropriate effectiveness indicators and effectiveness measures to monitor and report its performance in meeting key elements of the Public Interest Criteria, including: diseases of public health threat other than tuberculosis; significant cost to the Australian community; and prejudice to access; and
- effectively utilise data to set and review the health criteria, procedures and guidelines.

DIAC's response

8.27 Agreed. The development of effectiveness indicators will be informed by a number of concurrent activities including, a review of the health risk matrix, the release of the *National Health Security Act 2007* (sponsored by DoHA) and a recently initiated review of diseases of public health threat.

8.28 The Health Services Project has initiated a subproject on reporting. The creation of a centralised health data repository and the implementation of appropriate effectiveness indicators will improve the Department's ability to measure and report on performance against the Health Public Interest Criteria.

Ian McPhee
Auditor-General

Canberra ACT
17 May 2007

Appendices

Appendix 1: Legislative and Policy Framework

Legislative and policy framework for the health requirement

The Migration Act 1958 (the Act)

Section 60 of the Act states:

If the health or physical or mental condition of an applicant for a visa is relevant to the grant of a visa, the Minister may require the applicant to visit, and be examined by, a specified person, being a person qualified to determine the applicant's health, physical or mental condition, at a specified reasonable time, and specified reasonable place.

The Migration Regulations 1994 (the Regulations)

Regulation 2.25A indicates: In determining whether an applicant satisfies the criteria for the grant of a visa, the Minister must seek the opinion of a Medical Officer of the Commonwealth (MOC) on whether a person meets the requirements of paragraphs 4005(a) to (c), 4006A(1)(a), 4006A(1)(c), and 4007(1)(a) to (c) of Schedule 4 unless:

(a) the applicant is for a temporary visa and there is no information known to Immigration (either through the application or otherwise) to the effect that the person may not meet any of those requirements; or

(b) the application is for a permanent visa that is made from a country (whether Australia or a foreign country) specified by Gazette Notice… and there is no information known to Immigration (either through the application or otherwise) to the effect that the person may not meet any of those requirements.

Public Interest Criteria (PIC) 4005–4007 requires: that the applicant is free from tuberculosis,[166] and is unlikely to result in significant costs or prejudice of access to public health—regardless of whether health care or community services will actually be used.

Public Interest Criteria (PIC) 4005 (d) requires: if the applicant is a person from whom a MOC has requested a signed undertaking to present themselves to the health authority in the State or Territory health of intended residence for a follow-up medical assessment, the applicant has provided that undertaking.

The Health Waiver (PIC 4006A): is a prescribed Schedule 2 criterion for Educational (418) and Business (Long Stay) (457) visas. PIC 4006A allows DIAC to waive the health requirement if the intended Australian employer gives a *written undertaking* to DIAC to

[166] Tuberculosis is the only public health disease specifically mentioned in the Migration legislation. Tuberculosis can be spread, incubated and 'suffered' without the knowledge of the person with the condition. Of every 1 000 cases of tuberculosis in Australia, 85 per cent are in the overseas born population. The minimum treatment costs for tuberculosis is AUD $6 000, but the cost can be as high as $250 000.

meet all costs related to the disease or condition that was the subject of the MOC adverse opinion.

The Health Waiver (PIC 4007) provides: for officers to waive the requirements of criterion 4007(1c), which essentially states that the applicant must not have a condition that would be likely to result in a 'significant' cost to the Australian community, or prejudice the access of an Australian citizens or permanent residents to health care or community services. The waiver requires officers to consider and decide whether the costs or prejudice are unlikely to be 'undue,' given the particular circumstances of the applicant.[167] For the waiver to be used, all other criteria for the grant of the visa must be satisfied by the applicant.

DIAC policy

Other matters relevant to the health requirement are set out in the Procedures Advice Manual 3 (PAM3), schedule 4, 4005–4007. This provides procedures and guidelines for assessing persons against the health requirement and interpretation of the requirement, including:

- health examination requirements for temporary visa cases, including by country and period of stay;
- health examination requirements for permanent/provisional visa cases;
- delegations, record keeping, and clearance processes for assessment of applicants against the health requirements; and
- guidance for assessing cases against the PIC, including health waiver and health undertaking provisions.

[167] The judgement of whether, if the visa were granted, the cost to the Australian community or prejudice to others would be 'undue' can import consideration of compassionate or other circumstances. For example, Australia could be considered to benefit in moral or other terms from admitting a person even if it was anticipated that the person would make a significant call upon health and community services.

Appendix 2: Interdepartmental Coordination

A2.1 Summary of Interdepartmental Migration Health Forum meetings

Date of Forum	Attendees	Agenda items
8.7.1999	2 DoHA 0 FaCS 2 DIAC	- Concerns with DIAC's definition of 'special significance' travellers - Recent Typhoid cases - Risks for health care, aged care and food industry in disease spread
03.12.2001	5 DoHA 0 FaCS 6 DIAC	- CDNA Guidelines - Vector Control Willie Creek detention - X-ray procedures and issues for young arrivals - Health Waiver to encompass skilled applicants - Dialysis used by temporary applicants - Removal of persons when injurious to health - Front end loading - Shortages in Nursing - Costing of Medical procedures
12.04.2002	4 DoHA 0 FaCS 10 DIAC	- X-ray procedures for young arrivals - Health Waiver for skilled business applicants - Dialysis use by temporary applicants - Removal of persons when injurious to health - Nursing shortage - Medical costings - CDNA Guidelines - TB cases in Australia - DHA/DIAC Channels of relationship
25.09.2002	1 DoHA 0 FaCS 5 DIAC	- Naltrexone - WHO international health regulations - DNA testing - DIAC/DoHA relationship - Analysis and review - Notes for Guidance
23.10.2003	4 DoHA 1 FaCS 5 DIAC	- ANAO recommendation 2003: Notes for Guidance - ANAO recommendation 2003: Waiver administration - HIV testing for temporary entrants - Arrangements for quarterly meetings - CDNA
10.12.3003	3 DoHA 2 FaCS 2 DIAC	- Principle costings papers for significant costs, Notes for Guidance. - Notes for Guidance
18.06.2004	7 DoHA 1 FaCS 6 DIAC	- ANAO recommendations 2003 - DIAC draft discussion paper on costing principles for significant cost, Notes for Guidance - DIAC's draft MOU - CDNA

Date of Forum	Attendees	Agenda items
		- Refugee vaccination - Quantiferon TB Test Study - HIV/AIDS Temporary entrants - HIV/Hep B & C for temporary and permanent visa applicants based on occupation risk
31.03.2005	9 DoHA 3 FaCS 5 DIAC	- Actions arising previous minutes - Removal of persons when injurious to health. - Health waivers for skilled and business migrants - Over 70's - Pre and post arrival screening arrangements - Passenger cards - HIV/Hep B & C for temporary and permanent visa applicants based on occupation risk - MOU draft provided to participants - Notes for guidance - Working arrangements for the Migration Health Forum - Update on the 205-06 Migration Program
26.10.2005	8 DoHA 2 FaCS 9 DIAC	- MOU draft provided to participants, to be commented by 30 November 2005 - Notes for guidance - Pre and post arrival screening arrangements - Health waivers for skilled and business migrants - HIV/Hep B & C for temporary and permanent visa applicants based on occupation risk

Source: Agenda items and minutes for the Interdepartmental Migration Health Forum 1999–2005.

A2.2 Summary of outstanding issues: ANAO analysis

- HIV Pilot study of Sub Saharan African students
- HIV/Hepatitis B & C testing of temporary and permanent visa applicants based on occupation risk of transmission (Health Care Workers)
- The ANAO's 2003 recommendation on the MOC Notes for Guidance
- Dialysis
- The development of a Memorandum of Understanding
- ANAO recommendations concerning health waivers
- DIAC/DoHA relationship—collaboration and coordination

Appendix 3: Draft Memorandum of Understanding

A draft Memorandum of Understanding (MOU) between DIAC (then DIMA), DoHA and FaCSIA, was presented to agencies by DIAC to the Migration Health Forum October 2005 meeting. Attachment A of the draft MOU outlined specific 'areas in DIAC involved in health assessment of visa applicants'. Attachment B of the draft MOU outlined 'areas in which advice may be sought by DIAC from or proffered to DIAC by DoHA.'

Attachment A

Health Policy Section - Canberra
Health Policy Section has oversight of health-policy issues and legislative and visa health requirements for entry to Australia both onshore and offshore and administers the health requirement, as determined by the Department of Health and Ageing. The Section manages the contracts with HSA. It is also responsible for the retirement visa subclass and preparation of Ministerial responses and waiver advice for cases where the estimated cost is $200,000.

Global Medical Unit – Global Medical Directors - Sydney
With the appointment of Global Medical Directors, the Global Medical Unit manages the overseas panel doctor network, consisting of 4000 doctors and radiologists worldwide. Centralising the management role of panel doctors also provides for consistency in auditing of medicals submitted by panel doctors and targeted follow up including site visits where required.

Local Clearance Unit - Sydney
The Local Clearance Unit processes health assessments associated with repatriated visa programs and eVisa categories.

Health Assessment Service (HAS) - Sydney
The Health Assessment Service is located in Sydney and handles mainly health clearance work for offshore posts and regional offices that process offshore cases.

Director, Special Health Projects - Sydney
This specialist position handles health related review and project work and contributes to the overall policy and operational aspects of immigration health. The position has prime responsibility for providing specialist advice when preparing guidelines for panel doctors, health instructions and procedures as well as coordinating the update of guidelines for Medical Officers of the Commonwealth on health costing of various health conditions.

Health Services Australia
Health Services Australia handles health clearance work for onshore visa applicants and DIMIA regional offices. Under contract, HSA provides a medical director and a business manager for the HAS.

DIMIA staff onshore and offshore
DIMIA missions and regional offices have direct involvement in the health assessment process. DIMIA staff request medical examinations where required and liaise with HAS on any follow up of outstanding assessment. DIMIA staff check and update Movement Alert List as part of health assessment and health undertaking requirements. Where local clearance is provided, case officers may finalise applications.

Panel doctors and radiologists overseas
The Global Medical Unit manages the worldwide network of panel doctors and radiologist who conduct medical assessments as required by various visa categories including the eVisa categories.

International Organisation for Migration
The IOM functions as international panel doctor providing medical examination services in locations where it is difficult to obtain reliable services locally. The IOM provides medical assessment of Australian bound refugees in various African refugee camps.

Attachment B

Infectious diseases –

Tuberculosis	Relevant epidemiological aspects Risk-rating of countries Physical examination of applicants Radiological examination of applicants Investigative/diagnostic testing Laboratory confirmatory testing Treatment Procedures to follow in health clearance process Health undertakings
Hepatitis	Relevant epidemiological aspects Appropriateness of inclusion of testing Physical examination Investigative/diagnostic testing Laboratory confirmatory testing Treatment Procedures to follow in health clearance process Health undertakings
Leprosy	Relevant epidemiological aspects Physical examination Investigative/diagnostic testing Treatment Procedures to follow in health clearance process Health undertakings
Other infectious diseases	Relevant epidemiological aspects Appropriateness of inclusion/extent of testing Physical examination Investigative/diagnostic testing Laboratory confirmatory testing Treatment Procedures to follow in health clearance process Health undertakings
Non-infectious diseases	Physical examination Investigative/diagnostic testing Laboratory confirmatory testing Treatment Procedures to follow in the health-clearance process
Medicare -	Access / Costs
Pharmaceutical Benefits	
Scheme	Access / Costs
Costings -	Diagnosis Related Groups Inpatient and outpatient costs Equipment, aids and prostheses
Scarce resources	Catalogue
Notes for Guidance	Steering committee Other input as for infectious and non-infectious diseases, costings, and so on.
Detention health	Admission examinations Management of public-health issues Mental health Vaccination

Vaccination For entry to Australia

Forms and instructions - significant changes
Information forms on health-related matters
Health declarations on application forms and passenger cards
Medical-examination forms
Guidelines for medical and radiological examination of Australian visa applicants
Guidelines for medical and radiological examination of applicants for onshore- protection visas

Liaison
Australian Institute of Health and Welfare
Australian National Committee on AIDS and Hepatitis C Related Diseases
Communicable Diseases Network Australia
National Tuberculosis Advisory Committee
Health Insurance Commission
Medibank Private
Other health-insurance funds
State and Territory health departments

Appendix 4: Notes for Guidance

Date	History of developing the migration *Notes for Guidance*
1990–1992	Australian Government Health Service (AGHS) policy section produced 'briefing' papers for renal disease, psychiatric conditions, intellectual disabilities and peripheral vascular disease.[168]
1992	A Parliamentary Committee report on Australia's migration health rules finds that guidelines for assessing whether migrants meet the health requirement are incomplete. The report recommends the development of suitable guidelines.[169]
1993	Various attempts to write guidelines since 1992. Project continuing in AGHS to develop the briefing papers.
1995	The Government accepted the recommendation of the parliamentary committee report on the Migration health rules, stating that it 'strongly endorses the need for relevant, comprehensive and current medical information to be available to support the medical assessment process.' Tender process results in no viable bids (lack of expertise available).
1996	AGHS prepared a Statement of Requirement, and new request for tender advertised in September 1996.
1997	Only one viable tender submitted. Contract signed between DIAC and Contractor in February 1997.
1998	Contract for production of 15 papers due to be completed by February 1998. Work not completed.
1999–2001	Work on project stalled and contract terminated, due to complexity of work and costs higher than first anticipated.
2001 (July)	Work re-commenced on project.
2001 (December)	Work on project stalled. Intermittent meetings held between DIAC and DoHA. Meeting minutes record DoHA agreed to assist in further development of the project.
2002 (March)	Work on project had ceased.
2002 (September)	'Ernst and Young' conduct internal audit of DIAC health processing and found that *health assessment guidelines* were still mostly incomplete and required 'significant work'. The audit recommended that DIAC establish a steering committee to progress the guidelines.
2003 (June)	ANAO report *Management of Selected Aspects of the Family Migration Program* is 'unable to determine whether current DIMIA guidance provides a sound and sufficient basis for the effective and accountable administration of the health waiver provisions.
2003 (September)	Letters exchanged between Deputy Secretaries DoHA and DIAC on the issue of progressing the *Notes for Guidance*.
2004	Inter-agency discussions between DoHA and DIAC to initiate tender process.
2005	DoHA contracts with new external contractor, and drafting of *Notes for Guidance*. Five papers including the Principles Paper, is undertaken. Discussions between DoHA and DIAC regarding agency responsibility for writing and funding the papers.

[168] Based on DIAC advice.

[169] Joint Standing Committee on Migration Regulations (1992), Conditional migrant entry: the health rules, Australian Government Publishing Service, Canberra, p. 45.

Date	History of developing the migration *Notes for Guidance*
2006 (March)	DIAC initiates tender process to complete remaining 14 papers.
Status at 2007	In January 2007 DIAC reported progress to ANAO. Progress of DoHA's external contractor: • Completed Principles Paper with DoHA (since March 2006) for approval; • Near completed Rheumatology Paper with DoHA for approval**; • Completed Nephrology Paper with Professional body for approval**; • Endocrinology and Tuberculosis papers nearing completion; and HIV paper nearly complete—under preparation directly for DIAC. This leaves 13 papers requiring minor review to re-writing. DIAC is progressing these through a new contract.

Source: DIAC and DoHA documents, and interviews.

Note: *Notes for Guidance* have been referred to over time as *health assessment guidelines*, briefing papers and guidelines.

** DoHA and DiAC advised these papers were endorsed by early 2007.

Appendix 5: PIC 4006A and PIC 4007 Visas

Visas to which PIC 4006A and PIC 4007 apply

Visas to which PIC 4006A applies

418 Educational

457 Business (Long Stay)

Visas to which PIC 4007 applies

(For visas marked *, PIC 4007 applies only to those applicants to whom regulation 2.07 AO applies)

100 Spouse

101 Child

102 Adoption

110 Interdependency

137 Skilled – State/Territory-nominated Independent (certain applicants only)

151 Former Resident (defence service applicants only)

200 Refugee

201 In-country Special Humanitarian

202 Global Special Humanitarian

203 Emergency Rescue

204 Woman at risk

300 Prospective Marriage

309 Spouse

310 Interdependency

415 Foreign Government Agency *

418 Educational *

419 Visiting Academic *

420 Entertainment *

421 Sport *

422 Medical Practitioner *

423 Media and Film Staff *

427 Domestic Worker (Temporary) Executive *

428 Religious Worker *

442 Occupational Trainer *

445 Dependent Child

447 Secondary Movement Offshore Entry (Temporary)

449 Humanitarian Stay (Temporary)

451 Secondary Movement Relocation (Temporary)

457 Business Entry (Long Stay) *

461 New Zealand Citizen Family Relationship (Temporary)

571 Schools Sector *

572 Vocational Education and Training Sector *

573 Higher Education Sector *

574 Postgraduate Research Sector *

580 Student Guardian *

787 Witness Protection (Trafficking) (Temporary)

801 Spouse

802 Child

804 Aged Parent *

814 Interdependency

837 Orphan Relative *

852 Witness Protection (Trafficking) (Permanent)

855 Labour Agreement *

856 Employer Nomination Scheme*

857 Regional Sponsored Migration Scheme * (and certain standard applicants only)

858 Distinguished Talent *

864 Contributory Aged Parent *

884 Contributory Aged Parent (Temporary) *

890-893 Business Skills

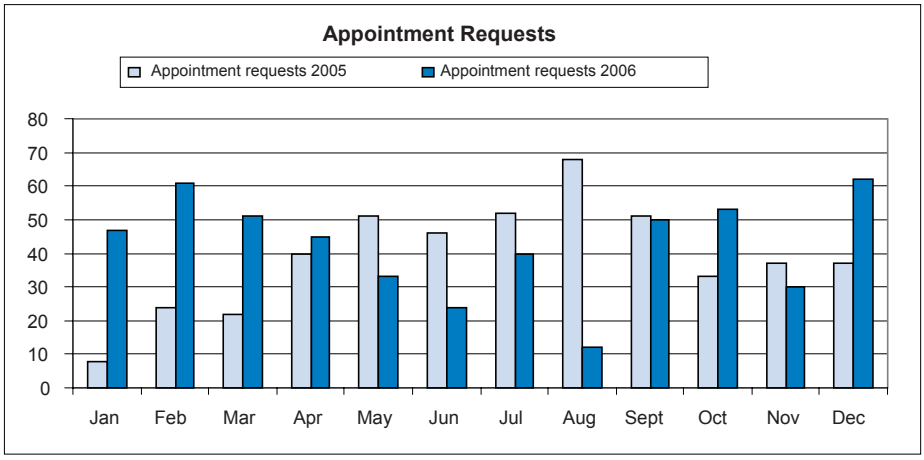
Appendix 6: Monitoring and Performance Data

The following data consist of extracts from DIAC's *Local Clearance Unit, Global Medical Unit, and Health Assessment Service monthly report for June 2006*, and updated information provided to ANAO on 20 April 2007.

A6.1 Panel doctor management

In June 2006 DIAC reported: 'Previous attempts to systematically establish where gaps in our panel doctor coverage exist have not produced a consistent worldwide picture of the panel network, due in part to the variety of standards of client service available/expected in different countries and the in-country medical resources. In the medium term, the GMU is examining alternate approaches to identifying coverage gaps so as to more proactively fill them—largely feedback from overseas posts as to their assessment of levels of need.

In April 2007 DIAC advised: 'The Panel currently includes in excess of 3627 appointed medical professionals. In December 2006, 62 requests for appointment were submitted by doctors themselves, by Posts, or as a result of Global Medical Director (GMD) trip recommendations. Thirty-three appointments were finalised and 293 requests are in progress'.

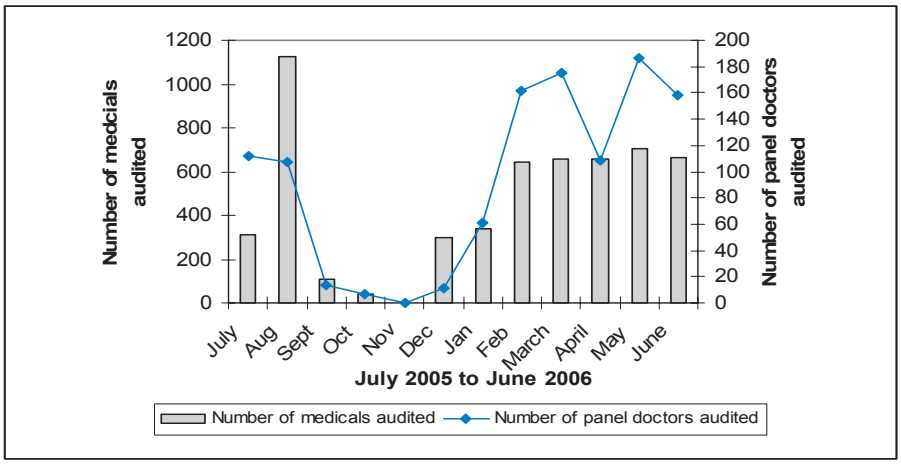


Breakdown of appointment requests ending December 2006

Request for appointment	Actual appointment	Cases outstanding
62	33	295

'The backlog of appointment requests requiring resolution remains significant, although the vast majority are unfinalised as a result of applicant inaction or non-communication (that is, requests have been made of doctors that have yet to be answered)'.

A6.2 GMU audits of overseas posts July 2005-June 2006



Source: GMU data as at June 2006.

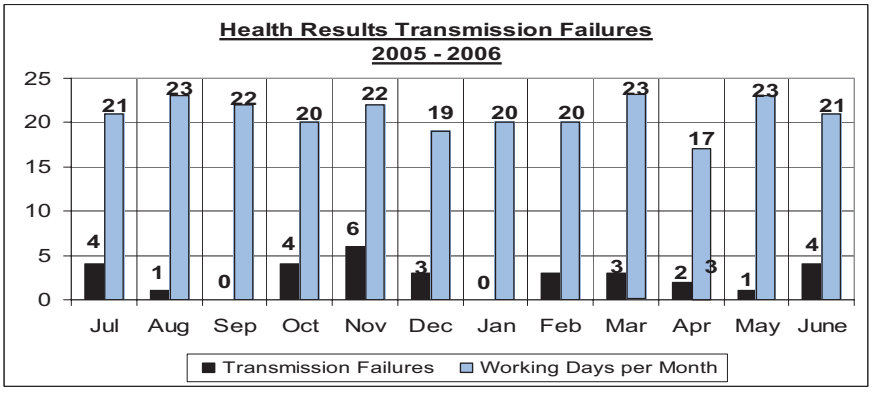
Note: The Local Clearance Unit is included as a post. All other posts were overseas.

ANAO comment: DIAC was refining its methodology for auditing overseas panel doctors.

A6.3 Health Results Transmission Failures

'The Health Assessment Service (HAS) health results are sent to both overseas and onshore posts electronically & automatically overnight. On occasions, this process breaks down due to technical failures at [National Office]. When this happens, HAS must notify [National Office] the next working day to have the health results re-sent as soon as possible. If the results are not resent straight away, it can cause processing delays at the post as well as extra emails and telephone calls to HAS.'

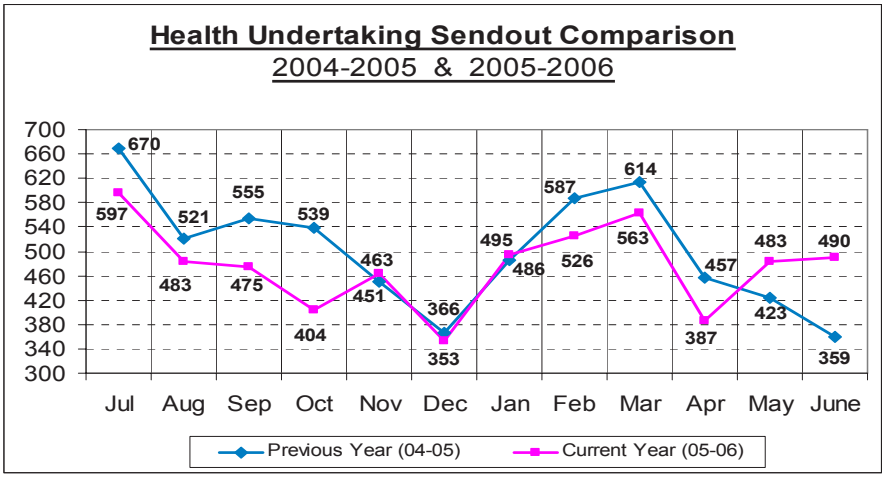
'From July 2005 to June 2006 there were 251 working days. Of these, the automatic process failed on 31 occasions.'



Source: DIAC data as at June 2006.

A6.4 Health Undertaking Sendout Comparison

Jul 2004 to June 2005 = 6,028 cases referred to the State Health Authorities
Jul 2005 to June 2006 = 5,719 cases referred to the State Health Authorities

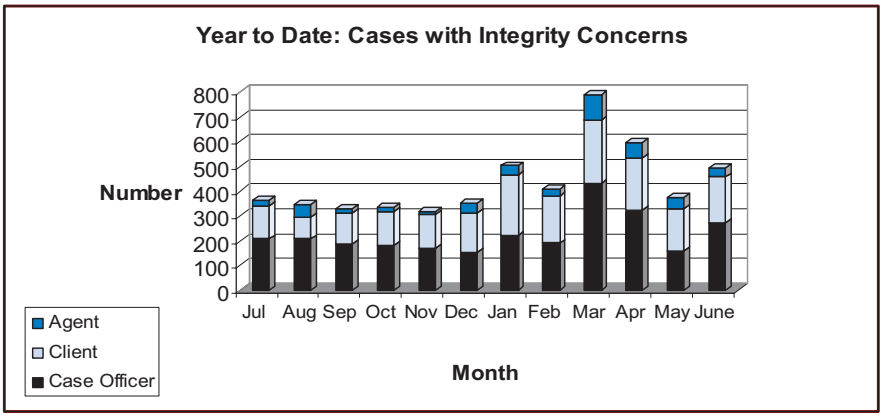


Source: DIAC data as at June 2006.

A6.5 Integrity Issues

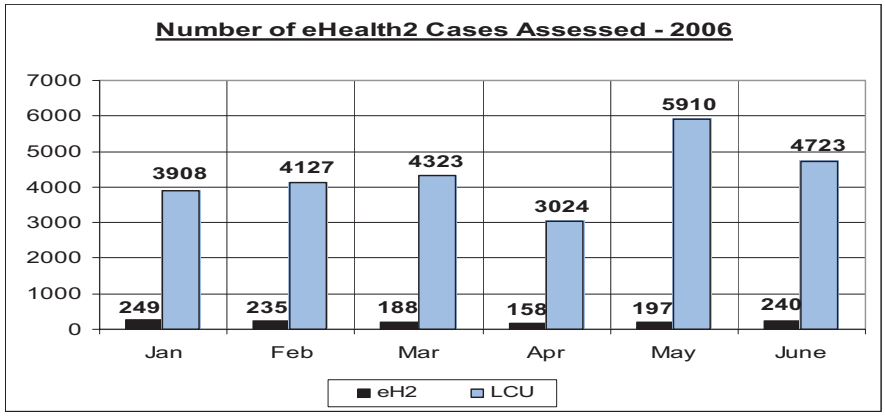
'During June 2006 the LCU identified a total of 496 cases that presented integrity concerns which represents 3% of the total number of cases received for the month. Of those 496 cases, 54% involved an incomplete Form 26 and/or 160, 38% involved identity concerns involving the applicant and 8% were not conducted by an approved panel doctor and/or radiologist. Major integrity concerns were reported to the GMU for action to ensure that they are aware of the training needs of panel doctors.'

eHealth cases with integrity concerns: July 2005-June 2006



A6.6 eHealth II

'eHealth II statistic recording commenced in January 2006. Approximately 80 per cent of eHealth II cases are received electronically. 20 per cent are received as inconsistent cases because the data in ICSE is different to the data in eHealth II and so it is referred manually to HAS via the LCU. As these assessments cannot be completed as fully electronic/digital cases, HAS also refers them to the Health Strategies Unit for systems review.
LCU cases January to June 2006 = 26,015. Of these, there were 1,267 (4.9%) eHealth II cases referred to HAS.'



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