



# CONCERNS ABOUT THE FUTURE OF HEARING SERVICES FOR DEAF & HARD OF HEARING CHILDREN

Submitted to:-  
Senate Select Committee on Health  
10 JULY 2015

## ABSTRACT

*This submission raises issues regarding the future delivery of hearing services for deaf and hard of hearing children that must be addressed satisfactorily by the Government before any changes are made to the existing systems.*

*The future ownership options of Australian Hearing, and funding and support arrangements through the NDIS, should not diminish in any way the current world class delivery of the Community Service Obligation (CSO) by Australian Hearing, or the pathways to appropriate early intervention supports.*

*These are the views of Parents of Deaf Children (PODC) representing some of the NSW parents of deaf and hard of hearing children.*

*Our group is run by parents with the lived experience of raising a child with hearing loss.*

*We are confident that our concerns and experiences speak for a wider community: national; regional and remote; culturally and linguistically diverse and representative of a wide range of socio-economic backgrounds.*

**Anna Messariti**  
President PODC



**Submission to:**

**Senate Select Committee on Health  
Hearing at Australian Hearing Hub  
Macquarie University, NSW  
10 July 2015**

Dear Senate Select Committee Members,

Thank you for providing an opportunity for *Parents of Deaf Children (PODC)* to participate in the *Senate Select Committee on Health*, to discuss the many and varied issues associated with the proposed privatisation of Australian Hearing. The invitation to discuss hearing impairment, deafness, and related health issues and in particular, access to healthcare and services for people who are deaf or have a hearing impairment, is greatly appreciated.

At the present time, high quality hearing services are delivered and made accessible to all eligible Australians, by expert practitioners. This high level of care must be maintained, so that the outcomes for deaf and hard-of-hearing children in Australia now and for future generations, can be maximized. Quality of care and outcomes must remain as the highest priorities. These should not be placed at risk by potentially short-sighted policies and practices that seek to explore “market forces” and “contestability” in the context of delivery models.

PODC is concerned about the financial models that are being considered by the federal *Department of Finance* in relation to the *Community Service Obligation (CSO)* program and Australian Hearing. Ultimately, what is at stake is a health and social issue that will affect disabled children and their families, not a financial issue. It needs to be addressed carefully.

The primary focus of a hearing services program and the pathway to early intervention, should always be on deaf and hard-of-hearing young Australians gaining specific and appropriate supports associated with their hearing disability. This is so that they can communicate and learn effectively, resulting in those young people achieving their optimal developmental potentials in social, educational and personal spheres.

At this time, PODC believes that ‘best practice’ for a national hearing services program and the pathway to early intervention supports, has NOT been clearly and unambiguously defined by suitably qualified and independent health professionals and academics. This needs to take place PRIOR to the implementation of a potentially massive change in available services, service delivery mode, and/or funding provisions.

The future of the most vulnerable in Australian society is currently at stake.

It will not be possible to reverse the poor outcomes that emerge, as a result of poor hearing services or pathways to early intervention supports.

Successful early intervention programs rely on correct audiological assessment and frequent revision in the early years, as well as the use of appropriate hearing appliances and fittings. Access to these hearing support programs and services is required promptly and must be continued throughout the development of a child's youth, otherwise ongoing issues that cannot be addressed, will be the end result.

Yours sincerely,

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A handwritten signature in black ink, appearing to read 'Anna Messariti', written in a cursive style.

Anna Messariti  
President PODC

## 1 OVERVIEW

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With regard to the possible sale of *Australian Hearing* and the associated *National Acoustic Laboratories* and eventual integration of hearing services into *NDIS*, *Parents of Deaf Children* (PODC) ask: -

- “Why is the Government seeking to change an organisation and programs of support that are performing so well, and are recognised as world leading?”
- “Why is the Government making significant changes, when the full scope and functionality of an interconnected system involving: diagnosis; hearing appliances and equipment; medical services; client management; social and educational support and pathways to early intervention supports have not been: researched; defined; clearly understood and documented, in national policies and procedures?”

In 2014, the *Australian National Audit Office (ANAO)* reported that the *Community Service Obligation (CSO)* program, “is being effectively administered by *Australian Hearing*” [1].

*Australian Hearing* and *National Acoustic Laboratories (NAL)* are recognized as delivering world-leading hearing services to deaf and hard-of-hearing children [2].

The *ANAO* reported that the *Department of Health’s Memorandum of Agreement with Australian Hearing for the CSO Program*, has sixteen Key Performance Indicators (KPI’s), with which to monitor the achievement of the CSO’s objectives. This appears to be a significant number of performance metrics, but these 16 KPI’s only partly cover the full scope of the requirements of a good hearing services program. The lack of a full suite of KPI’s or a “best practice” benchmarking tool for a hearing services program, can presently be accommodated, because *Australian Hearing*, as the single service entity with national coverage, has been delivering a world-class service for many decades.

PODC’s investigations suggest that the *Department of Health* has not yet clearly, comprehensively, independently and unambiguously, defined - what is “best” or even “good” practice, with regard to hearing services delivery and pathways to early intervention supports for deaf or hard-of-hearing children. This is a matter of great concern.

In 2008, the *United Kingdom’s Department of Health* did define “good practice”, two years after the full introduction of the *Newborn Hearing Screening Programme (NHSP)*. [3]. The UK organisation, *National Deaf Children’s Society* was a key contributor with regard to this UK Government document and also has a position statement on *Audiology Service Provision* in the UK [4].

There has been a negligible amount of consultation or information exchange with the most affected or at risk, deaf and hard-of-hearing children and their parents or carers, and their representatives [5]. The Federal Government has been determined to progress the *Contestability Framework* as applied to *Australian Hearing*, without fully considering and understanding the linkages, pathways and client management that exists between audiological diagnosis, CSO, medical interactions and early intervention supports.

The Contestability Programme, initiated and led by the Department of Finance, is primarily concerned with two major elements: cost and making an exit from government provided service delivery. The *Department of Finance* has noted that the Commonwealth Public Sector:

*“..aims to continually improve its ability to utilise the skills and capacity of the private and not-for-profit sectors to deliver services at the same and better levels of quality at reduced cost.” [6].*

PODC believes that the level of service delivery that is required from a hearing service program, is poorly understood by the Department of Finance. As a result, the Department of Finance, cannot deliver on its statement. Service and quality levels, should not be defined by the *Department of Finance*, but by the *Department of Health*. Again, hearing services to deaf and hard-of-hearing children, is and must remain a Health and Human Services issue, not a Finance issue.

The *Scoping Study on the Sale Options for Australian Hearing*, conducted for the *Department of Finance* by PwC, will not be released for public review, because of commercial-in-confidence information. This highlights the fact that the focus of the government, is on financial issues, not hearing service delivery. This is not appropriate.

The focus of the government must always be on the best possible short and long-term outcomes for young Australians who are deaf or hard-of-hearing. Any changes to Hearing Services under the *CSO* or *NDIS* must be risk assessed. Changes should not be implemented unless there is certainty that the changes will not affect client outcomes. Currently, under the *CSO* Program, service provision maintains a client outcome focus, rather than a profit focus.

*“The lack of age appropriate language development and literacy skills have substantial negative effects on the child's cognitive and social development which, in turn, interferes with success in school and later life, especially in the development of reading and related activities.” [7]*

**PODC believes, that the balance of concern shown to date by the Federal Government, has been biased towards the current business operation and potential market models. The driving force has been around efficiencies and fiscal dividends, rather than the client outcomes that are achieved through service provision.**

**PODC requests that a national “best practice” model, and guidelines for a hearing services program and the pathways to early intervention supports, be clearly and unambiguously defined, by suitably qualified and independent health professionals and academics. This must take place PRIOR to any changes being made to available services, service delivery modes, pathways or funding provisions.**

This submission details parents’ concerns and likely risks associated with possible changes being considered by the Government in relation to the sale options of *Australian Hearing* and *NDIS* integration of the current hearing services program through the *CSO*.

PODC's requirements, detailed in this submission, should form some of the metrics for the scope, quality, pathways and management of service delivery, to deaf and hard-of-hearing children. These requirements must inform the way in which a "best practice" system is defined and measured as well as how it will operate in practice.

The knowledge contained within this submission has been gained through the lived experience of parents and carers. As parents, we are engaged in managing our child's/children's' disability 24 hours a day, from birth. PODC believes that the parent concerns that it has highlighted in this submission are of the highest importance, as they are the concerns that truly reflect and champion, the best outcomes for children.

## 2 FUNDING

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Any system should provide and prove to be ‘value for money’ in the context of services provided. PODC accepts that this should also be the case for the Hearing Services program through the existing CSO, or through any future funding arrangements made to provide hearing services through the NDIS. In striving to achieve the best “value for money”, it is important that a high standard of service delivery is always achieved, without sacrificing appropriate timeliness, type, quantity, or quality of supports. If these requirements are not met early in a child’s life, the future cost implications to the economy are significant, through additional or ongoing disability supports and welfare as an adult. Even more significantly, the future potential loss to the individual is lower socio-economic outcomes and quality of life.

*“When children are not identified and do not receive early intervention, special education for a child with hearing loss costs schools an additional \$420,000 [USD], and has a lifetime cost of approximately \$1 million [USD] per individual. (Johnson et al., 1993)” [8]*

*“The Center for Disease Control and Prevention has estimated that the lifetime economic cost to the public for a child with hearing loss is over \$400,000 [USD], mostly for special education services. (Honeycutt et al., 2004; Mohr et al., 2000)”. [8]*

- a) *An open market will allow for providers to operate without constraints and create an opportunity for multiple providers to operate. As a result, there will be no longer be bulk purchasing arrangements for hearing aids. The current buying power and not-for-profit nature of Australian Hearing, ensures that its CSO clients have access to high quality hearing aids, with higher levels of technical capability and features. This excellent provision is because of this volume price reduction and the existing business model.*

*Hearing devices are classified in a range from Level 2 to Level 7, based on the capability and features of each model. Australian Hearing supplies Level 5 as standard. In the ‘contestable’ UK and NZ markets, customers are averaging Level 3.*

This current bulk-buying advantages of Australian Hearing, provides a higher level of equipment to clients and as a direct result, better outcomes. The higher level of hearing appliances supplied must be maintained. If bulk-buying power is lost, operating costs will increase. The future potential for subsequent downward pressure on appliance quality or features will prevail. It is therefore difficult to see any economic advantage in this aspect of a completely open market arrangement, given the low unit cost for hearing appliances that is now being achieved.

- b) *Families have expressed that they would rather forego having a choice of service provider, to ensure that they receive a high level of hearing aid technology as well as the maintenance of trusted, reliable, quality services.*

If an open market model is pursued, the Government must ensure, through meticulous regulation and auditing, that private companies will not try to maximize profit margins by reducing overheads. The risk that we are seeing is that a market model will trigger a “race to the bottom”, with regard to: the quality of service; the reach of services and the quality of hearing appliances and equipment.

- c) *The development of high quality technology has changed the educational outcomes achieved by deaf children. For these outcomes to occur, research has shown that children need **appropriate**, high quality listening devices. These include hearing aids, cochlear implants and FM systems. The system “should ensure that maximum audibility has been provided to the child, thus offering the child optimal access to spoken language.” [9].*

*The NDIS operational Guideline “Planning and Assessment – Supports in the Plan – Assistive Technology” states “...It is expected that the NDIS will generally only fund the **minimum necessary or standard level** of assistive technology.” The **minimum necessary or standard level** of technology will deliver very poor outcomes and is not the same as the “**appropriate**” level of technology. Each child is unique and some children have quite complex needs. It is not possible to recover lost early intervention time, if the technology issued for accessing listening and learning is inadequate. A degradation of the quality of hearing technologies that are made available to deaf and hard-of-hearing children will undoubtedly result in less than optimal developmental outcomes. PODC believes that:*

- i. Children must not be disadvantaged under the NDIS with lower levels of assistive technology, when under the current arrangements with *Australian Hearing*, appropriate levels of technology are provided based on each child’s specific, clinical needs.
  - ii. The financial needs for technology upgrades, will change for children from year to year. Funding models must be able to accommodate prompt delivery of improved or more appropriate technology, or devices with improved features, *as they are released*, all of which assist in delivering better outcomes for children. The change in funding costs associated with technology changes, should not affect other funding that the child may receive for Early Intervention supports.
- d) Cost items associated with the use of hearing appliances, such as assistive technology (e.g. FM’s), consumables such as batteries, cleaning, storage and testing equipment, repairs, and provision for lost or broken equipment, all need to be included as standard support items in any *NDIA* plan for a deaf or hard-of-hearing child. There does not appear to be a support item price for ear moulds in the *NDIS* price schedules. Ear moulds need to be replaced frequently in the first two years of life and regularly as a child grows. Newborn babies need ear-mould replacement, at two-weekly intervals. Fittings require a visit to a specialist paediatric audiologist for new impressions to be taken. [3]



- e) *The support and advice that is provided to schools, itinerant support teachers-of-the-deaf, Early Intervention support organisations and service providers and other groups such as PODC, around hearing aids and a child-specific technologies, is currently provided free of charge by Australian Hearing. This service can be provided to a whole classroom, school or group, in one visit by Australian Hearing.*

In a 'contestable' scenario, the Government must seriously consider how it will achieve "value for money" on a cost-per-visit basis, if multiple organisations provide these types of services to deaf children, their families, communities and support groups. The Government must also consider how it will deliver these types of services, outside of individually funded packages.

### 3 PATHWAY FOR GAINING ACCESS TO SUPPORT AND SERVICES

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*“Infants with hearing loss typically will not spontaneously develop language and literacy because most language development occurs before 18 months of life and lack of typical auditory and/or supplemental visual input during this critical period will irreversibly interfere with the healthy development of language and literacy skills.” [7]*

*Currently, the CSO program is embedded within diagnostic and Early Intervention pathways for babies and children. This process is streamlined. There is little delay when it comes to gaining access to services and appropriate devices. This is critically important because early detection and amplification is the key to good outcomes. In terms of accessibility, the NDIS process is slower and less responsive, involving confirmation of eligibility, developing a plan with an NDIS planner, choosing supports, implementing a plan and reviewing that plan.*

*Having Australian Hearing as a single reliable, organised, quality service provider, means that there is less risk of a child missing out on the vital Early Intervention that we know is critical for infants. There is also less risk of older children who are diagnosed later, becoming lost in the system and not receiving the necessary follow-up services in a manner that is timely and effective.*

*“The initial emotional response to a diagnosis of hearing loss for most hearing parents may cause increased stress, rendering them emotionally vulnerable and susceptible to bias that may be provided by ‘experts.’” [7]*

*Over 90% of deaf or hard-of-hearing children are born to hearing parents. These parents need a trustworthy and reliable system to support them and their child, as their pre-existing knowledge of what is required to achieve the best outcomes for their child in relation to a hearing disability, does not exist.*

- a) Parents, medical and diagnostic services, NDIA planners and Early Intervention support providers, need to establish a “best practice” guideline to follow for the management and ongoing care, of a newly diagnosed deaf or hard-of-hearing child. The pathway needs to be clearly defined and documented and should not be left entirely to the parents to navigate, at a time when they are emotionally distressed.
- b) Under the NDIS, planning and funding pathways for infants and older children who are diagnosed with hearing loss, need to be prioritised to minimize any delays in accessing sound through hearing appliances.
- c) Assurances and systems must be in place so that clients will not become lost in a system, where there may be multiple service providers.
- d) Consistency of approach to appointment allocation is required, in order to ensure that sufficient time is provided for the audiologist to test and fit young babies and children with appropriate devices. Newborn babies need frequent ear-mould replacement, often two-weekly and they can be difficult to fit. [3]
- e) The NDIS must avoid the addition of another administrative layer that will inhibit timely access to Early Intervention services and support for newly diagnosed

families. Currently, access to the *Hearing Services CSO Program* via *Australian Hearing* is easy to manage with regard to administration and speed of delivery.

- f) Clients in rural and remote areas need to have access to an equivalent level of expertise and the quality of service that can be made available in urban areas. A coordinated approach to the screening of children, especially in remote locations, such as Aboriginal and Torres Strait Islander communities, must be continued.
- g) *Annually, there are around 2,000 children who are fitted with hearing aids for the first time, of which only approximately 250 are infants [10]. As a result, the clinician's exposure level to paediatric clients is low, and would be even lower, if these children received services from multiple providers. Special skills, specific training and a high level of experience in audiology, is required prior to servicing paediatric clients.*
- i. If CSO services are delivered by multiple organisations, it is difficult to envisage how commercial hearing service providers will see enough paediatric clients per year to maintain this specialist competency. This is an even more challenging question in situations where rare or complex needs arise. The UK Department of Health states that: *"To maintain competence and continually update skills in assessment and habilitation, individual audiologists need to assess 20 – 30 new cases per year to ensure best practice and improve expertise."* [3]
  - ii. The audiology profession is self-regulating at the moment. Parents and carers of babies and children need to be completely assured, that the audiologists who are and will be delivering services to their children, are qualified and experienced enough to undertake the complex, specialised paediatric work that is involved. It is not as simple as a professional declaring that they have 'an interest in working with children'. Government regulatory measures must be in place around the audiology profession to ensure that audiologists will be qualified, competent and declared safe, to work with children from 0-18 years of age. Currently, there is no legislative system of registration which requires proof-of-experience (detailing caseloads within specific time-frames), capability and professional qualifications for audiologists. Staff in audiology clinics will need to undertake "Working with Children" checks and compliance will need to be strictly monitored.
  - iii. Private audiology service provider organisations, have indicated that there are a number of *ex-Australian Hearing* trained paediatric audiologists now operating in the private sector and that these individuals are ready to provide a service. This may provide a service now, but if the large training infrastructure facilitated by *Australian Hearing* is a casualty of privatisation, there is a future risk that the number of newly-trained paediatric specialists will decrease over time. The number of appropriately skilled paediatric audiologists may drop below the numbers that required to provide adequate services. Also, the standard of quality of in-house or on-the-job

training for paediatric specialists in the context of a contestable market, is obviously going to be very difficult sustain or validate, in an environment featuring multiple small, service providers.

- iv. *Australian Hearing* has developed a number of technologies, for example specialised, cutting-edge cortical testing equipment. It is difficult to see how the majority of commercial providers would be able to own and provide the expected range of appropriate equipment and expertise, needed to test newborn and infant clients, given the low number of newly-diagnosed paediatric clients each year. It is also difficult to see why commercial providers, would invest heavily in technologies that will only equip them to deal with 'thin markets'. Any alternate service providers offering paediatric services would need to be transparently ranked, assessed, approved and regulated.
- h) Audiology centres must have wheelchair and pram access and the capability and size to be child-friendly, including carers and siblings. Equipment and sound booths must be appropriate for paediatric requirements. Staffing levels also need to be adequate to ensure that testing is carried out to the highest standard. The current practice with regard to hearing tests for babies and children provided by *Australian Hearing*, requires the scheduling of *two* paediatric specialists to be present during a test. This is to ensure that the process is well-managed and to objectively confirm a diagnosis.
- i) Any new system or model must ensure that *all* children, (including those whose parents cannot be a strong advocate for them, due to factors such as having English as a second language, low socio-economic background or poor education), continue to receive appropriate paediatric services.
- j) Translation services will need to be provided as required, including AUSLAN. Parents from English as a second-language backgrounds, will require more time and understanding, when communicating with Audiologists during appointments.
- k) *Aboriginal and Torres Strait Islander* families, migrant families and Deaf families, require culturally appropriate services and interpreters, so that they are able to understand their child's hearing loss and needs. This is essential for them to be able to make informed decisions. Some families have to deal with cultural sensitivities, such as family and group acceptance surrounding the birth of a child with a hearing disability. This may have a significant impact on that child's development, if hearing aids are not worn as often as possible and Early Intervention is not undertaken regularly during the first 18 months of life. Service providers need to be aware of the full range of these issues, when they are dealing with paediatric clients.
- l) Children and adults who are diagnosed with complex hearing problems, require specialist testing and technical support currently received from NAL. This highly specialised service still needs to be provided, supported and funded in the future.

## 4 ACCESS AND QUALITY

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*The Government has noted in Senate Estimates and in recent press releases, that access and quality will be protected with any decisions regarding Australian Hearing and services.*

*This assurance is given even though there are no national “best practice” standards for: service quality; timeliness; quantity; accessibility; delivery; protocols; safeguards, or pathways.*

- a) *The entire support structure for deaf and hard-of-hearing children in Australia, is built around the nationwide services provided by Australian Hearing. This includes liaison and interactions with not-for-profit deaf support and Early Intervention services, schools and other disability support organisations.*
  - i. The provision of hearing services and supply of hearing appliances is research-based and consistently applied across all of Australia, through *Australian Hearing*. This level of service and assurance of quality must be maintained.
  - ii. *Australian Hearing* interfaces with schools and other services, such as itinerant support teachers, Early Intervention supports and parents groups, in order to ensure that children’s access to their specific technology is well understood and functioning optimally in the classroom or home setting. This is currently provided free-of-charge and can be provided to a whole classroom or school, in one visit by *Australian Hearing*. This may not be initially considered or covered under a child’s individual NDIS support plan for Hearing Services, or be available from a private service provider. Potentially, multiple services providers may visit one classroom or school, rather than one provider, servicing all children in the class/school at once.
  - iii. *Australian Hearing* provides nationwide coverage through 127 hearing centres, as well as remote locations via 217 outreach sites. At a stakeholder meeting in Sydney on 19 June 2015, the *Department of Finance* provided very limited information from the PwC Scoping Study, detailing that *Australian Hearing* had a similar site profile to other providers when comparing metro, regional and remote locations. However, the basis of this analysis was not disclosed. The figures presented were decidedly odd. This lack of disclosure and explanation meant that the capability of the other provider sites to deliver or accommodate specialised paediatric service obligations, was also not disclosed. This analysis needs to be revisited.
  - iv. It is unlikely that providing hearing services to rural, remote and outreach areas will be as “cost effective” as city areas. There must be guarantees on the level of service delivery to ensure that all Australians receive an equitable national standard of service.

- b) *Currently, the pathway from diagnostic audiology to Australian Hearing, is both efficient and understandable for families, at a critical time. It is a time when families have minimal knowledge and are faced with maximum stress. This effective pathway reduces the burden of decision making. It also means that there is minimal delay in providing hearing aids to newly diagnosed babies. Australian Hearing prioritises access for newly-diagnosed families.*

NDIS administrative processes may have the potential to create administrative delays in the pathway to accessing hearing and Early Intervention services, slowing a child's access to assessment and hearing appliances. This could also increase the risk of poor outcomes in learning, language, and speech, because of the delays in accessing sound. Priority services are required for deaf and hard-of-hearing babies.

- c) *Parent counselling and support services at the time of hearing disability diagnosis varies from state-to-state. Often, Australian Hearing is the first source of comprehensive information, and the point at which families receive the 'Choices' booklet detailing aspects of a child's hearing loss, testing and contact details for support services.*

Parent support and information needs to be improved in terms of availability, timeliness of delivery, and consistency across the country. This will allow parents to start understanding the world that they have entered into *as well as* the pathway and decisions they need to take and make.

- d) *PODC knows that the current transition out of the CSO program for young adults, (i.e. under 26 years of age) is a daunting time even though they are experienced with hearing loss, hearing appliances and audiology testing, as they try to find a private audiologist who understands their hearing needs. If Australian Hearing is privatised or disaggregated, the 'search for an audiologist' is going to be infinitely more challenging for parents with a newly-diagnosed baby, as they have no experience in the hearing service provision world.*

Parents need to be provided with unbiased information when choosing Hearing Services providers. As previously stated, the quality, qualifications and capability of service providers, will need to be regulated, checked and controlled.

It is noted as a positive initiative that deaf and hard-of-hearing adults (those between 26 and 65 years of age) will now be able to apply for hearing services supports through participation in NDIS, and that legislative changes in 2013 expanded eligibility for CSO to NDIS participants.

- e) *The NDIA area coordinators have general disability knowledge and not specialist disability knowledge.*

Without a detailed, national Hearing Services and Early Intervention framework, or pathway for hearing impaired children, there is no system in place to ensure the NDIA coordinators fully understand, or include in an NDIS Plan, the complexity and requirements of a hearing services and Early Intervention program. This is essential

so that babies are quickly and appropriately referred, families are fully informed and available options are discussed and options considered, *prior* to an agreed *NDIS* Plan being finalised. The *NDIS ILC Framework* for supports outside of individually funded packages, is still being developed. As a result, the availability of information about hearing disability and support options, is reliant on existing services. Important information is currently not being delivered in a coordinated way, in association with *NDIS* processes.

- f) *Australian Hearing* is currently the primary training ground for paediatric expertise in audiology. It has in-house training for audiologists to cover paediatric and special needs clients. **This is not covered by the university degree coursework.** It is estimated that up to 30 to 40% of hearing impaired children have additional disabilities [11].
- i. Systems need to be in place to ensure that audiologists who decide to deliver paediatric services, are already experienced audiologists and that they receive comprehensive paediatric training, including dealing with children with additional disabilities. This system and training needs to be externally assessed and regulated. Showing '*an interest in children*' is not and should not be seen as an adequate level of competency or commitment with regard to delivering paediatric services.
  - ii. Recognized and approved *Continuing Professional Development (CPD)* and a minimum number of hours per year of delivered services in paediatric and special needs clients, needs to be part of a paediatric audiologist's qualifications, to permit continued delivery of these services.
  - iii. Given the low number of paediatric clients, as detailed in Section 3 g) above, it is difficult to envisage how non-*Australian Hearing* audiologists will maintain paediatric experience.
  - iv. Qualifications, experience, completion of approved training, competency, hours of specialised paediatric service delivery and *CPD*, will need to be checked and audited for compliance by a professional or Government body.
- g) *Australian Hearing* was reported to have an exceptionally low complaint rate of 0.02% for 2012-13 [1]. If the provision of a hearing services program is opened up to alternative providers, then an independent, national industry-wide standardized complaints system will need to be put in place. The system will require an open reporting system and a procedure for corrective actions.
- h) One third of private audiology clinics are owned by a hearing aid manufacturer. How will families receive independent and unbiased advice about: their child's unique hearing loss; the full spectrum of available options available to them and the comprehensive range of listening devices that are available and appropriate for their child's specific requirements and early intervention needs?

- i) A system of updating hearing appliances in a coordinated and fair way needs to be put in place, as technology changes, or the needs of the child change. The basis and rules associated with how frequently upgrades will occur, needs to be clearly established. *Australian Hearing* currently has an effective protocol around revisions and upgrades and this needs to be managed in any alternative scenario.
- j) Users of hearing appliances and associated equipment, such as FM devices, need to be assured of prompt delivery and capability when it comes to maintenance services for repair or replacement. This includes arrangements for a loan device whilst repairs are undertaken. Young children cannot be without access to sound and language. *Australian Hearing* currently has very effective systems in place to deal with these kinds of problems.
- k) *Australian Hearing* is accredited to AS/NZS ISO 9001:2008 and therefore has and provides a consistency of quality and systems across the nation. A recognised level of quality assurance delivery must be mandatory for any alternative service providers.
- l) *Service levels should not be based on a person's ability to pay.*
  - i. Safeguards must be in place to ensure that parents are not coerced into purchasing devices that have features that are not required by the child in a specific period of their life.
  - ii. The most vulnerable people must be protected against the practice of 'upselling', if there is an option for purchasing higher-level technology [12].
- m) Supplementary devices, such as FM's, must continue to be consistent in type. This is so that classroom technology aids can be easily operated by teachers and carers. The delivery of supplementary devices must be managed, including the roll out of new technology, and consistency of devices. The efficacy of these devices should be checked prior to issue by an independent body, such as the NAL, and outcomes measured.
- n) There needs to be regular auditing of service providers in order to ensure service and quality standards meet minimum delivery requirements. Consistency must be maintained, across all service providers and locations. Measures need to be in place to encourage and enforce compliance.
- o) Engagement, feedback, and input must continue between audiological service providers and parents, clients, and other user stakeholders. This ongoing dialogue is essential, so that service delivery meets expectations. This may be difficult within a fragmented service provider model. It may be reliant on the parents, clients and/or stakeholders, who are interfacing with a regulatory body that oversees the industry, such as the Government.



## 5 EVIDENCE BASED PRACTICE

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- a) *Any changes to the Hearing Services program or pathways to Early Intervention supports will need close monitoring and evaluation. This attention to detail is to ensure that the outcomes for deaf and hard-of-hearing children and their families are not compromised. It will need to include monitoring across the entire cohort of hearing impaired children, including: documenting child and family outcomes; knowledge and skills of the interventionists and family benefits from services.*

The quality, outcomes and effectiveness of the Hearing Services Program, pathways and early intervention supports, must be defined and benchmarked, prior to the implementation of any changes. These features must subsequently be measured continually over time if and when changes are made, to ensure that the level of service and quality is at least maintained, or more desirably, that it improves.

- b) *Deaf children and their families currently benefit enormously from the conjoined nature of Australian Hearing as a service provider and the research functions carried out by the high calibre staff within NAL. Long-term projects that investigate aspects of Early Intervention, diagnostic testing and the efficacy of specific technologies, are carried out by Australian Hearing's research staff. These scientists work in close partnership with audiologists and their clients at the coalface.*

*The National Acoustic Laboratories has been at the forefront of research into hearing aid prescription and features that optimise access to spoken language. It is a critical technical support for Australian Hearing's services. Children and young people have benefited from their research and use of the NAL prescription at Australian Hearing centres.*

*As clients of Australian Hearing, many children have been part of the world-first LOCHI study (Longitudinal Outcomes of Children with Hearing Impairment) – the largest longitudinal study of deaf and hard-of-hearing children in the world – undertaken by NAL. This study has provided evidence for best practice for services for deaf and hard-of-hearing children around the world [11].*

Any separation or break-up of the current arrangements between *Australian Hearing* and *NAL*, places at risk the excellent marriage of service and research, delivering practical knowledge and expertise that benefits all deaf children. New technology and information is disseminated from *NAL* across Australia to all *Australian Hearing* centres in a consistent manner, so that all clients can take advantage of improvements.

It is difficult to imagine how this extraordinary advantage, made possible because of the conjoined nature of the two organisations, would be possible in a 'contestable' scenario, or with multiple service providers. This leadership in hearing service provision must continue, so that current and future generations benefit with the most appropriate hearing appliances.

At a briefing with hearing services stakeholders in Sydney on 19 June 2015, the *Department of Finance* revealed that the *Scoping Study* undertaken by *PwC* had found how vital a role the *NAL* played in technically supporting hearing services and hearing health research and recommended that this role continue. However, the feedback indicated a likely requirement for *NAL* to complete for funding, rather than receive it through *Australian Hearing* and the *CSO*. This finding was reported to stakeholders as “*a greater opportunity to capture other research funding from having more experience in the broader contestable research funding environment.*” This skewed feedback, neglected to state the downside risk of the proposed change: that if *NAL* was unsuccessful in attaining funding, it would as a consequence, most likely be less able to continue its research programs.

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Parents of Deaf Children is the peak body for parents of deaf and hard-of-hearing children in New South Wales. The role of the organisation is to support families in NSW with the provision of independent information, referral and advocacy services.