Derek Moule

Committee Secretary

Senate Community Affairs Reference Committee

PO Box 6100

Parliament House

Canberra ACT 2600

Submission for Enquiry into Hearing Health in Australia

Dear Sir / Madam,

I wish the following points to be taken into consideration in the senate enquiry.

Adequacy of Access to Hearing Services, including assessment and support services, and hearing technologies

Hearing services are essentially not covered under Medicare. While some claims are made through a medical practitioner, audiologists can not directly claim through medicare and so there is a reliance of state funded services, which vary greatly in their functionality from state to state (some are near non-existent or have unacceptable waiting lists). While Australian Hearing provides hearing services to children, they are not a primary health service and so avoid seeing children for preliminary hearing screening.

The Office of Hearing Services (voucher) scheme has a narrow set of eligibility criteria (essentially pension card holders with a few minor additions). There is no government subsidy for persons requiring hearing aids who are not eligible for this scheme. The voucher scheme has created a competitive marketplace for large hearing aid providers to make large profits from this government funding. Given the lack of primary health services/funding, it is disturbing to see large hearing aid providers 'cold calling' pensioners to entice them to their clinic for a hearing test (paid for by the federal government, whether or not it is indicated). Once the contacted person attends for a hearing test, these companies will often also have sales targets both for the number of people they manage to fit with hearing aids and for the level of hearing aid (how expensive) they are able to sell the person (as top up aids with the additional contribution being made by the pensioner). I feel these practises have had a negative impact on how hearing professionals are viewed by the public. Voucher applications need to be signed by a medical practitioner however this has not prevented this practise and this requirement actually increases the likelihood of bad practises where large hearing aid providers build relationships with medical services and patients can be coerced to attend a particular clinic. It also places the medical practitioner in the position of making a decision about a person's suitability for rehabilitation where they are no trained to do this. A more appropriate way would be for audiologists to make these decisions but where incentives to act inappropriately are reduced by disallowing performance targets and the payment of commissions.

Low salaries and poor working conditions for state health based practitioners (compared to very attractive packages offered by some private clinics) also make recruiting to these positions difficult, especially in remote areas.

Adequacy of current hearing health and research programs, including education and awareness programs

The Office of Hearing Services (voucher) scheme has an emphasis solely on rehabilitation and even within that focus, on hearing aids. Hearing health programs seem almost non-existent. Indigenous Australians have a remarkably high incidence of otitis media in comparison to the rest of Australia and the rest of the world. High incidence of otitis media is generally seen in 'third world' countries with generally lower health outcomes and this is consistent with the situation in Indigenous Australian. 'Hearing health' cannot be seen separately from the rest of a person's (or community's) health. Contributors to poor hearing health (in particular otitis media) are such things as poor hygiene, overcrowding, smoking and poor nutrition (among others) and so to improve 'hearing health' there needs to be an emphasis on general health education.

Specific Issues effecting Indigenous Communities

Staffing problems, emphasis on rehabilitation rather than prevention and a lack of a coordinated approach to general health education has ensured that improvements in hearing health amongst Indigineous Australians have been negligible. Programs such as the Federal Government Emergency Response have had a very narrow, short term focus where a long term plan that involves Indigenous people is required. Prior to the Australian Government Intervention, in the Northern Territory there were already diagnostic audiology services available at Royal Darwin Hospital and NT Hearing Services. Australian Hearing provided rehabilitation services. The Australian Government Intervention provided another diagnostic audiology service. It is not uncommon for a given person to be seen by all these services, and so the amount of time spent reporting to all the other hearing service providers is very inefficient. There is a need for one audiological service in the Northern Territory to be built out of the existing services that can then work with other health services to provide an overall, coordinated health service. This would also mean the same audiologist could visit a community several times in a year rather than several audiologists visit once a year and allow the building of rapport and trust between the audiologist and community they visit. It would also mean staff could be shared in a way that ensured the continuation of services, rather than have periods where a particular service is unstaffed.

There is a need for health education programs to be delivered to Indigenous communities in the local community language. Pamphlets with simple messages in English have no more credibility than a TV commercial for a fast food chain. By delivering education in community languages, a much greater level of education can be provided and discussion can develop, rather than a one way message being delivered. It will also help the health professional build rapport with the community.

Yours sincerely,

Derek Moule

(Senior Audiologist Royal Darwin Hospital - views expressed are personal views only and should not be taken as representing the views of Royal Darwin Hospital)