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Committee Secretariat,
Standing Committee on Health, Aged Care and Sport,
PO Box 6021,
Parliament House,
Canberra ACT 2600

23rd December, 2016.

Dear Committee Secretariat,

Re: Inquiry into the Hearing Health and Wellbeing of Australia

Thank you for the opportunity to submit comment regarding the terms of reference determined by the Standing Committee on Health, Aged Care and Sport inquiry into the hearing health and wellbeing of Australia.

1: The current causes and costs of hearing loss, and ear or balance disorder to the Australian health care system should existing arrangements remain in place;

We have previously raised concerns regarding the over-servicing of Medicare which results from the use/misuse of a Memorandum of Understanding (MOU) between some audiology clinics, including the government-owned Australian Hearing (AH), and some participating General Practitioner practices. We are aware that at many medical practices the MOU results in administrative staff at the GP clinic contacting patients who are eligible for government-subsidised hearing services through the Office of Hearing Services (OHS) to invite them in for a “free” hearing test at the GP clinic. The test is billed to Medicare, using item number 11306. The testing protocol used guarantees most patients screened will fail. A referral for the patient to obtain a voucher to access OHS-funded hearing services is often given directly to Australian Hearing, not to the patient to take to a hearing services provider of their choice. We remain concerned that at the least this results in over-servicing of Medicare, and at worst is actually the bulk-billing of a screening program, which is outside the responsibility of Medicare. This MOU is offered by AH to GP clinics Australia-wide.

The audiology profession is self-regulated and, unlike other Allied Health professions, is not regulated under the Australian Health Practitioner Regulation Agency (AHPRA). This means that audiological professional practitioner bodies have no power to police unethical business practices, such as this MOU, and can only monitor the practices of individual audiologist members. This was noted by Dr Tony Coles, the CEO of Audiology Australia, in his letter to us, dated 19th August, 2015: “As you are aware our Code of Ethics and Code of Conduct are structured to provide guidance to audiologists who are members, and not to the employer of audiologists.” The current President of Audiology Australia wrote an article in *Audiology Now*, highlighting five breaches and a further three possible breaches of Codes of Conduct and Codes of Ethics resulting from the administration of this MOU. (Ref 1)

2: Community awareness, information, education and promotion about hearing loss and health care;

Audiology has become a highly competitive business, following the Access Economics report "Listen Hear", published in 2006, which highlighted the potential for profit in hearing aid sales. (Ref 2) There are approximately 240 businesses which provide hearing services to OHS-eligible patients, yet only six of these companies dominate 86% of the market, with the government-owned Australian Hearing being one of the largest. These large companies have immense buying power of devices and have large marketing departments, devising marketing strategies and business models, like the MOU mentioned earlier, making competition for the smaller independent companies significantly challenging and difficult. The profitability for these larger chains can be seen by the annual profit before tax noted in the AH annual reports, which for 2012/13 was $4.2M, for 2013/14 was $12M and for 2014/15 was $25M with no significant increase in staff wages which in 2013/14 was $71.76M and in 2014/15 was $73.89M. (Ref 3)

Much of the promotion about hearing loss is targeted at selling hearing aids and is aggressive. There is little public education and promotion about realistic benefits and expectations of hearing aid outcomes and other hearing rehabilitation outside the purchase and fitting of hearing aids.

3: Access to, and cost of services, which include hearing assessments, treatment and support, Auslan language services, and new hearing aid technology;

In Mildura, our relatively remote rural location, we have one resident Ear Nose and Throat (ENT) surgeon. The current waiting time to access a consultation with him is *eighteen months.* This means that many patients travel to Adelaide, Melbourne or other regional towns, such as Ballarat or Bendigo to see an ENT. For the many patients who are financially not in a position to afford to travel, or who are too unwell to travel, this is a barrier to obtaining medical services to diagnose and/or treat their hearing and/or balance problems.

In Mildura free diagnostic audiology testing to babies and children is available at the local public hospital, the Mildura Base Hospital (MBH).

Unlike many other public hospitals, MBH does not make further Medicare claims on audiological testing performed. We believe that is double-dipping.

In Australia, Pensioners and Veterans are eligible for OHS-funded hearing tests and hearing aids/devices. In our regional area there is nowhere an adult can go to access free-to-patient hearing testing as the hospital testing is restricted to a paediatric service. This means that the many patients who cannot afford private testing fees go without.

Medicare-rebatable item numbers are available to audiologists for hearing testing only if the patient has a referral from an ENT surgeon or a Neurologist or is on a care plan with a chronic illness, or is an Aboriginal and Torres Strait Islander (ATSI) patient who has a health check referral. This is the only access audiologists have to Medicare-rebatable items in our own right. Most other Allied

Health professionals have their services partly covered by Medicare; yet audiologists, who are university-trained healthcare professionals who hold a Masters Degree in Audiology, do not. This has resulted in many audiology clinics being owned by ENT surgeons, who use their own provider numbers to obtain Medicare-funded audiological testing, making competition for independent clinics significantly challenging. Audiological testing is also not covered by private health insurance, only hearing aids/devices are.

In our Mildura clinic, we are currently considering purchasing equipment to allow us to provide diagnostic assessment and evaluation of balance disorders. This equipment will cost us approximately $100,000.00 and in our own right we will have no access to Medicare rebates for the vestibular tests being conducted. We would need to have an arrangement with a Medical Practitioner to bill under his/her provider number to access Medicare rebates for our patients. This testing is currently not available in Mildura and patients travel to Adelaide and elsewhere to access this service, if they can afford to. For the patients with chronic or acute balance problems travelling when they are dizzy and feeling unwell is obviously not ideal.

In recent years there have been a number of complaints by patients regarding the aggressive tactics used by some audiology clinics. Business practices used include setting sales targets on hearing aid sales and 'top-up' and the payment to clinicians of commission on sales and top-ups. ('Top up' occurs when an OHS client elects to pay extra above the government contribution for devices with additional features.) We believe sales targets and commission on sales is unethical and it is the business model of many of the vertically-integrated chains, and of Australian Hearing, as announced in the ABC Radio National Programme 'Have I Got a Hearing Aid for You!". (Ref 4) This has also significantly driven the costs of running an audiology practice up as wages offered by the chains which utilise these business models, have to be matched. Most of the hearing aid manufacturers have their own chains of clinics. These vertically-integrated chains have access to hearing aids at much reduced costs, again making competition for smaller independent clinics difficult and potentially reducing access to services in rural and regional areas.

Access to community audiological services is often affected by regional hospitals being unable to attract audiological staff. There is a great disparity between audiology salaries offered by hospitals and the private sector, whereby a new graduate audiologist can be paid two and a half times as much working for a private hearing aid company than a hospital. This results in some regional areas of Victoria having no paediatric audiological services, and others having long waiting lists.

4: Current access, support and cost of hearing health care for vulnerable populations, including: culturally and linguistically diverse people, the elderly, Aboriginal and Torres Strait Islanders and people living in rural and regional areas;

As mentioned above, there is no access to subsidised hearing testing for adults in Mildura unless they hold a pension or DVA card. In Swan Hill, we offer paediatric testing for patients who elect to pay a private fee, which is not covered by Medicare unless they have an ENT referral. There is nowhere for these paediatric patients in Swan Hill to access free testing.

We have an arrangement in Mildura with the Mallee District Aboriginal Service (MDAS) to provide hearing testing to ATSI patients. Government-funded hearing aids are available to all patients below the age of 26 years and to adult ATSI patients who are on a pension or who are over the age of 50 years. Those ATSI patients who are not on a pension and who are between the ages of 26-50 need to purchase hearing aids privately. This is often outside their financial means and they therefore go without.

5: Current demand and future need for hearing checks and screening, especially for children (12 years and younger) and older Australians at key life stages

As mentioned above, pensioners and veterans are eligible for an OHS-subsidised hearing test. They are eligible to one subsidised hearing test every three years when they acquire a new OHS

voucher. Some patients (those who have fluctuating hearing or chronic ear problems and some balance problems) require testing more frequently than this and we end up doing this at our own company's cost, rather than charging our pensioner clients private fees.

6: Access, availability and cost of required drugs, treatments and support for chronic ear and balance disorders sufferers;

Again, access to ENT treatment is severely limited in Mildura. Patients who have chronic or acute balance problems are greatly disadvantaged, both physically and financially, when they have to travel to access these ENT services, often when they are dizzy and feeling significantly unwell.

7: Best practice and proposed innovative models of hearing health care to improve access, quality and affordability;

The aggressive and unethical business models used by many hearing services chains are not based on "Best Practice". Our profession should be regulated to protect vulnerable patients from the exploitation and financial risk associated with these business practices within the audiology industry and sales targets and commission on sales should be banned.

From the ABC Radio National programme (Ref 2): Hagar Cohen is quoted "Gina Mavrias is the operations manager of the government agency Australian Hearing. Audiologists there receive a 5% commission on the price of the device they sell. So, for example, they will receive $600 for the sale a $12,000 device. This is not disclosed to the patients… Australian Hearing clinics also have sales targets for the number of top-ups they sell. In fact, across the organisation, 20% of the sales are supposed to be top-ups; that is, the more expensive devices that require additional payments."

Professor Paul Komesaroff, a specialist doctor, medical researcher and ethicist who is director of the Centre for Ethics in Medicine and Society at Monash University, was also quoted in the ABC Radio National programme: "In the medical profession, if a doctor prescribed a drug in a setting where he or she gained a commission or where a surgeon utilised a device in a setting where he or she gained a personal benefit from the sale of that device, that would be regarded as corruption, as a corrupt practice. In the case of audiology, it's become, at least to some extent, embedded systematically in the operation of the profession…It clearly documents the existence of an incentive system and a system of influence whereby audiologists are subjected to pressure to sell more of their products or sell more expensive products for their own benefit rather than primarily for the benefit of their patients…It represents a dangerous duality of interest that I believe, in many cases, does actually constitute a direct conflict of interest. I feel that it is, in general, wrong and inappropriate for a clinical practitioner to obtain material gain from a clinical recommendation that he or she may make regarding a particular therapy, whether it be a pharmaceutical drug or whether it be a device."

9: Whether hearing health and wellbeing should be considered as the next National Health Priority for Australia; and

It has long been recognised that there is an increased incidence of social isolation, depression and dementia within the hearing-impaired community. A significant correlation has been identified between deafness and those incarcerated in prisons. The impact of deafness on quality of life, reduced education and employment achievements, along with other associated health factors should mean that hearing health is definitely considered as a National Health Priority.

10: Any other relevant matter.

Within the audiology profession, there is significant uncertainty regarding the future rollout of the National Disability Insurance Scheme (NDIS) and we have grave concerns about the long-term financial sustainability of this. There have not been clear guidelines from the NDIA regarding

exactly how hearing services are to be provided. There is also a lot of angst within our rural community about the possible privatisation of Australian Hearing and the impact this will have on services to paediatric and complex patients.

We would be willing to discuss any of this material further with the Committee.

Yours sincerely,

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References:

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