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JOINT COMMITTEE OF PUBLIC ACCOUNTS AND AUDIT

Reference: Review of Auditor-General's reports Nos 21 (2006-07) to 3 (2007-08)

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JOINT STATUTORY COMMITTEE OF

PUBLIC ACCOUNTS AND AUDIT

Wednesday, 19 September 2007

Members: Mr Barresi *(Chair)*, Ms Grierson *(Deputy Chair)*, Senators Mark Bishop, Chapman, Hogg, Humphries, Murray and Watson and Mrs Bronwyn Bishop, Mr Broadbent, Dr Emerson, Dr Jensen, Miss Jackie Kelly, Ms King, Mr Laming and Mr Tanner

Members in attendance: Senators Hogg and Watson and Mr Barresi, Ms Grierson and Ms King

Terms of reference for the inquiry:

To inquire into and report on:

Review of Auditor-General's reports Nos 21 (2006-07) to 3 (2007-08)

WITNESSES

CLOUT, Mr Jamie, First Assistant Secretary, Portfolio Strategies Division, Department of Health and Ageing **1**

FARRELL, Mr Paul Damien, Assistant Secretary, Temporary Entry Branch, Department of Immigration and Citizenship **1**

GEUE, Ms Alex, Audit Manager, Australian National Audit Office **1**

HALBERT, Ms Cath, First Assistant Secretary, Office of Health Protection, Department of Health and Ageing **1**

HUGHES, Mr Peter, Acting Deputy Secretary, Department of Immigration and Citizenship **1**

KALISCH, Mr David, Deputy Secretary, Department of Health and Ageing **1**

LACK, Mr Steven, Executive Director, Australian National Audit Office **1**

LEARMONTH, Mr David, Deputy Secretary, Department of Health and Ageing **1**

MEERT, Mr John, Group Executive Director, Australian National Audit Office **1**

PARSONS, Mr Anthony, First Assistant Secretary, Migration and Temporary Entry Division, Department of Immigration and Citizenship **1**

Committee met at 11.46 am

GEUE, Ms Alex, Audit Manager, Australian National Audit Office

LACK, Mr Steven, Executive Director, Australian National Audit Office

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CLOUT, Mr Jamie, First Assistant Secretary, Portfolio Strategies Division, Department of Health and Ageing

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FARRELL, Mr Paul Damien, Assistant Secretary, Temporary Entry Branch, Department of Immigration and Citizenship

HUGHES, Mr Peter, Acting Deputy Secretary, Department of Immigration and Citizenship

PARSONS, Mr Anthony, First Assistant Secretary, Migration and Temporary Entry Division, Department of Immigration and Citizenship

CHAIR (Mr Barresi)—Welcome. I ask participants to remember that only members of the committee can put questions to witnesses. These hearings are formal proceedings of the parliament and attract parliamentary privilege. If other participants wish to raise issues for discussion I ask them to direct their comments to the committee; it will not be possible for participants directly to respond to each other. Secondly, given the short time available today, statements and comments by witnesses should be relevant and succinct. I also remind witnesses that the hearings today are legal proceedings of the parliament and warrant the same respect as proceedings of the House itself. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament.

Mr Hughes—In view of time restraints I will try to keep my opening comment very brief. The Department of Immigration and Citizenship has welcomed the report by the ANAO into the administration of the health requirement. It has provided us with a very useful independent view of how we can improve our business in this area. I think you know, Mr Chair, from your involvement in migration issues over some time that the intention of the health requirement is to protect the Australian community from public health risks, to help contain public expenditure on health care and to safeguard Australians' access to health services in short supply.

Administering the migration health requirement on a global basis is a very complex task. In 2007-08 we expect to process some 500,000 medical assessments around the world. We anticipate 170,000 permanent visa health assessments, 16,000 refugee and humanitarian

assessments and 314,000 temporary visa assessments. We will be doing this utilising 4,000 panel doctors and radiologists worldwide. Australia is considered in the migration area to have one of the most comprehensive systems of health screening. Nevertheless, I think that improvements can be made. The ANAO has made eight recommendations on ways we can improve the way we do this area of our business.

We have accepted fully the eight recommendations and we are progressively implementing them as quickly as we can, including the signing of the memorandum of understanding with the Department of Health and Ageing to formalise cooperation between the two agencies to make sure we do this work as well as we can. We would be happy to answer questions from the committee.

Mr Kalisch—The Department of Health and Ageing also welcome the report from the ANAO. We have accepted the two recommendations pertaining to our areas of interest and we are working to implement those recommendations.

CHAIR—I am pleased to see that the memorandum of understanding recommendation has been accepted and you are working towards it. In the absence of that, how was that relationship categorised? How did you actually define or determine what you needed and what they gave you and how your assessment of public health would then translate to the department? How did that all take place? Was it simply just past practice rather than in any particular formalised procedures in the systems?

Mr Hughes—The memorandum of understanding has been signed. We have been negotiating over a period of time and we have now concluded it. I think you are right to say that there had been a series of practices over time that just simply had not been formalised in a document, and I think that was criticised by the ANAO in not providing enough clarity of the contribution each agency should make to this. So our effort in coming to an agreement on a cooperative MOU is to clarify who does what and the contribution each agency can make in this area. I will ask Mr Farrell to talk about some practice before that.

Ms King—Do you have a copy of that MOU with you that we could see?

Mr Hughes—We do and we can give it to you.

Ms KING—It would be helpful for the committee to have that. It would be useful if that could also be supplied to the ANAO.

Mr Farrell—For example, in terms of issues the notes for guidance is one significant area of publication that the ANAO referenced in their audit, and we have signed a contract for all of the papers. In particular the principles paper gives us the overarching policy framework for diseases and conditions which medical officers of the Commonwealth might look at. For example, Health chaired a meeting when I first joined Immigration in January 2006 which was the result of about a year’s consultation on how we might revise that paper, and that was subsequently issued. As the ANAO observed, we are trying to formalise that more around specific timetables so that we will have a better timetable to review those. But in the past it was, I think, on the whole as near as issues arose, but there were regular meetings between the departments and of course day-to-day consultation if any tricky issues arose.

Ms GRIERSON—The contracts have been let for those individual disease guidelines—

Mr Farrell—For 13 of them we signed a contract in March. For the remaining five papers we have a contract which we hope to sign next month.

Ms GRIERSON—What is the position with the HIV paper?

Mr Farrell—That is in the bunch of papers that is in the October contract we hope to sign, but that has been—

Ms GRIERSON—And what is the timetable for development and implementation?

Mr Farrell—It is being progressed nevertheless and we anticipate that the HIV paper will be completed within about one month.

Ms GRIERSON—That is the paper itself?

Mr Farrell—Yes.

Ms GRIERSON—How long before the contracts are let for the others to be developed? What do the contracts say in terms of timeliness?

Mr Farrell—It is a rolling program out to 2011, so in terms of the contract that was signed in March 2007 we are hoping that the papers will be finished in batches of around four to five—

Ms GRIERSON—And are they in a priority area in terms of health risk and health need?

Mr Farrell—Yes, they were prioritised. For example, with HIV, even outside of a contract we are progressing a lot of work, and the other papers were prioritised in terms of those that might be required or those that were not updated recently.

Ms GRIERSON—Did the Department of Health and Ageing have any involvement in prioritising those health conditions.

Mr Farrell—Yes, the Department of Health and Ageing, to their credit, provided funding to review five of the papers, which we have subsequently taken over. A consultant named Andrew Dalton was engaged for those. We and the Department of Health and Ageing worked with Mr Dalton to progress those papers. So there was cooperation all along the way for those.

CHAIR—One of the criticisms from the Audit Office was that the health risk matrix that you had was not up to date. Until now what actually triggered a review of your procedures or health risk? Was it time-based or based on some sort of alert from the health department? I made the point a little earlier that health is an ever-changing public policy area in terms of what is a risk today and what is not a risk tomorrow or what is costly from a public health point of view—which is one of your criteria—and what may not be as costly tomorrow. How did you determine that and what was it about your system that allowed you to review these factors? It seems like a review did not take place as often as it should have been.

Mr Farrell—As I mentioned, we fully recognise that, based on the ANAO report, we need to formalise a timetable to review both. We have done that for the notes for guidance through the contract, which will be reviewed annually once they are written, but also for other things like the health matrix.

CHAIR—That is now. I was talking about the past. You are rectifying a situation, but it is more concerned with what took place in the past. It just seemed to be a bit ad hoc.

Mr Farrell—It might be portrayed that way but we monitored the health matrix with the Department of Health and Ageing and other agencies. So whilst there might not have been a formal review with a formal paper and formal outcomes to government, it is not as if we were not monitoring the relevance of it over time. As Peter Hughes mentioned, with nearly half a million assessments per year, we are obviously looking for trends where the health matrix may be deficient.

Ms KING—In terms of the category ‘public expenditure on health and community services’ and that being contained, how do you determine what categories go in that? I will alert you to the fact that I had a case where someone was denied their application on the basis of post-natal depression. That case was resolved individually, but I am concerned about that as a category.

Mr Farrell—As to what categories we might look at in terms of significant cost, $21,000 was really an average cost based on various procedures. That said, we do look at cases individually to determine what level of resources that person might draw upon when they are in Australia and if, for example, they have been able to access those services in the process of the visa application. If they cannot, we are then obliged to look at whether an Australian may be disadvantaged.

Ms KING—I understand that. I note that a number of Federal Court cases have blurred the boundaries to some extent in this matter. Does the MOU state that you will work with the department to update your understanding of those particular medical procedures or health services costs?

Mr Farrell—Yes, absolutely.

Mr Kalisch—The MOU is quite clear about the roles and responsibilities and the areas in which we will provide advice to Immigration around a number of these matters.

Ms KING—So prior to that you were not providing advice, or was it on an ad hoc basis?

Mr Kalisch—Advice was certainly being provided but as was mentioned earlier it was provided officer to officer and it was sometimes elevated up the line for more senior people to be aware of and sometimes it was not. What we have done now is formalise an arrangement where there is a senior engagement between the two departments and clarity of roles and responsibilities.

Ms KING—It would strike me that there was previously—and is, I hope, under the MOU—the potential for great inconsistencies in the decision making process. That is just a comment.

CHAIR—Were there any threats to our public health leading up to today that might have been picked up if the recommendations of the ANAO had already been in place? Can you attribute anything that might have happened in our public health to the weaknesses that are already there?

Ms GRIERSON—Weren't there some public cases of TB recently, in the last six months or so?

CHAIR—They may not have been due to this.

Mr Hughes—I can give a generic answer to that, because with a system of the nature that we have, screening so many people—and I mentioned the kind of volume—there is always the interesting question of: what is the total effect of the system, on the one hand, and could an individual case slip through, on the other? This is particularly the case since tuberculosis was mentioned, which is considered to be 'the' public health risk and one that we concentrate on most. I would like to share with the committee some figures. The fact is that the TB rate in Australia has remained at 5.3 per 100,000 for 20 years.

That is one of the lowest in the world and we have managed to keep it that low at a time when the growth of migration to Australia and the movements of people on a temporary basis from countries that have TB have obviously grown very dramatically. I think that is an important key indicator. Also, in our annual report last year, we tried to produce a performance indicator to measure how well the health system was working, and that was by looking at the number of TB cases as a percentage of the overseas-born population in Australia, compared with other developed countries.

On the figures we produced, Australia was the lowest. To quote these figures, the TB cases, as a percentage of the overseas-born population were: 0.02 of a per cent for Australia, 0.025 for Canada, 0.091 for France, 0.063 for Germany, 0.042 for Sweden, 0.152 for the UK and 0.04 for the US. So, as a result of our health screening system and our particular focus on tuberculosis, the indicators are that we have kept it low by world standards and overall there has been no sign of it going up in Australia, despite the dramatic increase in movements of people. So we think that our screening has been successful at the macro sense. Of course we get individual cases reported from time to time, where someone might have had TB in the past but was cured and after arrival in Australia it may re-emerge. At the macro level, the figures show that the system has worked.

CHAIR—Did you mention New Zealand in those figures?

Mr Hughes—I did not mention New Zealand, no. These are figures published in our last annual report.

CHAIR—How does New Zealand rate? Obviously, some of the entrants to Australia might be coming via New Zealand. I would assume that our checks through the New Zealand gateway are not as strict as through some of the other ports.

Mr Hughes—I would have to get those figures for you, because we did not have New Zealand as a comparator in our last annual report. I am not sure why we did not pick New Zealand.

Ms GRIERSON—We were five times higher than some of those comparators, weren't we?

Mr Hughes—No, five times lower.

Mr Kalisch—To answer your question from the health perspective: we are certainly not aware of any increased or enhanced risk that we have seen to public health as a result of formal structures not being in place and we have seen nothing that would be of risk. The key to the ANAO report and why both departments have worked hard to accept the recommendations and worked hard to implement them is that we are looking at managing the future risk better.

Senator HOGG—I have a couple of process questions and they follow on from what the chair was asking. Whilst both departments welcomed the independent report and embraced the recommendations, my question goes to the issue of: why was it necessary in the first place to have the ANAO report bring both departments to the realisation that there were major deficiencies? In other words, what was wrong with your own internal audit processes that they did not recognise these gaps? If your own internal audit processes did not recognise these gaps, what have you done with your own internal audit processes now to monitor these things into the future?

Mr Hughes—I will start by answering that. It is not unusual for the ANAO to recommend improvements in particular systems in any agency and improvements in the way that government departments do their business. I think almost every audit report would—

Senator HOGG—I am a great fan of the ANAO, so don't worry about that.

Mr Hughes—Almost every audit report in any area would recommend things that are generic across government—for example, formalisation of arrangements. I do not think it is unusual that agencies have formal arrangements, partnership arrangements; at other times, things are done informally. I think the ANAO would usually urge us to be formal, as we have now been in this case.

Senator HOGG—But my question goes to internal audit processes; that is what I am interested in.

Mr Hughes—On the internal audit, I will ask one of my colleagues what has been done in the past and how that has interacted with the ANAO's external audit.

Mr Farrell—As I mentioned before, we are going to formalise procedures where in the past we monitored them. So we recognise that is going to be an improvement. I think the ANAO would acknowledge it.

The absence of formal procedures did not necessarily mean we were not doing anything. For example, with the IT recommendations, we already had a health portal planned. We had already done an end-to-end review process about processes, with a view to seeing how we could improve that and also how we could translate that into the e-world, to make sure we have a better process. Also, in terms of their other recommendations around our overseas panel doctor network, again that is something we monitor constantly, and we are looking at ways of improving our management of that system.

In terms of our interaction with Health, as you have seen we have developed an MOU. In terms of other protocols et cetera which they wanted, my reading of a lot of the ANAO recommendations was that there were things there, but they were just not documented in the way they would like them to be, including around the health matrix for example. That is obviously viewed as a deficiency, but, as we have been explaining, we of course monitor the TB rates in the country et cetera and monitor trends around the half-a-million people who come in annually. So, if there were trends that we saw, we would of course make adjustments to our processes and our policies.

Senator HOGG—I accept all of that, but monitoring is one thing; having an internal audit process is another. That is what I am interested in: is there an internal audit process that oversees your programs and identifies the weaknesses? I understand how very good the ANAO are across a whole range of departments; they will go in and find difficulties—

Mr Learmonth—I chair the audit committee within Health and have done so for about a year. I would make a couple of comments in respect of this area. Our role is largely one of technical advice to the Department of Immigration and Citizenship on the administration of the act. So, in terms of priorities, in a context where there are good operational linkages, my suspicion is that the audit committee has not focused on it as a priority compared to other things.

That said, what the audit committee does is to monitor very carefully all of the indicators that it can, for risk in our programs. We look at our own internal compliance reports and our own internal audits. We have a self-reporting compliance tool that all of our managers are required to use regularly as part of compliance work. We look to a whole range of indicators that we review regularly, and try and discern themes from that about where we think the risks are that feed into our risk plan and our focus for our own audits. So we are very active in that.

With respect to ANAO recommendations, we also review outstanding recommendations regularly at the audit committee meetings—we take them seriously and we look for progress. John will correct me if I am wrong, but it is, perhaps, slightly unusual in that we have a member of the ANAO—Mr Meert in this case—on our audit committee, which assists us as well in that fashion.

Mr Meert—Yes.

Mr Hughes—I have some supplementary information on that point which we left not fully cleared up. We similarly have a very active departmental audit committee and a very active internal audit program. We have an external chair of the audit committee, and ANAO is represented on the committee. Again, the audits are risk based. I cannot recall there being an internal audit of health processing issues, but we can find that out for the committee and advise you later.

CHAIR—We are running out of time. I thank our representatives from Thailand. Thank you very much for coming along from the Thai parliament. Welcome and goodbye.

Ms GRIERSON—How current are all the personnel at the table, and your departmental sections that are dealing with this, in their formal risk management training of any kind?

Mr Learmonth—I will take Health to start with. We are right in the very midst of a significant enterprise risk management exercise which has involved discussions, workshops, external training consultants, executive scrutiny et cetera, and we are near a final version of all of that culminating in the latest iteration of our enterprise risk management plan—something that is right at the forefront at the moment.

Ms GRIERSON—I would have thought that DIAC, in its restructure and reappraisals, would have had that sort of program implemented.

Mr Hughes—Yes. Similarly we have a very active assessment on risk management and we have corporate level risk management plans, but we also cascade these—

Ms GRIERSON—I mean training.

Mr Hughes—I was coming to that. That cascades down into division and branch risk management plans, including covering these areas. There is some training, but I cannot give you details of that on the spot. I could find out for you and advise the committee later.

Ms GRIERSON—Okay, thank you. I am a great supporter of the IHSS program, yet I know its costs on the ground. Audit does an audit in terms of performance, systems and process. That is wonderful. It is a rigorous audit that deserves great scrutiny and response. But when I look at the IHSS and immediate risk in terms of health priorities—TB, HIV, physical and emotional trauma; although someone is shaking their head—and a thousand new settlers in a region like mine, I would have hoped that that was really well informed by analysis of those needs by a health department and advice to you on how to best manage that. I am talking about African settlers particularly, who have high health needs. Did that process occur, for example, in an important program like that?

Mr Kalisch—There has been a separate process within government around looking at the settlement programs. Government has made decisions about expanding a number of those programs, including support for sufferers of torture and trauma, for example, and a number of other things that have taken place on the immigration side.

Mr Hughes—I think it is fair to say there has actually been a great deal of work done on the potential risks associated with the settlement of people from new countries where there might be diseases or conditions that we are not familiar with in Australia, or for which there is not a great deal of expertise in Australia. That has been done from the point of view of both the health of the individuals coming to Australia and the community. For example, one of the initiatives that were introduced as a result of that work was pre-departure medical screening. For example, we found people who were screened—

Ms GRIERSON—It is the follow-up services, and that is a side issue for you but not for me. The follow-up issues were raised by the audit report in terms of the people who come with health undertakings and health waivers. The monitoring of those health waivers and the follow-up presentations to the state government agencies were found to be deficient. What has happened to improve that since that report?

Mr Hughes—We have developed a number of proposals which are being considered within government for funding at the moment. The only issue is that a formal system of follow-up is very resource intensive. It has not been previously done in the history of use of these undertakings, but there are some major proposals before government at the moment for which, hopefully, the outcome will be known soon.

Ms GRIERSON—Does this require additional funding?

Mr Hughes—The health undertakings are for people who pass the health requirement but for whom some follow-up monitoring might be advisable. If you are talking about doing that for a very formalised system of checking on a very large number of people, then it requires resources for a system—if you are saying that we need to guarantee that every one of those people is linked up with a state health service.

Ms GRIERSON—Is there not a simple software program or monitoring system that could be put in place that triggers some sort of response if there is no report?

Mr Hughes—If you are going to interact with it with a number of people, there are resources involved. We want to not just report on who has done it but ensure that everyone has done it, and that requires resources.

CHAIR—The report addresses a lot of the public health issues. It goes through hepatitis and tuberculosis, and we have those pretty well articulated. What about things which fall outside that area? How do you identify one-off risks to public health? How do you manage that screening process, and where does it take place if, for example, it is a variant flu or some other very localised illness which we do not know about until all of a sudden someone appears dead on your doorstep?

Ms Halbert—Obviously, we would have to be notified of a health risk that occurs offshore or detect it in some way. But if the Department of Immigration and Citizenship were to provide us with information about a new, emerging, perhaps unknown health risk, we would seek the advice of experts through the Australian Health Protection Committee and the Communicable Diseases Network Australia to try to provide—if it were urgent—very quick advice on the potential health risk. It might be avian influenza or another known or unknown disease. We would provide advice about the potential health risk and, probably, advice about whether it was advisable for that person to travel at the time, rather than advice about immigration policy. We also have obligations under the international health regulations to potentially notify the World Health Organisation if we saw an unusual and potentially international health risk.

CHAIR—But that is when you know the person has got it.

Ms Halbert—If someone came into Australia and was ill, they may be detected by our border measures at airports where the quarantine service provides services to support the airlines. They may be detected in a general practitioner's office. In fact, in the recent case of someone who came to Australia—he was on a tourist visa in Australia but went home to Pakistan to visit his family and came back with active polio—he was diagnosed by a general practitioner who took the case to hospital. We immediately put in place our contact-tracing procedures. We have a

cooperative arrangement with the states. We ensured that his close contacts were quarantined and that he was put in hospital isolation and treated. It was detected and dealt with very quickly.

CHAIR—It sounds to me that in that sort of situation, because of the international focus and the fear that is created, there is a heightened level of activity and coordination that takes place between Health and Immigration, which perhaps has not been replicated in some of the more standard diseases which are there and perhaps not updated.

Ms Halbert—We have taken similar action in relation to measles and so on. The key action from Immigration in that case is to provide us with the passenger list so that we can contact trace anyone who might have been in close contact with the person with the contagious disease. It is a routine activity that we undertake for common diseases as well as for unusual ones.

Mr Parsons—I would add that one of the things that was formalised under the MOU was the provision of a fortnightly, I think, international health surveillance report that the department of health receives from the international community. That is, I would think, a means whereby new and emerging issues in the overseas arena can be brought to the attention of both the department of health and the department of immigration. So we can be alerted to new strains of disease which have high mortality rates in overseas locations before they actually arrive onshore.

CHAIR—As to the 3,600 or 4,000 overseas panel doctors: how do you determine their credibility and expertise? Is there a set procedure in place there? How often is that updated to make sure that we do not have anyone with cornflake-box certificates providing a service because they happen to be the only person in that geographical area?

Mr Farrell—We have a global medical unit, based in Sydney, which manages the panel doctor network. Initially it would, of course, make them aware of Australia’s requirements in terms of assessing applicants, put them through a process to make sure they could abide by that and meet our standards for screening applicants, and screen them in the appropriate way. So an initial assessment is done and then there is regular follow-up, either through emails or by personal contact with the panel doctors, to make sure they are up to date and their procedures follow our standards.

CHAIR—Does the Audit Office have any comments to make on anything that they have heard?

Mr Meert—I think it is a very good response to the recommendations and the support we had through the audit, so it is great.

Senator WATSON—Do you have any response to recommendation No. 6? I do not think I am satisfied. It is on page 116.

Mr Lack—That recommendation is to do with following up with the states and territories, with a view to trying to put in place some arrangements whereby they could better monitor and report on compliance with the health undertakings.

Senator WATSON—In the first part, the ANAO recommends that DIAC:

... develop guidelines on health undertakings to provide the basis for more transparent and consistent decisions ...

Yes, they have agreed, but then they go on to say that they have ‘commenced a review’. That still does not tell us very much about what they have really done. So, yes, you are reviewing it, but I do not think that is really an adequate response. What has happened since you wrote those words as a result of the review? I think that is what we really need to know.

CHAIR—Well, who wants to answer: Immigration or Health?

Mr Hughes—As has been observed, there are two parts to that: there is looking at the guidelines on the actual requirements for health undertakings, and the other is making sure, as much as we can, that people who are subject to a health undertaking do actually connect with the medical services. I mentioned, in response to another question, that we have a funding package before government to put in place a set of arrangements that will give us a higher level of compliance. In relation to—and as part of that process—we have been looking at the guidelines on when health undertakings are required.

Senator WATSON—Did you set any guidelines as a result of that recommendation, though? You may have developed some guidelines, but where are the guidelines? Have you got them for us? Where are the guidelines?

Mr Farrell—Once government tick off some measures that are before us—we need to make sure they are comfortable with our approach—those guidelines will be developed. There are already guidelines in place. There will be enhanced guidelines around the new procedures.

Senator WATSON—But, obviously, your guidelines cannot be satisfactory if the Audit Office has told you to develop guidelines on health undertakings to provide the basis of more transparent and consistent decisions. So I am saying to you: you have agreed with the decision or the recommendation, so where are the guidelines?

Mr Parsons—The guidelines are part of the package that is before government.

Senator WATSON—But you have not developed them yet?

Mr Parsons—The guidelines—

Senator WATSON—These are the ones they are referring to.

Mr Parsons—The difficulty we have is that if we develop guidelines against a package which is rejected by government then the guidelines are worth nothing. So our sequence of events is: to propose a policy response, which is part 2, and then, once that is accepted in full by government, it is appropriate to develop the guidelines as part of the implementation of the new—

CHAIR—When do you expect the government to tick off that package?

Mr Parsons—I am not certain. I know Minister Andrews outlined at the very highest level the thrust of the policy in a media interview some months ago, but my understanding is that the paper will be going through consideration very soon.

CHAIR—Does it need a Minister Andrews tick-off alone or also a Minister Abbott tick-off? Does it require tick-offs from both ministers?

Mr Hughes—Just our minister.

Senator WATSON—The report was issued in May 2007 and you still cannot give us any of the guidelines because you are waiting for a minister to tick off some recommendations from the department as to how you should proceed?

Mr Hughes—In relation to the eight recommendations, that time has been spent developing a whole lot of new processes across the eight recommendations, of which the guidelines are one. A lot of work has gone into that and the mechanism for following up health department undertakings. I think what we are saying is it is very close to fruition.

Senator WATSON—I would like to see some sort of follow-up. I would like to see the guidelines submitted to the committee to show your bona fides on this issue.

Mr Hughes—We can do that when the package is signed off by government.

CHAIR—Thank you. There are a couple of things we have asked for which I would like to see.

Senator WATSON—It is all very well to just accept these undertakings, but we want to see an implementation.

CHAIR—We have a commitment that they will provide those to us, John, so we will follow that up. One of the other criticisms was about data management and there not being a central repository for information, particularly health data. You have accepted that recommendation. Where is this all going to be located? Is it going to be located in Immigration or in Health, or are there two systems that are finally going to talk to each other?

Mr Parsons—The issue that the ANAO drew to our attention there was within the Immigration portfolio. There are many and disparate computer systems that have data for particular visa classes but no overarching ability to draw that together. In the Systems for People IT initiative, one of the early deliverables was a health portal specifically designed to provide that horizontal service across all vertical visa classes. Again, the health portal has not been released yet. It is in the final stages of construction and it is on the agenda for implementation, I believe, in the next calendar year. So it is well advanced.

CHAIR—And it has been budgeted for?

Mr Parsons—Yes. It is part of the Systems for People program.

CHAIR—We have run out of members because they all have speaking engagements elsewhere. I apologise for that, but I think we have probably exhausted our questions, unless there are closing comments that representatives of either department or the Audit Office would like to make. No?

Mr Kalisch—No.

Mr Hughes—No.

CHAIR—Thank you very much. We may have additional questions. If we do, we will submit them to you and we would like you then to respond if possible.

Resolved (on motion by **Senator Watson**):

That this committee authorises publication, including publication on the parliamentary database, of the transcript of the evidence given before it at the public hearing today.

Committee adjourned at 12.28 pm