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SENATE

SENATE SELECT COMMITTEE ON HEALTH

Health policy, administration and expenditure

FRIDAY, 10 JULY 2015

SYDNEY

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SENATE

SENATE SELECT COMMITTEE ON HEALTH

Friday, 10 July 2015

Members in attendance: Senators McAllister, McLucas, O'Neill.

Terms of Reference for the Inquiry:

To inquire into and report on:

- a. the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting;
- b. the impact of additional costs on access to affordable healthcare and the sustainability of Medicare;
- c. the impact of reduced Commonwealth funding for health promotion, prevention and early intervention;
- d. the interaction between elements of the health system, including between aged care and health care;
- e. improvements in the provision of health services, including Indigenous health and rural health;
- f. the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services;
- g. health workforce planning; and
- h. any related matters.

WITNESSES

COLLINGRIDGE, Dr Louise, Executive Officer, Independent Audiologists Australia.....	49
COWAN, Professor Robert Samuel Charles, Chief Executive Officer, The HEARing Cooperative Research Centre Limited	43
DAVIDSON, Mr Bill, Managing Director, Australian Hearing	1
DEININGER, Ms Rosemary, General Manager, Whole of Government Coordination Division, Department of Human Services	71
DEWBERRY, Ms Margaret, Adviser, Deafness Forum of Australia	16
DUFFY, Ms Tracey, National Manager, Office of Hearing Services, Department of Health.....	71
DUNCAN, Ms Sara, National President, Better Hearing Australia.....	66
HUNGERFORD, Dr Jim, Chief Executive Officer, The Shepherd Centre	59
HUTSON, Mr Jonathan, Acting Deputy Secretary, Enabling Services, Department of Human Services	71
JACKSON, Ms Leonie, Chief Executive Officer, The Deaf Society of New South Wales, through Vanessa Sweeney and Kerrie Lakeman, sign language interpreters	54
KENNEDY, Ms Kate Amelia, Coordinator, Parents of Deaf Children	24
MAVRIAS, Ms Gina, Operations Director, Australian Hearing	1
MESSARITI, Ms Anna, President, Parents of Deaf Children	24
MIERS, Mr Kyle, Chief Executive Officer, Deaf Australia, through Vanessa Sweeney and Kerrie Lakeman, sign language interpreters.....	37
ONG, Ms Sharon, Assistant Secretary, Commercial and Claims Division, Department of Finance	71
PORTER, Mrs Ann Kathleen, Chief Executive Officer, Aussie Deaf Kids	11
REHN, Mr Christopher John, Chief Executive, Royal Institute for Deaf and Blind Children	31
RENWICK, Mr Robin, Acting First Assistant Secretary, Commercial Claims Division, Department of Finance	71
RULE, Ms Catherine, First Assistant Secretary, Medical Benefits Division, Department of Health	71
WILLIAMSON, Mr Stephen Lindsay, Chief Executive, Deafness Forum of Australia.....	16
WYBURN, Mr Mark William, Ordinary Committee Member and Regional Representative, Parents of Deaf Children.....	24

DAVIDSON, Mr Bill, Managing Director, Australian Hearing

MAVRIAS, Ms Gina, Operations Director, Australian Hearing

Committee met at 08:03

CHAIR (Senator O'Neill): I declare open this public hearing of the Senate Select Committee on Health and welcome you here today. On behalf of the committee I would like to acknowledge the traditional owners of the lands on which we meet and pay my respects to elders, both past and present. I also extend that respect to Aboriginal and Torres Strait Islander people attending today.

This is a public hearing and a *Hansard* transcript of proceedings is being made. The hearing is also being broadcast on the Australian Parliament House website. Before the committee starts taking evidence I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to a committee. The committee generally prefers evidence to be given in public, but under the Senate's resolutions witnesses have the right to request to be heard in private session. If a witness objects to answering a question the witness should state the ground upon which the objection is taken and the committee will determine whether it will insist on an answer, having regard to the ground that is claimed. If the committee determines to insist on an answer a witness may request that the answer be given in camera. Such a request may, of course, also be made at any other time. Would you like to make an opening statement?

Mr Davidson: We have already made a submission to the committee, and I do not think I need to add to that at the present time, so we are more than happy to take any questions the committee may have for us.

CHAIR: Mr Davidson, could I take you through some of the key points and recommendations of your submission. You initially describe the nature of hearing loss in Australia and then talk a little bit about Australian Hearing and the National Acoustic Laboratories. Finally, you go to current issues in hearing service delivery. For the public record and for people who might be picking up this transcript as their first contact with Australian Hearing, could I ask you to give us a summary of those first few points—hearing loss in Australia, Australian Hearing and the National Acoustic Laboratories, and CSO delivery—and then we will come to the questions that are more related to the other issues you have raised in regard to service and policy principles.

Mr Davidson: I will tag with Gina on these matters, as I defer to her on technical issues. Perhaps Gina could start off with a bit about hearing loss in Australia.

Ms Mavrias: As our submission, and a number of others, points out, in terms of the incidence of hearing loss, it is estimated that one in six Australians has a hearing loss, and that is expected to increase to one in four by 2050. So it is prevalent. In terms of children born with a hearing loss, about one in every 1,000 children are born with a hearing loss, but that incidence actually increases, because children can acquire the hearing loss in their early years, so we find that it is somewhat closer to five in 1,000 births in terms of prevalence. Hearing loss has a very significant impact, obviously, in the child's development, ability to learn language, and also to realise their education and career goals, with regard to their contribution to society.

Australian Hearing provides services under the Hearing Services Program. The two main streams of services we provide are that we compete with one of 250 other providers in the voucher program. That is essentially providing services to adults who are eligible—generally pensioners. We are the sole provider for services in the Community Service Obligation. That entails providing services to children and young adults—that is, people aged from zero to under the age of 26, and Aboriginal and Torres Strait Islanders over the age of 50. We also provide services to eligible adults—so adults who would have been eligible under the voucher program but who have more complex hearing needs, either by virtue of their degree of hearing loss or other disabilities, and so require more specialised services.

Australian Hearing has nearly 1,200 employees, of which a little under half are clinical staff providing hearing services. We have over 130 permanent sites and nearly 400 visiting sites. We also do a little over 200 outreach visits to Aboriginal and Torres Strait Islanders. National Acoustics Laboratories are a research arm or division of Australian Hearing, and they are also funded through the Hearing Services Program to do research into hearing loss, rehabilitation and prevention. They are known for a number of initiatives, and I am happy to answer any questions on those. In terms of the size of Australian Hearing, we provided almost 450,000 services the financial year before last. I am not sure what other details you might want us to cover in terms of the program.

CHAIR: Thank you very much. That gives us a reasonable outline of what is going on.

Senator McALLISTER: Before we to delve into the services, I am interested in the consequences of deafness and hearing loss if it is not treated. I note that, in the early part of your submission, you talk about some of your research about what happens when support is not provided as well as some of the social and personal consequences of that.

Ms Mavrias: Certainly, there is significant evidence showing the importance of early interventions for children. The consequences can be significant in terms of, as I was saying, the whole language development as well as the ability to cope at school and find employment. When we are talking about adults, there is also a significant impact in terms of isolation. People who are unable to hear can find themselves unable to participate in the activities that they used to, so there can be isolation. There is even some more recent research around the relationship between hearing loss and early onset dementia. So, again, that goes to the importance of being able to stimulate the acoustic system, the hearing, so that they stay involved. There are a lot of consequences. There is also an economic impact in terms of people being unable to find employment and, therefore, the additional burden on governments in terms of supporting those people. There is also an economic impact on the individual in terms of maintaining whatever device or solution they require in order to be able to hear. So it is far-reaching. Our goal is, obviously, to try to minimise the impacts as much as we can.

CHAIR: Was there anything that you wanted to add, Mr Davidson?

Mr Davidson: I think that is pretty comprehensive, thank you. Thank you, Gina.

CHAIR: Fantastic.

Senator McLUCAS: Thank you so much; it is nice to be back here. I was just commenting to the chair that it is a shame that we had not arranged to have a quick look at the laboratory. Mr Davidson, I know that we have a very full day of hearing, but there is a lunchbreak. I have been to have a look, and it is amazing; we should make sure that we educate as many senators as we can about what we do have in this facility. Could we have a 15-minute whiz around at lunchtime?

Mr Davidson: I do not see why not.

Senator McLUCAS: That would be great.

CHAIR: Thank you.

Mr Davidson: I will get it organised once we have finished.

Senator McLUCAS: Thank you. I want to go to the third point that you make in your submission, which is the service effectiveness and efficiency. I want you to talk to us about how you can make the claims that you do. I do not disagree with you, but could you give us the evidence that confirms that Australian Hearing uses taxpayers' money effectively and efficiency for the cohort of patients that you serve?

Ms Mavrias: Certainly. There are a number of points we would make there and I am happy to go through all of them.

Senator McLUCAS: How you measure that is what I am trying to get to.

Ms Mavrias: Sure. One of the advantages of the size of our business is that we do have significant buying power, so we are able to negotiate good prices for government for the product, the devices and the other supplies that we use. Essentially, we are able to then offer, what we believe, is a very high-quality product to community service obligation clients at a very good price to government. I think that is one of the advantages of our scale. There are a number of others.

Because we are a national program, as I outlined, quite a large organisation, there is ability for us to also use our clinical resources very effectively right across Australia. We have almost 470 clinicians within our hearing centres, so we are able to move things around and better respond to changes in demand and to any gaps. Again, that provides some savings to government just in terms of being able to fully utilise the resources you have for where the demand is.

The other thing we do is we have national standards right across our organisation, so there is consistency both in the experience, the quality people get, and in setting a standard for what we believe is required and reasonable for the funding that is available. There is always new technology. This might be an example. New technology is always being released and there needs to be a process to evaluate that whenever it comes out, so that we can determine which clients most benefit from the features that are being offered and, again, ensure that the funding that is available in that space is used for the clients who would most benefit. Again, we have to make decisions around what technology enters into the program and who needs it and at what frequency it needs to be refreshed. So there is a lot of thought and a lot of work going on in the background to make sure that that funding is spent appropriately and to get the best outcomes for our clients.

Senator McLUCAS: That is the point I wanted you to make: because you have that national purchasing power, we are getting the best value for money as Australian consumers of hearing aids and hearing support that, frankly, a privatised system would not necessarily be able to deliver. That is my assertion. I do not know if you have a comment about that.

Mr Davidson: It is fair to say that, as large as we believe we are, we are one of three or four major players in the Australian market. The other large players are international, multinational and multicountry providers. Some of them are actually hearing aid manufacturers and they would get the benefit of aids at wholesale rates that we only get because of the bulk purchasing that we have. So it depends on how government run future programs as to whether they would lose that benefit. Not having foresight into government decisions and government practices, I cannot comment, but it may well be that there is another way around that should there be privatisation.

The issue also is that in the voucher services market, we only hold 30 per cent of that market. So that means that 70 per cent of the rest of the market is provided by other providers. And it is a competitive market so I would assume that the standards in Australia generally are pretty good because we are not gaining clients and not losing clients. It tends to be around the 30 per cent mark for some significant time.

Senator McLUCAS: I want you to talk to us now about the structure that we have with Australian Hearing, with the National Acoustics Laboratories and then Cochlear and here with the Hearing Hub. Are we really unique? Talk to us about international comparisons of that structure that we have in this country?

Mr Davidson: Cochlear is a near neighbour, but that is as close as it gets really. We do not do fittings. We do not actually do the surgery and we do not do the implants. We only support the program by supplying upgraded processors on a needs basis. So our relationship with Cochlear is friendly. They have a cafe, we have a cafe and we bump into each other from time to time. But there is no close correlation at present.

With regard to the National Acoustic Laboratories and Australian Hearing, we are unique. I do not think there is another provider who is not a manufacturer who is so deeply embedded in research and research for public benefit. It is not research for commercial benefit at the present moment. All the NAL stuff goes into the public sphere to improve hearing solutions and to try to avoid hearing difficulties.

We work closely with NAL. They have access to some of our clients in order to do research and to collect data. We get no commercial benefit by having NAL in the family. It is really an arms-length, separately managed organisation doing great stuff. We bask in the afterglow, if you like, of having NAL in the family. I think they also benefit by having a larger parent so they can wrap their arms around them and support them on a needs basis. We do not support them financially and we get no commercial benefit.

Senator McLUCAS: It has been put to me that that relationship between a research arm and a service provider is unique in the world and is the reason that we lead the world in hearing services and the speed at which we get new devices. The fact that Cochlear is Australian is because we have an Australian owned service arm with a research base sitting with it. My question to you is if we were to privatise Australian Hearing, what would happen to the National Acoustics Laboratories? What would happen to the potential for another fantastic discovery that Australia could give to the world?

Mr Davidson: Obviously, it depends on government decision and the process. That is a matter for government. I have no insight into that. With all due respect to NAL, at times I feel conflicted being the managing director and having NAL in the family because they are off trying to devise self-fitting hearing aids and I am in the business of fitting hearing aids. So I have a division that is going to put me out of business in the short term, potentially, but for the common and grace of god. I am really conflicted on a commercial side and fully supportive on my big-hearted side, if you like. It is an interesting relationship and it is one that we are very proud of, of course. But, again, it does not give us any commercial advantage, but it does make us feel good about our brand and the good that we deliver through NAL at the present time.

Senator McLUCAS: That probably answers the question then: if it does not give you any commercial advantage and if Australian Hearing were to be privatised. If there is no commercial advantage to it, why bother doing it?

Mr Davidson: I cannot comment on that.

Senator McLUCAS: I understand that.

Senator McALLISTER: I wonder if we could talk about the services that Australian Hearing is providing to the Aboriginal and Torres Strait Islander community. It is a core group in terms of the CSO program and I think we are all conscious of some of the challenges of service delivery for that population, including but not restricted to remote service delivery. Could you talk us through what it is that you are currently doing for your ATSI clients?

Mr Davidson: Because the CSO is exclusive to Australian Hearing, obviously there are no other providers directly providing those services unless they are part of a more holistic medical service. There are other organisations, like Deadly Ears, going into certain communities to assist. But, as Gina has already said, we service in excess of 212 communities at the present moment on a visiting basis—fly in, fly out; drive in, drive out. We do that almost 100 per cent—we have a memorandum of understanding with the local community. So we are culturally appropriate, we are clinically appropriate, and it is with the full agreement of the communities themselves.

We service that by drawing from about 98 clinicians, who volunteer to support communities, and they volunteer to support for two years. So, there is that commonality of clinicians going in so that the relationships remain strong. But it also means that the clinicians' skill standards go up and we have a good pool of clinicians to draw from. It is a complex and complicated service, in many ways, as servicing any community is. As you would imagine, apart from the cultural challenges there are the sheer physical challenges of going in there. Where possible we try to go in with other agencies so it is not a stand-alone visit and it can be a much more holistic service to the communities.

I think there is room for improvement there, but the challenge is how we collaborate with states and private entities to make sure we are going in as a group to provide a service that is much more meaningful, rather than having five agencies flying in at different times. But the collation of that would be pretty difficult, I would think, and there really needs to be a significant task force to look at how we can effectively service remote communities better.

Senator McALLISTER: As I understand it, in your remarks you are emphasising the relationship you are able to form with other service providers in those communities.

Mr Davidson: Where possible, yes.

Senator McALLISTER: You also mentioned the process whereby you maintain skills for your clinicians and associate that with a long-term commitment to service provision in a particular community. Talk a little bit about the kinds of skills that are necessary to provide these services in a remote context and in a culturally distinct context.

Ms Mavrias: In providing services in Aboriginal and Torres Strait Islander communities there are a number of skills that we expect our audiologists to have. Only our audiologists do this work. There is cultural awareness training that all our staff need to do. It is about understanding working within a different community and having a better appreciation around the needs of those communities. Also, because a lot of the work we do in those communities involves children, there is a very high incidence of chronic middle ear problems. So the audiologists who do this work have training specifically around providing services to children and awareness about middle ear conditions. Sometimes the solutions need to be different compared with if it was more permanent hearing loss. So there is specific training just on the audiology around that service.

There are also challenges in working within the communities, so additional training is provided for people who go to the outreach sites, because they need to have the skills for liaising at a community level within both the school and other health services. There is additional work around being able to collaborate with those other service providers but also being quite flexible in terms of how you provide the services. It is quite a different model than the mainstream hearing services. When we go out there it is not like the senators have probably seen, with people coming in for an appointment in a nice room where everything is done. Services may be provided in different locations under different conditions and may not always be just straightforward hearing tests. There is more education involved, and a lot of working with others—teachers and families—around prevention and listening strategies. So the training is around paediatric skills but also around culturally appropriate skills.

Senator McALLISTER: I imagine that the cost profile for providing services in this way is quite different, even when compared with perhaps supporting clients who have complex needs in a metropolitan environment. Do you have any sort of information about the kinds of costs that are associated with this kind of service?

Ms Mavrias: It really does vary depending on where the community is. Obviously there are significant travel costs if we are flying in and out. That is one of the factors. There are costs also in terms of the effectiveness of the time. There are unplanned things that happen when you go to the communities. Sometimes you go and things happen in the community and you may not be able to see the same number of people you had intended to see. The investment in time is higher just in terms of how many people you can see at any particular time. So for the program itself it is more expensive to provide those services. We also use higher-skilled audiologists to do it, so there is obviously the cost of maintaining that level of experience and qualification.

Senator McALLISTER: Can you quantify that at all?

Ms Mavrias: Within our organisation we report back costs of each type of program. I do not have the exact figure here. But we certainly have a portion that just relates to travel. We capture that separately.

Senator McALLISTER: If it were possible at some later point for you to provide information about the relative costs per client or whatever the appropriate metric would be I think that would be quite useful. It does not sound like an environment where, should we move to a different model or should Australian Hearing be privatised, there would be many competitors ready to provide a service of this kind, given the complexity of skill currently involved in delivering the service.

Mr Davidson: That is probably true. In fact, I think it is true at the present moment. If I were to put a commercial hat on, I would say that unless government was going to pay me excessive amounts I would be unlikely to put my hand up for that type of work. I think that is another issue government has to consider with regard to the program going forward.

Senator McALLISTER: There are many interesting things to talk about, but I am conscious that the chair probably has some questions also.

CHAIR: Yes. I am very glad that we still have half an hour, because there is so much more to discuss. In the first instance, though: you mentioned 212 communities that you attend. How many of those are in the Northern Territory?

Mr Davidson: I will get back to you on that, if I may.

CHAIR: If you could possibly provide us with a breakdown of where those services are provided, by state, that would be very helpful.

Mr Davidson: Yes, absolutely.

CHAIR: Thank you very much. I want to take you to one of the submissions. I am sure all the submissions have been of interest to you, but I want to take you to the submission of Parents of Deaf Children, because I really want to talk about children and early intervention. In their letter to our committee they put it into context. Part of the reason we are having this hearing is the imminent demise of Australian Hearing as it is currently constructed. That is why such attention is being focused on this matter at the moment. The parents have written to us stating that they are very concerned that the quality of care needs to be maintained, particularly for early intervention and children. They say:

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.

They go on to say

... best practice for a national hearing services program and the pathway to early intervention supports, has NOT been clearly and unambiguously defined ...

They say that any change that would happen would require, 'PRIOR to the implementation of a potentially massive change', an assessment of 'available services, service delivery mode and/or funding provisions'. Clearly, the tone of the letter and their subsequent submission, where they make a significant number of points about concerns about a race to the bottom as a consequence of privatisation and fear of unintended outcomes, makes me very alert to the wisdom of these parents, who have just recently lived the experience of finding that they have given birth to a deaf child or a child hard of hearing. Could you take us through the sort of journey that people go on and explain why the quality of service you provide through Australian Hearing and the scale of what you do are of such importance to parents that they are writing to us about being willing to forgo competition for the sake of confidence in quality of service. Could you take us to that issue—the quality of service issue. A baby is born. What happens?

Ms Mavrias: In Australia we are very fortunate. When a baby is born, we have newborn hearing screening, and something in the order of 96 per cent, at least, of children who are born in Australia get screened at birth. If the child does not pass that initial screening, they are referred for a further diagnostic test, which is usually done within a hospital, and that either confirms that there is a hearing loss or not. If it does, that child is then referred directly to Australian Hearing, and we give priority to all new referrals. So all parents, when they are informed of that result, are offered an appointment within 10 working days, if not within the same week, to be seen somewhere within Australian Hearing, at one of our hearing centres. So the parent would come in. The Australian Hearing audiologist would do some further testing if that is required at that appointment. Usually they have come with some objective tests, and we might do some behavioural testing to give the parents a feel for what the child may or may not be hearing, and there will be a discussion then about options. They could be varied, depending upon the degree of hearing loss.

You need to be—and I am sure you would be—aware that it is a hugely emotional, very sensitive period for parents. We want to try to give them as much information as they need but also at the pace that they are comfortable with and can take in. Over multiple appointments—this is not necessarily all in one—there is a discussion whether hearing aids are required and whether a cochlear implant is required. There is discussion around early intervention. There is information given to parents, both in written form to take away and during appointments.

There is a lot happening in those first few months—a lot happening. A hearing aid will usually be fitted quite quickly, subject to the parents being ready for that and that being the appropriate solution. Then there is the ongoing support that comes with that, in terms of supporting the patients and making sure the hearing aid is appropriate. There is additional testing that Australian Hearing does to set up the hearing aid. There is making sure the hearing aid is accepted, so there is support we provide in terms of the child being able to wear it and it being comfortable. There are multiple ear moulds, because the child is growing at quite a rapid pace at that point, and so they outgrow their hearing aid within weeks. Every six weeks at least, we are bringing them in again to readjust it so again it is comfortable and they are able to wear it. All that is just in the first six to 12 months. But the good news is that our data shows that children are getting picked up in the first year and that that pathway generally works really well in supporting parents.

Then there is the ongoing support. As a child gets older, there are different milestones where we need to support the families: entering into preschool, primary school or high school. There are different needs and different technology solutions that might be required depending on those situations. Then there is learning to use your hearing aid with the phone, learning to use the telecoil because you are going to the movies more now. So there are different milestones and we are preparing them as best we can to enter into the workforce.

CHAIR: One of the things that has been proposed to us in one of the submissions is that children have very different needs in the space between zero and six months, then seven months to three years, three to six years, seven to 12 years and 13 plus years, which you have indicated in your comments more generally. Can I take you to the fact that one in four children, I think you said—

Mr Davidson: One in six, plus—

CHAIR: Your submission says:

Approximately one quarter of children with permanent hearing loss have at least one other disability.

Ms Mavrias: One quarter have another disability. Yes, that is right.

CHAIR: So we sometimes have very complex needs clustering with these children, and the cost of dealing with this at a time when people are perhaps on maternity leave I am sure is of great concern to people. That is one of the things that has been raised here.

Ms Mavrias: There is no cost to the parents for any of these services. It is fully funded through the government Hearing Services Program. That includes all the appointments and the devices that the child is fitted with.

CHAIR: There is no cost when they get connected to you. Can I ask a question about the differentiation of access from state to state. Is it the same for all parents in all places to access the care that they need?

Ms Mavrias: For Australian Hearing, absolutely.

Mr Davidson: Yes.

CHAIR: What about travel to appointments? I am sure they have multiple appointments in the first year.

Ms Mavrias: That is one of the challenges we picked up in our submission. There is a travel assistance scheme, but it only covers medical appointments. It does not cover audiology appointments. So what we do with parents—and they do require quite a few appointments in the early stage—is, if the child has other disabilities or medical needs, we try to link the appointments so they are at the same time, so they can take advantage of that in meeting travel costs. Because we have such a large footprint, as quickly as possible we try to make sure they can access services at the closest Australian Hearing centre. That might not be possible for the very first appointment, because when a child is under six months we need particular equipment and specialised skills. But as soon as we can we move them to an Australian Hearing clinic that is as close to their home as possible to reduce some of the burden of travel.

Senator McLUCAS: Just a point of clarification: in your submission you talk about a travel scheme. That is the state based patient travel scheme you are referring to?

Ms Mavrias: That is right.

CHAIR: Could I take you to the size of your footprint. One of the fears that has been raised is that, if Australian Hearing were privatised, the footprint would shrink and there would be many differentiated points of access. What are your fears about what would happen to the integration that you are able to offer now if that fragmentation begins to happen, in terms of access and also research, tracking and quality?

Mr Davidson: Some of our current clients, irrespective of the government's decision with regard to Australian Hearing, will have the opportunity through the NDIS to get the services wherever they so wish. There will be freedom of choice. Let's say it is 2018-19. We will be in a position where we will have to compete with other providers for the NDIS eligible clients in the marketplace. So we believe that having a footprint is great for sustainability. But I also know that we do not have the largest number of permanent centres. We have a competitor who has more permanent centres than we have across the nation. Again, it is a Danish public company but their Australian operation is slightly larger than ours in terms of permanent centres. So I believe that there may well be adequate coverage at the present moment because we do it, but we have a competitor who is as large as we are and as capable as we are.

But it depends on how government may elect to deliver those services in the future. I am not sure that I can really answer that effectively until we know the model that government determines to roll out in the future. Currently, with the NDIS there are, as you probably know, a raft of local consultations about to take place with stakeholders, and we hope we will know more about the NDIS and its impact on hearing services by the end of the year.

Senator McLUCAS: Going to the two launch sites, in the Barwon area and Newcastle, what is your experience in those two areas around NDIS to this point in time?

Mr Davidson: We are talking about this, obviously. We believe that, in all of the pilot sites—and there are now eight because the eighth one kicked off on 1 July—we have approximately 6,000 clients currently in those eight sites. We only have 60 who have registered for NDIS. So the numbers are pretty low at the present moment and we do not know whether that is due to the fact that they do not qualify for the current threshold or whether they are not doing it because there is no advantage at present to register for NDIS. But at the present moment the uptake from our client base is pretty low.

Senator McLUCAS: I know you are talking about the eighth launch sites at the moment; can we just go to the two, which are whole of population and have been going the longest—the Geelong site and the Newcastle site. Can you cut those figures down to the potential number of clients in those two areas and the number who have registered with NDIS?

Mr Davidson: I am happy to do that. We will get back to you with those figures.

Senator McLUCAS: I think the point you are making is that there is no need to register with NDIS because you are linked in with Australian Hearing getting the full service there.

Senator McALLISTER: I suppose my question follows on from Senator McLucas's questions. It seems to me that not all hearing impaired persons will be eligible for the NDIS and so any policymaking should not proceed on the assumption that the NDIS will fill all gaps.

Mr Davidson: You are meeting with the policymakers this afternoon, I understand, so that would be a good question to put to them.

Senator McALLISTER: We will certainly discuss it. Thank you.

CHAIR: Was there anything else that you needed to talk to me about with regard to children and access? One of the things that struck me in the submissions that I have read was that a parent's first engagement with deafness on the birth of a child might be the first time that they have an encounter with a person who is deaf or has a significant hearing loss. In that context, parents continually raised the question of trust. Clearly, that is important emotionally, but, when it comes to competition in a marketplace, what are the vulnerabilities of competition at that point of time for parents whose knowledge would be very limited and whose capacity to seek out independent and verifiable information would be also pretty limited? What are the inherent risks if we have massive competition in this space?

Ms Mavrias: I think you have summarised it. It is a very difficult period for the families. One of the challenges will be: 'Where do I go and who will have the skills to help my child?' At the moment, they come to Australian Hearing and they know that the person they see has the skills to provide the services. Whatever service arrangement is around that needs to consider how parents quickly access services. Speed is really important in this time—we know speed is important for that child getting the best possible outcome. They need to know where to go and how to get in quickly, and there are also the challenges around what the best solution is for their child. Again, there is the need to walk them through the options—whether it is a hearing aid or a cochlear implant or

something else—and knowing that they can make those decisions and that it is not a cost decision; it truly is a question of: 'What is the best outcome for my child?'

CHAIR: There are always questions about evidence, about claims, about how excellent you might be on self-reporting. But given the quality of the reports that have been provided to the committee by parents, you have a glowing recommendation from parents. One of the pieces of evidence that I have read in the submissions is that the standard of the hearing support devices provided in Australia is very different from the standard provided in other jurisdictions, such as the US and the UK, where there are different systems in place. Could you speak to that?

Ms Mavrias: As I mentioned before, because of the number of devices we purchase each year, we have been able to get quite high quality devices for the government at a very affordable price. Why that is important is that we are talking about people, both children and adults, who depend a lot on their hearing aids. Because of their particular needs, they need access to particular features.

CHAIR: In the submission they talk about a classification range of different sorts of hearing aids.

Ms Mavrias: That is right.

CHAIR: It is from level 2. Is that a low or high level? What is the scale?

Ms Mavrias: Level 2 is a lower level.

CHAIR: Until level 7.

Ms Mavrias: That is top of the range.

CHAIR: In some jurisdictions people have to settle for the less than optimal level, because the buying power is not there or because of government decision making. What is the rationale? Why are Australian parents finding themselves giving birth to wonderful young people, but who have a hearing disability, getting good service here and not in other jurisdictions? What is happening to make that possible?

Ms Mavrias: Australia is very fortunate in that we have a fantastic Hearing Services Program—one that we can be very proud of. Yes, they do get higher featured products, as you were saying. The levels are interesting, because how people classify them varies with the type of device manufacturer. In the scale you were giving, we give level 5 devices to our Community Service Obligation clients. That is a higher level than some other programs would fund.

CHAIR: The submission I have in front of me states that in the contestable UK and New Zealand markets customers are averaging a level 3.

Ms Mavrias: They may be different manufacturers. That is what I am trying to say. We believe that the device we provide within Australia has more features and therefore is a higher level one than in other programs.

CHAIR: What does that mean on the ground for the young person who is getting the advantage of that higher level device?

Ms Mavrias: If we talk about children, we potentially are talking about classrooms that can be noisy, and they need to be able to hear over distances. There is quite a variety of listening situations. They are also learning about language, so various cues are really important. We believe that having more features allows them to hear better in noise and those sorts of situations. It allows them to better couple with other devices—remote microphones, for example, which are really important to listening in classrooms or other noisy situations. In the end, we want to give them the best quality sound so that they are able to cope in educational settings as well as other places where they wear their hearing aids.

CHAIR: Which goes back to the evidence you gave Senator McAllister earlier on about the significant additional outcomes, apart from being able to hear—about participation, fulfilling your potential and being able to advance. The critical thing is early access to high quality, and Australia is achieving very excellent standards internationally.

Ms Mavrias: Yes.

Senator McLUCAS: You do work on longitudinal outcomes of children. Has any work been done to compare the outcomes for children who are receiving better quality and earlier intervention, with children with similar types of hearing loss in other countries? Has any comparative work happened with that longitudinal study?

Ms Mavrias: I am not aware of any direct comparative work in that sense. Within the research, because of the timeline, we started new-born hearing screening. There is certainly comparative work showing the benefits of early intervention and non-early intervention. We certainly have that data. But in terms of relating a particular level of technology in our program versus another, there is research showing the benefit of the different features.

There are lots of research showing that directional microphones should be standard in hearing aids, and things like that. There are also the benefits of remote microphones and the improvement that they make in hearing in noise. So there is research to support those features, but I am not sure there is any research to directly compare our program with others.

CHAIR: The reason we are having this hearing today is to find out why the future of Australian Hearing is under question, and the process that has led to this point. I read over some of the testimony that was given in the Senate estimates inquiry. There has been a review. Who has been involved in that, and where do you understand the process to be at this point in time, Mr Davidson?

Mr Davidson: Government determined that they would conduct a scoping study, managed through the Department of Finance. They appointed a couple of advisers to conduct that scoping study—PricewaterhouseCoopers and solicitors Herbert Smith Freehills. The scoping study was completed in the latter part of last year. The report was given to government and we have not seen it. So as yet it remains a document that we are not privy to, not a party to. It is a matter for government at the present moment.

CHAIR: Are you aware of anyone, other than government minister and members of those ministries, who has seen this document?

Mr Davidson: No, unless it is the public officials who have been conducting the study.

CHAIR: Thank you. Please continue.

Mr Davidson: We are currently not aware of the scoping study outcomes and recommendations. Government announced at the last budget that the decision regarding the future of Australian Hearing was to be deferred for further consultation to take place. I believe that is as a result of there being some confusion around the NDIS, and who is in and who is out, and the realisation by some parties that maybe there has not been adequate consultation with the various stakeholders. So the government has determined that they will do more effective consultation and come back with a recommendation, we believe, by the end of the year. Australian Hearing has registered to be involved in the next round of consultation, but we have yet to get a date for that consultation.

CHAIR: Taking you back to your evidence on 3 June, you said that your advice was that during July a series of information sessions would be run in three centres. Is that the case?

Mr Davidson: Yes. They have been completed. They were in Canberra, Sydney and Brisbane. I think there are other people in the room who were actually at those meetings. They were conducted by Finance, OHS and Health, and we believe DSS were involved with regard to NDIA.

CHAIR: Could you identify people you know were at those consultation sessions?

Ms Mavrias: Australian Hearing was not at those sessions.

CHAIR: Do you know from your contacts in the industry who was at those sessions? Are you aware of anybody here we could ask about the sessions?

Ms Mavrias: There are some people we believe were invited, but we do not know who actually attended. We believe some of the early intervention agencies did—the Shepherd Centre, who are here in the room, were there.

Mr Davidson: The Deafness Forum. I think you will also see them today.

CHAIR: It is good to know that we can find out a little bit more from them. Regarding the scoping study, you said they thought there might not be adequate consultation. Was there any consultation with the hearing sector at all—parents, audiologists or your agency—prior to the findings of the scoping study being announced?

Mr Davidson: Again, the process was all conducted by Finance. I do not actually know who was involved in the stakeholder negotiations. But I believe that PWC did meet with most of the stakeholders they believe were party to it. So I would think they were consulted.

CHAIR: Right. But we cannot find that out because we have not got the scoping study available to us.

Mr Davidson: Nor to me.

CHAIR: And if any parents of young deaf children wanted to find out what was going on, they would not be able to find out either, would they?

Mr Davidson: I believe not.

CHAIR: It is not a very transparent process. In the time that we have remaining, which is not very much at all, can you to speak to the ageing population, which was one of the issues that you raised in your submission to us?

Mr Davidson: Yes.

CHAIR: Can you speak about the scale of need going forward and why access to hearing services for that population will be so important?

Mr Davidson: I will give you a broad context and then Gina can come in after that. The average age of our current client base is 72, and probably the average of those clients, when we fit them at the age of 72, would have had a need for some years prior to that. We understand that the journey can take as long as 20 years from first being diagnosed to having a fitting. The average length, I think, globally is seven years. That is the journey. If we could find a way to shorten that journey we would get people into hearing faster and we would, I think, improve quality of life as such. Our concern is that hearing is mostly an age related issue and we are moving into a period of an ageing population. Therefore, the need will continue to grow, and we think the growth in the industry is about between four and six per cent globally, but the ageing population is such that the above-72s are growing at twice that rate. So there is going to be a significant issue over the next 50 years. I think we said earlier on that by the year 2050 one in four Australians will be affected. Currently it is one in six. That is a rapid increase over a fairly short time.

CHAIR: In terms of the current service provision, is there a significant difference in access to hearing support and supplies between people who are wealthy and those who might be on a fixed income, such as pensioners?

Mr Davidson: We only see pensioners. By dint of the current process, we do not have access to what is called the private market, and that is people above age 26 until pension. That whole market is not available to us at the present time. So we do not see people who are maybe self-funded retirees or are independently wealthy. We have to actually turn them away at the present time, which is a dreadful situation, but that is just exactly the way it is. So I do not know the level of service that the self-funded retirees get, but I do know that, under the community service obligations, we service that age group—our pensioner client base—with the same dexterity and attention to detail as we do the children that we have on our books.

CHAIR: Thank you very much for the work that you have clearly been doing and also for your evidence here this morning before the committee.

Mr Davidson: Thank you very much. I was wondering where an hour would go. I thought it was going to be too long.

CHAIR: We could tell from your submission that it was good investment of time. Thank you.

PORTER, Mrs Ann Kathleen, Chief Executive Officer, Aussie Deaf Kids

[09:05]

CHAIR: I now welcome Mrs Ann Porter, the chief executive officer of Aussie Deaf Kids. I invite you to make a brief opening statement, and then we will have questions.

Mrs Porter: When a baby is identified with a hearing loss, it changes the life of that family forever. Their life need not be better or worse but it will be different to the one that they had imagined. However, with the right services and support around them, their baby should lead a full and independent life. But learning to navigate this life trajectory is dependent on the services and support surrounding the family. Since the advent of newborn hearing screening, the diagnosis of hearing loss comes at a time when families are least able to navigate the complexities of the system and to understand what the diagnosis will mean for their baby and family, both now and into the future.

In recent years a number of position statements have been published both here and overseas, outlining best practice for newborn hearing screening programs and for family-centred early intervention services for deaf and hard-of-hearing children. Each of these position statements outlines the principles that are known to assist families throughout the growing years of their child. Families need a clear, timely and equitable pathway from newborn hearing screening to diagnostic audiology, appropriate fitting of devices and early intervention services. They need information that is meaningful and relevant to their needs and situation, and that allows them to participate in shared decision making with the professionals who will assist them to make informed decisions about the management of their child's hearing loss.

Services must be provided by qualified practitioners who work regularly with babies and children, and whose goal is to optimise the child's ability to communicate, to learn and to participate fully in the life of their family and community. Children need access to listening devices that will optimally support the development of their communication and language skills at home and at school. Families need emotional and practical support from family, friends, professionals and other parents of children with hearing loss so that they can gain the necessary knowledge and experience to confidently parent their child with a hearing loss. When any of these principles is compromised, the result is likely to lead to poorer outcomes for the wellbeing of both the child and the family.

In Australia, we have been leaders in getting this right. We are not perfect but we are better than comparable systems around the world. Our ability to achieve this has been possible because of the evidence-based, government-funded services provided by Australian Hearing. Our newborn hearing screening programs, early intervention and education systems are all built around the services provided by Australian Hearing. But we are clearly now at a crossroad for deaf and hard-of-hearing children and their families, with the transition of services—particularly the Hearing Services Program—to the National Disability Insurance Scheme. Parents have been enthusiastic supporters of the NDIS, as we can see the opportunities the scheme will provide for our children throughout their lives. However, the contestability of the Hearing Services Program is not one we support. It is a model that is untested for this group of clients in Australia. The UK has made adult hearing services contestable but has refrained from doing so for children's services. As parents, we are all too aware of the issues and burdens faced by parents in the US, where the process is contestable. This is not one that we want to see replicated here.

There is no evidence that there are providers with the skills, equipment, facilities and coverage to effectively deliver the hearing services required by children and their families. It is our contention that contestable hearing services have the potential to compromise the principles of good practice and put at risk the future of deaf and hard-of-hearing children and their families. We have identified numerous areas of concern that must be addressed to ensure that the system we transition to complies with the principles of best practice and continues to provide the services and support that the child and family need to optimise their potential.

CHAIR: Thank you very much. Have you appeared before a committee before?

Mrs Porter: I have once, but I have to say it is fairly nerve-racking.

CHAIR: I could see that you took a deep breath at the end of that. Thank you very much for your careful preparation and your articulate presentation to us this morning about the concerns. Have you personally or as a representative of Aussie Deaf Kids, or anybody from Aussie Deaf Kids, seen the scoping study that Senator Cormann has referred to?

Mrs Porter: No. We did a submission when we heard about the scoping study. We decided to do a submission which we sent to the Department of Finance. After we sent that, we did get asked to go to PwC, who gave us a fair bit of their time. We have not seen a scoping study.

CHAIR: Have you had any formal feedback?

Mrs Porter: No.

CHAIR: Anything in writing?

Mrs Porter: No.

CHAIR: Any email, phone calls or anything?

Mrs Porter: No. I work really closely with Parents of Deaf Children. We do a lot of our submissions together and Parents of Deaf Children did attempt under FOI to look at the scoping study and they were told that most of it was commercial-in-confidence, and that if they wished to progress with the FOI then they could pay a certain amount to see the parts of the scoping study that were not commercial-in-confidence.

CHAIR: This is a very interesting piece of information. Others on the committee might be aware of it, but I am certainly not aware of that. Let us be clear about what you just said.

Mrs Porter: You might need to clarify it. Parents of Deaf Children are on the list today and they are the people who put in the FOI.

CHAIR: Under the freedom of information legislation and its capacity, Parents of Deaf Children have asked for a copy of the scoping study and they have not received that?

Mrs Porter: No. They were told—and they will clarify—that there was some cost to go through and take out all the stuff that was not commercial-in-confidence and they would then receive that. We decided that we probably knew what was in that part that was not commercial-in-confidence and that it was not worth to continue with the process.

CHAIR: So cost was an impediment to getting it but also your fears that you would not get access to any of the information—

Mrs Porter: Yes, we felt that we would not get what we wanted to know, basically.

CHAIR: Because what you really want is the full document so you can participate in the debate?

Mrs Porter: Exactly.

Senator McLUCAS: Thank you very much. It is good to see you again. Going back to the preparation of the scoping study, you said 'PwC gave us some time.' What sorts of issues were they canvassing with you?

Mrs Porter: I guess the pathways and really the interface with the NDIS: how Hearing Services would interface with the NDIS, which we have found difficult to conceptualise. The Office of Hearing Services seems to feel that parents do not understand the NDIS. We do actually understand the NDIS, but we do not understand how the NDIS and the Hearing Services Program will actually interface and how that will work.

It is just such an incredibly stressful and difficult time when your baby is diagnosed with a hearing loss. I have a deaf daughter. She is now 26. She first of all had a unilateral hearing loss, but then she lost her hearing overnight in her other ear. So I went from having a hearing child to a deaf child overnight, which is basically what happens with newborn hearing screening, where parents feel they have a hearing child and the next day they find that their baby is deaf. It just leaves you rudderless, I have to say. It is an incredibly challenging experience.

I started Aussie Deaf Kids. I am an occupational therapist. I worked within developmental clinics and in the assessment and follow-up of NICU babies at Westmead Children's Hospital. I could speak English. We had just incredible troubles navigating the system because she came at a time when, really, there were no pathways. We anticipate the same thing happening.

At the moment, we have these really clear pathways for families. We have seen some of the issues in the NDIS—with the introduction of the NDIS and the issues that families have around choosing early intervention services and before the NDIS with Better Start. If we then add in trying to navigate finding the right hearing services, we really do think we are going to lose a lot of people. We have a less than two per cent loss to follow-up after newborn hearing screening because we have this pathway that is so clear. In the States, I think it is nearly 50 per cent loss to follow-up. We can see it particularly in families from migrant backgrounds. As parents of deaf children, we do not really have much contact with Aboriginal and Torres Strait Islander families, but we do have a lot of contact with migrant families and the challenges that they face. So we are really fearful of the loss to follow-up with those families if we do not have very clear pathways and good information for those families.

CHAIR: Why is that? Is it just the overwhelming nature of the experience that people can become disempowered and find that they cannot—

Mrs Porter: I cannot tell you how difficult it is to absorb it all, particularly at a time when you are least able to deal with it. If you think about having your own children—you are just trying to feed the baby and then to have

to do with all these other things is so stressful. It is so out of our realm of experience. Also, it is just so hard to imagine what it is going to be like. It is an incredibly challenging time.

The other issue that we see is that mothers get very stressed in particular. We see a lot of mothers on antidepressants and things like that. Where deaf children and deaf adults already have very high levels of mental health problems, when you have a mother who is really stressed in the beginning and is unable to deal with the challenges that they are facing with their baby, the consequences for that child not only in terms of their hearing management but in terms of their long-term wellbeing and mental health are quite significant.

CHAIR: You are saying that Australian Hearing is actually critical as a part of that prevention of mental ill health for parents?

Mrs Porter: We still have parents in that situation and we fear that that is going to become more challenging if families have to look for hearing services as well. At the moment, early intervention services are clearly geared towards deaf children. If it changes and families can go to any audiologist, there needs to be so much rigor around that to ensure that that is appropriate for children and families. With children and families, it is not just about testing their hearing, putting in a hearing aid and saying 'goodbye'; you need a family-centred service. It is about supporting the family, giving them information. It is a holistic thing about integrating with early intervention and education. It is not just a single moment in time. We heard with older people that it is about seven years before they first get their hearing aid. They come to realise what their hearing loss means for them, what they need in their life to make it work for them; whereas families have not one clue. We parent from our experiences of growing up. We think 'Well, my mother did that; I'm not going to do that,' or vice versa, whereas with a deaf child you actually have no idea how to parent that child at all. We do not have any reference point to actually do it. When Bonny, my daughter, went deaf, the only constant that we had was Australian Hearing.

Senator McLUCAS: I was going to ask what Aussie Deaf Kids' experience was around the trial sites for NDIS. Do you have any experience that you can share with us from parents in those two areas? The two areas that I am talking about the areas that have been for the longest and for the whole of population.

Mrs Porter: I run online groups, and it has not been an issue a lot with parents, except for the amount of paperwork. Also, I suppose, it involves parents who are already generally in the system, so they understand what the needs of their child are—for most of them, it has come down the line. I have not had any information that I can think of from a new family going into the NDIS. I am on this early intervention working group for the NDIA, and a thing just came through from the trial sites. They had a workshop in Newcastle—I think this week—and the findings coming back from that are mostly what we fear with the hearing services being contestable around the fact that there is no registration, there is no rigour around who can provide the services and there is inadequate support for families to make the correct decisions. That is coming out in the workshops that the NDIA are doing around early intervention. So these issues are emerging as significant issues within the trial sites. I think that that is just for early intervention. So if we add hearing services onto that, the complexity for families is just—we do not want to go there, basically.

Senator McLUCAS: In terms of the scoping study deferral and now this level of consultation, have you been engaged in any of those consultative processes from the Department of Finance?

Mrs Porter: We were invited to the recent workshops. I have been overseas, so our chair went. But we were invited. The feedback that I got from him, though, was that it was more telling us what was going to happen, rather than asking us our perception.

Senator McLUCAS: What was your chair told?

Mrs Porter: Just how things were happening—you know, that hearing services would go under the NDIS. Yes. Really, we had compiled a really long list of questions that we have constantly sent to the Office of Hearing Services, the Department of Health and the Minister for Finance about all the issues that we are concerned about. From my understanding, those were really not addressed at that consultation.

CHAIR: Could you provide us with a copy of that list of questions? If possible, today—that would be very helpful—if not, at your earliest convenience.

Mrs Porter: Yes.

CHAIR: Thank you.

Senator McALLISTER: Thank you, Mrs Porter. I am conscious of the time, but could we speak very briefly about the idea of family centred early intervention? The reason that I am interested in understanding what you believe are the core elements of such an approach is that—assuming that the other objections to contestability are set aside—one would need to define the kinds of services, beyond the raw testing and fitting services, that are

associated with effective early intervention in children. Could you set out for me what 'good' looks like when we see a family centred early-intervention service?

Mrs Porter: I have been involved in an international collaboration that has looked at family centred early intervention, and I can give you the journal article if you are interested in having a look at it.

Senator McALLISTER: Please do.

Mrs Porter: I guess a lot of it is around acknowledging the role of the family in the life of the child and the right of the family to make the decisions and the need of the family to make informed decisions and, within that context, how important high-quality information is—information that gives them all the options and that guides them through the process of making informed decisions. In the context of research around deaf children, early intervention is actually not early intervention as we define it, which is more often the education process. Early intervention combines both the provision of hearing services and early education services—early childhood services. The document actually goes across the whole spectrum.

Senator McALLISTER: In a practical sense, when you see examples of that in the Australian context—and I assume you do—what does that relationship look like? Is there one service provider? Is there a team? What is the family's interface with the service provider in looking towards that goal?

Mrs Porter: Each of the services talk about having family centred practice. Really, around that you also need an interface between all of them. It is about trying to make the journey for the family as seamless and holistic as possible. We do not do that wonderfully. I think there are impediments in terms of sharing data and things like that between education and health and between state and federal and everything like that. I think one of the massive issues that is going to be a problem with this is that we still do not have a national database of newborn hearing screening. One area where we do actually know a lot about what is happening with children is through Australian Hearing. And to lose that in the face of the fact that we do not have a national database—the states all have databases; some are better than others—without Australian Hearing I just do not know how we will follow these kids up and know where they are going.

Senator McALLISTER: So, further fragmentation of the sector provides risks, not just to the hearing support but to other kinds of supports that might support hearing impaired children.

Mrs Porter: Yes. And we just cannot conceptualise how in a fee situation people are going to take time to provide the family with the support and time they need to come to the decisions they need to make.

CHAIR: Have you been advised by any of the departments about further engagements as part of the consultation process around the scoping study?

Mrs Porter: Not really. We know that the Office of Hearing Services is having further consultation through its audiology reference group and is looking for a parent to attend that. But I am not aware of anything else.

CHAIR: If you could provide us with any details of what you know is happening, that might shed some light on what is a rather dark area at the moment.

Mrs Porter: Yes.

CHAIR: I want to just take you to one word that you wrote in your submission. You said at the top of the second page that we are now at a crossroads for deaf and hard-of-hearing children and their families. And you made the comment about the contention that contestable hearing services have the potential to compromise principles of good practice and put at risk the future of deaf and hard-of-hearing children and their families. Why has this crossroads moment emerged? Was there a problem?

Mrs Porter: We did not think so. I guess we knew that with the NDIS clearly there was always going to be the issue of possible contestability if hearing services went under the NDIS. But we were not really aware that the hearing services were going under the NDIS. We did see that there was a COAG agreement a number of years ago that we were not really aware of. As parents we were not aware that that had occurred. We were under the impression that the NDIS and hearing services would remain separate. But the sale of Australian Hearing was where the alarm bells first started to ring for us. We have really been told only in the last few weeks that hearing services will go under the NDIS. We are just trying to catch up all the time.

I also think parents are often the last people consulted. It seems to be that the providers and everybody else are the people who are often the first to know about anything. It must also be remembered that parent groups are largely run by volunteers. We have spent huge amounts of time trying to keep on top of this, and it has been hugely difficult for us. We all have other things that we do. Parents have really been on the back foot the whole time and trying to catch up along the way.

CHAIR: Would it be an advantage to your parent group, your active citizens who are advocating for deaf children and the families of deaf children, to have access to that scoping study?

Mrs Porter: Yes, it would. We would love to see it.

CHAIR: Thank you.

DEWBERRY, Ms Margaret, Adviser, Deafness Forum of Australia

WILLIAMSON, Mr Stephen Lindsay, Chief Executive, Deafness Forum of Australia

[9:32]

CHAIR: Welcome. I invite you to make an opening statement, and I am sure the senators have a bank of questions.

Mr Williamson: Thank you for the opportunity to speak on matters of interest and concern to our members and on behalf of the one in six Australians represented by the national not-for-profit organisation Deafness Forum. Hearing impairment or deafness and the effects of ear disorders such as Meniere's and tinnitus represent a grossly underestimated public health problem in Australia. The number of Australians affected by hearing health issues and loss is projected to increase to one in four by 2050, due largely to our ageing population. A loss of hearing acuity limits a person's ability to communicate and through this limits their ability to interact with society. This has social and economic consequences for the individual, their family and society. Reduced communication ability impacts on a person's life opportunities because it limits their ability to participate in education, to gain competitive skills and employment, and also to participate in relationships of all types. Hearing loss can lead to social isolation and increases the risk of mental health issues such as depression and dementia. Hearing loss may be present at birth or acquired through injury, health conditions or as part of the ageing process. Acquired hearing loss caused by excessive noise exposure such as industrial noise or listening behaviours is largely preventable.

Hearing loss represents a significant and quantifiable economic cost and impact to Australia—one that far outweighs the current investments and expenditures. A report by Access Economics in 2006 identified that the real financial cost and net economic impact of the loss of wellbeing, when taken together, is a debt to the nation in the order of \$23 billion every 12 months. Due to the high social and financial cost that hearing loss has on Australian society a coordinated strategy that encompasses prevention, treatment and management would achieve improved health outcomes for the large proportion of the Australian population that is and will be affected by hearing loss. Deafness Forum believes that this would be best achieved by making hearing health a national health priority.

Deafness Forum of Australia has advocated for many years for access to affordable hearing services for people who do not qualify for services under the Australian government Hearing Services Program. We will soon see this become a reality as the National Disability Insurance Scheme will address the needs of some deaf and hearing impaired people under the age of 65. It is an excellent outcome for people of working age. The scheme is not means tested so, provided the person meets the criteria for assistance, they will receive the support they need. However, people aged over 65 years of age who remain in the workforce and self-funded retirees miss out on support with their hearing aids. Unless the person qualifies for a Centrelink pension or they are a veteran, they need to access hearing services privately. Given the prevalence of hearing loss increasing with age, people over 65 years are more likely to need hearing assistance, at a time when their incomes may be limited. Consideration, then, needs to be given to supporting people over 65 years with hearing loss who do not qualify for government funded programs.

Work is currently underway to develop a strategy to transition client groups from Australian government Hearing Services Program to the National Disability Insurance Scheme. The group most affected by this change are deaf and hearing impaired children and their families. This would not necessarily be a problem if it were just a change in program responsibility and Australian Hearing, which as you have heard has an international reputation for delivering a high quality paediatric program, remained as the sole provider of services to children. However, the change will see the introduction of contestability. This is concerning as the private market is untested in the delivery of these services to these clients. The introduction of contestability introduces significant risks in terms of access, expertise, quality and standards. Additionally, as you know, the government is still to make a decision regarding the sale of Australian Hearing. If the sale proceeds and the new owner decides to withdraw from providing services to these more costly and challenging client groups then the safety net of the government provider will be lost. Deafness Forum of Australia has developed a paper outlining the issues that need to be addressed in the transition plan and has made it available to the committee.

CHAIR: Thank you for those thoughtful opening remarks and for your submission and for the work that you do as well. Have you or any member of your organisation been provided with or seen a copy of the scoping study commissioned by Senator Cormann?

Mr Williamson: No.

CHAIR: Would you like to see it?

Mr Williamson: Very much so. Indeed, we have been asking since, I think, last October if we could have a look at the work that would be created. We are particularly interested in the recommendations.

CHAIR: In what form have you requested copies of that?

Mr Williamson: Letters to the relevant federal ministers and their secretaries of departments.

CHAIR: And have you received any replies?

Mr Williamson: I recall receiving a letter on behalf of the honourable finance minister advising that the matters are commercial in confidence.

CHAIR: If you could provide us with a copy of any correspondence, that would assist us in our understanding of the timing and the processes that have been undertaken to date. Have you been invited to be part of the consultations that were advised in July?

Mr Williamson: Are you referring to those facilitated by the Office of Hearing Services, the Department of Health and the Department of Social Services?

CHAIR: Yes.

Mr Williamson: Yes, indeed. Deafness Forum was represented at the Sydney Melbourne and Canberra consultations and at that time we were advised—formally advised, if you want—of the transitioning of services within the CSO programs across to the NDIS. We also received a PowerPoint presentation from a finance department representative which briefly mentioned some of the matters that had arisen during the scoping study.

CHAIR: If you have any reports or further details about that, we would appreciate receiving information about what happened at those meetings.

Ms Dewberry: The Office of Hearing Services have put the PowerPoint presentation on their website, and a summary of the discussions from those consultations. I have a copy with me. I am happy to table it here or you can gather it from the website.

CHAIR: Thank you. Senator McLucas, would you move that we accept that.

Senator McLUCAS: I so move. Thank you for that. That covers the consultation process to my satisfaction. Can I go to the question of contestability for the CSO clients of Australian Hearing. The principle of the NDIS is choice and control, and choice would lead you to think that a participant in the NDIS would be able to choose. But I think you are right to point to risks that may appear. Can you take us through what those risks are and how and whether they can be ameliorated.

Ms Dewberry: The risks occur predominantly because it is untested in the private market whether there is the capacity and the capability to undertake some of the services that are currently delivered by a sole provider. We would like to see more evidence that that capacity and capability exists before the decision is made to move it. We feel that we are on a pathway regardless. As others have said, it is a bit like playing catch-up to say, 'These are the things that are concerning, please mitigate these risks.' A key one is expertise. Because Australian Hearing has been the sole provider for so long—they have been nearly 70 years in that area—the private market has not been asked to step up and deliver that service. That is not to say that there is not the capacity to do so, but they have not been required to; you would not build a business model on doing something where you are not going to get that sort of work. So we do not know what sort of expertise is out there. I know the office is undertaking some gathering of information through the professional bodies by asking them, but there is not actually a formal qualification in delivering services to paediatric clients or clients with complex needs as Australian Hearing delivers it currently. Nor is there any registration of audiologists. So there is huge nervousness around what might happen. Anybody can set up as a hearing services provider and there is no way to check because there is no registration. That really is concerning.

CHAIR: Is there a framework established for registration of any kind?

Ms Dewberry: The Office of Hearing Services was obliged to set up an accreditation scheme when the voucher scheme started in 1997 because there was no registration scheme for audiologists. But what they look to is for the person to be a member of one of the professional bodies that exist. So they rely on that. I do not have an issue with that under the voucher scheme; I think it is very legitimate. People have a master's degree in audiology, so that should certainly give you confidence that they can deliver services. But when you are getting to these more specific and specialised services, Australian Hearing does invest a lot in ensuring that the person is well trained and has the necessary skills. They have a mentoring program and a strong network to support the clinicians working in that area. We do not know where that is going to come from if Australian Hearing is not going to deliver that. That is a question. It is not to say that there cannot be something put into the universities or other training organisations, but there is nothing at the moment. Also, there is a difference between the expertise you

need in seeing a baby and the expertise you need in seeing a teenager with a hearing impairment; your knowledge and skill base is quite different. That is why, in our paper, we recommended that, if you are going to ask about paediatric experience in the membership of the professional societies, then could you be very specific about the sort of expertise that is out there. Again, that is just about trying to build confidence in that area.

Coverage is another concern for us. Australian Hearing has a big network. We know that other providers have a big network, but we do not know whether those other providers will put paediatric services into those locations. You need specific expertise. You need specific facilities and equipment. It is a big investment, so commercially what you would do is centralise those services to maximise your utilisation of that equipment and the staff. That is one model that you would use, but it is not very good for families who happen to live in rural and remote areas if you do not happen to get a centre near you. I do not know how you can assess that in the future, since it does not exist now. There has been no obligation on the private sector to do it, so there is no real way of measuring it. And there is concern that, if Australian Hearing is privatised, the new owners would say, 'It's a bit expensive to keep all of those sites operating with that specialised skill. We will centralise it or we will not do it at all.' So we do not know what that new owner might choose to do in the future. So there is huge concern around the expertise and the coverage.

Another thing about expertise is that you need to be seeing a particular client to maintain your skill level—a certain number of cases constantly. There are roughly 20,000 children fitted with devices in Australia. Approximately 2,000 children are fitted with hearing aids each year. Looking at referrals from the Newborn Hearing Screening Program, there are about 250 or 300 babies each year. That is spread across Australia but it is within one organisation at the moment. When newborn hearing screening started I was actually working at Australian Hearing at the time. We put a lot of thought and effort into how we were going to skill up people who possibly had never held a newborn let alone taken an ear impression of a newborn's ear. So it was set up that we had some specialised infant fitting centres because the numbers were not there to spread it across every centre and we needed to build expertise very quickly because these babies were coming and the audiologists providing these services needed to be skilled. If that service gets fragmented, I am not sure how clinicians would maintain their skill level if they might only see a baby referred to them once every few years. It is concerning how that would happen.

On standards and quality, we would certainly like to see what is going to be specified and how that will be done. I know that work is underway because Deafness Forum of Australia has been asked to provide a representative for a reference group to develop best practice standards in audiology. And that is a bit confusing as well. There is work underway but, again, you are playing catch-up on what that work is. We would like to see what the blueprint is. I thought the Office Of Hearing Services had made an offer for people to attend a transition planning workshop, which I had interpreted to mean that we would be part of developing that blueprint. But it seems that the blueprint is there. So I do not whether that is just a consultation process now or quite what it represents. So yes, there is this feeling of always playing catch-up on what is happening.

So I think risks are around people falling through the gaps because there are multiple providers. At the moment the pathway is very clear and very quick. Even at the information session we had with the office and NDIA, we were saying that the pathway to NDIA could be quite slow if you have to check your eligibility and then you have to meet with the planner and you have to determine your plan and your supports and then you go ahead with that. That is not an issue if your child is already diagnosed and within a system, but if you are a new family that is much too slow. At our information session, the NDIA were very clear: 'We're the funder. We don't want to interrupt things.' So I think they understand they have to think about how their system is going to not impede families getting the very quick service that they need, but how do they choose? There is no register to go to to say, 'This is a person who is good at this sort of work.' So what happens if they do not make it from the hospital diagnostic centre to the intervention service for hearing services? Who is going to track that? You have already heard we have no database, which is a major concern and a great need that has been identified for a long time. If English is not your first language, what happens then? Who is going to make sure that you do not get lost in that pathway? Who is going to make sure you have written information in your language that you can follow?

We have tried to detail as many things as we could possibly think of about where risks are. We are not saying you cannot mitigate these risks, but we would like to know those risks are mitigated before the big step is taken to say it is happening.

Senator McLUCAS: Thank you. You talk, Ms Dewberry, about a blueprint. Is that your language or is that the language that is coming—

Ms Dewberry: That is what I thought had been written, actually, when I registered for one of those transition workshops. I am not sure if I have been accepted, but that is the language I thought I read on the invitation on the website: it was about a blueprint for the transition to the NDIS.

Senator McLUCAS: For hearing services to go to?

Ms Dewberry: Hearing services, yes.

Senator McLUCAS: Was that from OHS?

Ms Dewberry: Yes.

Senator McLUCAS: Thanks so much for that. I think the big issue that you have pointed to is where there is early diagnosis of a newborn and that newborn baby then has to go across to the NDIA and a planner. We need to work now, and that pathway is very clear now. I think you have made some very important points. Thank you.

Senator McALLISTER: Thank you so much for your submission. I found it very thorough, and I suppose what it piqued in me was a series of questions around the most appropriate structure of service provision. We are often working in a situation where there is an assumption that contestability or competition might deliver the best options, but there are many questions here that go to the role of networks in maintaining an overall level of quality of service. I wondered if we could just talk through some of the specifics in your submission, particularly in that context.

One of the things that strike me is just that there is a massive information-gathering process for a person who is new to hearing impairment, particularly for parents, and that there is a service being provided currently, in a context of central service provision, to provide information that might not be accounted for in planning for a more fragmented service provision. Is that correct? Have you been told anything about how people would be supported to get the information they need?

Ms Dewberry: No, I cannot think of any information around that so far, and it is a major concern. When the scoping study was first announced, Deafness Forum decided to put in a submission. There was no call for submissions that I was aware of, but we wanted those consultants to really understand about hearing loss and hearing services, so Deafness Forum and several other organisations put together some submissions to help inform on that. We consulted as part of that process, and it was very strong from families particularly that impartial, unbiased information was just so important. They did not have to think: 'Is somebody running a different agenda here? Is it a commercial interest? Is it just about their service and not the broad services? I'm not really getting to make an informed choice; I'm just hearing about a particular area.' They just did not have to think about that, and when they are thinking about so many other things, when they are a parent of a newly diagnosed child, they just want to think, 'Oh, good; I can just go there and they are going to give me the information I need and then I can think about what I want to do and what would be right for my child and my family.' I do not know how that can be replicated in the new proposal of the NDIS, but it is so important for families to have that trust in who they are seeing and to know that they are getting the information they need to inform them.

Senator McALLISTER: Just incidental to that, as to Australian Hearing, is it your understanding that they have a particular relationship with any particular provider of equipment?

Ms Dewberry: Of hearing aids?

Senator McALLISTER: Yes.

Ms Dewberry: Well, they tender—they run a tender at a particular period of time, to determine—

Senator McALLISTER: So they are not vertically integrated?

Ms Dewberry: No, they are not owned by a manufacturer. They get the best value for money they can through a tender process.

Senator McALLISTER: But other providers of audiology services are integrated?

Ms Dewberry: Some businesses are vertically integrated, yes.

Senator McALLISTER: I want to go also to the coordination with education facilities and the relationship between education services and hearing services. Could you talk me through your understanding of how that works?

Ms Dewberry: It has to be a really close relationship, because the audiologist is trying to get the hearing aids fitted optimally, and it takes a lot of information to know if you have done that well. You can do some objective testing, certainly, and now we can even do that with babies, thanks to the National Acoustic Laboratories developing a bit of equipment so that we could actually measure what the child was hearing very early on. That is all great and necessary, but you also need to know how the child is functioning in their own environment at home

and in the classroom. So those relationships with early intervention agencies, schools and itinerant teachers of the deaf are all very critical to knowing what we need to do to best support the child. It also has to be a two-way street. The audiologist has to inform the educators about what they have found, what the degree of hearing loss is and how they think the child should be functioning with their devices, and then you need to get information back about: 'This is what we are finding in the classroom or in the program.' Australian Hearing also does on-site visits to early intervention services and schools so that they can see firsthand, talk with the teachers and run some education sessions for the teachers if that is of interest to them. So it is a very close relationship. Also there might be other therapists involved with the child; the child may have other disabilities. You may need to be talking to an OT or a speech pathologist. So there is a lot of information flow between all of those people working in the best interests of the child.

Senator McALLISTER: And that is a typical profile of services provided for an Australian Hearing client?

Ms Dewberry: Yes.

Senator McALLISTER: The final area where there is a coordination function that it is hard to imagine being delivered is data, and you have noted shortcomings in the availability of data under current arrangements. What data management is undertaken now? We heard earlier about Australian Hearing maintaining some data and information.

Ms Dewberry: For a very long time, Australian Hearing has collected and published information. It actually dates back to the rubella epidemics early on. It was how you could assess the effectiveness of the vaccination when it came in, because the number of deaf children decreased significantly in the year that that vaccination program started. So there were papers published around that.

Australian Hearing knows, because they are the sole provider of services, how long it has taken for that child to be fitted with hearing aids, at what age that occurred, what degree of hearing loss that child has in the better ear and the worse ear, and what sort of device they have—whether it is a hearing aid, a cochlear implant or some other assistive listening device. So it is quite a picture of hearing loss in children in Australia that Australian Hearing has and makes available, and it does help with the planning of other services to know how many children there are. Educational services, for example, are always very interested in the data so as to know how to plan their services in terms of how many people they will need. There has been an upward swing in the birth rate in Australia. That means the number of deaf children has been slowly growing over a period of about five to 10 years. So people can plan their services based on that information.

Senator McALLISTER: So at least four areas—the provision of information, coordination with educational facilities and other providers assisting the child, the coordination of data and skill formation, as in your earlier comments—are functions that are presently coordinated through Australian Hearing, but we cannot imagine yet what the mechanism would be under a contestable market for the same services to be delivered to the community. Are there any other areas where you see a gap between what a single provider can do and what a contestable market could provide?

Ms Dewberry: I think the other challenging area with multiple providers will be children in schools. Most children are integrated into mainstream classrooms, so the teachers learn about how to help the child with their devices. Multiple providers will mean multiple devices, which may work very differently, so I think the teachers may find that somewhat overwhelming.

There is another device that children are often fitted with, particularly for use in a classroom, which is an FM system. The teacher wears a microphone and transmitter and the child has the receiver linked to their hearing aid, so it overcomes that distance factor and some reverberation issues in the classroom, so they get a better signal. If you have different providers fitting different devices that each run on a particular frequency, who is going to coordinate the frequencies to make sure they are all compatible, or does the teacher have to wear five different transmitters?

Senator McALLISTER: So it is about the ability to have a network approach to technology for some additional benefit.

Ms Dewberry: Yes, and coordination around what is happening. It will have an impact on others—educators, particularly, in that example.

Senator McALLISTER: Yes. It is hard to imagine that the efficiencies from contestability could overcome all of the costs associated with losing these services. Thank you very much for your testimony.

CHAIR: Ms Dewberry, following on from Senator McAllister's questions, could I take you to page 9 of your submission to put on the record your consultation with families, which I dare say was asking them a series of questions rather than telling them about what was going to happen.

Ms Dewberry: That related to the first submission, on the scoping study. We were just saying, 'There is a potential sale of Australian Hearing,' and asking people their views—not only families but the general population. I should put on record as well that there was a diversity of opinion across the age groups. Some consumers were very keen on the privatisation of Australian Hearing because it meant they would get access to Australian Hearing, which they currently cannot do because they are over 26 and not on a pension. So there was some keenness there to have it opened up for that reason, as well as some—

CHAIR: So the keenness was for access to the service rather than the dissolution of the current service?

Ms Dewberry: Yes. So there was that aspect. There were some people who expressed dissatisfaction with the service as well and wanted the opportunity to have choice, but that was an older age group rather than the families. Among the families, I cannot think of any dissenting opinions. They all said, 'We just need that support and information, an unbiased opinion and the best evidence based practice that is available, which we know is available at Australian Hearing. What else is out there that is going to deliver that?' So it was a very strong, very clear message that they would prefer to forgo contestability rather than lose all of those other supports.

CHAIR: The language of finance is often in ascendancy in our current political debates, isn't it? 'Contestability' is one of those very appealing words that you might read frequently in the newspapers, but you are providing us with very important evidence that, given the choice of contestability, parents who are currently in the process of negotiating their way through providing the best opportunities for their children who have a hearing loss oppose the notion of contestability because they understand it would not meet their children's needs.

Ms Dewberry: That is right. We would certainly support the Office of Hearing Services testing the market to see if they can come up with another organisation or another way of doing what is required in order to make a decision. We do not want a decision made until it is very clear what that decision should be, and that decision also needs to factor in that there may not be a safety net there if Australian Hearing is eventually privatised.

So we have got the two things. We have got the transition to the NDIS and all that surrounds that and then we have got: what if there is no Australian Hearing or they elect to pull out of those services? There are two aspects that need to be considered. There is if Australian Hearing is found to be the only provider who could see a particular age range of children. At the moment it is nought to 26. There is no reason why it has to remain at nought to 26, but we would like it to be a particular age range. We have suggested until the child leaves school for that issue about the education facilities and so on. If it is found that Australian Hearing is the only provider and if privatisation is going to be considered then something needs to be built in to make sure they are still there to deliver as a sole provider, even if they are privatised—so some requirement for them to remain in that market as the sole provider.

CHAIR: That is an interesting way to go forward. Mr Williamson, I was listening reasonably carefully to your opening statement where you talked about a different scoping study, if I heard you correctly. You referred to some research early on in your statement. Can I take you back to that and provide me with a little more information.

Mr Williamson: Senator, are you referring to the proposition of creating a national health priority?

CHAIR: I think it was what the failure to invest in hearing intervention would cost.

Mr Williamson: Certainly. The evidence in 2006 was a report commissioned by the HEARing CRC, with a Victorian not-for-profit deaf organisation. It came up with two figures. One was a direct real cost to the nation of slightly over \$11 billion per annum, and the report, which I will make available to this committee, goes into the detail of that. Then there is the loss of wellbeing cost—the impacts of disability years, for example, which are estimated to be roughly about the same amount of money. We cannot say that the Australian demographic has changed that dramatically since 2006; however, we simply know that that information is coming on 10 years old. On that basis, while governments most certainly invest in the provision of appropriate hearing services, a more coordinated national and state based approach, with appropriate investment, could realise significant financial benefits for the nation in offsetting those costs.

Let us also note two things. We are all expecting to live longer. I think many of us in this room would like to be healthy, active 80-year-olds. So this issue of hearing in the future and hearing services is not academic; it is rather personal at this point. It is necessary for our economic wellbeing that we remain in the workforce as long as possible. Progressive loss or sudden loss of hearing takes highly-skilled people out of the workforce. We also have great concerns about the current leisure listening habits of young people. We are fearful that it will create somewhat of a crisis in the next 30 or 40 years. We found through research conducted by specific research bodies into farmer health that a typical 20-year-old farmer—and also their partners and children, because they are all exposed to noise in an agricultural environment—has hearing equivalent to a 40-year-old.

We have seen that the government's national health priority programs have been most effective when we think about the national diabetes plan and the tremendous focus on obesity and the rest. They are all very deserving health issues and it is appropriate that they are national health priorities. We hope they will remain national health priorities. Hearing health is also an important issue. We believe that, given it is so prevalent yet so overlooked, misunderstood and neglected and there is an economic case for addressing it, the creation of it as the 10th national health priority would be a very sensible investment by all governments in Australia.

CHAIR: In the current context of the federation white papers and many times hearing ministers say, 'That is rightly a matter for the states,' if there were a dissolution of Hearing Australia and it became a series of state and territory based organisations, what might the impact be? I think you have talked about differentiated service access across the states already.

Ms Dewberry: The whole conversation that I have focused on has been about the CSO client groups, and that is because those numbers are so small. To be fair, in Australian Hearing 70 per cent of business is the voucher business. We do say that there are other providers in the market that could do that, but we do need to really look at this small proportion of people. It is very hard to keep expertise in all of the places where people live unless you have a national organisation to do it. You need that resource pool to move people around the country. When I was working with Australian Hearing—and it is probably still the case—80 per cent of audiologists were female. That meant a lot of maternity leave and people returning part time, so it was very hard to keep the resource levels up such that the client still got the level of service they needed in the places where they needed it.

In particular, when you look at the Indigenous outreach program, where you are going to places all around Australia, again you need that central coordination to make sure you have the right people in the right places with the right skill for a very small amount of work but very important and very intensive work, but it is very hard to find the skill unless you have a big pool of people to draw from. That is why the size of Australian Hearing and its national reach are so critical. In breaking that up into states, one thinks about the Northern Territory, for instance, with the services that had to go in there when the intervention first started. They had to put out a call amongst the audiology profession to say, 'Can you come and help us?' They got a lot of retired people, actually, going up to the Territory to do that. There is just not the pool of people that you need to deliver the services in some states or territories.

CHAIR: You spoke about the critical element of timing, and I have asked about the need for a very quick response. What sort of timing are we talking about? If a baby is born Monday, Mum might be home on Wednesday if everything goes well.

Ms Dewberry: The infant would, hopefully, have had their hearing tested before they left hospital. If they were found to have a problem that required referral to a diagnostic centre, that would happen, I would think, within a week. If that child was diagnosed with a hearing loss, they would be referred to Australian Hearing. Before Australian Hearing proceed with a hearing aid fitting, they require a medical clearance from an ear, nose and throat specialist. When newborn hearing screening started, there were negotiations with the diagnostic centres at the hospitals to say, 'Could you also get the ENT clearance so we can then immediately fit the child.' So there was a lot put into making this time frame as short as possible. Usually they would then be referred to Australian Hearing. They would be given an urgent appointment for within five to 10 working days and, knowing the child had a hearing loss, they would probably take impressions if whether the family were ready and that was the direction they wanted to go in, and they would fit within two weeks. So when an infant is six to eight weeks old they are fitted with a hearing aid.

CHAIR: It is a while since I have had a newborn—funnily enough!—but I am thinking back to those moments of coming home and trying to get used to things. The first six weeks were a blur with getting things organised and, especially with the first child, trying to figure out how you do everything. It would be very easy for six weeks to pass while you are coping with just the newborn nature and perhaps denial about the need for assistance. If these systems do not kick in immediately around you and support you in every possible way, by the time a baby gets to six weeks, key milestones in early intervention would have been missed.

Ms Dewberry: Yes. Certainly, the sooner you can intervene with the amplification, the better the outcome for the child. That is not to say that there are not reasons for delaying—if the family are not ready or if the child has other disabilities or health issues, then they have to take priority over hearing. So there are very good reasons for not acting as quickly as that. But the aim is to action things at the right pace for the family and as quickly as possible for the child.

CHAIR: So, as an audiologist, if there were no other impediments, that sequence is what you currently consider to be best practice?

Ms Dewberry: Yes. Work very hard to make that happen as quickly as possible.

CHAIR: In the contestable environment do you believe that would still be the outcome?

Ms Dewberry: I could see many reasons why it would not happen that quickly, unless you had a dedicated provider who was working in that area. I think it does need a sole provider, and for the families just to be assisted through that to that provider.

CHAIR: Thank you for your evidence this morning.

Proceedings suspended from 10:15 to 10:35

KENNEDY, Ms Kate Amelia, Coordinator, Parents of Deaf Children

MESSARITI, Ms Anna, President, Parents of Deaf Children

WYBURN, Mr Mark William, Ordinary Committee Member and Regional Representative, Parents of Deaf Children

CHAIR: I now welcome Ms Anna Messariti, Ms Kate Kennedy and Mr Mark Wyburn from Parents of Deaf Children. Do you have any comments to make on the capacity in which you appear?

Ms Kennedy: I am a parent myself.

Mr Wyburn: I have a 10-year-old deaf son, and I am coming up to one year in the NDIS up in the Newcastle area.

CHAIR: It looks like Ms Messariti will be giving the opening statement.

Ms Messariti: Thank you very much for providing us with an opportunity to speak at this important hearing. I am here with two of my parent peers who represent a not-for-profit organisation, Parents of Deaf Children, which is constituted in New South Wales. As a parent organisation, we work on behalf of parents of deaf children throughout the state, respecting the diversity of their pathways and choices in raising a deaf child or children. I am here today with Kate Kennedy, who is our key staff member, and Mark Wyburn, who is on our management committee. Like me, both of my peers are parents of deaf children, and they will tell you more about themselves and their children in a moment.

My son Xavier, who is now six years old, failed his newborn hearing screening shortly after he was born. He was tested at two days of age and then again at six days of age. The second time he failed, we received a referral to the audiology department of Sydney Children's Hospital. At that stage, it had not even crossed my mind that he could be deaf. At 13 days of age he was tested again, this time more thoroughly by a senior audiologist at Sydney Children's Hospital in Randwick. It was a very long process. By the end of it, I went home with my baby, the diagnosis of a severely sloping sensorineural mild to moderately severe hearing loss, a *Choices* booklet, a couple of pamphlets about early intervention, referrals to Australian Hearing and a hospital service called Hearing Support, and a list of follow-up appointments. My partner was not even with me on that day, as we had not really comprehended the seriousness of our situation as a family.

At that point, I did not know what I was dealing with. After a few days of reading followed by comprehension, grief and fear, I slowly began to formulate many questions in my mind. There were too many to name. I had realised by then that interventions would be necessary and that I had to make critical decisions that would affect Xavier for the rest of his life. At the age of five weeks old, Xavier was fitted by Australian Hearing with his first set of hearing aids. He is now a thriving six-year-old and Australian Hearing is very much a part of our lives.

I would now like to hand over to Kate Kennedy to introduce herself, followed by Mark Wyburn.

Ms Kennedy: Our experience with hearing loss is different from Anna's because my children are now in their late teens and early 20s. I have three children, and two of them are deaf. We did not have the benefit of newborn screening in those days. So I suppose my experience is perhaps a cautionary tale for where we maybe could go back to, because both my deaf children were diagnosed late, and I suppose what then took place was us really trying to catch up, because my daughter in particular had quite a language delay and, because she was nearing going into preschool, there was so much to do and so much to think about. I think finding Australian Hearing, for us, was when it all started to fall into place, but up until that time there were a lot of pieces of the puzzle that we were having trouble putting together. When we finally got a diagnosis, it was a relief, I suppose, but there was a lot of guilt attached to the fact that there was a late diagnosis, and what followed was that really we were playing catch-up for quite a long time. I suppose that just gives you a little bit of a snapshot into our personal experiences.

CHAIR: Can I just ask, Ms Kennedy, what you mean when you say 'a late diagnosis'. At what stage?

Ms Kennedy: My son is a twin. He has a hearing brother, and he was diagnosed at the age of 2½. You would think that, with the next child, there would be some flags raised about the fact that maybe there is a hearing loss factor, but because our twins were premature we were informed that his hearing loss was due to his prematurity. We had a term baby following: my daughter, who is now 18. There was no checking that she had a hearing loss. We were just so grateful for the fact that she was not a premature baby, so we just went ahead. She also had a late diagnosis—even later, actually: she was not really aided until she was three. The pathway now is so quick and it is quite clear, and I reflect on our experience and how different it is, I suppose. That flags for me the concerns if we are unpacking this pathway, changing this pathway or moving services from this pathway—what the risks might be in terms of that story for a whole lot of other people. We are an engaged family. We are well resourced. It was a nightmare.

CHAIR: Thank you very much, Ms Kennedy. Mr Wyburn.

Mr Wyburn: My son who is hearing impaired is the youngest of three children. State-wide infant screening had just started. On the day that he was due to get that test done, the equipment did not work. We are not sure now in hindsight whether it did not work or it just did not give a result. Up to six months, he was not reaching his developmental milestones, so the paediatrician recommended hearing tests and eye tests to cover off some of those areas. At Australian Hearing, when he was seven months of age, we found out that at that time he was diagnosed with severe deafness. That has since come back with a lot of work, and we can talk about that later, but it took over two years to get a full audiogram for Luke because of his other disabilities: he has a neurological condition that he was born with and will have for the rest of his life, which has led to global developmental delay, and he has low muscle tone. So a lot of work goes in there, as well as into the hearing disability. He was fitted with hearing aids two weeks after he was diagnosed as being severely deaf, and he has been going to Australian Hearing ever since.

Perhaps the effect of a deaf child on the whole family unit has not been discussed completely, but it changes the whole family dynamic. It has a major effect on our two older children as well whilst we address our younger son's therapies and his condition and all the other things that go with having a disabled child.

CHAIR: Thank you for coming to share your stories with us. Were there any further comments that you wish to make before we go to questions?

Ms Messariti: Yes, there are a few points we would like to make. As representatives of Parents of Deaf Children, we believe that at the present time high-quality hearing services are delivered and made accessible to all eligible Australians by expert practitioners. We believe that this level of care must be maintained. This is so that the outcomes for deaf and hard-of-hearing children in Australia now and for future generations can be maximised.

Quality of care and optimal outcomes must remain as the highest priorities. These should not be placed at risk by potentially short-sighted policies and practices. The exploration of market forces and contestability, in the context of delivering models around hearing services, could place these standards at risk. Parents of Deaf Children is concerned about the financial models that are being considered by the federal Department of Finance in relation to the Community Service Obligations program and Australian Hearing. Ultimately, at stake is a health and social issue that will affect disabled children and their families. This is not merely a financial issue; it needs to be addressed very carefully. The primary focus of a hearing services program and a pathway to early intervention should always be on deaf and hard-of-hearing young Australians gaining the specific and appropriate supports that they need for their hearing disability. This is so that these young people can communicate and learn effectively.

In surveying and considering the concerns of our constituency, Parents of Deaf Children in New South Wales, who are located in cities as well as in regional areas, and include many people from culturally and linguistically diverse backgrounds, have formed the view that when it comes to the provision of hearing services for babies, children and youth the government can and must do this better than private service providers. The position we have adopted is practical rather than political. We would like to point out that, as an organisation, Parents of Deaf Children does not reflect a specific political persuasion or have any party allegiances or preferences. The common ground that we share is that we have a lived experience of parenting a deaf child or children and that we know and understand the complexities of service provision that are involved.

It is difficult to imagine how multiple service providers could ever deliver the kind of hearing services that a government entity such as Australian Hearing is currently delivering. Personally, I can vouch for the fact that Australian Hearing has provided my child, since his birth, with regular appointments and fittings, very high-quality devices and regular revisions of his diagnosis in the form of ongoing testing. In order to determine the efficacy of his hearing devices for his unique hearing loss, before he was even one year old, when he could not provide feedback, he was able to receive cortical testing using the HEARLab device invented by NAL. This testing resulted in a change in the hearing devices that he was being provided as it became apparent that he needed specific technology that better catered to his particular hearing loss.

When it comes to providing optimal solutions for paediatric cases, the HEARLab equipment and procedure are the envy of the hearing services world. It is hard to imagine why a private provider would purchase such costly equipment as the HEARLab to provide specific testing for what is likely to be a very thin market or, also, why a private provider would cover the cost of professional training for its staff to use such equipment to assess a tiny market of clients. On this basis, a single, larger and more portable service provider in the form of a government service inspires greater confidence in parents. Likewise, in knowing that appropriate testing procedures for paediatric cases require two audiologists to be present at the time of the appointment for both the running of the hearing test and the objective verification of results, how would a small individual commercial provider of

audiology services manage such a requirement in a commercial context? It is not possible to expect a not-for-profit ethos in terms of service provision in a commercial context. It is this not-for-profit ethos that actually results in the outcomes that work for parents.

As my son has travelled through preschool and now primary school, I can also vouch for the fact that Australian Hearing staff have made themselves available to liaise with teachers, early intervention specialists, school principals and his itinerant teacher for the deaf. Australian Hearing audiologists and a technician have visited his primary school and provided expert support in the form of additional assistive technologies, as well as formal written advice about everything including the management of his classroom and school building acoustics.

The hearing service provision that parents can currently expect for their child is wide-ranging and complex. It is our view that parents would expect government to be at the forefront of hearing services for children, because government can obviously do this better because of the scale, buying power, expertise, portability and consistency of service that a single large entity such as Australian Hearing can deliver. It is unimaginable to think that the federal government would seek to change an organisation and its programs of support when they are performing in an exemplary way and are recognised as being world leading.

Most parents probably do not know that Australian Hearing has 127 sites, 368 visiting sites and 217 outreach sites, as we heard earlier this morning, for those who live in remote communities. Yet they have come to expect that they can receive a very high standard of service provision irrespective of their location, cultural background or socioeconomic status. With almost 600 audiologists on its books, Australian Hearing is in a position to ensure a consistency in the professional capacities of its staff and to train a decent number of those health professionals to be paediatric specialists. This scale of operations ensures that there is access and equity, a high standard of service and clinical outcomes and timely, effective and efficient service.

In light of this scenario, parents can only see that there are many risks associated with the possibility of multiple private service providers. On behalf of the parents, families and children that PODC represents, with regard to the notion that hearing services for children might be placed into a contestable framework, we must ask why the federal government would consider dismantling a highly efficient and effective service like Australian Hearing. We would urge senators to consider very carefully the implications of pushing ahead with significant changes in the model of hearing service delivery for babies, children and youth. It would be harmful to make changes without fully understanding the complex scope, functionality and complexity of the interconnected system that is currently available. Until this system is meticulously researched, documented and understood, and until there is a well-defined and comprehensive health-driven model of what constitutes best practice in terms of services and supports, it is best to leave things as they are. Australian Hearing remaining at the forefront of hearing service delivery for paediatric clients is, to our way of thinking, the best possible future.

CHAIR: I wondered whether we might have you table that document. And if we could have copies to refer to, that would be very helpful for us today. Thank you.

Mr Wyburn: I just want to pick up on the point Anna made near the end about the coordination in the overall plan. The whole process that has come about since the budget announcement last year has been very expedient and perhaps in our mind not engaging. We have actually had to put our foot in the door to get submissions into PricewaterhouseCoopers when they were announced as the contractor that was going to do the scoping study. So, we were not asked to put information in; we actually had to submit that so that we could get a hearing. The hearing we had was for three hours. In our mind that is not an extensive hearing. Also, they are looking at a business model. We are concerned about service delivery and client outcomes. I do not think the focus of that has been there, and we do not know the focus, because the scoping study has not been released, so we cannot even make an assessment of the level of academic or professional input they have had into what is best practice.

We know from some of my more learned colleagues in the room that this national framework for neonatal screening that was produced through the COAG Health Council is sitting on a shelf gathering dust. Ann Porter and Margaret Dewberry can talk to you about that. That is a framework they have put in place to try to have a harmonised system for neonatal screening, yet it is not being used across the jurisdiction of all the states.

If we are looking to change a model, firstly, we do not know what the overview is; we do not know what the framework model is. Consultation has been happening for parts of that, but the overall umbrella framework we do not know. Someone talked about a blueprint. We do not know where this is all fitting in. Consultation has been changed on the run. There was a framework request for comment on service delivery. That was then service delivery for voucher service. That now encompasses audiology, and now we have been asked to provide paediatric input into that from a parent. So, it has gone from voucher system delivery to CSO, and that change happened this week—two days ago.

CHAIR: Before we go any further: there is a whole lot that you have said there. First of all, you said you had to get your foot in the door. You heard about a PWC inquiry—

Mr Wyburn: By keeping an eye out for when the tenders from the Department of Finance were released—that is how we knew that the tender had been advertised. We have a fairly intelligent bunch of people here, and when it was announced at the budget we started keeping our eye out for that. I cannot remember who we actually sent our submission to, but we wanted to participate. There was no call for participation, so ourselves, Deafness Forum, Aussie Deaf Kids and Canberra Deaf Childrens Association all put submissions in so that we would have a hearing. That was the only opportunity we had.

CHAIR: And you made the request for your submissions to be received.

Mr Wyburn: Correct.

CHAIR: Is that the case for each of those other bodies?

Mr Wyburn: Yes.

CHAIR: And we can verify that.

Mr Wyburn: Yes.

Senator McLUCAS: When was that?

Mr Wyburn: We will have to get our submission to check. It was late last year, before Christmas.

CHAIR: We might have some questions on notice that will seek clearer detailed information from you in writing, just to verify all of this.

Mr Wyburn: Our engagement in the whole process really only started from May this year. Prior to that we had sent more questions to government to try to get engagement with the clients, the people who have the most skin in the game—parents, and the parents who will follow behind us.

CHAIR: Perhaps you could provide us with the documentation of the questions you sent to government prior to the budget—

Mr Wyburn: Sure.

CHAIR: seeking information. Did you receive any responses or correspondence in return?

Mr Wyburn: We have had the general standard letter that comes back saying, 'Thanks for your inquiry; we're doing the best to maintain quality and services', as it says in the dot point for the tender document. That will be one of the parts of the scoping study to maintain quality and delivery. But that is pretty much the only dot point that covered our concerns in that scoping study. It was more about the business model and implementing the contestability framework that the government had announced last year.

CHAIR: Thank you very much for that. There are a few more steps along the journey, then. We have had further considerations and discussions since what happened in May. Have you or any of the members of your organisation been provided with or seen a copy of the scoping study that was commissioned by Senator Cormann?

Ms Messariti: No.

Ms Kennedy: No.

Mr Wyburn: No. The only thing we have had are some slides from the Department of Finance at a presentation on 19 June, which Margaret Dewberry referred to, in Sydney, when OHS, the Department of Health and DSS had their meetings in Melbourne, Canberra and Sydney.

CHAIR: In the absence of being provided with that report—and clearly you are pretty alert to things, having looked at the ads to figure out that there was a tender going out, and that triggered your participation in what would be called a civic process of sorts—have you sought to obtain a copy of the report?

Mr Wyburn: Yes, through PODC we have requested it through—

Ms Kennedy: Through the Freedom of Information Act—

Mr Wyburn: John Alexander first, through representation—

Ms Kennedy: That is right.

CHAIR: Ms Kennedy, do you want to take us through the process?

Ms Kennedy: We made representation to John Alexander MP to ask through Senator Cormann, the Minister for Finance, whether we could cite at least some overview of the scoping study, or something from the scoping study. So we made that representation through him, and a letter from Minister Cormann was then sent to us in

response to that. It took probably about a month. It said that we would not be able to sight it, because it was a cabinet in confidence document, I believe. I will need to give you that letter.

CHAIR: If you could provide us with a copy of the letter on notice that would be very helpful. Then what did you do?

Ms Kennedy: We thought we might try to get access through a freedom of information request, so we formally submitted one. We received notification back that we would need to pay quite a lot of money in order to get access to information about the scoping study, and that information would not be guaranteed.

Mr Wyburn: That money was to investigate whether they would release the document in the first place. So we may have spent the \$1,700 to ask the legal department of the Department of Finance whether we could have access, and then they could come back and say no, anyway.

CHAIR: Not a lot of people put in freedom of information applications. So you decided you wanted to do it, then you filled out the paperwork, then you handed in the paperwork and then you got a reply saying, 'We are not sure if we can give you this information, but if you would like us to proceed and tell you if we can or cannot give it to you we would like you to pay us \$1,700.'

Mr Wyburn: Yes, before we could appeal on the grounds that we did not have the financial means to pay for it.

CHAIR: What happened then?

Mr Wyburn: I think we asked again to be considered in that light.

Ms Kennedy: I believe that we did ask for it to be waived. I am not sure if we received information back about that, so I need to check it.

CHAIR: If you could, and provide us with that information at your earliest convenience. That would be very helpful. And if it should furnish the report I am sure there would be a lot of people who would like to read it. Did you want to advise us of anything else before Senator McAllister asks some more general questions.

Senator McALLISTER: Thank you for your submission. We appreciate your having taken the time. I am interested in your suggestion that a precursor for change to the system would be a clear definition of good practice. It has been very valuable hearing from each of you some of the elements of your personal and family experience with Australian Hearing, so far. Based on those experiences, could you share with us some descriptors of what you would see as being good practice in this context?

Ms Messariti: Personally, I would feel more comfortable if, with my son, I were to see an audiologist who sees a certain number paediatric clients every year. I would find it very difficult to have confidence in somebody who might have only one paediatric client a year.

Senator McALLISTER: Paediatric expertise?

Ms Messariti: Yes. I believe that in the UK to qualify as a paediatric specialist you must see between 20 and 30 clients per year. So there are certain standards. I suppose that because audiology is an unregulated profession, in a contestable environment that places children, in particular, at risk.

Senator McALLISTER: You have spoken personally about the range of coordination services, particularly in your case, in terms of liaison with the school. Was that you?

Ms Messariti: I do not think that our case is unique.

Senator McALLISTER: Can you talk a little bit more about the coordination with the school and what that has delivered for your children.

Ms Messariti: In dealing with Australian Hearing on an ongoing basis, as my son gets older—for example, when he entered primary school—I was concerned about some of the acoustic spaces in primary school and how his devices would deal with that. I wanted to be able to make representations to the principal and his teachers about changes they could make.

When I discussed this with my audiologist at Australian Hearing, they were able to directly contact the school. They visited the school. They met the school principal. They went to his classroom. They saw him in his classroom. They went to all of the spaces in the school that he used. They wrote a formal report that went to the principal. It came to me and also went to his itinerant teacher of the deaf who visits him—it is a kind of follow on; all deaf children have that service in their schools to varying degrees—and they also then recommended some additional technology that we could use that would make his situation even better and provided the school and us with a lot of information about how to use that technology. I can give you an example of what it is, if you are interested.

Senator McALLISTER: That is really useful, because I guess my question is: can you see any way that that kind of integrated service—integrating with other institutions relevant for your children—could be provided through a more fragmented service model?

Ms Kennedy: Can I just point out that probably today you will hear that there are paediatric audiologists out there in the private sector and that they are certainly in diagnosing hospitals and that they are there in some early intervention centres, for example. But I think we just want to flag that, at the moment, those are in concentrated metropolitan areas and, again, that model of that specialty being available to the same depth and breadth as Australian Hearing certainly is not there in any capacity at the moment.

Senator McALLISTER: Thank you, Ms Kennedy. Chair, I am conscious of the time.

CHAIR: We will go to Senator McLucas.

Senator McLUCAS: I want to go to the question of regulation of audiologists. From your perspective, is that an absolutely necessary condition before we go to some contestable space? Before we move to contestability, would you have to have some system of regulation of our audiologists? Do parents of deaf children have a view about that?

Mr Wyburn: It is incredibly difficult to deal with small children and getting audiological services. As a parent, you almost need earplugs to go there as well. The speciality comes from dealing with a lot of clients, because they get that experience. Australian Hearing has that in-house training. The other thing that happens is that, at that time of diagnosis, you are not in a position to make very rational decisions, so you need to not start flicking through a Yellow Pages to look for an audiologist. You need to be able to go to someone that you know will provide a high level of service and that is experienced. Now, people can be qualified, but the number of clients they see would perhaps reflect on their proficiency to deliver those services. So I think having that exposure that Australian Hearing have and also having that national standard of service delivery means that new technology is rolled out and the latest advances are found out through the whole organisation and are given to our children at the right time as soon as they are available.

Senator McLUCAS: That goes to that question of trust that people have talked about. A lot of the witnesses this morning have talked about that. In your view, you said that you are going to go to an organisation that you know, as a parent, will provide a quality service. Is that because it is government owned?

Mr Wyburn: I suppose it perhaps is, because you know that there is no vested interest in the paediatric delivery to service that person and that they are after giving the best possible outcome for your child and that they will likely have involvement with your child right through their childhood and into adulthood. I believe that you build up that relationship and it is a necessary part to have that organisation, and size of organisation, behind that.

Ms Kennedy: Just to make another point on that, I think Senator O'Neill had noted about the blur that new parents are in in those first few weeks and months. I think parents are obviously dealing with so much at that time, but they are in a bit of a blur. It is a fact that that pathway is so clear and you are basically just finding yourself at Australian Hearing. To know that expertise is there, there is that trust that is built over time because it is a place where you can start to understand your child's hearing loss. It is a place where that person has the expertise that you do not have, yet you feel that you need to get so much information on board to make those decisions for your child. It is such an important part of so many family's lives, especially in the regional areas. Often the paediatric audiologist is maybe the only other person that fully gets it.

Mr Wyburn: If Australian Hearing was not there, the regulatory framework, standards and protocols are not in place across all jurisdictions to fill that gap. Australian Hearing is the hub at the moment. We are not saying this standard should not be developed, because absolutely there is no best practice guide being developed for the national hearing services at the moment—and we need that. But, at the moment, Australian Hearing holds it all together. Some states have social workers that manage the process. In New South Wales we have not quite got that. You have to do that yourself as a parent, so that pathway is not exactly as clear as it should be. The national approach is a bit disjointed and could be better.

Senator McLUCAS: I have one more question. Please do not think I am leading the witnesses here. People have talked a lot this morning about what a wonderful service we have, that it is world's best practice, that it is fantastic. My question is: are we overservicing? Is it too gold-plated in your view as parents?

Mr Wyburn: We only go if we need to go. We don't want to turn up. We never wanted to be there in the first place. The appointments are made on a regular basis, once you slot into that process. Repairs are done on an as needs basis. You cannot overservice that with a child. If the equipment is broken, it has to be fixed straightaway or a spare provided. I do not believe it is overserviced.

Ms Kennedy: I do not believe it is overserviced either. I remember when my son Oliver was 15 that he was really struggling with his identity and he did not want to wear his hearing aids. Our relationship was quite impacted by that, because I was the one who was saying, 'You've got to.' He was really struggling. We went to his audiologist, who he had quite a longstanding relationship with. The time spent, which some people might perceive as perhaps overservicing, was actually a deal breaker for us in terms of my role was to sit in a corner with a box of tissues and her role was to work out with him how they were going to get this sorted. He became the client that day. That is something which we completely rely on, because we were up against it. That is an example, I suppose.

CHAIR: I think the parents of any 15-year-old would feel very much the journey you are on there, and how critical it is in terms of the future and what might be possible. Of course, there are many more questions that I would like to ask but our time is coming to an end. Ms Messariti, I think we are at the end of your verbal submission for us today, for which I thank you. I also thank you sincerely for the work that you are doing. The quality of the submission that you have given us is really outstanding and very well referenced with evidence, which is excellent. You spoke about the scope, functionality and complexity and then I think you spoke about the common ground that parents have across the political divide in their lived experience, knowledge and the grasp of complexity. I acknowledge the knowledge that you have brought to us today but also the wisdom to foresee and foreshadow some potentially significant problems if your advocacy were not so active and maybe ingenious, actually, to find out a way to participate in the process. Thank you.

REHN, Mr Christopher John, Chief Executive, Royal Institute for Deaf and Blind Children

[11:15]

CHAIR: I welcome Mr Christopher Rehn, the Chief Executive of the Royal Institute for Deaf and Blind Children. I invite you to make a brief opening statement.

Mr Rehn: It is a pleasure to be here. RIDBC is Australia's largest non-government service provider in both hearing and vision services. We operate nationally through 17 sites and through several hundred virtual sites. We also have within our service remit the Sydney Cochlear Implant Centre, which is Australia's largest cochlear implant service provider. There are about 6,000 Australians who are helped each year through our organisation, which is 155 years old and the oldest in the disability service sector. We cover areas of education, health, disability and specialist professional education.

We looked at the issue of the hearing service environment, and it really is an amazing mix of government, private and not-for-profit organisations that make, if you like, a very effective whole. While we acknowledge that total service does not presently exist in any one model, it really is the collective efforts of all of the organisations to get the job done for a child or, indeed, adult and deliver success, however defined. The number of Australians with hearing health needs is increasing, particularly within our ageing population. RIDBC does not necessarily have a view of what governments should retain or not retain but is focused on how you preserve, protect and potentially extend the services to make sure that you service an increasing population with hearing health needs. In Australia, we have a good supply of hearing technologies. The access, both physical and financial, is there and awareness becomes a bit of an issue for Australians who take up hearing health services. Whilst our organisation has 'children' in its name, it actually services the full age spectrum in hearing loss, all the way through to elderly clients with cochlear implants and adult rehabilitation.

Whilst we recognise that the NDIS has a broader capture than the CSO in the main, the market contestability does open up a whole heap of issues that we think are important to better understand ahead of any decision around what government will do next. Contestability is great in that it gives choice. As mentioned by previous witnesses, the question of whether you can create market failure in areas where some of the most vulnerable Australians reside, particularly in remote and rural areas, needs to be further investigated. Equally, the NDIS challenges clients to know what they do not know. When you consider that a lot of parents come to hearing loss through the birth of a child with significant hearing loss and that that is their first awareness of hearing health issues, it becomes a minefield. As Mr Wyburn indicated earlier, navigating the journey from diagnosis to the appropriate technologies and service regimes is complicated—and I think it is also complicated in the adult picture—but is made somewhat easier by the existence of Australian Hearing under government ownership.

Importantly with Australian Hearing, the capture of children from newborn screening into service options that may be government or non-government provided has been really effective. We do not lose clients in Australia, in the main, through a gap between diagnosis and them finding their way into appropriate service provision. That is in the bilateral hearing loss category; I think it widens if you consider single-sided deafness issues. If Australian Hearing is not to exist or is to be fully privatised in a fully contestable marketplace, preserving our track record from diagnosis through to intervention becomes really important and begs the question of how it is achieved. Whilst Australia is the natural homeland of the world's best cochlear implant, the uptake rate in adults is actually significantly low—presently about eight per cent, which by world standards is high but still a very small proportion of the population with hearing health needs. Some of the issues relating to that are people's lack of awareness of what hearing health interventions might service them, the access to cochlear implant programs, including geographical access, and conversion issues from hearing aids and challenges in that space.

I think that what we probably recognised with Australian Hearing is that the federal government saw fit to build a beautiful Rolls Royce model of service delivery but lock it down to a small group of recipients in need. The opportunity of extending that footprint to create other services, such as education, cochlear implantation and adult rehabilitation, is obviously a very positive opportunity. RIDBC is a non-competitive organisation, and really what we would like to see is the building of what we call a total service model which actually uses the locations where services are presently provided and leverages them for a much broader group of activities in support of good outcomes for people with hearing health needs. We talk about length and breadth because it is everything from those in the public domain to those in the private; those who are children and those who are adults; and those who are involved in education and those involved in health. The spectrum is large, and I think really the idea of building a total service model on the footprint that Australian Hearing has occupied is a really exciting opportunity.

We see hearing loss, in terms of outcomes possible, as a treatable condition in Australia. What we would like to say is that Australian Hearing has been a centrepiece of our industry in making sure that the job gets done for the vast majority of people who seek services for their hearing loss, be they children or adults. When we considered and when we submitted to PricewaterhouseCoopers, we made this observation: if government are to see it move into private ownership, do not break it up, because the intrinsic link between the services of the National Acoustic Laboratories and the service arm of Australian Hearing actually deliver better outcomes. Studies like the LOCHI study only demonstrate that other interventions, if you like, can lead to good-quality outcomes for those who we would classify as vulnerable Australians.

Equally, I think that the choice of who would then consider taking Australian Hearing forward becomes important, because it should not be determined on price alone. I think that if it becomes a cost exercise—as in whether government can make money on the sale of Australian Hearing—a lot would be lost in that process as organisations step forward with the opportunity of potentially reducing cost and potentially reducing service. Again, it is the vulnerable clients. RIDBC could take a more selfish model and say that, in a fully contestable marketplace, we can reposition ourselves to service our current clients better. The problem with that is that there would be clients that Australian Hearing currently service that would fall through those cracks. As an organisation that is focused on hearing health and vision services, we are just as focused on that group of people, even though they do not currently fall under our remit.

So I think there are a lot of things to consider if Australian Hearing is to be privatised. If it is not to be, we would suggest that government seriously consider what would be an appropriate extension of service delivery to take advantage of the fact that Australian Hearing enjoys a footprint around the country that allows for a lot of services of a high quality to be provided, but not all of the services needed. The important piece that has been largely missed with Australian Hearing, not necessarily by their own ambition but literally by the rules by which they have to play, is the market between 27 and 65—what may be under the NDIS—and also the cochlear implant space, the education space and the rehabilitation space. So our view would be that if government were to retain Australian Hearing, which has some definite appeal, things would need to change.

Just on that, cochlear implantation has a state-by-state discretionary allocation when it comes to government funding. That means that, depending on where you live in Australia, you have great inconsistency in access. We believe a total service model would seek to address that with government, because there should be, if you like, a federal viewing of how cochlear implants are provided in the same way that has been applied to the community service obligations under the current Australian Hearing charter. Thank you.

CHAIR: Thank you very much, Mr Rehn. I wonder if you might provide us a copy of your opening remarks.

Mr Rehn: Of course.

CHAIR: That would assist us. The secretariat will approach you now.

Could I ask that question: have you or any member of your organisation been provided with or seen a copy of the scoping study that was commissioned by Senator Cormann?

Mr Rehn: The short answer is no. Yes, we participated in the stakeholder engagement run by the ministry of finance in the last few weeks, and we had some degree of information provided in regard to the scope. Some of the findings and the options were briefly touched on. We have spent a lot of time at the Royal Institute for Deaf and Blind Children.

CHAIR: Just before you go on, do you have any documentation around those matters that you just indicated to us?

Mr Rehn: I have a slide deck of those, yes.

CHAIR: The slide that is public information?

Mr Rehn: That is right.

CHAIR: You have no additional information?

Mr Rehn: No, I do not have any additional information.

CHAIR: Thank you.

Mr Rehn: We have spent a fair bit of time talking to the ministry of finance, to disability and to Human Services in recent months—obviously since the PwC process ran its course. What we noted—and again it is just an observation—is that government over the last eight weeks changed its communication from what might be a potential sale process for Australian Hearing to an NDIS strategy and how that NDIS strategy could apply if Australian Hearing was not in government ownership. So a lot of conversation has been around what the

organisational response would be to a fully contestable marketplace and the issues that we see moving forward, rather than a discussion about the sale process that might happen with Australian Hearing in the future.

CHAIR: That is different from previous conversations, in your view?

Mr Rehn: Yes. We put a submission to the Commission of Audit and we then followed through, obviously, with the stakeholder discussions with PricewaterhouseCoopers.

CHAIR: Can you take me through the timing of that? When did you put your submission to the Commission of Audit? Were you sought as a participant or did you seek the opportunity yourself?

Mr Rehn: Through personal connections we were connected with the chair of the Commission of Audit and he asked the question whether there would likely be a response from the Royal Institute for Deaf and Blind Children in regard to the future of Australian Hearing, and we provided one.

CHAIR: Through a personal association you were invited?

Mr Rehn: That is right.

CHAIR: Are you aware of other hearing advocacy groups that were, by personal association, invited to participate in the Commission of Audit?

Mr Rehn: It would be appropriate to say we were not invited; we were asked the question whether we were going to make a statement in that regard and we did.

CHAIR: Okay. What happened then?

Mr Rehn: We furnished the commission with our view of how things sit, relative to Australian Hearing. We were then invited to be part of the PricewaterhouseCoopers discussion. We literally came in as a team of four and presented a view that said, 'These are the things that we think are critical in the future of Australian Hearing.' As I outlined before, if government were to see it move into non-government ownership, we recommended that it not be broken up, to protect the vulnerable clients particularly and preserve what is good about Australian Hearing. That is very important to us.

CHAIR: What was the timing of that invitation to participate in the PricewaterhouseCoopers discussion? How were you advised that you were invited to participate?

Mr Rehn: We had direct communication from the person who was heading up that group.

CHAIR: Was that by association as well?

Mr Rehn: No.

CHAIR: So how did they locate you? Do you know?

Mr Rehn: The Royal Institute for Deaf and Blind Children is very well known in the space. I do not seek to understand how they came to ask us. I am delighted that we were asked.

CHAIR: Is the submission that you made to them a public document?

Mr Rehn: We are happy to provide the information that we provided then. I do not have it with me now, but I would be delighted to provide it.

CHAIR: Thank you very much. That would be very helpful. When you received your invitation to participate in the PricewaterhouseCoopers process, I think you just indicated you had some time with them. How long was the consultation process?

Mr Rehn: Our meeting with them went for approximately an hour.

CHAIR: And it was only your organisation that was in that meeting with the investigators for PWC?

Mr Rehn: Yes. My understanding is there were other organisations that were present on the day, but at the time when we went in it was just the Royal Institute for Deaf and Blind Children.

CHAIR: Do you know the other institutions that participated? Are you aware of who they were?

Mr Rehn: Just by visuals, Cochlear Ltd were presenting prior to us going in. I am not aware of other organisations.

CHAIR: Did you contact any of the parent groups that use your service or that you are in touch with to invite them to be part of your submission, or did you alert them to the process?

Mr Rehn: No. Our submission was a stand-alone submission.

CHAIR: Thank you very much.

Senator McLUCAS: Thanks for coming along, Mr Rehn. I want to go to the question around the process changing. My observation is that there was a government decision that it might sell Australian Hearing and a

scoping study was done. Then the consultation that seemed to come off the back of that informed a different question, and that question is about the interface between the NDIS and Australian Hearing as something that needs to be considered. Is that a reasonable judgement of what has happened over time?

Mr Rehn: Yes. We speculated about what the government process might be, particularly if there was a view to move to Australian Hearing being in the private sector. The question then came: what of the CSO? Would that be an area that would be retained by government? Would it be under a contract term to other organisations or to Australian Hearing in its new ownership? Would it be part of the transition plans? We had no knowledge of that. While we tried to investigate what some of the considerations were, suddenly there was a different message. The message was very much a case of: look, it seems that the NDIS is going to catch all, and—if it is going to catch all—it is going to be CSO inclusive; so what are the organisational responses to not just a fully contested world but to a world that is inclusive of those clients? Again, from our organisation's perspective, we did not take a view that we could just look after our current cohort of clients in a more comprehensive way if it is all contestable. It was a case of: what of the other clients that Australian Hearing currently services and the future for them? But, again, the position was now more about, 'Talk to us about your NDIS strategy,' as opposed to talk about what might be the future of Australian Hearing as an entity going into non-government ownership or, in part, with National Acoustic Laboratories—those sorts of issues.

Senator McLUCAS: I am troubled that I might be jumping to a conclusion, so I am going to test it with you. It is almost like the Finance driven discussion about whether or not you can sell off this thing which happens to be called Australian Hearing was put onto a different track because they finally realised that Australian Hearing is providing this incredibly important service—in particular to CSO clients—that warrants another discussion. I would like your view on whether or not Finance should be running this sort of conversation. Should this conversation be perhaps driven by an entity with less of a financial consideration and more of a service delivery consideration?

Mr Rehn: We would be very much of the opinion that any movement of Australian Hearing into non-government ownership should not be driven out of what price it could attract. I do not personally believe that the sale process of Australian Hearing would move the government's financial dials one bit. It is a very small entity financial terms. Having said that, the fact that this has been driven out of Finance is an oddity to us, because it probably ignores some of the most important issues, which are those vulnerable clients of the Community Service Obligation. If I were being cynical, I would say that the Finance driven model suggests that it is really about the price, the sale process and those things. As an organisation that is dedicated to those with hearing loss and vision loss, I am more interested in whether market failure is created as a result of the transition arrangements and the changes that, it has been suggested, might happen.

Senator McLUCAS: You said earlier that RIDBC's view is, 'Don't break it up'. Are the drivers for you to say, 'Don't break it up' the natural internal cross subsidies that occur because it is a nationwide organisation?

Mr Rehn: No. The integrity is important for a number of things. Yes, the business model is predicated on the idea of cross subsidisation. We have been around for all of Australian Hearing's history and then some, and our understanding is that Australian Hearing was built around market failure and the need for government to intervene in a sustainable way that, probably, the private or non-government sectors would not be able to. Obviously, the world has changed since 1947—the starting point of Australian Hearing. But, from our perspective, the integrity of the link between evidence based research and clinical practice has been very attractive—the dovetailing of high clinical standards.

We are a very large paediatric audiology employer, but Australian Hearing is the most appropriate place for a lot of audiologists to learn paediatric skills to do their job. It is not the only place, but it is a very important part of that. I think that Australian Hearing has stepped in to create service for some of the most financially unattractive client with really important service needs, which the private sector would probably not step up to, irrespective of price. You could pay \$10,000 to fly into a remote location and out, but it may not necessarily make us move our service offerings to do that, because our focus may be: is there a better way, is there another opportunity and is telepractice going to help?

Our picture on it is that it does work, because Australian Hearing is a comprehensive service provider. It does not cover all aspects, but it covers a large bit. The fact that it sees clients move well from diagnosis, in the paediatric sense, into service provision, be it government or non-government, and we do not lose clients in that process, it says to me that there is a lot at risk if it were to be dissipated and the private sector alone, and the non-profit sector, were to step up to try to fill that void. It is an integral piece of the architecture of hearing services. Pulling it out or breaking it into smaller parts actually means it is probably not sustainable in the long term—not sustainable from a service provision or business perspective.

Senator McLUCAS: Does RIDBC have a view about whether or not Australian Hearing should move into the 25 to 65 year old group?

Mr Rehn: I think it goes to my earlier comment. If the federal government saw fit to build a beautiful model of service delivery for those with hearing health, why lock it down to a small cohort of the population? I grant you that the challenge is how the private sector competes if Australian Hearing is a much more competitive organisation than it currently is, and operates in spaces from which they are currently precluded. Again, I am going to take a very altruistic view on it that says that if this is about the hearing health needs of Australians, and that is a growing population, there should be more market for all of the providers to step up. But the idea that the infrastructure, both the physical and staff infrastructure, is locked down to a small proportion of the population—and a small proportion of the technology these days—does not make a lot of sense to me.

Senator McALLISTER: Could we explore a little bit more about the linkages to the NDIS, partly because I think even today we are seeing different people from the sector make different connections about what is intended. Is it your understanding that the Hearing Services Program would be entirely transitioned to the NDIS?

Mr Rehn: I do not think we are clear on that one. The position has not been made crystal clear as to whether there would be a transition period and whether it would be fully contested or whether the government would retain some of it. It is just not clear. The discussion has been more about how, if CSO is captured under an NDIS, organisations like ours and others respond.

Senator McALLISTER: I appreciate that you are operating with the same constraints on information that others are. Is it your understanding that all people who would currently be eligible for the CSO stream would be likely to be eligible participants in the NDIS, or do you see that there is a gap there?

Mr Rehn: As it has been explained to me—and this came out in the stakeholder discussions recently run by Finance—there is a grandfathering arrangement that is likely to see all of the current CSO cohorts being captured in the NDIS. But that does not necessarily suggest that all future CSO type clients will be captured in the NDIS. Again, that is a position that is not clear.

Senator McALLISTER: It is tricky, isn't it, because the submission from the Department of Health suggests that the Hearing Services Program will be transitioned, but they acknowledge that it is in part. It is quite confusing. Do you have any thoughts about what role Australian Hearing might play in that context? You have expressed a preference for it to be retained as a coherent entity that is able to deliver that full suite of services. Do you have a view about how it might interact with CSO clients, both within and without the NDIS?

Mr Rehn: I think Australian Hearing is well placed in terms of its human and physical infrastructure to respond very, very well. If you look at the types of professionals you would need to be dealing with under an NDIS, whilst you do have complexity of clients that require other service organisations to come into that part, I do not see why Australian Hearing could not compete in that space in a fully contested world. If you consider the statistics—and people tell me they get them wrong—Australian Hearing moving from 100 per cent ownership of what are now the voucher clients, 10-plus years on it is presently retaining 47 per cent, so it has actually stood up quite well in terms of competing in an open marketplace. So I would see that same issue happening in the new era of NDIS.

Where NDIS becomes important is in the package and suite of services that clients need. If you look at hearing loss, having a 30 per cent secondary disability space et cetera, there would be a need for Australian Hearing to either provide or partner with organisations to provide that. It depends on what the new owners look like. Personally, we believe a consortium approach with corporate non-profits and others may actually be a potential acquirer of Australian Hearing, if government is serious about moving into non-government ownership. Our reason for doing it is literally that preserve, protect and extend picture. We want to preserve the important parts of Australian Hearing that have kept the country in good stead for those vulnerable clients, protect those vulnerable clients and extend services to capture other areas of importance when dealing with hearing health.

Senator McALLISTER: What kind of incentives would be necessary for a consortium of operators, as you describe, to take on the complex and, one suspects, costly obligations associated with delivering services to either people with complex needs or to Aboriginal and Torres Strait Islanders in remote communities?

Mr Rehn: It is an interesting point, and a really important one. RIDBC is into sustainability, but we are not focussed on profit centres en masse. We operate a centre right next door to Australian Hearing in Darwin. We could never make money out of that service, even under an NDIS, with a broader capture of clients. Our reason for being there is actually market failure. There is a need for our services in the Top End. Inclusive of Cochlear Implants, it is not being fulfilled by any other organisation. Is it sustainable? It is, as long as our organisation is sustainable in the main. We take an aggregate model as to how we deliver our services. There is a challenge in

that, if it was just down to a commercial operator to operate it, because it would be easy to say, 'We will just put a line through that one because it is not going to be a profitable centre.' That is why I think that if government is going to move Australian Hearing into non-government ownership, be very careful about who the potential new owners are, because you could achieve market failure very quickly under the wrong sorts of ownership.

Senator McALLISTER: Motivation matters when it comes to these kinds of contracts.

Mr Rehn: Our focus is twofold. One is looking after those people who are currently in need of a quality service like Australian Hearing. But, equally, to extend that to a greater group of Australian who actually need hearing health, because that infrastructure is important to service a much broader population.

CHAIR: Thank you for your evidence. We have more questions than we have time for. There is significant interest in this very important matter. If we have any further questions we might send you some on notice.

Mr Rehn: Thank you.

MIERS, Mr Kyle, Chief Executive Officer, Deaf Australia, through Vanessa Sweeney and Kerrie Lakeman, sign language interpreters

[11:43]

CHAIR: Welcome. Mr Miers is speaking Auslan and Vanessa Sweeney and Kerrie Lakeman will act as sign language interpreters. Would you like to make an opening statement?

Mr Miers: Deaf Australia is a national organisation. We are the peak organisation representing deaf people, by deaf people, for deaf people. We look at the range of issues that are related to deaf people, the deaf people who use services, access related issues—a number of issues. Over the years Deaf Australia has received some Commonwealth funding to be able to provide advocacy services. Unfortunately, that funding has been cut, so we are now running as a voluntary organisation. Having said that, we are still looking at a range of issues—education, employment, transport and a whole suite of issues really. We are affected by a lot of areas, and we are also looking at representation that is needed by deaf people to fight for these services.

Having the opportunity here in this inquiry gives a fantastic opportunity to discuss children that are born deaf. Previously we heard that the biggest gift you could give children is to be able to speak. However, we would say that the greatest gift to give a deaf child is language, not necessarily speech—and fluent language as well. So I think we need to change the attitude that is out there at the moment. We need to be able to shift the current attitude and the access to service that is out there. We need to be able to increase access to that language acquisition.

Talking about education and employability, the access to services that we get is completely reliant upon the information that we are able to get. If a child is born deaf, usually that child is referred to an oralism medical situation and they are deemed to have a hearing issue and to need to learn how to speak. The total focus is on speech rather than the acquisition of language itself. So quite often those children do have a language delay, and that obviously creates a huge impact to deaf people—a lifelong impact to deaf people that can affect their education and then later on their employability. So deaf people often miss out on information due to the language barrier. So again that focus needs to be on language: they do not have the language or the access to the information. People are also denied the ability for promotions within the workplace as well due to the disadvantage, and again that focus on just the oral/aural model really does provide a deficit to deaf people. That has been the focus currently. So we believe that the model needs to be expanded to include full social inclusion and a social model, not just a medical model, because at the moment the focus is totally on the medical-oral-auditory model. We need to be focused as a human being, not just somebody who cannot hear, with just trying to resolve the hearing issue.

In the services at the moment, we believe there are some issues with the models that are out there at the moment, and those models need to be extended to include a more holistic approach. We need to ensure that deaf people themselves are consulted and included within the discussions, because so far deaf people themselves have been excluded. We need to be able to access these services and information, and so far quite often that is not being offered to deaf people and is not available to deaf people. Children need to be able to have the opportunity to learn sign language. However, there is no opportunity for children to do so. A lot of deaf adults actually acquire mental health issues, but there is no access to mental health services for a lot of deaf people. Up in Brisbane we have the Princess Alexandra Hospital, which offers specialist services and counselling to deaf people. However, it is the only organisation in Australia to do so, so a lot of deaf people find it very difficult to navigate the health industry and the mental health industry, and also those professionals are unable to know how to deal with deaf people.

We think that the National Disability Insurance Scheme is a good opportunity to potentially expand some services for deaf people but, having said that, there are also gaps. We need to be able to provide that bridge for them to be able to access the community fully—the Deaf community. We need to be able to provide support. We need to provide that support to families and to individuals. We need to ensure that those people and families are able to get the full gamut of information and the full range of services that are out there. At the moment that is not happening. We are seeking to establish a deaf centre and to be able to include both approaches—not only hearing acquisition but also language acquisition and societal acquisition. We think a central hub would be the key goal, to be able to include both models—medical and social.

CHAIR: Thank you, Mr Miers. I have some questions about your presentation, but can I commence with the first question that I have asked a number of witnesses today. I am sure that you are aware of the scoping study that was commissioned by Senator Cormann.

Mr Miers: Yes.

CHAIR: Have you or any member of your organisation been provided with or seen a copy of that scoping study?

Mr Miers: Not that I am aware of. I have heard about the scoping study. I know Deafness Forum of Australia have done some research into that or been participating in that and potentially offering some advice, but I have just been able to offer some advice to Deafness Forum. I have not participated myself per se, but I know that there is a process going on.

CHAIR: Was your organisation invited by PricewaterhouseCoopers to be part of the consultation of that scoping study?

Mr Miers: No, it was not.

CHAIR: Thank you very much. I am going to Senator McLucas.

Senator McLUCAS: Thank you very much for coming along today.

Mr Miers: You are welcome.

Senator McLUCAS: First of all I want to briefly go to the question of the defunding of Deaf Australia. What has been the impact of the defunding of your organisation in terms of your capacity to engage with the questions around privatisation of Australian Hearing?

Mr Miers: There are a number of things. Previously, we were doing a lot of research and a lot of submissions to the government, an example being that in 2012 we had a national education and early intervention summit, and that was to look at best practice models. We then provided that to the Commonwealth government. We talked about the appropriate approaches for deaf children and for their education. We also worked with the Transport Commission as well. For example, we were talking about the fact that, for deaf people who were needing their licence for business purposes and for employment—for example, truck drivers—the commission insisted they actually do wear a hearing aid. That advice was given to them by audiologists, again creating barriers in the workplace for people. So there are a range of issues that are of great concern to us. The defunding of Deaf Australia is a huge concern to us because, if we are not there and we do not have the funding, who is going to be able to address those issues if not us.

Senator McLUCAS: What was the amount of money being provided to Deaf Australia as a peak body?

Mr Miers: It was \$200,000 per annum.

Senator McLUCAS: It is not a lot of money.

Mr Miers: No, it is not.

Senator McLUCAS: Thank you. I have asked those questions about funding of disability peak bodies in Senate estimates, so we have probably canvassed that already. Does Deaf Australia have a view about the privatisation of Australian Hearing and, if so, what is it?

Mr Miers: Yes. Our view of the privatisation of Australian Hearing services is really a two-pronged approach or opinion. We believe they provide an excellent service for deaf children and that service should be maintained absolutely. However, we also need to ensure that it is inclusive in a holistic way. We need to focus on the holistic needs of the child to be able to access the deaf community as well, and we think it is that second part that is missing. If we have a look at being able to cover those gaps in that inclusion on a holistic level, taking into account the social and the medical needs, then we believe that that would be the appropriate model rather than only focusing on the auditory, hearing, speech access.

Senator McLUCAS: Do you think, though, that it is Australian Hearing's role to undertake the training and inclusion of Auslan or alternative communication methods, or should that belong to someone else?

Mr Miers: It is not currently in Australian Hearing's purview, no. However, you will see in my submission that I am talking about establishing a national deaf centre, and that will include research and education, and will include a number of areas. So we are also wanting the government to be able to work with families and work with the deaf community just to include full inclusion as a social model. That model is currently being used overseas. We would like Australia to adopt that model. We need to consider how we can improve that access. Again, I reiterate: we need to have a social model, not only a medical model. We need to ensure that people can be engaged and can feel comfortable. We need to bridge the gap that is there at the moment.

In Victoria in 2012, the VET curriculum at TAFE was providing Auslan. However, now, under the new Smart and Skilled project that the government is now adopting, a lot of the courses have been defunded. Where are people going to learn Auslan? With NDIS, people may be able to access interpreters for TAFE courses. They may

be able to use their funding from their NDIS package to pay for interpreters for the course. However, there is a real risk that that may not happen and a real risk that their availability to attend courses will suffer. So, again, we need to look at the big picture. We need to look at the availability of interpreters, services and courses because the long-term effect will, of course, affect people's education and employability in the future. So we need to put pressure on the government to ensure that that availability is there, and we need to have a policy to actually state that.

Senator McALLISTER: Thank you, Mr Miers, for being here. I am interested in your thoughts around a social model of support and the practical elements it might contain.

Mr Miers: A range of things. With mentoring programs, for example, you would have a deaf person go out into the home and into the family environment to act as a language role model and to teach deaf children about the language and also about their social identity as well. Those role models need to be available for children and for people to see. We also need to have people to go into the homes to offer family support and to teach Auslan—to teach sign language—so that people also know how to fit in, how to relate and how to interact in the wider community.

Many children in the deaf community go into mainstream school without access to sign language. Then, when they hit about 20 years of age, their eyes are really opened up because they have exposure to the deaf community. They realise what they have been missing out on; they realise there are opportunities within the deaf community. It is a huge impact on their work situation and their capabilities. Sometimes it is a little bit too late to have those realisations at such a late age, so we need to encourage deaf people to increase their skills and to have the same opportunities as their hearing counterparts. The deaf community feels a responsibility to look after them as well. We are always trying to encourage deaf people, but, quite often, it is a little bit too late. We need that early intervention to ensure that these problems do not occur in the first place. We need to have a holistic approach. We need to ensure that that social model is included as well. That early intervention is vital.

Our vision of having a national deaf service is that the service would provide a range of services in a central hub so a deaf child knows that, when they go to that hub, they will see the whole range of services. They will see what is available to them. The child, in turn, will be able to make their own decisions in life about what services they need and what they feel they need as an independent individual with their own identity. At the moment, those services are just not available. As the parents of deaf children could access that centre, they would see a range of services. They could go in with their children and see not only that medical model but also the social model. That is lacking at the moment. The perception here at the moment is that parents are making decisions solely reliant upon what the medical facility or industry is preaching to them. Therefore, it becomes a matter of what the parents feel they need instead of what the best needs of the child are. We need to ensure that the child's future is a positive one. That is obviously based on those decisions made by the parents early on. And those decisions are based on the information they have access to.

Senator McALLISTER: So at the heart of this idea is a belief that the wellbeing of a child is best secured by being in community with other deaf people, as well as being integrated into the broader community?

Mr Miers: Yes. I will give you an example. In Sweden, they have successfully done some research into deaf children, checking their comprehension in a bilingual education. They have done some research with three different cohorts: deaf children who have no access to sign language, deaf children with access to both signing and spoken language, and deaf children who sign only. They then tested the comprehension and fluency of children. In the last two groups—those with a bilingual approach and also the children who had only a signing approach—their comprehension levels far outweighed those of the first group, who were of the spoken-only model. Not only in Sweden but in America as well, there is plenty of research out there, so we really want to raise that issue here in Australia. When we have tried to do so and to talk about the overseas research, we were somewhat dismissed, because people want Australian based research. However, there is no Australian based research; they are saying there is no funding for the research. There is no funding to have that happen in Australia.

Senator McALLISTER: One last question: you mentioned briefly in your written submission that the National Disability Insurance Scheme may offer opportunities for this model to be developed and implemented. Would you like to share with us any of the key opportunities as you see them?

Mr Miers: At the moment, there are many deaf children who are only accessing hearing services. Under the NDIS, there will be the opportunity for families or the deaf child, or deaf adults, to be able to access a suite of services. That should give them better exposure to the services that are actually out there and may meet their needs. As I previously said, the problem is: who will actually be leading those people? Who will be giving them the advice? That is just not available here in Australia at the moment, so that is why I was suggesting the establishment of the national deaf centre to be able to provide that advice to families and to let them know of a

range of services that are available to them so they know what professionals are out there—mental health services as well. They can actually advise the professionals as well about other services and how to interact and work with the deaf people.

Senator McALLISTER: Thank you so much.

CHAIR: Can I just go back to the funding question that Senator McLucas asked. You indicated that there was a funding cut of \$200,000. What was the sum total of your funding from the federal government before that cut?

Mr Miers: From the federal government it was \$200,000. Eighty-three per cent of our budget was the government funding. Seventeen per cent was just through membership fees and donations. It was a very small percentage, but 83 per cent was reliant upon the federal government, and that made a huge impact to the ability for us to advocate for the Deaf community.

CHAIR: So you have no other source of funding from any state?

Mr Miers: No, we do not. The state governments—Deaf Victoria, for example. Deaf Australia have five state organisations under our banner. We have one here in New South Wales, Deaf Australia (NSW). We have one in Queensland. We have a Victorian association as well. For example, from their state government, they are receiving funding, but only for advocacy within Victoria. So we are trying to approach different state governments to seek funding, and most of those people are saying, 'Oh, but the deaf societies have funding from the state governments.' They are a service provider; they are not actually an advocacy service. So they are actually a different kettle of fish. Deaf Australia does not play the same role as a deaf society, so when the state governments approach the deaf societies they are actually talking about a different thing altogether.

CHAIR: We have had quite a bit of evidence over the last few months of different organisations being defunded for any advocacy.

Mr Miers: Yes. It is true

CHAIR: It is not exclusive to the deaf community.

Mr Miers: Yes, I know. It has happened to a lot of organisations out there.

CHAIR: I won't make a snide comment about watching the advertising in the business pages.

Mr Miers: Could I just add a small thing.

CHAIR: Yes, please.

Mr Miers: It is just a comment. I think it was November last year that the Commonwealth government were talking about the captioning reform. We did supply a submission and we said we completely disagree and object to the reform. We then had to go to the inquiry. It was based across disability organisations that are receiving Commonwealth funding for advocacy—for example, PWDA, Women With Disabilities Australia and Children with Disability Australia. It was across organisations. They have deaf people involved in those different areas, in those subsets, as well. So the question is: how can those people communicate with each other? How are our needs met? We just do not understand how that situation will work.

I have spoken to the DSS, the Department of Social Services. I have raised that issue with them and they are a little bit, 'Well, we don't really know.' So we are trying to reiterate the impact that that does have on deaf people, that we are not just an isolated group. We are actually a mix of groups and we do fit into various subsets as well. So it is vital that we have that capacity to be represented and that the deaf community is represented.

CHAIR: It is good to be a human with multiple identities rather than just belonging to a single community.

Mr Miers: Yes.

CHAIR: Could I ask a question about your written submission, and this will bring us to a close.

Mr Miers: Sure.

CHAIR: You spoke about the hearing industry being an unregulated business. We have heard about that from a number of submitters this morning. You say:

Many hearing aid companies offer incentives to audiologists to promote their products.

Could I ask you to speak more fully to that.

Mr Miers: I will give an example. There is a private hearing aid company—I am not too sure where they are based; I think they are in Victoria—and they have asked if we can engage in partnership with them. We have said, 'Sure, no problem, but let's just have a look in terms of what that would entail.' They said, 'We are considering giving a \$400 incentive to audiologists if they are referred to their particular company to buy their particular brand of hearing aid.' Then they would give us a \$100 incentive to refer people to use their hearing aid. I believe

that sort of thing does happen everywhere. Is that in the best interest of the deaf person or the service provider or the person providing the technology? Whose interest is that actually serving? I would say that it is actually not about the human need.

CHAIR: I think I would agree. The next part of that same paragraph states:

Australian Hearing is the only provider that is not wholly commercial and so is in a better position to offer unbiased advice on the best hearing products to suit individual need rather than advice based on making maximum profits.

Mr Miers: Yes.

CHAIR: Would you like to expand on that point.

Mr Miers: My understanding of Australian Hearing is that they are not seeking to make a profit. That would be my understanding. They are receiving funding under the CSO, the community service obligation, so we need to ensure that they are complying with government and they need to be able to provide cheap hearing aids that will suit the person's needs. The other hearing services do not look at that. They are looking at making a profit rather than actually servicing the client, to meet their needs. So I think there are very different perspectives from private and public. One is about making money; the other one is providing services. I do feel, though, that even in providing services there is still a bit of a gap there and that we can extend on those services.

CHAIR: One of the concerns that has been raised here today by witnesses and I think most recently Senator McLucas, sitting at the table, is concern about the undertaking of this process of consultation, not just because of the opacity of the process but because it is being undertaken by the finance department rather than Health or Social Services. What concerns do you have about what you know of the process and about seeking a financial benefit to the Commonwealth by the sale of Australian Hearing?

Mr Miers: Really I am not aware of this inquiry—not until someone from your office, I think, recently emailed and invited me to give evidence. It was quite new to me, so I really appreciate the fact that I have been given this opportunity. Having said that I was unaware, the audit does need to ensure that it looks at the human value, because it is the human value that is obviously vital, and it is significant for the deaf community, as opposed to just focusing on funding. We need to consider mental health services. We need to consider education opportunities. If people do have those barriers, if they are disadvantaged, then obviously poor education leads to poor employment opportunities. Obviously that has a huge impact on the deaf community. I think the scope of the audit is quite narrow. It is obviously focusing on saving money and making money for the government. But at the end of the day it should be about human value and not just financial value, and that is obviously what is missing.

CHAIR: The material that arises from the National Commission of Audit goes through a process of explaining the idea of privatisation and the way in which that should happen. It says:

... the minimum timeframe generally required to progress the sale of a major entity is 12 to 18 months ...

It says:

Established practice is for the privatisation process to progress in two phases.

- Phase 1: a scoping study to consider the objectives for a sale, including: any community service obligations; regulatory or legislative requirements; actions required to prepare the business for sale; the industry in which the entity operates; and preferred method of sale.
- Phase 2: proceeding with implementing the sale, subject to the findings of the scoping study, prevailing market conditions and obtaining policy approval.

My briefing document says that Australian Hearing was marked as a short-term privatisation, which would put it on the 12- to 18-month schedule. What do you believe would be the impact if Australian Hearing was sold in time with this sequence, where we are pretty well up to 18 months nearly?

Mr Miers: Just looking at the time line, from the establishment of the NDIS to the actual full rollout, we have a three-year gap from the sale. From the end of this financial year, 2015, to the full rollout of the NDIS, which will not be happening until 2018, there will be a three- or four-year gap. What will be happening in the interim? If the sale is made, then what happens? People are in a bit of a twilight zone, so to speak. Those people will be impacted, because they will not have access to services if Australian Hearing Services is sold or privatised and the NDIS has not been fully rolled out, where do people go? They are in limbo. That will affect people nationally. They are left in limbo until about 2018, so what are people to do? They are left without services in that time frame, so who will be supporting them? There will be no support. There will be nothing. It will make the situation far worse, and it is not allowing for a proper transition.

CHAIR: Has the government contacted your organisation to participate in consultations in the future?

Mr Miers: No.

CHAIR: Thank you. I hope they might reconsider. Thank you very much for your evidence.

Proceedings suspended from 12:15 to 13:12

COWAN, Professor Robert Samuel Charles, Chief Executive Officer, The HEARing Cooperative Research Centre Limited

CHAIR: Thank you for the opportunity to tour the facilities here and see the remarkable work that is being done by Australian Hearing. I now welcome Professor Robert Cowan from The HEARing CRC and HearWorks. Do you wish to add anything about yourself or the capacity in which you are appearing here today?

Prof. Cowan: Yes. I am a principal professorial research fellow at the University of Melbourne.

CHAIR: Would you like to make a brief opening statement?

Prof. Cowan: The HEARing Cooperative Research Centre is a government and public/private funded organisation, a consortium of 23 different individual members, who are dedicated to improved protection and improved remediation of hearing loss. I have brought some information for the committee to look through. It covers what we do.

CHAIR: Would a member like to move that the committee accept these as tabled documents?

Senator McALLISTER: So moved.

Prof. Cowan: In opening, there are three points I would like to make. The first is that we need to understand that, when we think of hearing loss, up until now we have tended to think about it as a medical model, that there is a problem with the hearing system. But in fact it is really a disorder. When we look at disability, the disability is actually a defect on communication. So what we should be assessing is communication, not the disorder itself. It is the effect of the communication disability that really impacts on people across employment, their social enjoyment and across health costs.

One of the key concerns I have is that communication is fundamental to everything we do. If we think about the last time you visited a physician, the first thing they did was take a history, and then the exchange that you had with them was all oral communication. You might have got some written communication out of that, but a lot of it was orally based. But there is not necessarily any assessment done of people going into aged care about their communication ability, yet all of the communication that is then done with them is oral. But we do not know how well they can communicate. We do not know what their hearing thresholds are. We do not know what their ability in background noise is. Often people can, I believe, be—I do not want to use the term 'misdiagnosed'—misidentified as having perhaps a cognitive decline when in fact at least part of that could be a communication problem. It is a very easy fix to do, which is to look at doing both a hearing screening and a communication assessment for people entering aged care as a requirement of having them enter that and having them get a government subsidy. That can be done online. It is a really easy fix. We have the technology. We have demonstrated that that is available. That is the first point.

The second point is about the fitting of hearing aids, or at least what we should be thinking about is repairing communication problems. You have probably had or seen evidence that a proportion of the hearing aids that are currently provided under the OHS and under private sector schemes are not actually used. We believe that the rationale for this is that people are not ready to accept a hearing aid fitting. They still need assistance with their communication, and that might be through use of assisted listening devices or rehabilitation that gets them ready to move into that hearing prosthetic. There are ways to assess this. The Ida Institute and others have tools. We have published papers demonstrating that, through history taking and through careful observation of patients, you can identify which patients are ready to progress to a hearing aid fitting and which ones are not. But that is not part of the standard assessment package that is done now, and it should be, because that will lead to better outcomes.

The third issue I want to raise is that we spend a good deal of funding in Australia on remediating hearing loss—and that is very good; we need to do that—but we spend a very small modicum of funding on hearing loss prevention. Certainly we need to be spending more on that. Again, research that the HEARing CRC has done has indicated that venues are open to ideas to help people both to assess the risk and to identify ways of limiting their exposure through a better understanding that hearing loss is like sunburn—it is a combination of the degree of the insult, the length of the insult and the repetition—but there are ways to assess the risk and to remediate the risk. They need to be targeted at individual ages and individual risk groups, but there are things that we can do. What it needs is, in some cases, interaction with government—for example, changing the liquor laws on a state basis to limit the sound inside a venue. Currently the only limitation is on the sound outside the venue, but there is no limitation inside. That is a fairly quick fix, but it requires a whole-of-government approach and federal-state changes.

Those are my three points.

CHAIR: Thank you very much, Professor Cowan, for that succinct presentation. I am sure that you have given many, many presentations where you have had to be very clear in your communication over the years that you have been transferring information to others. Could I go to the second item that you raised, because there was new material there that we have not heard at all today, which was with regard to papers that you said that you have created yourself—and also I am sure there would be some body of work from which you have built with regard to the history-taking and observation skills that would allow you to create, basically, a standard set of observations about readiness for people to go through to having a hearing prosthesis.

Prof. Cowan: Yes, that is actually correct. In fact, on the flight up here, I was reviewing a paper from our group based at the University of Queensland with Louise Hickson, who is a member of the CRC. That is set to be submitted for publication. What I did was look at 40 clients and assess them in terms of categories 1 to 5 as to their readiness for hearing aid fitting based on observations of the interactions in questioning between the audiologist and the patient—or the patient and their family, if they had more than one person.

By categorising those people in one of those five categories, three of the categories are ready to proceed to hearing aid fitting, two are not. When you then follow on and look at those clients in terms of the ones who were fitted with a hearing aid who were categorised as 'not being ready' and what was the percentage of those who wanted to proceed with a hearing aid or who, if they did proceed, were successful, 80 per cent of those people did not want to proceed with a hearing aid initially and—I do not want to use the words 'talked into it'—perhaps came to accept that as what they were going to do with remediation because it was available to them. But were they ready to proceed with a hearing aid fitting? Probably not. What they really needed was habilitation or perhaps assisted listening devices at home so they could use headphones with their television, which would then lend them experience with how these things could benefit them. Then when they did decide it was time to move ahead with a prosthetic, they would be ready, they would be engaged and they would become good users.

CHAIR: It sounds a little bit like how I resisted getting my first pair of reading glasses, Professor Cowan.

Prof. Cowan: None of us get old, do we?

CHAIR: No. We do shoot the messenger from time to time, don't we?

Prof. Cowan: Perhaps that is an issue of what I just said, which I said for an effect. We associate hearing aids with getting old, and that is the wrong association. You will have seen this in advertisements on TV for health funds that have said: 'I don't need hip replacements. I don't need hearing aids.' But in fact we know that many people in the age range of 25 to 60 do have mild hearing losses and could potentially benefit from amplification.

CHAIR: Could you speak a little more to the difference between listening devices, hearing aids and hearing prostheses. Is there a gradation there?

Prof. Cowan: I class them all as hearing prosthetics. When I first came to Australia in 1982 to work with Graeme Clark, we basically had cochlear implants and hearing aids. You used the hearing aid until it did not help you anymore and then you used the cochlear implant. That is no longer the case. Most of the people who are using a cochlear implant or an implantable prosthetic also have some residual hearing, and so many will use an acoustic and electric input together. We also have middle ear implants, we have brain stem implants and we have bone anchor hearing aids—all of which you class as medical prosthetics under the TGA.

Hearing aids, as you know, can be in the canal in the ear and behind the ear. Some still are body worn, but very few. These are all dedicated prosthetic devices, which again come under the TGA, are labelled as hearing aids and provide amplification which can be adjusted to the individual thresholds of the person using that device. What is happening in the hearing aid field is a move towards what is called personal sound processors. Your mobile phone, using standard earphones, is an amplification device. You can program in a way of changing the amplification across a frequency range that adjusts for small differences in your hearing thresholds. So more and more of what we are seeing is a consolidation of devices where we have mobile phones that will transmit information to hearing aids being worn, that will transmit information to cochlear implants and that are being used more and more independently as individual amplification devices.

CHAIR: That is very helpful, practical information to give us a better understanding of the field.

Senator McLUCAS: Thank you very much, Professor Cowan, for attending today. You may not want to have a conversation about the hearing infrastructure we have in our country, and if you don't I totally accept that. We have a thing called Australian Hearing. We have the National Acoustic Laboratories. We have Cochlear. We have your organisation. We have a range of entities. Do you want to make any observations about how we rank in terms of our infrastructure? I mean that in the broadest sense—so the human resources as well as the architecture, so to speak. How do we rank? How good do we get? And if you want to, what would happen if we privatised Australian Hearing?

Prof. Cowan: I will answer that in two parts. On the first part, in terms of ranking, it depends on what you actually want to look at. Do you want to look at access to the devices or a range of devices or do you want to look at access to professionals? In Australia we have very good access to professionals—audiologists and audiometrists—who can provide services. That is very different, particularly in developing countries. I think Australia has one per 100,000 people. In some of the developing countries, it is at one per million. ENTs are fairly well represented across countries but audiological services are not; there is a real difference. We rank well in terms of access to professionals. We rank well in terms of access to technology and, arguably, the price of that technology when you look on a world scale. From that aspect, we are doing very well.

The one thing that is of great benefit in terms of looking at children—and remember that children only represent about 10 per cent of the hearing impaired population in the country—is the consistency we have in service delivery. The main benefit in terms of children is in early identification and early rehabilitation, the early fitting of devices. Our longitudinal study on hearing aids and cochlear implants, which is being done by the National Acoustic Laboratories as a partner and the HEARing CRC, has clearly demonstrated that implantation or the providing of a hearing aid at an age of less than six months provides a greater advantage that is closer to peer progress and peer performance than the implantation and provision of an aid later. That does not mean provision later is poor; it just means that early implementation, when the system is really plastic, does make a difference. To do that you need universal newborn screening and then you need a consistent program that can provide devices very quickly, well fitted to that individual, so that they are getting their program done in that first six months. That makes a huge difference. Australia fits very well there in terms of that ability to provide a consistent early intervention service, and that is followed on by the Shepherd Centre and other centres that provide rehabilitation. There are equivalent services in the United States and in Europe as well.

If we look at adults, the DVA is of course the largest single fitter of hearing aids worldwide, the largest single contract, and the services provided by the DVA to returned servicemen are quite exceptional. For services in the United States and Canada, it varies by state and province. When you look at the private sector in Australia, again, because we have the universal system of hearing aid provision through the Office of Hearing Services and the private sector working very closely together, we rank very well in terms of access to devices.

In terms of the privatisation of Australian Hearing, the key issue for me is about consistency of service to children in particular. The key benefit we have is consistency. In providing those services, it is important that it is consistent and nationwide. In the cochlear implant field, we currently have a difference depending on which state you happen to be deaf in.

CHAIR: We heard a very brief reference to that in evidence this morning. Some more detail about that would be very helpful.

Prof. Cowan: The funding of cochlear implants is quite different than for hearing aids. It is based on a medical model and you have both public and private funding. It varies between private funds but, in general, basic private health cover will cover you for the full cost of a cochlear implant in Australia regardless of which state you are in. The public side is quite different and the number of devices that are available varies significantly from state to state. The eastern seaboard of Australia is very well represented—Queensland, New South Wales and Victoria—particularly for children in Queensland. The base fitting is two cochlear implants for each child. That varies significantly when you move to South Australia or to WA, where the number of cochlear implants that are provided each year is less. This can increase waiting times, particularly for adults, who may need to wait longer for their first implant and, in particular, for their second implant unless they take out private health cover. So, in terms of waiting lists, access varies in the private system quite a bit depending on which state you are in.

Senator McLUCAS: Thank you very much for that. I appreciate that international comparison.

Senator McALLISTER: Professor Cowan, I was very interested in your opening remarks about the challenges and the key tasks ahead for Australia, and I was thinking about which aspects of our institutions are likely to be able to deliver on those challenges—clinical approaches to supporting older people who are approaching being hearing impaired and hearing loss prevention. How do you see the landscape responding to those challenges?

Prof. Cowan: That is a very good question for me because one thing the HEARing CRC is very much looking at is providing solutions that enable equal access to clients regardless of whether they are in metropolitan, regional, rural or remote communities. I should note that one of the key things that Australian Hearing does is, of course, provide those services to remote and, in particular, Indigenous populations. Again, consistency of approach there is absolutely critical to making a difference. One of the things we are looking very carefully at is that historically, looking back to my involvement in Australia in the early eighties, we had basically a one-size-fits-all approach to the provision of devices and services. That is very much changing. In particular, the boomers

like to fool with their own technology. But some people do not like to fool with their own technology. So having one methodology of service delivery is, I believe, a dead horse. We now have the ability to buy a hearing aid over the internet, download a fitting program and basically do it yourself if you wish to. There are other organisations that provide some level of assistance for you. We can program devices over the internet—either cochlear implants or hearing aids. We can test hearing over the internet.

What I believe we are going to be seeing as we move forward and as these PSPs and other mobile phone based technologies come in is a range of service delivery models that are more patient centric. This in some ways fits very well with the NDIS approach, which is looking at what individuals need, how they can access that and how we can deliver those services to them in a cost-effective way that supports them in the community they exist in, whether that is in aged care, in a rural setting or in a metropolitan setting. We focus on rural, but the metropolitan settings are limited by the amount of infrastructure. If you have one soundproof room in your clinic, you can only fit so many people a day; whereas if you have that plus the ability to do telework, or e-health, on both the diagnostic fitting and rehabilitation, and under an audiological management model, that significantly increases the throughput of patients.

The big issue we need to look at in Australia is that it is not just about the number of people who have hearing loss; it is about the installed base. When we look at cochlear implants, for example, the installed base is becoming a significant issue. Hearing loss is not static. In some ways it is like vision. Vision changes, and you go to see your optometrist and you get new spectacles as your vision changes. Hearing loss is the same. The majority of adult hearing loss is progressive, so fitting with an implant or a hearing aid at one point does not necessarily mean that that is where you are going to end up. It does not fix the problem; it is the start of a long-term prosthetic and rehabilitative journey that someone is going on. So we need to think about how we can provide those services on a longer term basis. The number of people getting cochlear implants is exponential. There is no way that the one-on-one clinician to patient model can service that installed base on an annual basis and deal with new clients. So we have to find a different way of providing those services.

Similarly, on the hearing aid side, if we really want to be looking at providing services to those with mild and moderate hearing losses where we can get a lot of productivity benefit—and those people are necessarily the most resistant to doing something early—we need to change the way we provide those services. This is a key issue. Again, an unknown factor about hearing loss is that it is quite different than vision. Most vision loss is about the focus on the retina, but it does not affect the performance of the retina. Sensory neural hearing loss is very different in that once you start to lose hair cells, or the sense sells, you then start to lose peripheral processors—the nerve endings—and you start to have fewer synapses in the auditory nerve pathway. So, basically, knocking out the sense sells starts to result in degeneration of the auditory neural pathway. We believe that the average length of time between someone saying they have a problem with their hearing and doing something about it is between four and seven years. What is happening during that time is that they are getting degeneration of that auditory neural pathway. You then put in a device that improves peripheral access, but it does not do anything about the processing. It is not just about providing a device; it is about providing a device plus the appropriate rehabilitation and training to overcome the sensory deficit. It is quite a different approach. We need to be very much rethinking the way we are providing services, what services we are providing and to which individuals. It needs to be more patient centric.

Senator McALLISTER: That brings us back to children. While we are talking about a diversification of the clinical pathways or the models of service for adults, I wonder if the plasticity in children, which you referred to earlier in your presentation, means there are some very clear directions that we need to be taking with children and whether perhaps greater flexibility in what is offered to children might not be such a helpful thing.

Prof. Cowan: What our research tells us—and I believe in evidence based research—is that early identification through universal newborn screening, early fitting of devices and early intervention programs, particularly aural, for the vast majority of children are what we need to be providing.

CHAIR: Is that what Australian Hearing is providing?

Prof. Cowan: In combination with other agencies.

CHAIR: Could I ask you about the process of the commissioning of the scoping study and where we are up to with that. Have you or any member of your organisation been provided with or seen a copy of the scoping study commissioned by Senator Cormann?

Prof. Cowan: Yes.

CHAIR: You have?

Prof. Cowan: Sorry, not the scoping study; we have seen the outcomes of the scoping.

CHAIR: We thought we had hit gold!

Prof. Cowan: Sorry, I did not listen carefully!

CHAIR: Did you hear the collective drawing of breath across the room with all these people!

Prof. Cowan: I have not seen the scoping study. I have seen comments about the scoping study.

CHAIR: And what were those comments?

Prof. Cowan: These were about submissions that various organisations, including our own, had made to this study.

CHAIR: Could you characterise those comments that you are referring to.

Prof. Cowan: I can only characterise what we said, which was primarily focused on the National Acoustic Laboratories and the need to continue the support for research in that area—in particular, when we are looking at work with Indigenous populations and with improving the way services are delivered.

CHAIR: Were you able to see responses to any other submissions?

Prof. Cowan: No. There is just what I have been told about other submissions.

CHAIR: Can you report any of that conversation to us?

Prof. Cowan: I think in terms of hearsay information, many people have strongly supported Australian Hearing continuing in a format that it currently exists.

CHAIR: Were you invited by PricewaterhouseCoopers to participate in their consultations?

Prof. Cowan: Yes, I was, and I had a fairly extensive verbal interview with them.

CHAIR: Did you receive an invitation by mail, email or by a phone call? Or was it by personal association?

Prof. Cowan: Email and personal association.

CHAIR: With the remarks that you provided them, did you provide any documentation to support your submission to that process?

Prof. Cowan: When we talked with PricewaterhouseCoopers, they indicated that they were not really looking for written submissions, so we provided a verbal submission.

CHAIR: In what form did you give that? Was it as part of an open panel discussion or was it—

Prof. Cowan: It was a telephone interview.

CHAIR: Do you know how many people were listening at the other end?

Prof. Cowan: It was just myself and two or three people—I think it was two or three.

CHAIR: Okay—and you were just trying to pick out the number of voices at the other end. How long did that go for?

Prof. Cowan: A little over one hour.

CHAIR: Is there anything that you said to them that you think would be important to put on the public record today?

Prof. Cowan: Nothing that I have not already covered.

CHAIR: Going forward, have you been invited to participate in any further capacity?

Prof. Cowan: Not at this stage.

Senator McLUCAS: Professor, I just want to follow up on that. Evidence we have received today, and from a number of witnesses, has noted the fact that the original construct of the consultations was around a scoping study to potentially privatise. Now, we are going on this other round of consultation which seems to have turned into a conversation about how the NDIS will work and how Australian Hearing will interface with the NDIS. Is that your observation, as well, of what has happened over that 12-18 month period?

Prof. Cowan: My analysis is that two things were happening at the same time. We had the rollout of the National Disability Insurance Scheme. People were concerned about how that was going to impact on the way services were being delivered across the board by all service providers. At the same time, the government announced the review of the four different agencies—the Royal Australian Mint, Australian Hearing and, I am sorry, I cannot remember the other two—in terms of looking at privatisation. So these two things happened at the same time. I believe it is really just a timing linkage in the way people have looked at them. People are very passionate about hearing health care and, so, have made that linkage. There is a lot of concern about how we are going to provide the best possible services to children and to adults with hearing loss in Australia. There is a lot of

concern for how are we going to ensure that we do not see any derogation of those services but can, perhaps, as many agencies feel, better focus the available funding, recognising that there is only so much funding and that there are many health issues. So the concern is how we can focus the funding available to get the best outcomes.

Senator McLUCAS: Are you at all concerned that this review is being led by the finance department rather than a department that has a service delivery frame of mind?

Prof. Cowan: Aren't there two questions being asked here? The first is: is it financially viable to do so? The second is: what is the economic benefit of doing it? I believe finance has the expertise to do that. I believe that that was one of the intents, because they were looking at four different organisations.

Senator McLUCAS: I am particularly worried about Australian Hearing and the potential impact on the service delivery to patients of Australian Hearing. I do not really care about the Royal Australian Mint; I do, but not as much as Australian Hearing. I suppose my point goes to the following. This was going to be the sell-off of an entity, whether it be Australian Hearing or the Royal Australian Mint. If you are going to do an assessment of whether you can sell something—whether it is worth selling—then, sure, finance can do that. But now the conversation has transformed into this conversation about what will happen, with the introduction of the NDIS, to services for people who need hearing health, but it is still in the financial paradigm, so to speak. Do you have any concerns about that?

Prof. Cowan: What I could say is that I am very happy to see that the Senate committee is actually looking at this as a broader issue about how services should be delivered. I think that is a welcome development.

Senator McLUCAS: Thank you, Professor.

CHAIR: Thanks, Professor Cowan.

COLLINGRIDGE, Dr Louise, Executive Officer, Independent Audiologists Australia

[13:45]

CHAIR: I now welcome participants in this inquiry from Independent Audiologists Australia. Thank you, Dr Louise Collingridge. Could I ask you to provide us with an opening statement.

Dr Collingridge: Thank you, Senators, for inviting me. Independent Audiologists Australia is a not-for-profit professional association incorporated in the state of Victoria, with membership from across Australia. Our members offer audiology services in more than 130 clinics across Australia. We as an association offer ongoing education to audiologists, both for our own members and also for audiologists not associated with independent practice, and we advocate for the profession of audiology. We have a memorandum of understanding with Audiology Australia, and we discuss matters of mutual interest on a regular basis. We also have affiliations with Independent Audiologists New Zealand and the Academy of Doctors of Audiology in the USA, and we offer a combined ongoing education program in conjunction with those associations.

Audiologists are trained at university, spending a minimum of five years on undergraduate and postgraduate study, as healthcare practitioners who prevent, assess and rehabilitate hearing and balance disorders to people of all ages—newborn through to the elderly. I just want to quote here: 'As I see it, the only way to prevent the employment of unqualified persons by law would be to ask state governments to legislate for the registration of audiologists.' That statement was made in 1965 in Australia, when only 25 people were working in the field of audiology, 17 of them in what was to become Australian Hearing. We now have over 2,300 audiologists in Australia, one of the highest ratios of audiologists to the population, with around 400 to 500—we heard 470, I think, this morning—audiologists employed at Australian Hearing. So we may say we have come a long way, but have we?

The profession of audiology is not synonymous with the hearing device industry, and I underline that. But many audiologists, due to the funding model that we have in Australia, spend a fair amount of time prescribing and dispensing hearing aids. Although the audiology profession is separate from the hearing device industry, relationships between the two are not always transparent to the public. Government policy refers to hearing services, but the specifics of government policy and funding are all about hearing aids, and we have heard that all morning: hearing aids fitted, hearing aids fitted, hearing aids fitted. So government supplies and subsidises hearing aids for eligible Australians, government regulates how those hearing aids are supplied, government allows vertically integrated outlets owned by hearing aid manufacturers to supply hearing devices to the public, including subsidised ones, and government competes with the private sector to supply hearing aids to pensioners. Government-owned provider Australian Hearing is allowed to compete aggressively with the private sector, become more profitable than most private providers, work to hearing aid sales targets and pay commissions to staff on hearing aids fitted.

Policies that apply to hearing aids and audiology would be unacceptable in other aspects of health care in Australia. So even though Australian universities train audiologists at the postgraduate level to undertake all aspects of audiology, including diagnostic audiology, paediatric audiology and geriatric audiology, the government gives little recognition to the skills of audiologists. Audiology is still not regulated as a healthcare profession under AHPRA. Medicare rules allow for medical specialists to be paid taxpayers' money to employ anyone. They need have no qualifications whatsoever to undertake audiology procedures on their behalf. Recently, Medicare introduced a parallel set of item numbers to be used by audiologists if they are requested by medical specialists, with fees that are substantially lower for audiologists to conduct those same procedures than the amount paid to the medical specialist.

The Office of Hearing Services contracts to service providers who need not have any qualifications in audiology at all. They only have to have an indirect relationship with practitioners. The Office of Hearing Services does not allow gap fees for services delivered but it allows top-up fees on hearing aids that are completely uncapped and unregulated. So government does not differentiate between hearing aid audiometrists and audiologists and it privileges hearing aid provision over all other aspects of audiology service. We heard this morning that addressing hearing loss involves far more than the provision of hearing aids. An example mentioned by the representative from Deaf Australia is that deaf children need access to sign language. There is worldwide research to prove that children who acquire sign language as their first language do better with the hearing aids that are fitted to them, but we do not have that research in Australia because we do not have the model in Australia.

Not all individuals with hearing loss are ready, willing or capable to benefit from hearing aids, contrary to notions put forward in the Access Economics report which suggested that only 25 per cent of people who have

hearing loss use hearing aids. That created a market for businesses to set up and decide to sell hearing aids to as many people as possible under the guise of getting people involved in wearing hearing aids to solve their hearing problems, ignoring the fact that many of those people are not really motivated or able to benefit. Audiologists, on the other hand, are trained to provide and explain the diagnosis of hearing loss, to counsel families, to work through the issues around hearing loss and to provide individualised training and individualised communication programs to ease the communication health and economic burden that hearing loss can bring. The success of those programs is in the audiologist, not in the hearing aid.

Many audiologists offer audiology services to Australians of all ages, newborn to elderly, in hospitals, private practices and intervention centres for children and adults, using the knowledge they acquired at university. Paediatric and complex adult audiology is not the exclusive domain of Australian Hearing. Audiologists undertake ongoing professional development in all areas of audiology, not just hearing aid work. Audiologists make a contribution to the health care of Australians, not just in the fitting of hearing aids. They keep people independent, they keep them out of emergency departments through improving their communication ability. Yet anyone in Australia can call themselves an audiologist and anyone can own an audiology related business. There is no way for the public to know who is qualified in audiology and who is not, because, like back in 1965, audiology is not a profession with mandatory national registration.

So we appeal to government, to you, senators, to recognise that hearing is an integral part of health and health care, not something to be treated in isolation with a device. We appeal to government to recognise the profession of audiology and the service that audiologists deliver. We urge you to recommend the incorporation of audiology into the regulatory framework provided by AHPRA for health care and to bring Australian audiology into the modern era and, in this way, possibly paving the way for government to relinquish ownership of Australian Hearing, without compromising on standards and public trust. Thank you.

CHAIR: Thank you very much, Dr Collingridge. Can I just ask the question that I have asked all of the participants today with regard to the scoping study commissioned by Senator Cormann: have you or any member of your organisation been provided with or seen the scoping study commissioned?

Dr Collingridge: No.

CHAIR: Have you participated in any of the inquiries so far?

Dr Collingridge: No. Our situation was that we were informed via Audiology Australia, which is the large professional body representing audiologists, that in the scoping study PricewaterhouseCoopers were not going to consult audiologists. We found that to be quite surprising. In January this year, I went to see my local member of parliament, and he wrote to Minister Ley. Our issue was around regulation and Australian Hearing, and that was a point we wanted to make. Subsequent to that, she wrote back to say they were two separate issues. We kind of went a different path: we knew it was happening, but we thought we wanted to try and make a statement. But we were not invited to any of those consultations.

CHAIR: Who is your local member?

Dr Collingridge: Paul Fletcher.

CHAIR: Do you recall the conversation that you just mentioned with your peak national body?

Dr Collingridge: It was not a conversation; it was a communication that they sent out.

CHAIR: Would you be able to provide us with a copy of that communication that advised you that audiologists were not going to be consulted?

Dr Collingridge: I can try, but it is from my memory. There are a couple of other audiologists here, and they send out a newsletter. I can check my email and try to get back to you.

CHAIR: Thank you. We would appreciate having that, and then we can have a look and see what the explanation for that was, if there was any explanation, or if you were simply advised. Did you make any approaches to PricewaterhouseCoopers yourself to participate?

Dr Collingridge: No, we did not.

CHAIR: Would you benefit from seeing a copy of the scoping study?

Dr Collingridge: We would be very interested to see what information has been factored into any decision that was made, but I think we see some issues as broader than the possible privatisation of Australian Hearing. I would be very interested in the context around the wording and whether what was referred to was hearing aids or hearing devices, as opposed to services that are necessary.

CHAIR: Given the evidence you have given us so far, clearly you believe that that is a critical part of the conversation of any provision of services and that the interplay between the devices and the service provision is a complex one and needs further careful scrutiny.

Dr Collingridge: It is a complex one, and it becomes more complex as people's health needs change and age related changes take place in auditory processing. For a very small number of people, just wearing a hearing device might help them in ideal listening circumstances, but by far the majority of people need a lot more holistic treatment in the sense of learning to recognise what the limitations of the device are going to be, where it is going to help them and where it is not, and what other adjustments can be made to communication, to the environment, to the architecture that they choose to have conversations within and so on. The scope of audiology covers all of those things. The scope of being a hearing aid dispenser or an audiometrist does not, and there is not that recognition of the difference between the levels of education and the scope of practice in the current system.

CHAIR: Just to reiterate, you said, as I recall, that anyone can call themselves an audiologist and set up an audiology practice. You are not required to have a qualification. There is no board. There is no registration process.

Dr Collingridge: If an individual wants to access the government funding through the voucher scheme, through Medicare, through WorkCover et cetera, they do need to belong to one of the self-regulating professional associations that are recognised by those bodies. But in fact the Office of Hearing Services contracts to service providers that need to supply a business plan. They do not have to have any qualifications. Those are not people who would call themselves audiologists. There is no protection of title. So if somebody wanted to set up a service—they read that Access Economics report from 10 years ago and thought, 'Here's a gap in the market, I think I'll go and start importing hearing aids and distribute them to Australians—they can do that and they can say they are doing audiology because there is no-one to stop them. Even if someone has qualifications in audiology, if they decide not to belong to a professional association, there is no where to stop that either other than—

CHAIR: They practice completely independently outside of the body of the profession?

Dr Collingridge: Yes. That is why we really are calling for national mandatory registration like other health care professions: so optometry, physiotherapy—there are 14 of them and I am sure you know all about that. We would like to see that audiology is regulated in the same way as health care. We see that as particularly important given the close relationship with industry. It is a very similar relationship to the medical and pharmaceutical fields, yet it has been one that has been neglected, in a sense, with the current system.

Senator McALLISTER: Can I ask you about the structure of the industry and the size of the private businesses that you work with? Are they small businesses? Are they very large?

Dr Collingridge: They vary. The requirement in our association is for members to have a financial interest in a clinic that is at least 50 per cent owned by audiologists. So we differentiate ourselves from clinics that are in the private sector but might be owned by people who do not have clinical qualifications—and that ranges. Some of our members have clinics with multiple sites and employ many audiologists to work for them and others are single, independent practitioners. So they vary.

Senator McALLISTER: What proportion of the market could you estimate is held by organisations which do not meet that 50 per cent ownership requirements test?

Dr Collingridge: That is really difficult to tell because there is no way to know. That figure of 2,300 audiologists is actually not really a known. That is what Audiology Australia estimates but there is no register. I know that there are audiologists from overseas who do not meet the criterion for Audiology Australia who are working in well-known, well-established audiology related businesses, but they would not be factored into any numbers. It is very difficult.

Senator McALLISTER: You spoke about the holistic nature of treatment when done well in your profession in this committee has heard elsewhere in a different context of the challenges in providing integrated services under a fee-for-service model. I am wondering if you have a view about the kind of financing model that would work to provide what you consider to be best practice services?

Dr Collingridge: One of the concerns is around Medicare. Medicare provides very little funding for audiology as such. I am sure that you have heard this because I have read from various submissions and I know that the way the chronic disease management is set-up with the GP having to nominate who is in the care plan and having to choose five consultations between a number of different allied healthcare professionals is not conducive to an integrated care plan. But I know you have heard that from many on others. Audiology has not been one of the professions that has been included much. Proportionately to the others, I think the podiatry is right at the top and I think they start at the toes and get up to the brain later on, in spite of the fact that hearing loss is a chronic

condition and living with it is a lifelong task, and the fact that many people with hearing loss also have concomitant conditions like diabetes, which is very closely associated with hearing loss. So an integrated care arrangement would involve funding that did not mean that professionals needed to compete with each other through the GP in order to get those services and that they were funded in a way that adequately met those provisions. I think that worldwide we are recognising that health care is no longer viewed as the doctor and the nurse and then a few other people who step, but that primary health care is provided by allied healthcare professionals on a daily basis.

Senator McLUCAS: Thank you so much for coming along and also for listening in as long as you have today. I want to go back to the regulatory and white audiology has not been regulated. I think the quote you gave was 1967, and in your submission, you talk about the fact that when this all happened in 2010 because you were not registered interstate. I want to step back from there. Why didn't a state somewhere between 1967 and today think, 'It would be a good idea if we regulate audiology'? It is unusual.

Dr Collingridge: Yes, it is unusual and we are not alone. The speech pathology is also not nor is noise dietetics. Yet some others are—for example, dental hygienists. Because they are under the dentists umbrella, they are. There are a lot of anomalies around the way that national registration happens. Clearly, audiologists have been talking about this for 50 years, so it is not that it has not been on the agenda. But there was, probably until the 1980s, a small section of audiology that was in the private sector. So up to that point, the hospital services offered far more extensive services and Australian Hearing was probably proportionately the rest. And there were audiometrists in the private sector.

Audiometrists are trained to test hearing at a fairly basic level and fit hearing devices. As I hope I have convinced you, audiology is more than that. Audiology grew out of recognising it is not just as simple as fitting a device. My impression, and I could be wrong because I was not working in audiology for quite as long as 50 years, would be that because there was regulation around Australian Hearing there wasn't that perceived need, or perhaps the numbers were too small in each state. But I do understand that where we are right now is we would have to approach all the state ministers of health and convince them that audiology needed to be regulated and then that would become a COAG decision, which would then feed into the AHPRA.

Senator McLUCAS: That explains it. I was just trying to work out how this could have happened. Essentially, you had quasi-regulation through your employment that militated against having to push to get a regulatory arrangement. Thank you, that now explains that to me. Can I now go to this question that Mr Miers raised—that is, the incentives for prescribing. We do not allow that in the pharmaceutical sector. We actually prosecute people who are doctors for doing something like that, but we blithely let this all happen—do we? How pervasive is this?

Dr Collingridge: Again, it is very difficult to know because it is not regulated. I do not know if any of you listened to the Radio National program about this topic. There is a transcript that you can read and that would probably be quicker than listening to the program. That was, to my knowledge, one of the first public disclosures around this question. Australian Hearing, who is a fairly large employer but not solely of audiologists in the rehabilitative framework, have offered commission for a while to their audiologists. When that has been discussed within the profession, the comments given have been to the effect of, 'It's just a small amount, and therefore we don't need to disclose it,' but I understand that they are disclosing it since the Radio National program.

In other sectors, it is difficult to know. Checking people's websites since that media program, I have noticed that some are saying, 'We don't pay commission'. So it is almost now a declaration of opting out of commission, rather than a declaration of who is paying commission. That is probably as much as I know. There are many audiologists that are very uncomfortable with it. They see themselves as healthcare professionals, and they recognise that it is inappropriate, that it is a conflict of interest and that it ought to be regulated.

Senator McLUCAS: The evidence that Mr Miers gave us was that audiologists were being paid \$400. That is his evidence. Is that in the ballpark?

Dr Collingridge: I think that in some commission arrangements there may be a payment that is based on which type of hearing aid is fitted. I really do not know where the \$400 figure would come from. Whether it is a percentage of what the hearing aid is sold for, I really do not know. I do not know what commissions people get. I do not know that anybody would have information about that. It would be very interesting to know.

Senator McLUCAS: Do the hearing aid manufacturers have people who go to door to door to say, 'Buy my new beautiful hearing aid' like the old pharmaceutical reps that you hear about? Does the same thing happen in the audiology business? Do they come along and say, 'If you use my hearing aid, we'll sell it to you for this, and give you a cash bonus of that'?

Dr Collingridge: They do have offers. They have the prices that they offer to audiologists, and that is their business of getting their products out. Some of them supply products to the retail companies like Costco as well as to independent practices and to Australian Hearing. Over the years, they have become more circumspect about the kinds of deals that are offered, because, worldwide, audiology has recognised that they need to follow the medical profession in that regard. It is a slightly different issue to the commissions issue.

Senator McLUCAS: Thank you very much.

CHAIR: Thank you very much. In your submission, you speak about the Office of Hearing Services. I invite you to give us a couple of minutes on the way that that voucher system works and on any problems that you see with it or any advantages to it, from your perspective?

Dr Collingridge: Well, initially when one looks at the Office of Hearing Services scheme it seems like a wonderful scheme for Australian pensioners to access hearing services. Working within the system and seeing how it has evolved, the Office of Hearing Services is essentially a hearing aid distribution scheme. There is an option where you can elect to have counselling instead of a hearing aid, but it is counselling that is very limited and very restricted in funding. As an audiologist you are not allowed to charge a gap fee on services within the OHS system. If somebody needs an additional hearing assessment or they need more counselling, then you can offer that, but you do not get paid for that by the Office of Hearing Services. You are not allowed to charge a gap fee on any of their services, yet you are allowed to charge a top-up on the hearing aids. The top-up on the hearing aids goes from a cheap top-up, which most companies offer, all the way through to thousands of dollars for what I would describe as more advanced hearing aids, and that is uncapped and unregulated.

So there is talk about the Office of Hearing Services needing to protect vulnerable Australians by not allowing a gap fee on services and by restricting the number of services that audiologists get, yet they will be happily allowing pensioners to be charged thousands of dollars for hearing aids. That applies across Australian Hearing. All suppliers through the voucher scheme are allowed to charge top-up fees on hearing aids, and some are set to top-up targets. They have an expectation that their staff will fit X number of top-up hearing aids.

From my observations and working within the scheme at the time, I think it was a very unfortunate development that they did that, because it has created a big business out of the pensioner market. I understand that the Office of Hearing Services is trying to shift its thinking on this. Certainly, a lot of people who are on that voucher scheme might benefit equally or better from a hearing aid that is fully subsidised and from a series of intervention therapy sessions with the audiologist which would not cost anything like the thousands of dollars that they are charged for the device, but that is not allowed within the scheme. The belief seems to be that the technology is going to do the job, that if you have more advanced technology you are going to get a better outcome—but that isn't necessarily the case.

CHAIR: Thank you very much for your insights. We appreciate the time that you have given to the committee today.

Prof. Collingridge: Thank you very much.

JACKSON, Ms Leonie, Chief Executive Officer, The Deaf Society of New South Wales, through Vanessa Sweeney and Kerrie Lakeman, sign language interpreters

[14.17]

CHAIR: Welcome. Do you have any comments to make on the capacity in which you appear?

Ms Jackson: I want to let you know that I am a deaf person who uses Auslan, and I am a parent of a deaf child who also uses Australian Hearing services. I was previously on the board of the Australian Parents of Deaf Children and I am also a committee member of the Australian Hearing Paediatric Program Advisory Committee. So I do have various hats that I am wearing today, and I thought I could bring a lot of perspectives to the hearing here today.

CHAIR: I now invite you to make an opening statement.

Ms Jackson: You would have seen my submission. I am representing the Deaf Society. The Deaf Society provides support services to deaf, hard-of-hearing and deaf-blind people in New South Wales and also in the ACT. We have been established for a long time—actually, for over 100 years. So, throughout our work with the community, we have gained a lot of knowledge and insight into the needs and the challenges that deaf, hard-of-hearing and deaf-blind people face every day.

Something that we feel is on the rise over the last few years is the fact that many hard-of-hearing and deaf blind people have been diagnosed with mental health issues. That is our No. 1 concern at the moment as an organisation: how we can work with healthcare professionals within that area. We also need to be dealing with many clients who come from families with which they are unable to communicate. Therefore they have a poor support system or no support system within the family, so they are requiring to come to us for that support, because they have had none in their lives.

In my submission, you will see there are four main areas that we are focusing on that we feel the need to improve. Of those four areas that need improving, No. 1 is early intervention. I have had a look through the Deaf Australia submission, and the Deaf Society certainly concur with Kyle Miers's recommendation and submission in relation to the fact that it is so important for the family to have access to information and support and to be able to look at all the different options available and also to be able to have access to Auslan—to be able to learn Auslan and have that training provided. They need to have access to deaf and hard-of-hearing role models also. We feel that is something that is critical. We need to be able to prepare the client and set them up for a good and positive future.

The second area is just general access to healthcare services. Many clients struggle with receiving appropriate healthcare services. We have many examples where a deaf client has come up against those obstacles: a person has not understood their language or their needs. Unfortunately, sometimes that will lead a misdiagnosis or a referral to a wrong service.

The third area is access to hospitals. We have received many stories from many clients where they have experienced some issues. They have gone to a private hospital and the private hospital is unwilling to provide interpreting access for the deaf client, and the client has in fact been told to go to a public hospital to receive their services there.

The last area that we have concerns about is the aged-care area. We work a lot with deaf and hard-of-hearing people who are over the age of 65, and they are also struggling to access the appropriate services, particularly within the aged-care program, because they are funded by the national government, not the state government, so sometimes people feel a little bit conflicted. Where do they go? How do they access the appropriate organisation? In fact, sometimes they are denied that access. So we have been doing a lot of work in that area.

All those four areas link to a high percentage of our clients having mental health issues. Over 50 per cent of our clients have a diagnosis of a mental health issue, so it is a big area of concern for us, and we are trying to deal with that area as an organisation.

CHAIR: Thank you very much, Ms Jackson. Could I go to your submission and the fourth point there, with regard to the capacity to have Skype and FaceTime to provide interpreting services. We have not had anything around this so far in our inquiry. Just as a matter of interest, you also say that this requires an excellent broadband service in the area for that to be possible.

Ms Jackson: Yes. I know that that is a work in progress. Having said that, we have found—particularly in New South Wales and the ACT—that there is a big demand for a video relay interpreting service. Interpreters cannot always physically get to the destinations, due to the distance that they need to travel. There is a service in the Hunter under the NDIS rollout, but a high percentage of clients are deaf-blind up there. The interpreters can

work with the deaf-blind clients, but they are unable to do that, because they are based in Sydney. Under the NDIS at the moment, they are refusing to pay for the travel cost for the interpreter to travel up to the Hunter, so of course the interpreters are unwilling to travel two hours without any travel costs being covered and then have to do the job and then travel back. That is a big area that we are struggling with at the moment. How can we overcome that? How can we free up the interpreters to provide the service when they are unable to physically get there? It will enable interpreters to be working through the video relay service. It will allow more access for interpreters to work that way, via the video relay service.

CHAIR: It speaks to two issues. One of the issues is, clearly, the real NBN as a provision of access for people with disability where they live, and the service provision that could enhance their life, work and study capacities.

Ms Jackson: Yes, you are right. I think at the moment, and it is very clear in New South Wales and the ACT, it is really a case of it being a bit of a postcode lottery. It does depend on where you live. Do you have a good broadband network? If so, great—you are set. You can have that provision of services. But, if you do not have a good broadband network, then it is bad luck for you.

CHAIR: Yes. Well, Labor did have a plan about that—about equitable access.

Ms Jackson: I know.

CHAIR: That is a different inquiry, I think; that is Senator McAllister's inquiry. But there was a second point—the matter of access to and payment of interpreters. I might go to Senator McLucas for a question with regard to that and for other matters.

Senator McLUCAS: Thank you very much, Ms Jackson, for coming to see us today. I have just a final question about the video relay for deaf-blind people. That is just not possible, I imagine.

Ms Jackson: No, it is not possible. Because the interpreter actually physically needs to go to where the deaf-blind client is, we are very limited. We cannot provide service to the client. They cannot access the video. We want to free up the interpreter to be able to provide their service. However, if we have interpreters going up to visit the deaf-blind clients in the Hunter, then there are fewer here to provide the interpreters required. So it is a related issue. The amount of time it takes to get interpreters up there in the Hunter means there is less time for interpreters to be down here. The challenge is to find that balance in terms of having the skills and the interpreter available to go to do the job and then also being accommodating of the needs of the clients in other areas.

Senator McLUCAS: Perhaps we need some more interpreters.

Ms Jackson: Yes. That is true. We are also working with the New South Wales government. Last year, they cut our funding for the provision under the Smart and Skilled program. People wanting to study Auslan, with the goal of becoming interpreters, are now hindered. As you can see, there are a large number of interpreters. In the Hunter area, we are unable to meet the demand. Currently, there are courses but there are just not enough at the moment. That is something we are certainly looking into and advocating for. We want to ensure that we are provided with the funding and that we can also provide the Auslan courses which will then, in the future, allow people to become interpreters.

Senator McLUCAS: I was wondering about the points you were making around aged care. What is the solution? Is it an interpreting issue? Or, for aged-care workers to communicate better with people who are hard of hearing, and given the complexity of, potentially, dementia, is it a training issue?

Ms Jackson: Yes. It is really everything. It is a related issue. Within the aged-care area, it is all related. We have clients who are living in aged-care facilities. The staff have no idea about how to communicate with deaf residents. We need to go up to train the staff in how to communicate with their clients. So we are actually providing that ourselves out of our own pocket, just to ensure that the residents have access. Quite often the situation is that there will be one deaf resident in the whole of the facility, so can you imagine? You have no access to your peers and you have no communication with anybody else that you are living with, and that of course creates isolation. So we have a program where we have a deaf staff member go up maybe once a week to visit those people who are living in isolation within those facilities. They might take them out shopping and provide them with someone just to be able to communicate with. We have also noticed that within the aged-care facilities there is a high staff turnover.

CHAIR: Yes.

Ms Jackson: That means that, even though staff may have received some training, the chances are they will soon leave, and then of course that training needs to happen again. So this is an ongoing issue.

Senator McLUCAS: The chair has just made an interesting point. In the Living Longer Living Better program, there is a supplemental amount that is paid for people from linguistically diverse backgrounds. I would suggest that Auslan is pretty linguistically diverse.

Ms Jackson: Yes, definitely.

Senator McLUCAS: Have you pursued that at all?

Ms Jackson: We are not aware of that, no.

CHAIR: I think there is funding for culturally and linguistically diverse, and LGBTI populations have received special funding in response to different needs of ageing communities, particularly in care settings.

Senator McLUCAS: We might continue that conversation offline to see whether we can do something about that.

Ms Jackson: Yes, that would be good. Thank you for letting me know. Thank you for passing on that information.

Senator McALLISTER: Thank you, Ms Jackson. Can I just ask about your submission in relation to mental health services. You make reference to the program at Princess Alexandra Hospital in Brisbane. Could you talk to us a little bit about what the key elements of that deafness and mental health guideline are.

Ms Jackson: Certainly. It is a fantastic model, and I think it is something that would benefit the whole of Australia and something that is quite good in terms of teaching people how to ensure they are making a correct diagnosis, because sometimes a deaf client may present and the hospital staff and the healthcare professionals may not even realise that the person is deaf. So can you imagine the challenge that they have trying to make a diagnosis and trying to make some considerations in relation to a person when they do not even realise that they are deaf? We had one example where a client went into the hospital and the healthcare professional said, 'Oh, that person has schizophrenia,' but then somehow something happened and they realised the client was deaf. So then they got a Deaf Society community worker and then they said, 'This person has some language access issues,' and then they actually realised they needed an interpreter. They went into a counselling situation and they realised that in fact it was not schizophrenia; it was a language delay.

At Princess Alexandra Hospital, that model shows the various symptoms. It talks about the deaf person and how that may present in a deaf person. There are some guidelines provided for them in relation to the process of diagnosis. So they have a process in place where, if there are any future appointments, the deaf person must be seen with a community worker or a deaf interpreter. An interpreter can work with the deaf person on a good day, but if it is a bad day it can be very difficult for the deaf client to understand a hearing Auslan interpreter if they are going through an episode that day, so a deaf interpreter can work with together with the hearing interpreter and facilitate communication.

We found that that model works particularly well up there in Princess Alexandra. However, we do not have that model here in New South Wales. I think it would be great to see that model replicated here. We have been lobbying some hospitals, and so far that has been successful for a few hospitals. So it is great if the person goes to that particular hospital. However, if somebody has to go somewhere else then we need to try to have that model replicated. I guess our goal would be to see that that model is replicated nationally.

Senator McALLISTER: I have lots of other questions but I think I need to concede to our chair, given the time.

CHAIR: It is all right. I think we have a bit more time. Senator McLucas, do want to ask some mental health questions as well?

Senator McLUCAS: That was the question I wanted to ask, so I am really pleased we have covered that. What was the motivation at Princess Alexandra Hospital? Do you know the history behind that? Or was it a misdiagnosis of the person with schizophrenia?

Ms Jackson: I think that example was highlighting many examples that had happened previously. Queensland Health had a relationship with Deaf Services Queensland. They were working very closely together and they have done so for many, many years to be able to set up an appropriate procedure. It was the last three years. So we have Deaf Services Queensland and DeafHealth working together to be able to develop their ideas and to pull their knowledge and expertise together to establish this policy. It has been working very effectively. That has occurred because of the many situations that have happened previously and the numbers of misdiagnoses that have taken place.

Senator McALLISTER: I have a related question. That protocol is obviously helpful when a person presents is seeking assistance with a mental health issue, but I gather from your submission and from other things we have

heard that in fact there are many people who are not presenting, not seeking assistance, and whose symptoms might be missed because of the communication gap when they are seeing their regular practitioner. Do you have any thoughts about how that might be addressed?

Ms Jackson: Each state within Australia has their own Deaf Society. They have a specific team that will be working in that area. So, with any health system or health program that somebody needs to access, it should be automatically flagged that the healthcare professional knows to contact the Deaf Society or the deaf related organisation who has the appropriate resources to be able to send somebody out to attend the appointment, to support that person within the appointment. So it should be flagged. What has been missing so far is a database. For example, at the Deaf Society we have a number of clients. We have some clients who would use specific services. However, we do not know when they are going to be attending those services at that particular hospital or that particular healthcare program. So, when the client gets to the program, there is no system at the moment that flags that need. If something happens, there is no way of knowing that or flagging that. So I think we need some sort of alert system. We need something that can flag it so that we know when we need to go and attend as a support person, and hopefully that will improve the situation and experience for that person.

CHAIR: Can I ask a couple of questions about consultation. Just on the back of that comment, what potential do you see in terms of e-health records assisting deaf people in the situations we have been talking about today?

Ms Jackson: When the records are set up for the clients and it is asked what language they use, maybe we could highlight the fact that they have minimum language—it depends on what language they use. The health records do have fields asking for information about the client and their preferred language, whether they have minimal language skills. If that were there it would help the healthcare professional to identify when a support person is needed and to know the appropriate service to contact. I think it is important to create a field where we can really highlight that. As I said previously, we need some sort of flagging system; so then it is automated. It is something that should be set up within that database. Princess Alexandra Hospital have set that up in their protocol system, but it is not happening here. Up there it is just an automatic thing—it is part of their database and their system—but it is not in New South Wales.

CHAIR: Thank you. In terms of consultation, particularly with regard to the recommendations that arose out of the Commission of Audit, which led to the scoping study commissioned by Senator Cormann, can I ask if you or any members of your organisation have been provided with or have seen a copy of that commissioned scoping study.

Ms Jackson: I have been invited by the Office of Hearing Services to attend their information session in Melbourne. That was two weeks ago. I did get a letter—I did have some information about that, yes. I have access to that information.

CHAIR: Did you attend the session in Melbourne two weeks ago?

Ms Jackson: Yes, I did. That is where I got that access.

CHAIR: Could you provide us with any information from that session.

Ms Jackson: Sorry, could you repeat the question.

CHAIR: Can you provide us with, basically, a short report of what happened at that meeting in Melbourne when you attended.

Ms Jackson: Yes. You would like me to provide that report to you now?

CHAIR: If you can verbally or, if you would prefer to give it to us on notice, in writing.

Ms Jackson: I am happy to tell you now. The information that I received was the same that I believe we would have received in Sydney. It was talking about the scoping study for Australian Hearing and how that service will be coming into a corporate model under the new NDIS world. They will still be providing services for the CSO clients—that area—up to the age of 26 and 65-plus. They said it could be good business for people within that 27-to-65 age group because, as someone was saying previously, that would mean that people like me within that age group will have access to a reputable audiology service. I personally have experienced going to a private audiology service, where I have been ripped off. They have tried to sell me a \$10,000 hearing aid that I did not need. They tried to charge me \$250 for the moulds, and I know it only costs \$60 at the most. So I have been very wary of private audiologists because of the experience that I have had previously myself. As a mother of a deaf child, I am very optimistic about the future. I am trying to be optimistic about his future, because I want to ensure that he has access to a reputable audiology service also.

CHAIR: Just to recap what I thought I heard you say, Australian Hearing is going to be turned into a corporate model. Is that correct?

Ms Jackson: Yes. I think they will be a serious competitor with other audiological services. They cannot continue with only the CSO cohort of clients at the moment; they just will not be financially viable to be able to continue along that model, just to be able to service CSO clients. So they need to be able to increase their income elsewhere to be able to compete within the market with other audiology services for that middle age group.

CHAIR: Was there any information sought from you at that meeting? Did you participate by giving information, or was information only received by you?

Ms Jackson: I did give some information and some feedback. There were concerns about my concerns. Currently my son is receiving services from Australian Hearing, and in that service he is provided with FM system hearing aids for the classroom. The problem that we have at the moment with the FM system that he uses in the classroom, for example, is that it does not work in the school environment. Nobody in the school is qualified or has the understanding or working knowledge of the FM. He is missing out on that good quality access to information because of the FM not working properly and because of people not knowing how to use it properly. We will go back to Australian Hearing to try and get it fixed. So we are backwards and forwards between the school and Australian Hearing. With the NDIS, that is great, the service will still be provided. However, that will not cover, for example, having someone at the school who is educated in the technology to ensure the FM is working properly and effectively for him. That person needs to be trained and needs to be competent and confident in terms of how the FM system works in order to be able to support him in the school environment. So, from what I can see, there are a number of gaps in the system at the moment.

The other concern I have is: if Australian Hearing becomes more of a commercial enterprise, what will be the time period from when a baby is diagnosed until when they actually get their hearing aids? If the audiologist is particularly busy with other clients—paying clients—then there is a big chance that that person will be left by the wayside. So I think it is highly important that a baby who is diagnosed with deafness and needs hearing aids or an implant is dealt with straightaway and completely because they need access to sound. My son was fitted with hearing aids when he was three weeks old. It has been very successful. He has a fantastic quality of access to sound. He loves singing and he loves talking—you can't stop him! My concern is about the quality when Australian Hearing becomes a commercial concern.

CHAIR: You are not on your own in articulating that concern today. You spoke about the service obligations. They have a very long-term impact. If they are delivered, that is a very positive impact. If they are not delivered, they have an equally long-term impact but it could be devastatingly bad. Given the risk involved in changing a system which, we have heard, seems to be working and providing a very high standard of response to Australian people who find themselves facing a new challenge in their family with somebody who is born deaf, what are your views about the need to retain Australian Hearing as it is or to undertake any change or to sell it?

Ms Jackson: If I had my way, we would just leave it as it is. It is not broken.

Senator McLUCAS: That is the quote of the day.

CHAIR: Thank you very much, Ms Jackson; you are very articulate.

Ms Jackson: Thank you.

CHAIR: Thank you for your evidence today.

HUNGERFORD, Dr Jim, Chief Executive Officer, The Shepherd Centre

[14:49]

CHAIR: Welcome. Would you like to provide the committee with an opening statement?

Dr Hungerford: I would. Before I do that, I want to pass my compliments to all of you for maintaining your level of interest and enthusiasm, and also for expressing your deep knowledge through such a long day. I have been incredibly impressed so far, so I wanted to say thank you for that.

CHAIR: It could all go downhill from here now, you realise, Dr Hungerford!

Dr Hungerford: Well, it is quite possible, but definitely so far it has not! I want to just give a bit of background about the Shepherd Centre and why we are here, and this is also reflected in the material that I provided to the committee. The Shepherd Centre is an organisation that is dedicated to making it possible for children who are born deaf or who develop deafness after birth—and I did want to say that, for every child who is born with a hearing loss, there are another two who develop their hearing loss before school; a lot of what we have spoken about is the newborn hearing loss, but we have much poorer systems for that postnatal development—to develop to their potential and through using spoken language. We believe that Auslan is an incredibly important communication method, and you have heard from Kyle and from Leonie how important that is, but, for the majority of children, spoken language makes for the easiest transition into the mainstream and gives them the possibility of having an independent life.

With the programs that we provide—and we have some other charities that we work closely with on the programs they provide—the children who come out of our early intervention programs at about age five, ready to go to school, graduate with the same quality of spoken language as any child who does not have a hearing loss. That gives them the best platform for being able to progress well in school and then achieve all of their economic and social participation outcomes, as you have heard from everyone today.

Those outcomes are not generated by the Shepherd Centre alone, or by one of the other early intervention agencies; it really is a culmination of the entire process. The diagnostics and the newborn hearing screening that we have in Australia are outstanding, and the loss to follow-up to confirmatory diagnosis and the loss to follow-up are outstanding. But diagnostics and aids alone do not make the difference; you really need to have very early diagnosis, as soon as possible; you need early fitting, as soon as possible; and then you need very early entry into a transdisciplinary early intervention service—one providing audiologists, therapists and counsellors—and if you bring all of those things together, you achieve the types of outcomes that we do. As far as we know, the type of outcomes that we achieve in Australia are not beaten by anybody else around the world.

The services we provide are very much based on the outcomes focus. So we are here to help these families, for their children to achieve all their potential in life. We have a very strong evidence and research base for that. We are very much focused on the children achieving their social inclusion outcomes as well as their speech and language outcomes, because one of the things that is very clear to us—and the research backs this up—is that social skills issues often accompany communication difficulties, and there are higher incidences of theory-of-mind difficulties. I do not know if the committee is aware of theory of mind, but it is about the kinds of characteristic social features of children on the autism spectrum. There are higher incidences of those with children who have a hearing loss, due to that effect on their development of communication skills, and we think it is incredibly important—as echoed by many speakers today—for children to not only have their speech. Speech alone is not enough. You really have to have the communication, and then also the ability to use that communication in a socially appropriate manner. But if you bring everything together it produces fantastic outcomes.

We work very closely with a range of stakeholders, including all of the groups that you have heard from today—Deaf Australia, Deafness Forum of Australia et cetera, and of course Parents of Deaf Children and Aussie Deaf Kids—servicing children who are often in metropolitan areas, but we have a lot of children in regional, outer regional and remote areas as well, who are supported by telepractice, via the NBN or otherwise, and those children very happily achieve the same spoken language outcomes as the children who are physically able to attend our centres.

We support children prior to the age of five but also children at school, and we offer an integrated cochlear implant program. In about a third of our kids their degree of deafness is such that they cannot achieve their potential with hearing aids alone, and so they require a cochlear implant in addition, and we integrate that within the service. You have heard a lot today about how it is not just the provision of the device, or it is not just the testing of the hearing loss; it is the same with the provision of the cochlear implant service: if that is able to be

provided in what is called a transdisciplinary manner, integrated in with everything else, then you get much better outcomes for the children.

From my point of view, there is a whole bunch of other things that I could go through, but I want to just finish my opening statement there and then discuss other things as the committee desires.

CHAIR: Thank you. You have given us quite a bit of information to unpack, but I will commence with the question I have asked all of our witnesses today: have you or any member of your organisation been provided with or seen a copy of the scoping study commissioned by Senator Cormann?

Dr Hungerford: I would love to say otherwise, but no.

CHAIR: In terms of your engagement with the process, what engagement have you had with that scoping study? Were you asked to participate?

Dr Hungerford: Our engagement commenced with a phone call approach by PwC to provide our verbal input, as you have heard from a number of other people, into the impacts and possibilities for the privatisation of Australian Hearing and what that may cause for the children and families that we support. I provided that in some verbal sessions, one over the phone and one face to face. Subsequent to that, I have been involved in the more recent Office of Hearing Services meetings. I know that those staff members are here this afternoon and they will be able to provide you some more detail there. I think those sessions were mutually very educational. I would see them much more as a kind of two-way information session than as a consultation session. We learnt a lot about the expectation of the government in terms of the transfer of the CSO responsibilities and the potential—but only potential—privatisation of Australian Hearing.

CHAIR: Could you provide me with your mud map of your understanding of the transfer of the CSO obligations as you understood them from that meeting?

Dr Hungerford: My understanding is that, of the broad range of CSO obligations, which I cluster as children with hearing loss, Aboriginal and Torres Strait Islander and then adults with complex needs, virtually every child with hearing loss should be able to move across to the NDIS and be supported within the NDIS. For the Aboriginal and Torres Strait Islander, they will not be able to move across, because the NDIS is only for permanent disability. The Indigenous children go through a long phase of recurrent otitis media, which eventually causes a disability but prior to doing that is not part of the NDIS. You have to become disabled before you can get assistance. Then the complex adults, if they develop their hearing loss prior to 65, will be able to enter the NDIS. If it is post-65, they will not be able to enter the NDIS. As a result of that, there are two areas that we see as being dropped: the Indigenous children and also the adults who develop hearing loss after 65.

CHAIR: Do you have any concerns about that?

Dr Hungerford: Hugely. The ATSI situation is just a horrible tragedy. We see this reflected in terms of incarceration rates and the relative ratios of hearing loss of Indigenous youth with and without hearing loss. You can see that causative effect there. Also, as you have heard from previous speakers, as you develop hearing loss in older age and can lead on to social isolation, that appears to be strongly correlated with early-onset dementia, and that is obviously tragic for everyone involved. So there is a very strong medicosocial reason for being able to provide strong support and prevent that social isolation that arises from the deafness. So I think it would be very nasty effects.

CHAIR: I assume you raised some of these concerns with OHS.

Dr Hungerford: Yes. The focus of our discussion has been ensuring that the fantastic outcomes that are currently possible for children with hearing loss are not lost. That has been the bulk of my input. The submission that I sent to the committee is a subset of the submission that we sent to the OHS with our concerns and with the recommendations in my paper. They are more detailed but the same recommendations regarding ATSI children and also the aged onset in there.

CHAIR: Why are you so concerned?

Dr Hungerford: About which ones?

CHAIR: About the early onset. When I asked you about your advocacy emphasis with OHS, you went straight to the neonatal dimension. Why are you concerned about that? Why do you feel you need to be such a strong advocate given how many other people are already talking about this and the fact that this is a health agency that is involved?

Dr Hungerford: For two reasons. I am taking this as an assumption, but it is obviously subject to change. If we assume that the CSO responsibilities transit into the NDIS and become contestable, we believe that there is a huge amount at risk with the children who currently benefit from those CSO responsibilities. If Australia operated

as the US does or as many other countries do then, instead of having hundreds and thousands of children who enter school and are able to progress normally at the age-appropriate rates, we will end up with the same sort of situation as is often seen in other developed countries, where children with hearing loss end up being years behind their hearing peers in terms of their academic outcomes. Then you get all the terrible social impacts that we are aware of.

CHAIR: Would you concur with Ms Jackson's closing statement? She said Australian Hearing is working and we should not—

Dr Hungerford: Unfortunately not. The reason for that is that, from my point of view, whilst it is fantastic, I do not think it is perfect. There are a number of aspects that I do believe could be substantially improved. As you have heard from previous speakers, the focus of Australian Hearing is to fit hearing aids. That is their overwhelming thing, and they generate their income from fitting hearing aids, doing upgrades et cetera. But what is required for children to achieve their potential is to receive an integrated service that goes all the way through to early intervention. We would love to have a much closer relationship with Australian Hearing as the primary providers of audiological health to our children, but they are not funded to be part of our service. Now children who have hearing loss have to attend at least two services, and that just doubles the number of things, invites possibilities of mishandling and things like that.

Then there are also the other advantages that could potentially come from competition. The Shepherd Centre was started because of the need for competition. Our founder had two profoundly deaf children and he was not happy with the services that were available to children who were deaf at that stage—this was about 45 years ago. That led to us being founded. Us being a separate service in New South Wales and now in many other locations has caused innovation in other service providers as the other service providers have caused innovation in us, and that has raised the standards for many more children than we have helped directly. I do believe that having the ability to compete will incentivise people to do a better job as long as they are not incentivised simply on a pay-per-service model.

We have heard lots of concerns about the issues of incentives around hearing aides. From my point of view, the trust that we have heard Australian Hearing enjoys is absolutely integral. The commercial pressures do exist within the adult hearing aid business, but Australian Hearing has protected the paediatric business from that. It is entirely voluntary from their point of view that they have protected the paediatric business from that. If that were extended into the paediatric side, it would be tragic. Ninety per cent of these parents do not have any experience with hearing loss and therefore cannot make an informed choice about what their child requires.

CHAIR: If I heard you correctly, you indicated that there is already competition in this market and that you indeed provide competition to Australian Hearing. I do recall Ms Messariti's comments this morning about this being a very thin market and the need for a consolidation of capacity to provide quality of care. Marketisation and opening it up to competition for competition's sake in a thin market would surely be a very unhappy event for all participants, particularly in terms of outcomes for young people.

Dr Hungerford: Absolutely. I am sorry; I misspoke. When I said that we were brought in for competition, it was on the early-intervention service program, not on the audiological services. We do have a large number of paediatric audiologists in our practice, but they are there to provide support—in particular Cochlear implant support—for our children. They are not there to provide the same services that Australian hearing provides. So I was referring to early-intervention services.

CHAIR: Thank you. I may have misheard you, so thank you for the clarification. Senator McAllister.

Senator McALLISTER: Thank you for your testimony. What are your sources of funding? I am sorry not to know that.

Dr Hungerford: No, of course not. We receive 26 per cent of our income from state government grants. The remainder we have to raise ourselves. The vast majority of that is philanthropic support which is mainly from individuals but to some extent also from trusts and foundations and a small amount from companies. Then there is also service income. We invoice against Medicare for the audiological services we provide for the Cochlear implant children and a whole range of other things: Better Start income and those sorts of service related fees.

Senator McALLISTER: Thank you. One of the things this committee has taken a broader interest in is how these kinds of services that you are providing—integrated care models—can be supported in the context of a medical system that is largely structured around fee for service. I am always interested when we see examples of organisations being able to do that.

Dr Hungerford: We have appealed a number of times to be paid on a service model basis—to be paid for outcomes rather than on a fee-for-service basis. Whether it is block funding or other sorts of funding, we always get paid on an activity type thing rather than outcomes. We would much prefer outcomes.

Senator McALLISTER: I go back to the conversation we are having about competition. We have heard other evidence today about the significance of Australian Hearing in skill formation and maintenance in paediatric audiology. The assertion in that evidence was that the market is in fact so small and so thin that a fragmented series of organisations would not be able to maintain the requisite level of skill to consistently provide good-quality services to children. Do you have a response to that?

Dr Hungerford: Two. I do think that the requisite skill is the primary requirement. Any system that gets put in place, whether it is a continuation of the current system or any other system, has to have as the primary outcome the care of the children and their needs. However, in terms of paediatric audiologists in Australia who currently work in the field, about 50 per cent of them are in Australian Hearing and the other 50 per cent are in other providers—principally the not-for-profit providers like us and a range of others. Then, of course, there is a huge interchange of audiologists between Australian Hearing and the private practice side, so you get lots of paediatric audiologists who move about and those sorts of things.

In terms of the requirement to maintain skills, I totally agree. I think that, if there are any options for opening up competition in that area, it would have to ensure that anyone who is providing service is expert at providing that service and maintains their skill levels. The only comment I could make is that the current system maintains approximately 100 or so specialised paediatric audiologists across all the different things. I imagine that in future those same hundred would be maintained. We were just discussing whether or not 50 per cent would be clumped in one organisation and 50 per cent would be spread among 10 or 12 different organisations or if there is some other arrangement around that. But the skill maintenance is obviously imperative.

Senator McALLISTER: Yes, I think it is an open question as to whether smaller organisations—that other 50 per cent that we speculated might be divided up amongst 10 different smaller bodies—really could sustain the professional development of the handful of people that would be working within each of them.

Dr Hungerford: I think it is very difficult. Regional and remote is obviously very challenging. We have seven paediatric audiologists in our service, and all they do is paediatric audiology, so they are the ultimate in that area there. Of the paediatric audiologists within Australian Hearing, some are highly specialised and some are much more spread. That same sort of range would extend around. So I think it is an open question. Lots of people have said, 'How can we just rush into this not knowing what we are about to do?' and I agree totally. From my point of view—and I have said I am pro competition—I am not pro breaking up Australian Hearing or privatising Australian Hearing, because I think it is such a body of expertise that it would be tragic for it to be lost. It is just that I do believe in the benefits of competition as well.

Senator McALLISTER: We have also heard today from a number of different witnesses about the significance of a trustworthy source of information particularly for the parents of children who are receiving a diagnosis. We have heard that Australian Hearing is extremely important currently in the institutions providing that kind of advice. Do you have any observations about other organisations that fulfil that function either now or in some future configuration for service delivery?

Dr Hungerford: There is no-one in the Australian Hearing space at the moment, so here are no direct comparators. If you talk about who else is also similarly trusted, I would argue for the specialised EI services like us or IDBC, who you have heard from today, and a number of other, similar organisations around Australia. Attendance at all of those organisations is entirely voluntary. People only go there when they do have that trust, and there is a big commitment from the family's point of view. We see the effects of this. I will draw an analogy to cochlear implantation services. We run this CI program that is integrated within ours. The average age of implantation for children in our service is seven months if they are diagnosed at birth, and as you heard from Bob Cowan that is seen as being the optimum age. The separate services that are not integrated within an EI service typically have an average age at first implementation of 12 to 18 months or even later. That is because they have not been developing this personal, highly trusted relationship with the family from birth. We normally see families at one or two months of age, and so we are with them all the way along. So you see the consequences of that trust developing or the consequences of not having that trust. If we set up a situation where that trust does not exist, I think we will get tragic consequences.

Senator McLUCAS: Thank you, Dr Hungerford. The way you have set out your submission makes it pretty easy to work out where we could go and where we should go. Can I firstly go to the question about registration. Do you think it is a necessary condition prior to any of the CSO moving into the NDIS or any potential

privatisation? How high up the list of risks as a necessary condition prior to change does registration rank in your mind?

Dr Hungerford: I would put some sort of registration or accreditation system as an absolute condition. There are two prerequisites for a child being able to achieve good outcomes. The first is that their hearing loss is identified. We are very good at that for neonatal but we are equally as bad as most countries for post birth. The second is the good fitting of hearing devices. Australian Hearing does a fantastic job, and without accreditation I think that fantastic job would degenerate to the type of anecdotal reports that you have heard today. We had a leading expert from the United States at a conference in Sydney a week or two back. She was portraying the loss of follow-up from diagnosis to fitting, which can often be 30 per cent as an average and up to 50 per cent or more. But also there is the fitting of the hearing aid; it is a very complex process to make sure that that aid is going to work well with that child. In the United States, where they do not have a dedicated service like Australian Hearing, they did a survey of children and they found that 40 per cent of the children had a hearing aid that is inappropriately fitted—not just not optimally fitted but totally inappropriately fitted. It is because they were going to generalist audiologists and things like that; they were not going to a dedicated service. As a result, I do believe that accreditation, registration or whatever—some sort of maintenance of quality—is absolutely imperative.

Senator McLUCAS: I understand now, from the conversation we had earlier, about the history that has led us to the circumstance. What is happening in other countries? Do other countries have registration? I should have asked that of the audiologists.

Dr Hungerford: I am afraid I would not be able to comment on that.

CHAIR: That might be a question on notice to the audiologists.

Senator McLUCAS: Can I now talk about transition to NDIS and, in particular, about Better Start for children with disability. Your evidence earlier was that you should be paid on outcomes. Better start does not pay you on outcomes; it pays you on events that happen. Do you see any appetite, through NDIS, to move to outcomes based funding?

Dr Hungerford: We have requested that. I think the NDIS has said that they do want to pay for outcomes—and they have got all of the assertions about evidence based and outcomes based et cetera. However, because they see achieving robust measurement of outcomes in many situations as being so difficult they have currently parked that in the too hard basket. In a number of areas, it is quite possible to achieve; but to achieve it in the broad way that the NDIS would be happy to roll out may well be too challenging. Specifically in our area, whether it is a child who is learning language through Auslan or through spoken language, we know what we want to achieve: we want the child to have native language proficiency in whatever language it is and the ability to use that language in a social situation. That is a highly measurable outcome and it then puts them in the best situation for the future.

Senator McLUCAS: I do not know how you would do it either. It is a hard thing to do. I understand the principle but as to whether a child has a vocabulary of a certain number of words by the age of five or can communicate effectively for that age is a very subjective judgement really.

Dr Hungerford: In our area, there is an internationally standardised test. There is a graph in our submission—from memory, it is on the last page—where we are able to show that the language outcomes of children going through our program match the population outcomes—people have a normal range. So when you are talking about language, there should be 15 per cent of children below the normal range, 15 per cent above normal range and 70 per cent in the middle. As you can see from those graphs, that is what we achieve. They are called 'normed'; they are standardised against populations in a number of different countries. Unfortunately, there are no normed assays for many of the non-English languages and so it becomes very difficult. We have many children who speak Arabic, Cantonese et cetera at home but we still have to measure them in English.

Senator McLUCAS: Which is hard. Can I go to the third dot point in your list of potential improvements that could occur with change. Are you suggesting by that statement about 26- to 65-year-olds that Australian Hearing should move into that market? I am unsure what you are trying to tell me there.

Dr Hungerford: The fact that the support ceases at 26 is a huge concern for our families. They receive excellent support from Australian Hearing until their child turns 26. Hopefully at that stage they are in employment and producing for society. However, they then lose all of their support. For instance, if they need to get an upgrade to their cochlear implant processor it is \$10,000. They have to buy all of their batteries and all sorts of other things. That sort of support is provided by the NDIS. Those individuals would be supported under an NDIS model but they are not supported under the current Australian Hearing model. That is causing a lot of hardship. I have had anecdotal reports—I do not know if anybody has looked at it—of somebody who has an

issue and drops out of work for a short period of time and they then do not have the cash to maintain their hearing devices, which means they can never get back into employment again. The NDIS solves the problem.

Senator McLUCAS: So you are saying that the NDIS will fix that?

Dr Hungerford: Yes.

Senator McLUCAS: I have another question on registration. Would you have specific registration for paediatric audiologists?

Dr Hungerford: Yes. Registration of audiologists in general is advantageous—from our point of view, looking at our concerns, specific expertise in paediatric. And also, in terms of who you would fund, it is about not only the expertise but also the facilities; you need physically different facilities for young children as compared to adults.

CHAIR: Can I ask one quick question about the pathways that you have identified here for children diagnosed between birth and school and when school aged. You alluded a couple of times to our capacity to fall to international standards at that stage rather than raise the standards and be right at the forefront in the neonatal context. You make a number of suggestions about the way things might be improved here. Have you been giving those suggestions at any point of time in the consultations that you have been part of recently?

Dr Hungerford: Not in these current consultations. At previous times we have made representations—both individually from the Shepherd Centre and in First Voice. First Voice is six organisations who have joined together, and we represent several thousand children with hearing loss and tens of thousands of people in total. We have made representations to government. That was part of the representations around Better Start and things. So we have made those representations but there has not been any traction. I think one thing has been the crying need for some newborn hearing screening. With the successful implementation of that, there has been less policy priority. It has been like, 'Fantastic, we've done a really good thing,' but in actual fact we did a great thing for the newborns and we have dropped the ball a bit on the toddlers.

CHAIR: Earlier I asked you about your consultation and you indicated that PricewaterhouseCoopers approached you. Do you have any understanding that you might be able to share with us about why they approached you but did not approach the parents of deaf children, for example? There seems to be no rhyme or reason at this point why that is the case.

Dr Hungerford: I did not inquire why they did approach us. I did make representations saying that they needed to also approach other people, including PoD and some other stakeholders in the area. I had presumed at the time—but I never asked—that we were approached because our name was known due to our previous activity with the government.

CHAIR: Are you planning to participate in any further consultations that have been—

Dr Hungerford: Yes, as much as we can.

CHAIR: Do you have a timetable for those consultations proceeding?

Dr Hungerford: No—and the Office of Hearing Services may speak about this in a little bit. We are aware of further public consultation going on, hopefully over the next month or two. We—that is, the Shepherd Centre and also the other members of First Voice—want to be as vocal as we possibly can to support these children.

CHAIR: Do you have any sense of the timing of the end of the consultation period?

Dr Hungerford: No. The timing is a major issue in many aspects. It is not only about the timing of the consultations. We do not know the timing of the introduction of the NDIS, the next rollout. We do not know the timing, if it does occur, of the transfer of the CSO responsibilities from Australian Hearing to the NDIS, nor of the sale of Australian Hearing. So because of everybody's lack of awareness, it makes it very difficult for any planning or understanding.

CHAIR: The short term sale of Australian Hearing Services, Snowy Hydro, the Department of Housing and the ASC were priorities for the government, and the Department of Finance is overseeing those. Do you have a sense that this is a short-term process?

Dr Hungerford: I hope not. I believe that, if it is taken in a rushed way and poor decisions are taken, there would be a huge loss. So I hope that it is not a short-term priority. I think if they do privatise Australian Hearing then they need to take a lot of time to think about it. I have presumed because of the comments about 'not at this stage' that they put it off for a period of time, but I do not know if that period of time is months or years.

Senator McLUCAS: Dr Hungerford, you have heard me ask this question of other people. We are pretty well placed here in Australia. We have got Australian Hearing and the National Acoustics Laboratory. Cochlear is over

the road. We have got the Shepherd Centre and IDBC. We have got all this fantastic EI services. What would we lose if we went down the road of privatising Australian Hearing in that overall architecture of hearing services research dynamism that we have in Australia?

Dr Hungerford: My personal opinion—I will call it that because I am not saying I am representing any other organisations—is that all of those fantastic outcomes have been driven by the presence of Australian Hearing. It has provided a centre of gravity—it is like an ecosystem—around which lots of other things can thrive. You can put up the argument about whether you still need that centre of gravity given where we are now and the changes that are occurring, particularly with the NDIS, but I really do ascribe our success associated with that now to Australian Hearing. And that is enabling all of our are advantages to come through. Other people have done the components, other people have got universal newborn hearing screening or nice EI services or whatever else, but nowhere else is producing the consistency of fantastic outcomes that we are.

CHAIR: Thank you.

Proceedings suspended from 15:24 to 15:41

DUNCAN, Ms Sara, National President, Better Hearing Australia

CHAIR: Thank you very much for coming to give us your evidence. Would you like to commence with an opening statement?

Ms Duncan: Yes, thank you. Better Hearing Australia is Australia's largest consumer-led independent hearing management service. We help people with a hearing loss navigate through the maze of hearing services and technology that we have heard about today. BHA is proudly independent, focused on consumers and has been serving the community for more than 80 years. We provide positive advocacy and a national voice to end discrimination and increase opportunity for Australians with a hearing loss. We help to build a better life for Australians with a hearing loss by finding the right solution without commercial influence. Our professional staff and volunteers focus on the needs of the person with a hearing loss, not just the latest technology. Last year Better Hearing Australia released a policy paper, *A fairer hearing*, with the University Canberra to raise awareness of the policy challenges in providing hearing services. I have tabled that.

CHAIR: You have provided a copy and Senator McAllister has moved that we accept that for tabling.

Ms Duncan: Improving hearing health will improve Australia's health outcomes and reduce cost to the Australian health system.

Hearing loss is a deeply personal issue. No two experiences are the same, with impacts being personally felt by individuals, their families and their local communities. However, what is common among those with a hearing loss, as has been mentioned here today, are feelings of social isolation, frustration at significant service gaps and poor health outcomes—which lead to great cost for our health system.

For me, one of the most enduring images of people I know with a hearing loss is watching them being excluded in both professional and social situations. It is watching my mum unable to join in the conversation at family gatherings and elsewhere. It does not matter how often she reminds everyone, 'I can't hear', it never seems to stick. I often feel frustrated when I see her lack of interest, her sternness and what some have called rudeness. What I have come to learn, through my work and through getting to know her better, is that it is simply her sheer frustration and not being able to engage fully in life and what is going on around her.

The biggest issue when we look at hearing services is the restrictive nature of Australia's hearing programs. This means that many Australians are left with limited options for accessing help and simply struggle along with their hearing loss. This affects many people in their 30s, 40s and 50s, representing some of our community's most marginalised and disadvantaged groups. This is single- and low-income families. This is the underemployed or the unemployed. This is people who are struggling along on casual employment and the like. All Australians should be given access to a hearing intervention that is appropriate to their needs and available at a cost they can afford.

How can we fix this? Lots of people have spoken about this today, so this might seem a bit repetitive, but it is the core argument in our *A fairer hearing* document: we need investment in programs that are outcome driven, that demonstrate effectiveness and that target specific population groups. These programs must support prevention, early intervention and individual self-management. Hearing services should be reviewed to ensure that they are consistent with the National Disability Agreement and health agreements. People with a hearing loss should be able to access the National Disability Insurance Scheme. Better Hearing Australia's experience with the level of engagement from the NDIS has been poor to date. We have been engaging in the Newcastle area and in the Barwon area since those trial sites commenced. We have struggled as an organisation to get on the agenda to be able to meet with people from the NDIA. I have had feedback from one of my colleagues in Newcastle that she is ready to stop engaging altogether, because she turns up at meetings wanting to participate and is told—she has a hearing loss—'Sit at the front of the room; you'll be able to hear.' There is no provision of a hearing loop or of any assistance. And this is the National Disability Insurance Agency. Shouldn't someone with a hearing loss be facilitated to participate in how that is evolving? That does not occur.

We have also heard stories about people trying to get into the system who are having trouble. We heard this morning from Australian Hearing that people are being underrepresented in the numbers that are going across to the NDIS, and the assumption was made that maybe they are being served by Australian Hearing already. Our assumption actually is that people are going to the NDIS and are being rejected. They are not meeting the assessment criteria because it is potentially being set too high or NDIS is saying, 'Actually, hearing is not a disability that fits within our scope'—which is actually incorrect in terms of what the legislation says. So we are having trouble getting people engaged at that level as well, which we find concerning.

Publicly funded services should be effective, efficient and regularly evaluated and focused on achieving choice, independence, economic participation and social inclusion. They should include adequate support for families and

carers, because communication is not a one-way thing; it is a two-way thing. As much as someone with a hearing impairment needs to be able to communicate with other people, people around them need to understand how to communicate with them, and that is one of the things that is most lacking at the moment. Services should move beyond a narrow focus on technology to include health promotion and early intervention. Government and key consumer groups should develop and implement community education campaigns so that we can reduce the stigma and increase social and employment participation for people with a hearing loss. The Office of Hearing Services programs should be broadened so that they are not so device focused. Community organisations should be funded to cover the employment of training staff such as social and welfare workers, psychologists and rehabilitation counsellors so that they know how to work with people who have a hearing loss. Research should also focus on the social impacts of hearing loss and the development of solutions to address key issues, including better solutions for Indigenous Australians. While we are focusing in that area, we are still not addressing that issue enough.

One other area I want to talk about—and I do not think it has been covered here today at all—is the direct cost of hearing loss to the health system in the acute system. Increased costs to the health system are not just at the individual level; systemic failures within the health system that could easily be addressed with better understanding of how hearing loss impacts people are very common. One example is the needs of patients entering into the acute system who have a hearing loss.

Take the case of Joyce, a family member of one of our staff. She is in her 80s and came into an emergency department. She was having difficulty communicating and medical staff were concerned that she had dementia. She was admitted to a geriatric evaluation unit and a management unit for observation. These are specific units that are available to look at people to determine whether they need to go into aged care. Her family advised staff on a number of occasions that Joyce had a hearing loss and they were wondering where her hearing aids were—were they left at home, were they lost in the ambulance or what happened? No-one could find them. Eventually the hearing aids were found and fitted, and Joyce could hear. While she was confused, when she was asked questions again she was able to answer them effectively. Her medical condition could then be diagnosed and she could be sent home. This caused at least three days in hospital that Joyce did not need, simply because she could not communicate. That cost the health system at least \$6,000. If only that was a rare example, but it is not. Things like this happen all the time. Three out of every 10 hospital patients will have a hearing loss, based on the demographics of who has a hearing loss and who attends hospital. Not being able to hear in hospital means not being able to communicate your symptoms as well as not being able to adequately receive and understand information about your diagnosis and treatment, leading to poorer health outcome and higher costs. I have heard examples anecdotally about people not properly giving consent to treatment because they could not effectively hear what they were being told.

Hearing related issues should be promoted as a priority through the Australian Commission on Safety and Quality in Health Care. The Australian health workforce should be able to effectively communicate with people who have a hearing loss, and all healthcare facilities should have alternative hearing devices available for those who do not have theirs with them. These changes would make a real difference by focusing services where they are needed, making service providers accountable and improving access by people with a hearing loss to the NDIS and other services. Importantly, these changes would reduce discrimination and broaden the focus of services beyond the provision of the latest technology to the best overall solution for people with a hearing loss. It would help prevent hearing loss from increasing. It would help prevent people with a hearing loss from developing the comorbidities that we know they develop. And it would help develop the protective factors those people might need to prevent them developing those comorbidities. Change cannot come fast enough. Maybe we could introduce some changes over the coming years. That would be really good.

My undergraduate degree is in biomedical engineering. I remember my awe and excitement when I learned about cochlear implants—how they worked, how they changed lives and that they were invented in Australia. I thought it was amazing. Technology is truly a wonderful thing. However, the complexity of hearing loss requires a broader approach. We cannot keep simply focusing in this area. Better Hearing Australia believes that with some simple policy changes like those I have outlined a real difference in improving the social and economic participation of Australians with hearing loss can be made while at the same time reducing the cost of hearing loss to the Australian health system. Thank you.

CHAIR: Thank you very much. You have given us a lot of things to ask questions about. But my first question is: have you or any member of your organisation been provided with or seen a copy of the scoping study commissioned by Senator Cormann?

Ms Duncan: No.

CHAIR: Would you like to?

Ms Duncan: Potentially yes.

CHAIR: Were you approached at any point in time to participate in that scoping study by PricewaterhouseCoopers?

Ms Duncan: Yes. Our organisation was. I did not participate; two of my colleagues did.

CHAIR: Perhaps you could provide us with the documentation around how you were approached—whether it was by letter, a telephone call, personal association—

Ms Duncan: I believe it was by a telephone call, but I could not be sure. And then a time was arranged by email.

CHAIR: There were probably the same sorts of processes we heard about before, but perhaps you could just take it on notice to provide us with a bit of information about how that happened.

Ms Duncan: Yes. We have been talking to government quite significantly about some of our policy proposals. We have been meeting with ministers and the Office of Hearing Services, and we have published our paper *A fairer hearing*. It was our understanding that that is how our name may have come up in the discussions. Also, when the terms of reference for the scoping study were released I directly emailed Sharon Ong, the departmental person within Finance who was responsible for the scoping study, and asked how we could participate. Although she gave the response that there was no opportunity at that moment, we were then contacted by PwC.

CHAIR: Are you participating currently in any public consultations?

Ms Duncan: Yes. The Office of Hearing Services, the Department of Finance and the Department of Social Services have recently had some consultations regarding the transition to NDIS and the Community Service Obligations services and the scoping study. I attended a session on 19 June in Sydney, and one of my colleagues attended a session on 22 June in Melbourne.

CHAIR: What is your understanding of the scoping study from what you heard at that meeting?

Ms Duncan: I heard that the scoping study has been undertaken and that the government has not made a decision on what they are going to do with regard to the sale of Australian Hearing as yet. However, when undertaking the scoping study they became concerned that the sector was not aware of decisions that had been made by government already regarding the contestability of the Community Service Obligations funding from 2019. They believed that further consultation with the sector was required to understand the impact of that and to understand what views existed around that. In the consultation on 19 June the Department of Finance talked about some of the legislative frameworks that sit around Australian Hearing and how that affects their place within the market.

CHAIR: What was your understanding of that information about the legislative frameworks?

Ms Duncan: I think the issue was that while Australian Hearing competes in some parts of the market—for voucher clients, be they people over 65 or people on a DSP or whatever—that is a contestable part of the market and they are able to compete with other providers there. At the moment Australian Hearing is precluded from competing with the private side of the market for over-65s—self-funded retirees—and they are not able to compete in the market for people between the ages of 26 and 65.

Senator McLUCAS: On that cohort of the population—the 26-to-65 group—is it the view of Better Hearing Australia that Hearing Australia should be able to provide services on a fee-for-service basis? What is your view? What is the best way to serve that group?

Ms Duncan: Probably the best way to illustrate that is with a case study. Last year we helped a client called Lucas. He came to our Victoria branch, which runs a hearing aid bank for people who cannot afford hearing aids. Lucas had been a client of Australian Hearing until he turned 26. His current hearing aid was one he had got through Australian Hearing. It had some water damage and had stopped working. He had gone back to Australian Hearing to seek help and they said, 'We're unable to help you under warranty', and he was left feeling quite distraught, not knowing what to do. He is a young carpenter. Because his hearing aid was not working he had just stopped working, so he lost his job. He did not have the money to pay to fix his hearing aid or to purchase another hearing aid, and he had never had a relationship with another audiological clinic, because he had been a client of Australian Hearing until he turned 26, so that was his lifelong relationship with a provider. We were not able to help him, because he had an in-ear aid, and we do only behind-the-ear aids. He was quite concerned about keeping that aid, because he did not want people to know he had a hearing loss, because of the stigma associated with it. We worked with the Office of Hearing Services to seek an outcome for him. At the time, he said to us: 'I want to be able to pay for my own hearing aid; I want to be able to do this. Can someone, through the

government, give me a loan? I will pay for half of it; I'll do something, but I need some help.' The issue there for me is that I would like to see Australian Hearing, or whoever the provider is, developing up lifelong relationships. Sometimes when you have a lifelong disability you want to be able to keep going back to the same place and have that certainty.

The other thing that we see within the hearing aid bank is people aged between 26 and their early 30s coming into the bank saying, 'I need help with a hearing aid.' They cannot afford the new aid either because they have been used to having Australian Hearing pay for it or their aids have broken at some point and they have stopped using them; however, because they need to use them for work or study purposes, they need to get an aid, so they come to us as the first point of call to get them going again until they can afford to buy an aid or something like that. Aren't there better ways of doing that? Can't we have some insurance, can't we have something else? And while the NDIS will fix that, if Australian Hearing cannot work with those clients, then that is not going to fix all of it because you have this disconnect. Personally, I believe Australian Hearing should be able to work with all clients across the lifespan. I think that would improve services.

Senator McLUCAS: Is it your view that Lucas would be assisted by the NDIS, if it were in place in his location?

Ms Duncan: It is my belief that he should be able to be assisted by the NDIS. There are issues in the implementation of NDIS because we have not really transformed our thinking. The NDIS is an insurance scheme, but we are still in our own old service model and thinking about who have our disability clients been up until now, instead of thinking who should our disability clients be. The bar for entry to the NDIS should be low, but then, once you get into the NDIS you get only what you need. So if you just need help to fix your hearing aid, that is your plan and that is what you get. If you fix the hearing aid or if you give someone a hearing aid, then they are off back to work and they may never need anything again from the NDIS. That is a good outcome for the system as a whole if we are thinking about ensuring that we do not have escalating costs for people. At the moment some people are thinking, 'That's not really a bad disability; surely he can do something?' But if Lucas does not get help, does not get his aid, he cannot go back to work. He is then on Newstart, and what happens when he stays on Newstart? Does he get depressed, does something else happen—does he eventually go on to the DSP? He then costs us \$20,000 a year, so why didn't we just spend \$1,000 to fix his hearing aid?

Senator McLUCAS: We would prefer him to be paying taxes.

Ms Duncan: Exactly!

Senator McLUCAS: That would be a good thing.

CHAIR: I am sure his mother would prefer him to be working too—mothers are like that!

Ms Duncan: Having seen the interactions that happened between our worker and Lucas via email, Lucas wants to be working. As an individual, Lucas wants to be able to pay for his hearing aid; he just could not at this point in time.

Senator McLUCAS: Ms Duncan, we might send the *Hansard* of this discussion to the NDIA and ask for their commentary and to go back to you directly, as well as to us. My judgement—I am just a politician—is that he is a tier 2 person and we have to work out how we help him. We will send it off to the NDIA.

Senator McALLISTER: I had a chance to have a quick look at your document, and you reflect the concerns of others we have heard from today that the range of responses that are currently provided through government services to deafness and hearing impairment are not sufficiently broad. You and your colleagues spent some time in your submission looking at what I think you describe as a psychosocial approach to support. Do you want to share with us some practical things about what that would mean in the Australian context?

Ms Duncan: Yes. Currently within the Australian context most people go along to an audiologist when they have a hearing loss. They have a hearing test and most of the time they have a hearing aid straight away. As we have heard today, lots of people are not ready for a hearing aid and would benefit from some form of rehabilitation, whether that would be on an individual basis or in a group basis. There is evidence from overseas that indicates that some form of group intervention for people over a period of time which also includes their significant other—be that their partner or a close friend—can help them deal with some of the grief and loss issues associated with losing their hearing and some of the issues around the communication skills that they require when they lose your hearing. It also has the potential for measurement of some of their current health outcomes. That would look at whether that person has risk factors for diabetes, whether they are at risk around mental illness and whether they are at risk around cardiovascular disease. Then, through that process, we would see when they are ready to do something about their hearing. At that point, they would be sent off for a hearing aid and, if they need help in their workplace, sending them off for referral for some help in their workplace or

help to get employment if they need that. So it is looking at an individualised outcome and then working through those issues and continuing to monitor them through the group situation.

Also as part of that intervention, if someone has a risk factor for diabetes, they are referred off to an early intervention program. For instance, in Victoria there is the Life program, which is an early intervention program for diabetes. So it would be very simple for that person to be referred off to that. It is not necessarily about creating new programs; it is about looking at the individuals and saying, 'At this point, where else should we be sending you in the health system rather than just leaving someone isolated?' By that, we are potentially going to prevent that escalation in that person's health issues.

We have a model that we have worked on and we have a proposal that we have put to government that is around a trial program that looks at this. One of the things we are quite frustrated about at this point is that there is no investment in looking at alternative models, whether it be our model or someone else's model. In the lead-up to the implementation of the NDIS and given that everyone is saying, 'There's something not quite right,' there needs to be some investment to determine what models work and, if we do A, B and C, will that change health outcomes for individuals or will it not. So we have looked at the programming detail and what that might cost. We are looking at potentially \$1,600 per person to go through a change program like that.

CHAIR: Thank you for your evidence this afternoon. The committee may have some questions to follow-up with regard to the considerable amount of information you have given us. So we will be in touch with you if we require any further information on notice. Thank you, Ms Duncan.

DEININGER, Ms Rosemary, General Manager, Whole of Government Coordination Division, Department of Human Services

DUFFY, Ms Tracey, National Manager, Office of Hearing Services, Department of Health

HUTSON, Mr Jonathan, Acting Deputy Secretary, Enabling Services, Department of Human Services

ONG, Ms Sharon, Assistant Secretary, Commercial and Claims Division, Department of Finance

RENWICK, Mr Robin, Acting First Assistant Secretary, Commercial Claims Division, Department of Finance

RULE, Ms Catherine, First Assistant Secretary, Medical Benefits Division, Department of Health

[16:10]

CHAIR: I remind committee members and officers that the Senate has resolved that an officer of a department of the Commonwealth or of a state shall not be asked to give opinions on matters of policy and should be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted. I particularly draw the attention of officers to an order of the Senate of 13 May 2009, specifying the process by which a claim of public interest immunity should be raised. Copies are available from the secretariat. As no-one wishes to make an opening statement, we will go straight to questions.

Senator McLUCAS: I dare say you have some knowledge of the various issues people have raised in their submissions and during the day. I would like to begin with the chronology of the scoping study and what the study was intended to do. A number of witnesses have talked about a change in the study's focus. It would be helpful if you could talk us through that, and perhaps we could start with you, Mr Renwick.

Mr Renwick: I should have said that I look after a number of scoping studies. I have responsibility for the hearing services one and a number of others.

CHAIR: Mr Renwick, can I ask you which ones you do look after, because there are short-, medium- and long-term ones?

Mr Renwick: I had the ASIC Registry, Australian Hearing, Defence Housing, the Mint, the six buildings in the Parliamentary Triangle and I currently have the ARTC and ICON scoping studies. I think that is it.

CHAIR: And with regard to the Australian Hearing study?

Mr Renwick: With regard to the Australian Hearing scoping study, the decision was taken in the 2014-15 budget to undertake a number of scoping studies including the scoping study into Australian Hearing. Once that decision was taken and announced, the Department of Finance was requested to undertake that scoping study. It would have been in July that we first appointed advisers. We undertake that process because these studies are independent reviews of business activities and so we approach independent advisers. In this case it was PricewaterhouseCoopers and Herbert Smith Freehills were the legal advisers on that scoping study. They would have been appointed around about August. The scoping study is an evidence based review: it looks at the industry; it looks at the business concerned; it looks at the market; it looks at all the policy issues around the entity being considered; and it looks at the possible options for taking it forward. As part of that process it talks to stakeholders, and that process would have completed around the end of 2014 with a report going to government at that point.

The government would then normally consider the scoping studies in the context of the following budget, and so they were considered in the 2015-16 budget, but the ministers took a decision to defer further consideration, pending further consultation with the hearing impaired community. I might say that there are probably two reasons for that, which had to do with two findings that came out of the scoping study. One was a lack of understanding by the people that we spoke to around the implementation of the NDIS. In fact, most of the people we spoke to did not understand that hearing services would come under the NDIS. There were a number of issues that still needed to be resolved under the NDIS, and therefore there was a need to go out and let people know what was happening and what the implications for hearing services were.

The second key finding in that regard related to the implications of the NDIS on Australian Hearing itself, and that goes to the contestability of community service obligations. Currently, Australian Hearing can compete in the voucher market and has the community service obligations. It is prevented under legislation, and because of

broader constitutional issues, from competing more broadly in the open market. In a nutshell, that is the time line and possibly the reason people felt there was a change in the focus.

If I could just go back to the other scoping studies, most people believe that a scoping study is about a sale. It is the government reviewing its ownership of an entity. If I look at the ASIC registry, the government has agreed to market-test and see whether that is something that the private sector could undertake. It looked at six buildings in the Parliamentary Triangle and decided it would sell four of those and retain two, for various reasons. The Mint was found to be operating efficiently within government ownership, and it would make no changes. With Defence Housing Australia it was found that there were some transparency issues and some reporting issues, and so it decided to retain that within government ownership but to undertake some further reviews and some reforms to ensure that is sustainable going forward—there were some issues around sustainability. With Hearing Services, it felt that it needed to undertake further consultation before it even considered the scoping study report.

Senator McLUCAS: Thank you, Mr Renwick. I think we are looking at the Commission of Audit's description of what happens when a government decides to think about selling something. Their description of what happens is quite prescriptive: you do a scoping study and in stage 2—or phase 2 as they say—you proceed with marketing. That is a little bit different, but that is probably the context that our committee is having this conversation in. I think it is good to have it on the record that we sort of agree that that is the chronology that has happened over the last 18 months. Are there any other officers who wanted to make any comment on that chronology? No? Thank you. Then we might go through it.

Mr Renwick, when PricewaterhouseCoopers were appointed you said that they then went to consult with a number of stakeholders. Where did they get that list of stakeholders from?

Mr Renwick: There are a couple of stakeholder groups. The entity itself is a key stakeholder. Very early on in the process we organise a meeting and have a planning day with the entity. They undertake a review of their business. The CFO will come and talk about their financials. The board will give us views on where the entity is heading. This is to get a high-level picture and to start the process of getting further information. Coming out of that, PricewaterhouseCoopers would say: 'Can we have some further information on this? Can we have some documents to support that?'

CHAIR: When you are referring to the entity, are you talking about the general process or are you specifically referring to Australian Hearing?

Mr Renwick: Australian Hearing.

CHAIR: Thank you.

Mr Renwick: The next set of stakeholders are really the government agencies that have policy responsibility. In this case, the Department of Human Services had the shareholder responsibility, the Department of Health had the policy responsibility for Hearing Services, and the Department of Social Services had the broader NDIS responsibilities. From these discussions we then identified who were the key stakeholders within the hearing impaired community. We looked at industry participants and the not-for-profit groups. We looked at Parents of Deaf Children and other Deafness Forum groups. Because we do not have the expertise in understanding who all these parties are, we consulted and got a list of the key peak bodies to talk to.

Senator McLUCAS: Given the time constraints, I wonder if could you provide the committee with that list, and also identify which departments proffered these various names. I am sure there would be overlaps between them, but perhaps that is something you can reasonably easily do. There has been discussion today about that—that is all—so we just need to clarify that.

Mr Renwick: It was probably more iterative that we got together. We had a fairly broad list and people just added to that list. Rather than bits of paper flying around, there was more a discussion as to who would be the appropriate parties to approach.

Senator McLUCAS: So a number of people came together in a room and someone picked up a pencil and started writing down names of people? Tell me how it happened, please.

Mr Renwick: Essentially, we came together in a room and we started to put together a list based on people's knowledge of the industry and knowledge of the parties involved. We developed a list from there, which I think was then circulated. We may have added a few more at that point. Most people had had time to consider it.

Senator McLUCAS: DSS was in the room?

Ms Ong: The Department of Human Services, DHS. It was a meeting between our colleagues here.

Senator McLUCAS: The three departments that were here today?

Ms Ong: Yes.

CHAIR: And predominantly the personnel who were here today?

Ms Ong: No. It would be Ms Tracey Duffy and Mr Paul Hupalo from the Department of Human Services.

Senator McLUCAS: I do not think it is an accusation, but there has been an observation that, potentially, there are a number of disability organisations that should have been included in that list from the outset that have been overlooked, and it might be an observation that, potentially, if DSS had been in the room, that mistake may not have been made. Once we get that list, that will be helpful. The consultation that ensued was led by PricewaterhouseCoopers?

Mr Renwick: That is correct.

Senator McLUCAS: The report came to government in November last year, I think you said.

Mr Renwick: I think the final report was in December.

Senator McLUCAS: Regarding other scoping study reports that have gone to government that were underway during that period, have any of those been published?

Mr Renwick: No, Senator.

Senator McLUCAS: Is it usual that a scoping study would never be published?

Mr Renwick: It has been the practice of this and previous governments to undertake scoping studies—I have been involved guess since the Hawke-Keating government. So, with the Hawke-Keating and Howard governments, the Rudd-Gillard government and the current government, it has always been the policy not to release the scoping study reports.

Senator McLUCAS: Is a summary or an executive summary or precis of those scoping studies published?

Mr Renwick: Generally not. I am just trying to think back. We did one for the Moorebank intermodal terminal, but that was more of a detailed business case than a scoping study into ownership. I believe we issued a summary of that one.

Senator McLUCAS: Something was published that came out of that?

Mr Renwick: That is the only one I can recall.

Senator McLUCAS: I go to the FOI request from Parents of Deaf Children. Talk us through what the process was, please.

Mr Renwick: I will have to do talk in generalities because there are privacy issues around FOI requests. I know that Parents of Deaf Children have spoken to you and said they put in an FOI request, but I would need their permission to talk in any sort of detail. The normal process is that we receive an FOI request and we are then asked to cost that request. There is a standard spreadsheet within Finance and I believe there is probably a standard spreadsheet across agencies whereby you identify the number of files that you think would be involved, the number of documents, the number of pages and the amount of time that it would take to review those documents, and that comes to a time and a cost to undertake that process. That is advised to the party submitting the request. They are given a certain period of time—I think it is 30 days—to respond and either pay a deposit or seek a review of that. They can seek a review on the grounds of financial hardship or public interest. That is reviewed against a set of criteria and then a view is taken and a decision, again, is advised to the applicant. An FOI request has to be considered on its merits, on the basis of the documents concerned. In some cases, where it is unlikely that they would receive that document, we just advise them that there may be some cabinet-in-confidence or commercial-in-confidence reasons because we do not want them to go to unnecessary trouble. At the end of the day, it is their call if they wish to proceed with that.

Senator McLUCAS: Are you aware if the parents group requested a dispensation from having to pay the charge?

Mr Renwick: Again, I am bound by privacy in terms of an application from them. I would need their agreement to two answer.

Senator McLUCAS: It was canvassed earlier today. When you read the *Hansard*, you may want to come back to us—

Mr Renwick: I understand it was canvassed earlier but I just have obligations under the FOI Act, and I would need to approach them.

CHAIR: I think there are representatives in the room at the moment. I am sure they will provide in writing a request for you to provide that information to us at some point in time—and, hopefully, fairly soon.

Mr Renwick: That is fine.

Senator McLUCAS: You talked about cabinet-in-confidence and commercial-in-confidence considerations. Both of those terms have been used in the hearing today. Is the scoping study a cabinet document?

Mr Renwick: The scoping study will be considered by cabinet, so it will form a—

Senator McLUCAS: So, currently, it is not a cabinet document?

Mr Renwick: It will form a cabinet document. It has not been considered by government at this stage.

Senator McLUCAS: So, to this point in time, cabinet-in-confidence is not a consideration but commercial-in-confidence possibly will be a consideration?

Mr Renwick: There is information which could harm the commercial interest of the Commonwealth in terms of the commercial-in-confidence. It is yet to be considered by government. At this stage, it would be a report to government. It would come under cabinet-in-confidence once it is considered by government.

Senator McLUCAS: But, at this point, it is not cabinet-in-confidence?

Mr Renwick: Not as such.

Senator McLUCAS: I agree that there will be some very important commercial-in-confidence material that belongs to Australian Hearing in the scoping study and that we do not want in the public arena. That is reasonable. From what we have heard from the community today, there is a lot of other material that should be in some form in the public arena given the change of focus of this scoping study that has happened at this point in time. You said that the ministers decided to defer dealing with the scoping study in the normal trajectory as it would have gone through the government. Which ministers were they?

Mr Renwick: Minister Cormann, in consultation with—was it with the health minister?

Ms Ong: It would be Minister Cormann, and he would have discussed it with his colleagues.

CHAIR: Which colleagues?

Ms Ong: It would have been, potentially, with Minister Payne. I am not sure who else he would have consulted with.

Mr Renwick: We might take that on notice, if we could come back to you on that.

Senator McLUCAS: It is a fundamental point. I think the committee would really like to know the nature of the consultation—whether it was in a telephone call or in a letter, and which ministers were consulted.

Mr Renwick: We can make the request but we are not involved in that part of the process. We are advised that Minister Cormann spoke to his colleagues and that they decided upon it. We would need to put that to the minister.

Senator McLUCAS: I appreciate that. I am being very clear in that we do want to understand that. But my understanding is that Minister Cormann is the decision maker alone on this matter—in the finality. Is that correct?

Mr Renwick: No. The decision would be taken by the government—so through cabinet. The Minister for Finance would make recommendations.

Senator McLUCAS: Yes. That is what I meant to say. So Minister Cormann will make the submission to cabinet in the end?

Mr Renwick: That is correct.

Senator McLUCAS: But it is only one minister who will have to do that; it is not like the shareholding ministers have to collaborate.

Mr Renwick: No, I do not believe so.

CHAIR: Could I go to Ms Duffy and Ms Rule, following on from that line of questioning: are you aware if the Minister for Health was engaged in those discussions?

Ms Rule: No, I am not aware. We can take that on notice.

Ms Duffy: We are not aware of direct conversations that may or may not have happened, no.

CHAIR: Thank you. Going to the PricewaterhouseCoopers list of recommended stakeholders: as you said, it is an iterative process so there are a number from the agencies that are engaged here. Did any other agencies participate in the process of creating that list of stakeholders?

Ms Rule: No.

Ms Duffy: No.

CHAIR: So it is exclusively health, finance and human services?

Mr Renwick: We will confirm that for you.

CHAIR: Thank you. We also heard today from a number of witnesses that PricewaterhouseCoopers invited particular people to participate 'by association'. Do you understand what that means? Were there additional people who were sought out by PricewaterhouseCoopers who were not on your original list?

Mr Renwick: Not that I believe, no.

Ms Ong: Not to our understanding. It would be to approach those organisations.

CHAIR: So they would not have approached any organisation that you had not nominated?

Mr Renwick: They would have advised us in terms of industry participants who may be interested but not in terms of the various forums and hearing impaired community of people. The process would have been that we would identify the organisation, we would have spoken to Health and Human Services as to who the appropriate contacts would be and then Pricewaterhouse would have made contact according to those contact details.

CHAIR: In terms of appropriate people, what discernment was there around 'appropriate' people?

Mr Renwick: Sorry—I did not mean anything by 'appropriate' people. It was just that they identified the contacts that they would have had within those organisations. They would have identified the CEO or the person we should contact to make that first contact with them and to organise a meeting to talk about the scoping study.

CHAIR: Today, in terms of the witnesses that we have been able to locate through our committee, and this is not the extensive list—Parents of Deaf Children, Deaf Australia, Aussie Deaf Kids—none of them are on your stakeholder list.

Ms Ong: Parents of Deaf Children and Aussie Deaf Kids were on our stakeholder list.

CHAIR: Okay. Could you then begin to explain to me why they have not been participating in that process?

Ms Ong: I can take that on notice and check for you, but they were definitely contacted and a meeting was organised with them. I can double check if you want us to, but they were definitely on the list to be consulted.

CHAIR: It would make it a lot easier for us if we had the extensive list of stakeholders that you believe were asked to participate by PricewaterhouseCoopers. Based on the evidence we have heard today, there is quite a gap between what you believe has happened and what the evidence is revealing today.

Ms Ong: Sure.

Senator McALLISTER: Mr Renwick, could I ask you about the process of the scoping studies generally. You talked about it as a process of market testing. Can you talk us through what you are testing for?

Mr Renwick: It is not a process of market testing. It is an evidence based review of an entity. We will go and speak to the entity itself and understand the business, how it operates and its commercial factors. We look at the industry that it is operating in, so we need to understand the broader competition, what the industry looks like and how the industry operates. In that respect we will go and talk to some of the parties in the industry—some of the suppliers, the competitors, those sorts of parties. We will have a look at the policy settings. That involves Health and other policy agencies and talking to them and understanding how the policy is being formed, what the policy is and what the implications would be for the entity going forward. We also have a look at the market that it is operating in—so the broader market—and that goes to competition type issues.

In the case of Australian Hearing, we had a look at the breadth of its operations and how it was competing. One of the statistics there is that out of 2½ thousand sites where hearing services are provided I think there are only 17 regional sites and 11 remote sites where Australian Hearing is the sole supplier. On every other site there is competition, there is another provider.

Senator McALLISTER: The reason for asking the question and asking you about market testing is to clarify that the purpose of the review is to understand whether there is a role for government in servicing the demand. Is that correct?

Mr Renwick: That is correct.

Ms Ong: Senator, if I am not mistaken, when Mr Renwick mentioned market testing earlier he was referring to the outcomes of the scoping studying into ASIC, whereby the government was looking at market testing after that.

Senator McALLISTER: I am just trying to clarify around the purpose of the review being largely focused on this question about government's role in providing services. Is it the case that a foundation assumption is that the ongoing provision of service ought to be equal to or better than what is provided under the current arrangements?

Mr Renwick: There is usually a set of objectives that the government has, and I would have thought that they were in the terms of reference for the review. There is usually one that sits around the industry itself and the entity and the continued provision of services and the quality of those services—and there is usually one around the employees and the fair and equitable treatment of employees. So it goes to the industry, the company, to the employees and to the probity of the process. Then, having regard to those, we usually talk about optimising the value to the Commonwealth.

Senator McALLISTER: So from a financial transaction perspective.

Mr Renwick: That forms the framework for the scoping study.

Senator McALLISTER: In defining the services currently provided by Australian Hearing, can you talk to us about what the key elements of those services are as you see them or as the scoping study has defined them?

Mr Renwick: It might be best to talk about the issues of primary concern to the stakeholders, including access to the services—in particular to the newborns and the paediatric side of the service. We heard a lot of discussion around children being diagnosed with a hearing problem at two days old and having an implant or a hearing aid within three weeks, which then sets them up for life, compared to examples in the US and Germany and places where it can be 12 to 18 months before they receive those services. That was extremely important to people. Eligibility was also an issue. That goes to the NDIS and who can actually access the services. There was the quality of the services and the funding. Another one of particular interest to people was research—NAL, the National Acoustics Laboratory.

Throughout the scoping study we came back to those issues. Every option that the scoping study considers has regard to each of those and how we can ensure that those are addressed in any approach going forward. The scoping study really looked at three categories of options. One would be the status quo—can you continue things as it is and how would that address those issues? One would be making some changes within government—changing legislation and things to allow them to connect more broadly. The third category was around privatisation. Within each of those there are various subcategories—staged approaches, partial sales and those sorts of things. In every one of those it always comes back to how we can ensure that those issues of concern to people can be addressed in each of those options.

Senator McALLISTER: One of the things we have heard about today is the role that Australian Hearing has played in providing, I guess, a series of outcomes that are globally beneficial for the hearing services sector more broadly, and they include skill formation; technology coordination in terms of the integration of technology into school learning environments; a central role in integrating services for hearing-impaired people, particularly in ATSI communities but also for children; and, more broadly, supporting service users by addressing information deficits and assisting them in acquiring independent information about available services. It is common, I know, that in economic analysis those kinds of global benefits are difficult to consider and deal with. Are they dealt with in the scoping study?

Mr Renwick: They are to the extent, as I said, that they are considered as part of how to ensure that they can continue under any of the sorts of options that we are looking at. We did not do a cost-benefit analysis, if that is the sort of thing you are looking at, in terms of the value of those.

Senator McALLISTER: You did not do a cost-benefit analysis at all as part of the scoping study?

Mr Renwick: Not in terms of those sorts of issues.

Senator McALLISTER: But you did in terms of other issues?

Mr Renwick: No.

Senator McALLISTER: So there is no quantitative analysis?

Mr Renwick: It is a scoping study into the business itself and making recommendations.

Senator McALLISTER: So there is no quantitative analysis or economic analysis around those three options that you talked through earlier?

Mr Renwick: There is some economic analysis around them in terms of going forward but not, I guess, in terms of trying to cost them.

Senator McALLISTER: Is there financial analysis of the impact to government?

Mr Renwick: There is financial analysis, yes.

Senator McALLISTER: But not economic analysis of overall costs and benefits to community?

Mr Renwick: Yes, that is true.

Senator McALLISTER: Thank you.

CHAIR: Can I just ask a couple of questions around that.

Senator McALLISTER: Yes, please do.

CHAIR: Can you make clear for the record your understanding of the difference between financial analysis and economic analysis, the type of analysis you have undertaken, and the key elements of that analysis.

Mr Renwick: Okay. Financial analysis is really looking at the finances of the company in terms of its performance and its profitability. It is looking at the industry and the financial performance of the industry. It is looking at future, I guess, viability of the business. It is looking at how the industry might change, and that is probably where the economic assessment comes in. Part of the assessment was that the market is going to change dramatically under the NDIS. There is also, with a growing ageing population, an increased need for hearing services going forward. So there is that sort of economic analysis that is taken into account as part of the financial analysis, and then it is looked at in terms of policy settings and in terms of the sorts of quality assessments that we are looking at and how we can try to achieve them going forward.

CHAIR: Today we heard evidence of a report that is a little dated now—I think it was 2006—about the cost of not providing adequate health care and access for Australians. It was in the realm of billions of dollars from what I recall. Is the cost of making a mistake with this—the cost of getting it wrong or the cost of a failure to do this job properly—part of the consideration that you put forward to government?

Mr Renwick: We put forward options and recommendations, and it is for the government to assess where it takes it.

CHAIR: When you talked about options before, you went to three options that you proposed for consideration. The first one was—

Mr Renwick: I said there were three broad categories of options, but within those there are subcategories. What are the high-level options that you might go to? Is the business going to be viable going forward if you have a look at where the market is heading? A good example there is that the hearing services market is expected to grow at about four per cent over the next few years. What I call the private market, which is the one that Hearing Services cannot compete in, is expected to grow at about six per cent, and that is because of the ageing population. The market itself is changing dramatically around it. Australian Hearing does not have the flexibility or the agility to change with it. Therefore the status quo applies, where they are restricted by what they can do through legislation and that goes to their future viability. If we do nothing, are they going to be able to continue to provide the current level of services without some sort of government support?

At the next level down we look at: what are the options for reforming the business? What are the options for changing the model within government ownership? Can we change the legislation to allow them to compete in that market? Would that give them the agility and flexibility they require to compete in this changing market? Yes, it does to a certain extent, but government ownership continues to put constraints around what they can actually get involved in. Talking to both Australian Hearing and the industry, there are currently many more of those communication-type services assisting people once they have a hearing aid. Australian Hearing can provide them with a hearing aid, but then there are certain services they cannot provide. We heard the discussion earlier where they could not replace batteries and things like that. There are some areas in communication training—training them to sign, for example—that Australian Hearing cannot compete in. Can amending the legislation allow them to compete in some of those? It goes to the level of agility and flexibility that you provide to the company to compete in what is a dramatically changing market. Then you need to consider what would happen if it were privatised. Under a privatised model, how can you protect those factors I was talking about before?

One of the things that came through to me was that we are one of the best in the world for newborns and paediatric, and we need to maintain that. How do we do that under those models? Which of those models is going to be best to ensure that service continues?

CHAIR: Like others in the room, I am trying to listen to you very carefully. If I am reading you correctly, given the statistics you have given around the changing market, the no. 1 option of the status quo does not look the most likely and no. 2, changing the legislation, looks like getting a guernsey. But with the option of privatisation, I would take you to the community-service obligations, which you have already alluded to, and indicate that there are community members on your list who were telling us today that they were not contacted by PricewaterhouseCoopers and who have raised even more concerns. How will what you have heard today feed into your processes going forward from here?

Mr Renwick: My understanding, and I will check this, is that from the people you have spoken to today there is only one group—and I cannot say who it is because I have only been told there was one group we did not consult as part of the stakeholder consultation. Discussions I have had with some of the—

CHAIR: When you say 'we', do you mean PricewaterhouseCoopers?

Mr Renwick: Sorry, PricewaterhouseCoopers from the scoping study. I can confirm that, but I just need to check the facts. I was told earlier that there was only one group which you have spoken to today that PricewaterhouseCoopers did not meet with. In some of the discussions I have had subsequently with some of those entities, they seem to have had a concern with the fact that they were not consulted between the time of the Commission of Audit and the government's decision to undertake a scoping study. That seemed to me to be the concern when we were about to undertake the scoping study, rather than during the actual scoping study. As I said, I will confirm that bit of information for you and we will provide you with the parties that we actually met with—or PricewaterhouseCoopers. When I say 'we', we were in attendance or we had somebody from the scoping study in attendance with PricewaterhouseCoopers at those meetings. We will confirm who we met with and give you that information.

CHAIR: As fulsomely as possible would be helpful. Thank you. I go back to the terms of reference of the scoping study. I do not believe I have seen a copy of that. You just referred to it. Could you provide us with a copy?

Mr Renwick: It is on the Finance website. We could provide it.

CHAIR: The elements that you indicated were areas that you were mindful of as a result of, I assume, that scoping study—

Mr Renwick: That is right.

CHAIR: I want to make sure that I am right—access, eligibility, quality, funding and research.

Mr Renwick: That is right.

CHAIR: Were there any other areas?

Mr Renwick: I would categorise those as the primary areas. In broad terms, they were the main areas.

CHAIR: With regard to the requests that you have had from the community for this scoping study to be released, is that replicated in other areas of policy inquiry that you are undertaking—an inquiry regarding the privatisation of other entities?

Mr Renwick: I do not believe so.

CHAIR: Why do you believe that there is such a demand and a call from this community, representing deaf people from birth through to old age, for your scoping study to be released? We have had multiple requests and I am sure you have too.

Mr Renwick: Not directly.

CHAIR: Apart from the freedom of information request?

Mr Renwick: That is right, and apart from the committee.

CHAIR: We heard today that a number of members of parliament have been approached by people who have given us evidence today and have sought information about the scoping study and provision of copies through that. Have you had any requests from ministers or any members to undertake those processes?

Mr Renwick: Not that I can recall. I can confirm that for you.

CHAIR: Thank you very much.

Senator McALLISTER: Of the groups within the community service obligation program, I am interested in talking a little more about the approach that is anticipated for Aboriginal and Torres Strait Islander clients. We have heard today that the current program provided by Hearing Services is anchored in fairly significant investment in training and culturally appropriate service provision. It is also often conducted in remote environments and it has quite significant additional costs associated with that, as well as there being some very specific clinical requirements about the particular clients of hearing impairment and the need to work well with children. Could I ask either yourself, Mr Renwick, or Ms Duffy what you see are the principal criteria for continuing to adequately service that population?

Ms Duffy: The eligibility and the types of services that Australian Hearing provides to that group are pretty clearly set out in the legislation. How Australian Hearing delivers that is within its own qualifications and competency base. How that evolves under an NDIS model is a matter for NDIS, taking into consideration the current approach and how they may wish to view how they deliver services for Indigenous groups across all of the offerings that they offer. We are only at the journey of having those conversations with the NDIA and DSS and formulating those policies.

Senator McALLISTER: Do you anticipate all of those clients transferring to the NDIS or do you think that only some of them will and that others will have a source of demand that sits outside the NDIS?

Ms Duffy: The question of eligibility is a question that still needs to be resolved in more detail by the NDIS. What we do know is that the current policy is that anyone with a permanent hearing loss under the age of 65 can potentially be eligible for the NDIS.

Senator McALLISTER: In some Aboriginal communities, the concern is not permanent hearing loss but temporary hearing loss. Has the department given consideration to how that would be addressed?

Ms Duffy: We have certainly had conversations with the NDIA and DSS about the early intervention tier and what that early intervention tier of services encompasses. It could quite logically be considered as part of that service offering, but there has been no decision about what that involves. They are still formulating that, and there are discussion and submission processes going on.

Ms Rule: I think it is important to note that the work we are doing with NDIS and the Department of Social Services at the moment is about identifying those clients who will transfer to the NDIS under all of their rules and eligibility, but that is not exclusive. We are trying to identify the people who currently fall under the scope of the Hearing Services Program and would not be eligible for NDIA. We are working through what the options are for dealing with those groups. This is the reason the transition is taking place from now till 2019. We are trying to work out who is in the scope of NDIA, who is not and how we make sure we have all our bases covered so there are not people who fall through the cracks. Is it the role of Australian Hearing? Is it the role of the NDIA? Is it somewhere else that the people who currently get services under the Hearing Services Program will continue to have access to those services.

Senator McALLISTER: Does it seem logical to you to make a quite large decision about the future of Australian hearing when those questions that you describe—which I think are quite foundational—are yet to be resolved?

Ms Rule: That is really a matter for the government to think about. The way that I categorise it in simple terms is that we are currently talking about the what—what services are provided and who falls into what buckets of NDIA or hearing services. There are decisions to be made about who will deliver those services and how they will be delivered. Will it be Australian Hearing, NDIA or, as I said, some other approach? They are separate issues, and we are trying to work through the whole gamut of those issues, but really the decision about the scoping study and whether it is the right time is one for government.

Senator McALLISTER: Have you been provided with any instruction from government about how to sequence the timing of these two processes?

Ms Duffy: The government agreed to interim arrangements for hearing services because it recognised that it was a complex matter and it would take some time to work through the transition activities. The time frame we have to transition the clients is by 2019-20, so we are working back from that time frame. We are starting the process of identifying the key activities and the key time frames, and one of the main activities for us is legislative change, which does take some time.

Senator McALLISTER: I suppose in the document—I think it is your submission—you talk about the fact that in these interim arrangements people requiring these services within the NDIS will be referred to Australian Hearing. If Australian Hearing ceases to exist in its current form, who would they be referred to? That is why I am concerned about the sequencing; they do seem to be rather interdependent.

Ms Duffy: The current arrangements are that those who are normally eligible for CSO or for voucher can access those two programs. At the moment, the CSO is solely delivered by Australian Hearing. If a decision were made, that would have to be considered at the same time.

Ms Rule: We are currently working on the basis that the arrangements stay the same until government decides that they change or if they change. If they change then we will have to respond to that accordingly.

Senator McALLISTER: I suppose a close working relationship between you and the Department of Finance would be quite important given the significance of what the Department of Finance is contemplating for Australian Hearing in terms of your ability to deliver on this program.

Ms Duffy: Yes it is.

Senator McALLISTER: What does that look like on a day-to-day basis?

Ms Duffy: On a day-to-day basis we have just completed the information sessions that I think Robin spoke about. You have heard earlier today that going forward we would be advised on the process and the timing for the process of government consideration.

Ms Rule: In practical terms we are working very closely together. For example, the information sessions are trilateral sessions hosted by finance, us and the Department of Social Services to make sure that we can cover the full range of issues, whether it is the scoping study, the policy issues from the Department of Health's perspective or the transition to NDIA. So it is a very close working relationship.

Mr Renwick: I have just assumed you have them, but the slides from those presentations are available on both the finance and the health websites.

CHAIR: We were advised of that this morning. I go to the timing question that somewhat arises from the questioning that Senator McAllister was just undertaking. As I understand it, Australian Hearing was marked, out of the process of the Commission of Audit review, for a short-term privatisation.

Mr Renwick: I think they were the words in the Commission of Audit.

CHAIR: And short-term then aligned with the calendar years 2014-16; is that correct?

Mr Renwick: I do not have a copy in front of me.

CHAIR: That is what I am informed from the documentation. Given that timing and this sense of urgency, is that perhaps a partial explanation of why there is such anxiety amongst the community that we have had represented to us today—that they fear that it is marked for short-term and things could be moving very quickly with a degree of consultation that so far has clearly been inadequate as far as the community is concerned?

Mr Renwick: I think that is why the government asked us to undertake further consultation with the community: so it understands the NDIS and what implications that will have for hearing services and subsequently for Australian Hearing.

CHAIR: We have had the date 2019 given to us as a date in which significant change is going to happen with the NDIS. Has any consideration been given to pushing the privatisation of Australian Hearing out to 2019 after other complex changes have already been undertaken?

Mr Renwick: Government has not considered the report at this stage. Our task was to provide a scoping study report to government—provide options and recommendations to them.

CHAIR: Could I ask if one of the recommendations is the delay of the sale of Australian Hearing be undertaken to give community some comfort that an essential service will not just disappear while this transition to the NDIS is underway? Is that one of your recommendations?

Ms Ong: That is a decision for government.

CHAIR: I know it is a decision for government. My question is if that is one of your recommendations. I think the community's concern very much reflects that particular concern. Is that one of your recommendations?

Mr Renwick: It is getting to advice to government, so I really cannot comment on that.

CHAIR: And here lies the problem for the community, who feel so marginalised from this process and so excluded from vital information that affects their children. In terms of the advocacy we have heard today, it affects babies that will be born tonight in Sydney and parents who know that, if Australian Hearing is not there tomorrow or at the end of 2015 or 2016, there is a great risk to the life outcomes of that young person. It is a high-stakes event, isn't it?

Ms Ong: I think the issues we raised earlier which were foremost were heard by the advisers. They were about access, eligibility, funding and quality. It has been impressed on us through the information sessions as well that those are issues that have to be preserved and outcomes that have to be maintained. You are right in that you would want to make sure that the services that are currently delivered continue to be delivered. That was another thing that was mentioned in the information session. Australian Hearing is a service provider and provides, as Ms Duffy mentioned, under the legislation and the memorandum of understanding they have in terms of delivery and the roles provided by both departments in terms of ensuring quality and services are delivered. So I suppose you are right in that it is important that those services continue to be delivered, that whatever the ownership of Australian Hearing is those services continue to be delivered and that consumers continue to get those services. That is something that we are all in agreement on, that it needs to be preserved regardless of whoever owns Australian Hearing.

Mr Renwick: I think that is the case. Once the CSOs become contestable, there needs to be a mechanism to ensure that anybody providing those services will provide them to that same standard.

CHAIR: That is a very nice concept, that the community service obligations that are being met at world's best standard currently by a particular organisation can be arbitrarily handed off to a number of other organisations. Mr Renwick, the evidence that we have heard today does not support that claim which can be made in theory, but

in practice we have heard about the ecological tethering that happens because of the nature of what Australian Hearing has already done, its history, its current placement, the esteem with which it is held in the community and the flow-on and connected entities that have gathered around it.

While the theory says CSO can be spread amongst a number of other agencies, and by regulation we can demand that they honour this community service obligation, I have been in committee hearings where Telstra's community service obligations have been discussed and it was not discussed in the same terms as we have heard today of parents who have had the experience of being part of Australian Hearing. Again, given the level of concern that is clearly evident in the evidence we have received today, the number of submissions that have been put, the request through freedom of information from parents of deaf children, to find out what is going on, to have some assurance that Australian Hearing is not going to be dissolved while the process to go to the NDIS is happening, why can't you respond to the need for this community to receive that scoping study and have some assurance about what is going forward? They are clearly indicating to us that they feel like they are in an information vacuum.

Mr Renwick: We have provided the information that we have been able to. At the end of the day, it is a government decision as to whether to release the report. It is not a decision that I can take.

CHAIR: Thank you for that very frank answer, Mr Renwick. Perhaps it is clearer now to the people who were here today where they need to apply the pressure to get the answers to the questions they have. Can I now go to some questions that were raised today. First of all, there was mention from one of the earlier witnesses who had been in the consultations that you have had in recent times post the PwC scoping study, where they referred to the hearing about a blueprint for the way forward. Is that terminology familiar to you? Do you believe that at any of those presentations there was articulation of a blueprint?

Ms Rule: I am not aware of a formal document that exists that is called a blueprint. Part of those sessions was talking to the stakeholders about not just the scoping study—that was probably actually the smaller part of the discussion—but the transition to the NDIS and trying to flesh out the issues and the things we need to think about and the processes and the policy issues. It may have been mentioned in that context, but I am not aware of the existence of a document called a 'blueprint'.

CHAIR: Okay. Is there anything that could be conceived to be anything like a blueprint, or a finger painting perhaps?

Ms Duffy: What was explained was that, over the coming months, we are required to develop up a transition plan. I would have used the language 'a blueprint', which sets out the types of activities and the timing for things going between now and when we do full national rollout or transition. I have used that term 'blueprint', but it is a way of describing a transition plan of being able to segment and give people an idea of critical points in time for things to occur.

CHAIR: Is that transition plan under development or developed?

Ms Duffy: It is not developed. We are just starting to gather the information, and the information sessions were a starting point. We have also received a number of submissions that identified the important areas that we need to consider as part of the transition, which were all raised earlier today as well as being raised in the scoping study that will form a transition plan. So it is in the early stages.

CHAIR: Have you put out a public request for submissions as part of that process?

Ms Duffy: No. We have put out a public request to register your interest to come along to a workshop. At those workshops we will go through what you think are the important things that should be in a transition plan, to confirm we have everything and we have not missed anything. Then we will work off that initial grouping to develop a plan and we will continue to consult on that plan. Those activities will also include the NDIA.

CHAIR: How would you describe the consultation process that you are undertaking in comparison to the scoping study consultation process undertaken by PricewaterhouseCoopers? Are they the same in design and scope?

Mr Renwick: The scoping study is a fact-finding process, so it is trying to understand the industry and the issues of concern.

CHAIR: So you see one person at a time in an interview situation for a period of time?

Mr Renwick: It is a discussion, asking them what their views are.

CHAIR: Would it be like this, with five different industries?

Mr Renwick: No, it is not a—

CHAIR: This is what I am trying to understand. What does it look like?

Mr Renwick: It is more of a one-on-one discussion, or two on two—whatever numbers were in the room. It is a direct sort of discussion. It is finding the facts, understanding the issues of concern to the people we are talking to. That feeds into the scoping study. The consultations that we are undertaking now are because the scoping study found there was a lack of understanding of the NDIS and how it would affect Australian Hearing and hearing services. That is much more of a consultative process.

Right at the start I think Tracey made the point that this was an interactive process. We wanted to provide them with some information, listen to them and hear their views. It was that sort of process. It was a process of providing people information, and I believe the next stage for the NDIS is that transition process—involving people in the transition and discussions as to how the transition to the NDIS may occur.

CHAIR: Ms Duffy, in relation to the way in which the consultations have emerged, who identified the participants in that consultation process? Was it the same kind of process—getting around the table and putting names together? Where did you get your list from?

Ms Duffy: I think there are two processes that we are talking about. There is the process that the Department of Health and the Office of Hearing Services is undertaking to assist the planning for the NDIS transition. That process is starting with the consultation workshops following July. The information sessions were a direct response to the scoping study consultation process, where people identified they did not know about the government decision around NDIS. It is fair to say that among some people who came along to the information sessions there may have been some confusion between the two processes.

CHAIR: I am not surprised, because we are starting this conversation talking about a government proposal to privatise Australian Hearing. Where is the clear path for me as a citizen? I have had a great experience with Australian Hearing and I want to participate in this consultation. I want to be there to tell you why Australian Hearing should not be privatised. How do I get a guernsey? How transparent is this process? How easily accessible is it to me, if I am a person with a disability, if I am a deaf person in particular with a very rich knowledge set to contribute? How have you gone to that community? How easy is it to participate in this process?

Ms Rule: There are two separate issues. There is the issue about the consultation on the scoping study, and I think we have talked about that and we are going to provide some more information about lists and that sort of stuff. There is a second process about talking to the sector around the transition to NDIS. That is a very open process. We have asked people to register their interest. We are not inviting people to attend these workshops; we have asked them to register their interest.

CHAIR: Thank you for that clarification.

Ms Rule: As far as the Department of Health is concerned, those sessions need to be as open and as broad as they can be, but it is a separate issue from the scoping study. That is how we are treating it and that is how we are approaching the discussion with people—that a number of people who currently receive services under current arrangements will fall within the bailiwick of the NDIS sometime between now and 2019. Let's talk about how we do that in the best possible way.

CHAIR: The question remains, though: what is happening to Australian Hearing?

Ms Rule: It is a separate issue, and I cannot answer that question, because government has not made a decision yet.

Mr Renwick: There are two issues here. One is that the NDIS is a decision of government, and it is about implementing that decision. Australian Hearing is about letting people know what the scoping study has found in terms of those key outcomes and key findings—getting some people's views and understanding so that the government can then make a much more informed decision on how it takes Australian Hearing forward. There is no decision at this stage to privatise Australian Hearing. The scoping study report has not been considered by government. Ministers have said, 'Provide us with some more information; go and talk to people and come back to us and tell us what the views of the community are, and then we'll consider taking it forward and making a decision.'

CHAIR: Let's be clear, then: the NDIS is very transparent, open; you register interest et cetera. That is happening. What is the process with regard to the scoping study in Australian Hearing, given that this awareness has been raised? How do citizens Joseph and Mary get on the bandwagon and have their say?

Mr Renwick: The scoping study is not a public inquiry. The way we have done it is to go to the peak bodies—the bodies that are representing those individuals—and get the views of those bodies, that community. It is about getting that input through the people who are in the industry to provide those views.

CHAIR: It seems there is a bit of a gap between community expectation and desire and what the government is seeking in terms of an open and transparent process. Certainly there is quite a distinction between the methodologies that are involved here.

Ms Rule: I think it is important to note, though, that, as Mr Renwick said, the transition to NDIS is a decision government has made. What we are consulting on is how to implement that decision in the best possible way, whereas the development of the scoping study is at a different point in time.

CHAIR: Yes. I think it is at the point in time when the community is saying: 'Hands off. Don't break it. We think it's very important to keep it.' And they want to be heard. I think that is the point of contest we have been noticing today. There are a few more specific questions that I think might be appropriate for you, Ms Duffy or Ms Rule. I am mindful that Ms Duffy might have to leave shortly. I will just ask you if you could make the project plan for the transfer of services to the NDIS available to all stakeholders.

Ms Duffy: The transition plan?

CHAIR: Yes.

Ms Duffy: When it is developed, I would not have any problem putting that on our website.

CHAIR: When do you think that will happen?

Ms Duffy: We are unsure. It could be as complex or as simple as we need it to be. I would expect that we could start off with a simple plan, but then people want the detail. Depending on when we can organise the workshops and how much interest we get in the workshops, then pooling the information together with the workshops and having some of the policy decisions made by DSS and NDIA would then give us an indication of the time frame. But I cannot say at the moment. I would expect six months.

CHAIR: Yes, because if we are working backwards from 2019, there have to be some sort of key dates in your processes by which things have to have occurred. So, sometime in the next six months that might be available, and when it is developed—

Ms Duffy: I think it needs to be available, but it is dependent on some decisions by agencies that are not here today.

CHAIR: If services for clients transferring from the Hearing Services program to the NDIS are to become contestable, how will adult clients and families of deaf and hearing-impaired children know that the service provider has the expertise, facilities and equipment needed to provide the level of services required?

Ms Duffy: That is one of the questions and one of the pieces of work that needs to be worked through. It is certainly something that has been raised through the information sessions. The NDIA was present at those sessions and recognises and acknowledges that that needs to occur. How the NDIA addresses quality is part of a discussion paper and a process they are going through right now across all the service offerings.

CHAIR: And there is no information available about that yet?

Ms Duffy: There was a discussion paper on the website, and we are feeding into that process.

CHAIR: Do you know whether there are safeguards about protecting people in these vulnerable groups as part of that?

Ms Duffy: I expect that there would be, but I do not have the detail with me.

CHAIR: With regard to children with hearing loss who get individually tailored programs, there is some concern about the way things might move forward. Will the program for educational facilities be supported under NDIS?

Ms Duffy: I cannot answer that.

CHAIR: If there were multiple providers, would that make it easier or more difficult? How would the coordination happen then?

Ms Duffy: It would be a matter for the NDIA to work through how it wants to design the delivery of those services. Whilst there are individual packages available for people, there is also an early-intervention and monitoring group of services that it has not quite developed yet, so I am not able to answer that yet either.

CHAIR: I want to go to the question of expertise, which would be to do with the quality—

Ms Duffy: The qualifications and experience?

CHAIR: Yes.

Ms Duffy: What happens now?

CHAIR: Yes, and what is being proposed.

Ms Duffy: We are not at the stage of having clarity on what is proposed. As I said, we are at the really early stages of this work with the NDIA. What happens now? With CSO and with paediatrics what you have heard today about Australian Hearing developing and maintaining its own workforce is true. If there was something to change the model of service delivery under NDIA there would have to be mechanisms in place through either the teaching bodies or the practitioner bodies to have some way of assessing clinical expertise or skills to ensure that you can be guaranteed quality and clinical knowledge when you are dealing with hearing loss.

CHAIR: Were you here earlier today when we heard from the audiologists that there is no register of audiologists, that anybody can claim to be an audiologist and that you can set up an audiology business without any registration process?

Ms Duffy: My understanding is that, whilst there is no registration board as with other professional allied health or medical bodies, audiologists and audiometrists have to maintain continuing education with each of their practitioner bodies. So, they have to accumulate so many points every year to maintain their continuing professional development.

CHAIR: Can I get you to verify that that is the case? That is not what we were led to believe today. I am just very mindful of whether it was for a neonatal or an adult onset of hearing loss that there were concerns about the quality of experience people might get when they went to get some assistance, whether it was to get an assessment in the first instance or to commence the journey of preparing to go for a prosthesis or a listening device—hopefully I have improved some of my language throughout the day!

Ms Duffy: It is true that there is no register.

CHAIR: Yes, there is no register.

Ms Duffy: There is no register like there is with other medical professions.

CHAIR: And this is an issue that another committee, the Committee on Corporations and Financial Services, is dealing with. The financial services sector is dealing with this issue because a lot of people have been very much exploited by people operating in that field who fail to act ethically. They lost their life savings, but I expect that if you lost your capacity to hear then that might be somewhat more impacting.

Ms Duffy: COAG recently agreed to a national code for unregistered health professionals. Audiology is part of that new national code. States and territories are responsible for implementing that national code. Some have done so and others are moving towards that. That is a first step in terms of professionals and individuals. The Office of Hearing Services has a relationship with the service provider. The service provider goes through an accreditation process, and we do not have—

CHAIR: But the service provider could be somebody who has no qualifications in audiology at all.

Ms Duffy: They have to have qualified employees who have to be registered or be a member of one of the practitioner bodies.

CHAIR: We heard today that there are some people who are practising whose qualifications could be well and truly out of date, or who have qualifications from another country that have not been verified against Australian standards.

Ms Duffy: We have an audit process where we check those things, and there is also a self-assessment process where all service providers have to certify that all of their practitioners have current membership with the professional bodies. When we have become aware that there are issues with practitioners we take compliance action, and we also work directly with each of the professional bodies—so the professional bodies take action as well.

CHAIR: Regarding the time frame in which these professional actions can be taken, actions in response to failure to act professionally can be somewhat lengthy in process—months, 12 months, 18 months and longer in some instances—before sufficient evidence is gathered. In contrast to that sort of lengthy process we have been hearing about the importance of short-term, very fast, effective responses to people whose hearing loss is evident. Doesn't that seem a little risky?

Ms Duffy: In my experience I have not heard of a lengthy process. When something comes to the attention of the office we move quite quickly. We have a 28-day turnaround to work through what the issue is and get evidence. We work quite fast to either suspend the organisation or take other options for other compliance actions.

CHAIR: How many of these bodies have you suspended?

Ms Duffy: I would have to take that on notice. It is very minor.

CHAIR: How many are there out there?

Ms Duffy: Do you mean how many organisations we contract with?

CHAIR: For hearing.

Ms Duffy: We have contracts with around 260 service providers, with a workforce of around 1,900 audiology professionals.

CHAIR: Do you have random inspections of them?

Ms Duffy: Yes, we do.

CHAIR: How many people do the random inspections?

Ms Duffy: The audit team?

CHAIR: Yes.

Ms Duffy: I have an audit team of around six people.

CHAIR: To cover how many—1,900?

Ms Duffy: To cover 260 organisations.

CHAIR: And 1,900 people?

Ms Duffy: Yes, 1,900 practitioners.

CHAIR: Do you think six people observing that is sufficient to provide the quality assurance that people are telling us is part of Australian Hearing?

Ms Duffy: Our reviews of our audit processes over the years have indicated that they are sufficient.

CHAIR: Sufficient is not excellent.

Ms Duffy: There have been no negative reports or recommendations that have come through those reviews.

CHAIR: Thank you for your answers. I remain alarmed by the difference in a compliance-based process and a random-audit basis compared with the way in which we have heard Australian Hearing operates with ongoing training and the clustering of people together over a long period of time, and with the testimony of community about the quality of the experience they are having. They are very different models that he have seen over the course of the day.

Senator McALLISTER: I am feeling sorry for Ms Duffy and her impending flight. Do you need to go?

Ms Duffy: I do.

CHAIR: Thank you for your evidence this afternoon, Ms Duffy. We will continue with a few more questions.

Senator McALLISTER: I understand that we are considering the ownership and structural arrangements for Australian Hearing as separate from contestability of service provision, but I am most interested in the interplay between these two things. Can anyone tell me how contestability might work for remote communities? We have talked about how it might be canvassed under an early intervention and monitoring service, but do we anticipate that contestability for CSO for Aboriginal and Torres Strait Islander peoples will operate at an individual or a community level? How would it work?

Ms Rule: There has not been any government decision to change the current arrangements around the community-service obligation and so I cannot speculate about how that might operate on the ground, given that is not what we are doing. The government has not taken any decision on that yet.

Senator McALLISTER: No, although we do have an announcement that we are moving to contestability for the CSO, are we not? What does it mean then?

Ms MacGregor: I am stepping in for Tracey Duffy. Certainly there has been discussion with DSS and NDIA about what contestability might look like for delivery to remote or rural areas during the transition to the NDIS. I am not trying to speak on behalf of DSS, but they have certainly talked about different strategies and that is irrespective of whether you are delivering hearing services or any other type of service into Indigenous communities. For instance, because of thin markets, they might go to a tender process or there could be additional funding provided. There is a range of strategies that they could draw upon if they believed that was necessary.

Senator McALLISTER: Are there concrete options being developed?

Ms MacGregor: As Tracey indicated, it is in early discussion and it would certainly be part of the transition planning.

Senator McALLISTER: So a process by which to resolve those kinds of questions.

Ms MacGregor: Yes.

Ms Rule: The principle we are starting with for the transition planning is that we maintain an equivalent level of service to what we currently have. The best way to get from where we are now to these services being provided under NDIS is what the transition planning is all about.

CHAIR: Ms Ong, I would like to go to evidence we received this morning from Parents of Deaf Children, Mr Wyburn, who indicated that the only way they heard about the scoping study was through reading the public tenders in the paper. They were not invited and they had to find their way into that process. Could I ask you, perhaps on notice, to address that concern. I know that you will have a close look at the evidence we have had. I think it would be helpful to respond to that group and any other groups they might identify about the process failure of why they were not engaged. Clearly, they had a very different story to tell us this morning from the one that we have heard from your this afternoon.

Mr Renwick: We will have a look into it. But, as I mentioned earlier, from the discussions I have had, the concerns seem to me to be about the period between the Commission of Audit and the government decision to undertake the scoping study, not in terms of the involvement in the scoping study. But we will confirm that for you.

CHAIR: Yes, I think it was the scoping study, but we will find out one way or the other.

Ms Ong: Senator, when you are referring to the tenders, that means that we had not even appointed them at that stage.

CHAIR: So that was prior to PWC being appointed?

Ms Ong: Yes. If that is the tender you are referring to.

CHAIR: So in the time sequence, that would line up with what you were just saying, Mr Renwick.

Ms Ong: That is right.

CHAIR: I refer to the Senate estimates transcript of Wednesday, 3 June, when Senator Cameron formally requested a copy of the scoping study to be tabled. Senator Payne was the minister on duty and she suggested that he make the request to Finance. You are here now and, in Senator Cameron's absence, I am going to formally request that you table the scoping study.

Ms Ong: I think you will find that there was a response to the senator's question. That was responded to during the hearing.

CHAIR: I missed that. Did you table it?

Ms Ong: The response to the question was mentioned at the hearing.

CHAIR: What was that response?

Ms Ong: I do not have it in front of me.

CHAIR: Roughly, from memory.

Ms Ong: It was basically what Mr Renwick mentioned earlier.

Mr Renwick: I can read it to you.

CHAIR: Thank you.

Mr Renwick: The answer reads:

Scoping studies are independent reviews to government about its entities and activities and contain significant commercial information, the release of which would prejudice the government's commercial interests. The practice of both this and previous governments has been not to publicly release such reports. It should be noted that Australian Hearing is a commercially exposed business operation which operates largely in a competitive market where there are another 250 competing providers.

CHAIR: I am advised that, in doing that, you are making a claim of commercial confidentiality, and I believe that has to be made by a minister and in writing. So I might ask you to follow that process if that is required.

In response to the indication that a freedom of information request would cost the parents of deaf children \$1,700 and the nature of the correspondence which led them to believe that their \$1,700 might not be very well spent because there might be large chunks of material unavailable to them, and mindful of the commercial-in-confidence concerns that you raised and also mindful that we are in a pre-cabinet confidentiality phase, I would ask that the Department of Finance, after redacting from the document elements that are sensitive and commercial in confidence, provide a copy containing other elements that are of great interest to the deaf community and their

advocates and indeed to Australian Hearing and other publicly engaged and interested parties that could be available to the public within those constraints.

Mr Renwick: I will take that on notice and refer it to the minister.

CHAIR: So I have to be very hopeful with that question then. I indicate that there may be a few questions on notice that will arise after a closer reading of the transcript and any further discussions we might have with other parties who have some questions that they need some answers to. With the agreement of the Senator McAllister and Senator McLucas, I propose that Friday, 7 August be the date for the return of answers to questions on notice.

I thank all of the witnesses who have appeared before the committee for giving their time and I thank also the members of the public who have been here for a very long day of hearings. We appreciate your civic engagement and your advocacy. I thank Hansard, Broadcasting and the secretariat, who work under all sorts of conditions, even when they are not very well. I particularly thank our Auslan interpreters for their important role in the sharing of information today.

Committee adjourned at 17:40