Committee Secretary
Senate Community Affairs References Committee
PO Box 6100
Parliament House
Canberra ACT 2600

community.affairs.sen@aph.gov.au

October 5, 2009

Dear Sir/Madam,

Re: Inquiry into Hearing Health in Australia

Thankyou for the opportunity to submit my views to the Community Affairs References Committee.

Background

I express my comments as an individual and as an audiologist with over twenty years experience with Australian Hearing, primarily based in Victoria and NSW through:

1. Commonwealth Government's Office of Hearing Services (OHS) voucher program (and its predecessor the National Acoustic Laboratories)
2. Australian Hearing's Community Services Obligation (CSO) program to eligible clients including infants, children and young adults upto the age of 21 years, adults with more complex needs and indigenous clients

More recently in 2008-2009, I provided clinical services on a locum/visiting basis in the Northern Territory through Australian Hearing (as above) for approximately six months, the Australian Government Intervention program for two weeks in March 2009 and NT Hearing for six weeks. I've had the opportunity to frequently visit various communities in NT to clinics and schools (over twenty different communities outside Darwin) ranging from 1-4 days at each.

In addition, I have family members who accessed hearing services for themselves in Victoria and a relative who has been in the Deaf signing community.

Comments on Hearing Health re Terms of Reference

a) <u>the extent, causes and costs of hearing impairment in Australia;</u>

Noise induced hearing loss is well known to be a cause of acquired hearing loss. While there are hearing conservation programs widespread in industry, compliance with hearing protection at the individual level appears to vary and there is a **need for sustained education programs**.

Incentives to improve equipment design to reduce excessive and dangerous noise levels should be considered.

More information on the risks of excessive noise exposure in a recreational or domestic context should be made more widely available through public health promotion.

Fluctuating hearing loss and long-term conductive hearing loss associated with chronic otitis media is a problem for indigenous communities. Research is important to understand how chronic otitis media can be prevented and better managed from an earlier stage. The findings to date are well recognised, however, and we have not been more effective in implementing solutions. For example, the slow progress in improvements in overcrowding housing and adequate access to primary health are frustrating issues. So many other challenges present within this (including self responsibility). At the community level there needs to be more effective health literacy and health promotion which is appropriately resourced and supported with the shared commitment of communities. **We need to consider more innovative solutions to improve access to primary care** (see (e) below).

On the prevention of acquired childhood deafness, my observation is that although meningitis still occurs, I feel there has been a decreased rate of referral of deafness from meningitis since Hib immunisations were implemented in the early 1990s.

b) <u>the implications of hearing impairment for individuals and the community</u>

These are generally well understood by those with first hand experience and knowledge – educational, economic, social and psychological effects.
Unfortunately hearing loss still has a stigma and often individuals are reluctant to act. We need to continue to **improve the understanding and acceptance of hearing loss and provide well resourced and accessible services to address the range of individual needs.**

At the community level, the needs of hearing impaired are often overlooked – (for example, often at Flinders St train station or on trams in Melbourne, public announcements are poor quality sound, too rushed or not spoken clearly, even for those with good hearing. There are examples of announcements being made in a clear manner but it is not consistent so more awareness is needed. Important announcements should be supplemented with visual information).

Planning guidelines for public facilities should be systemic and consistently take into account sensory and physical impairments.
Aged care facilities should consider improved acoustics and design from the outset to help facilitate good communication eg dining areas are typically reverberant and open kitchens nearby contribute to noise levels.
Similarly, schools need to be mindful of good building design and classroom layout to minimise reverberation and background noise and ensure a good level of the teacher's voice above any background noise.
I recognise there have been efforts in the above areas with positive examples but I wonder how consistently well they are considered and applied.

Domestic appliances should have improved design to minimise any noise or an indication of noise levels or ratings. For example, domestic fume extraction units are typically noisy and this is one example of when communication between my parents in their kitchen becomes particularly challenging. It could be better managed through a less noisy appliance.

I note the introduction of a *"Cafe and Restaurant Acoustic Index"* by the Australian Acoustic Society. It would be worthwhile for them to receive more support to enhance their information and make it more widely known to the public and hearing impaired community.
http://www.acoustics.asn.au/joomla/crai-report.html

c) <u>the adequacy of access to hearing services, including assessment and support services, and hearing technologies;</u>

The two main barriers for access to hearing services are:

- **cost** (eg devices for those not otherwise eligible to 3rd party funded services such as OHS program or workers compensation schemes) and
- **geographical remoteness.**

Young hearing impaired and deaf adults who turn 21 and who are then no longer eligible for hearing services through Australian Hearing, are expected to bear the financial burden of funding future hearing devices (hearing aids and cochlear implants) themselves. This will depend on their capacity to pay and, assuming they have the capacity to pay private health insurance premiums, the rebates are often restricted. Without well maintained and fitted hearing devices, these people would not be able to maintain their life (economically, socially and overall well being) as well as they potentially could.

There is inconsistency in applying age restrictions to hearing services compared to other health services. Chronic health conditions (eg asthma, cancer, mental health, diabetes, cardiovascular) attract **appropriate funding for services with no restriction on age**. Optometric services are available through Medicare and do not have any age restriction. **So it should be for those who have had a longterm hearing loss since birth or childhood.**

The recent idea raised of a universal disability scheme like Medicare sounds interesting to explore further. It could help extend coverage of funding hearing services for those who would require service with the onset of hearing loss and otherwise receive no support from existing programs.

Workforce issues, sustainable capacity of resources and provision of a sufficiently regular service are challenges for audiology providers, moreso in remote areas. Other educational, health and allied health services are important for hearing impaired children to optimise development and reach full potential eg specialist educational intervention, speech pathology and for children who have additional disabilities along with hearing loss. **Allied health and educational services in remote areas often have unfilled vacancies, high staff turnover or waiting lists due to under-staffing.**

More incentives would help readjust the spread of workforce – eg living and housing costs in Darwin are quite high so employers could consider subsidised housing. The government could consider additional targeted tax rebates for health and educational professionals working in remote areas.

The availability of audiovisual services has become available to improve access (eg Royal Institute Deaf and Blind Children Teleschool Service). There is scope for more of this type of service delivery with the right infrastructure. However, there are occasions families need the right professional on site at the right time.

Clients in rural and remote areas should be eligible to receive funding to help cover transport costs to assist them receive specialist hearing services if specialist services are not easily accessible locally. This type of program exists in some eligible state funded health services.

My experience in NT provided the opportunity in some remote locations to use the **newly installed sound proof booths as funded through the AGI program. It is great to now have this audiological facility and work space available**. This enables better hearing service delivery and hearing assessments now possible for young children in the community.

It was also a positive experience in NT to travel in collaborative workteams with different services (eg working alongside an ENT and ear healthworker in AGI program or working as a collaborative team between Australian Hearing, NT Hearing and in some locations an ear healthworker). **Interagency collaboration, co-ordination and communication are important.**

For some clients eligible for **OHS services in remote locations, there were occasional examples of bureaucratic frustration with processes which could be simplified to expedite service and avoid additional delays** of between 2-4 months depending on when next available to visit. For example,

- clients not having an OHS voucher when in good faith they thought they did but did not fully understand the process (so having to reapply and wait for a voucher)
- clients deemed complex CSO and unable to have a full audiological review because the incorrect form had been signed with pension details and a “complex voucher” had not been processed (the correct form had to be faxed and client wait another 5-6 weeks until next visit)
- client expectations raised by a remote clinic they would be assessed for hearing aids only to have misunderstood the process and no OHS voucher application submitted (so voucher application completed and wait for next visit in 3-4 months).

For remote localities, a more flexible and straightforward process of documenting eligibility should be accepted and the audiologists focus on service delivery rather than untangling administrative processes (akin to CSO indigenous clients who present an eligible pension card and wish to be seen at that remote site on that day).

During 2008, OHS had a review of service delivery pathways. One proposal was that GPs would no longer be required to complete an application form for initial assessment. Given widespread problems with access to primary health services and wait for appointments with GPs, I was surprised OHS did not enact removal of GPs as the gatekeeper in the OHS program. **As professionals, audiologists have skill and expertise to identify when medical**

advice and intervention is warranted. Audiometrists are able to consult with audiologists when presented with clinical findings that audiologists can then help decide on need for medical opinion. **Why do we persist with requirement for GPs to sign an initial application form when their time is better focussed on other primary healthcare needs?**

Regarding technology, the tremendous advances in technology for hearing aids and cochlear implants have been fantastic. **Ongoing research for further innovations is important**.

Specifically for indigenous children with fluctuating or conductive hearing loss, **bone conductor hearing hats are a great innovation and generally well received. Improvements in design to help minimise damage or improve hat comfort in hot, humid conditions would be worthwhile.** It was impressive to observe some schools managing well co-ordinated programs supporting the use of hearing hats. There were, however, also examples of lack of awareness or co-ordination of this special need in some schools and on isolated occasions, disappointing to see some indifference by individual teachers. Staff turnover within schools and unfilled special needs vacancies are contributing factors to lack of co-ordinated support. **This highlights the need for effective and regular liaison with service providers and improving awareness amongst teaching staff.**

For indigenous children and adults with severe to profound hearing loss in remote communities who communicate via signing (often using "community signs" or gestures and signs developed within the family network) the outlook and complex circumstances was quite depressing. My limited observations suggested that although they could communicate with family members (and in one instance a younger deaf child with another much older community member) they did not appear to be or had been regular attendees at school. My impressions were they had limited language skills, limited communication ability with anyone outside their immediate community, limited access to fluent interpreters to communicate more complex matters and limited access to fluent Auslan (noting that English is not the first language in communities so my signed English was not so useful). **There needs to be improved service for the needs for language development and education of such isolated children.** In one case, a young signing girl moved from her community and now attending school in Darwin with better access to teachers with signing skills and since doing so, her hearing aid usage had also become more consistent. In another community, a new teacher arrived with Auslan skills who was able to work with the boy on a special needs basis but the boy was not attending school regularly and the teacher not able to continue with her contribution to special needs.

There is a challenge to address the perceived "shame job" that teenagers and students often report about hearing devices and acceptance of hearing loss (for me, two recent examples of students who rejected hearing aids). This is not unique and improvements in design to more cosmetically acceptable devices have greatly assisted. In one case (Darwin urban area) with more counselling, the student indicated a willingness to resume use with an undertaking to help facilitate her meeting other hearing impaired students and older role models. The second case was in a remote area and despite counselling by audiologists and teaching staff with interpreters, and family encouragement, she was steadfast in her refusal. She is limiting her own potential achievement and unfortunately trying to organise an opportunity for her to meet other young hearing aid users is more difficult in such remote areas. **Programs and appropriate counselling services to help support such isolated students are important.**

With respect to being able to best manage hearing services for the paediatric population, indigenous clients and remote populations across Australia, **Australian Hearing is an excellent model of service delivery that should be maintained and supported strongly in its endeavours.** As an audiologist moving across states, the benefit of consistent and uniform policies, procedures and systems, and access to clinical expertise makes an easy transition to walk into any centre and undertake clinical services.

d) <u>the adequacy of current hearing health and research programs, including education and awareness programs</u>

Australia's place in the area of hearing research is well regarded globally. Basic science research is important along with the transfer of knowledge into developing new technologies and procedures. I strongly advocate for ongoing research across different areas to improve

evidence based clinical practice and innovations in products and therapies. **Adequate funding should be available for continued research.**

With regard to hearing health programs, it has been **slow progress to achieving truly universal neonatal hearing screening across all states and even within states** (eg Victoria introduced a program to the major birth hospitals in Melbourne but not fully implemented across the State). As we know hearing loss can also be acquired after birth and fluctuating hearing loss experienced with otitis media in the early childhood years, so ongoing surveillance is important. **Hearing health programs need to provide appropriate services across the lifespan.**

Although there have been efforts by the Office of Hearing Services towards improving rehabilitation (ie not just funding hearing aid fitting) through the introduction of rehabilitation claim items, the focus and funding is largely still centred around hearing aid fittings. **The expectations of consumers and their families needs adjustment towards understanding the value and role of rehabilitation.**

Community education and awareness of hearing loss needs regular and sustained programs.

Many clinics and schools in NT have information resources to support healthy ears and healthy hearing campaigns. In NT, I observed variable implementation and awareness of public health campaigns such as "breathe-blow-cough" and well supported resources for use of tissue spears to help manage chronic ear discharge. **Sound field amplification systems were frequently installed in schools to assist with amplifying teachers' voices at a steady level above any reverberation and background noise.** Their use was not, however, consistent and a better understanding of their purpose and value often indicated. **We could be educating teachers on the availability and benefits of such systems at an earlier stage in their training to improve awareness.**

e) <u>specific issues affecting Indigenous communities</u>

I have experience of working with indigenous communities in rural Victoria, metropolitan Melbourne and in the Northern Territory. For a high proportion, hearing health and ear health are closely related.

One frequent barrier to me as a clinician in NT was being certain of an indigenous client's recent medical history (particularly with respect to management of middle ear conditions), where communication not straightforward due to lack of English or cultural differences. More information could be elicited where possible with help of other family members, healthworkers, teachers, and clinic files. Often enough though, it was not always possible to get that information quickly or if at all.

I would strongly advocate the **implementation of e-health records and that access be made available not only to primary health providers, but also secondary or tertiary health service providers.** This would facilitate more effective communication to be better informed of medical history and also to communicate management plans to other health providers.

Next G technology has been a valuable resource when available in remote areas – though access was sometimes not possible.

The challenges and opportunities to improve in remote areas and for indigenous clients are ongoing - eg providing an effective and regular service across vast areas, efficient systems and procedures, appropriate and effective engagement and communication with the community and clients, a commitment to self-responsibility by clients and families, access to timely and appropriate interventions and support from other services and professions as needed.

It has been **most worthwhile in recent years to simplify administrative procedures for and the extension of CSO hearing services to indigenous clients over 50 years of age or those who have worked in CDEP** (community development employment projects). I have observed clients now better able to hear and communicate with their hearing aids and clinical programs completed in a timely manner.

It was a positive experience in NT to travel in collaborative workteams with different services (eg working alongside an ENT and ear healthworker in AGI program or working as a collaborative team between Australian Hearing, NT Hearing and in some locations an ear healthworker). **Interagency collaboration, co-ordination and communication is important.**

On visits to clinics and schools, the need for primary health management for children and adults was evident (eg treatment for acute otitis media, chronic suppurative otitis media, foreign bodies or wax management, or ENT referral for otitis media with effusion or dry perforations). **In many instances, the primary care treatment could be arranged on the day at the clinic or (where seen at school) families advised when possible to attend the clinic for treatment.** Written reports would follow to the clinic and school with results and management plans. **Audiologists frequently take on a primary health role prior assessment in requesting children to blow their nose, apply tissue spears to mop ear discharge where indicated and/or wash hands and face.**

Often however, **access to a primary health care provider (doctor, clinic nurse or healthworker) was not always possible at the time for primary health treatment.** Advice would be given to clients and families to follow-up with the clinic for treatment but the challenge sometimes is communicating that effectively to the clinic, any family carers and the client themselves. **The opportunity for timely medical treatment could be lost.**

Upon return to some communities for subsequent visits, it was often apparent that despite best intentions, written reports and personal communication, **primary health care treatment did not always take place (possibly for various reasons).**

There is a case to **consider innovation in primary ear health care through introduction of suitably trained primary ear health practitioners with an appropriate scope of practice.** They could be drawn from audiologists, nurses and ear healthworkers and to manage specific ear conditions under clear guidelines (eg one model of CARPA manual guidelines used in NT) and arrange direct ENT referral when indicated. This would rely on appropriate training, systems, communication, local support, community follow-up and funding models for it to be effective and sustainable. It would be ineffective and inappropriate for this type of management to occur in isolation without all other things being in place. **This would complement existing primary health services and good working collaboration between professionals when all resources are in place. The intent is to enable appropriate management to occur at an earlier and more timely opportunity and avoid primary care management being missed or delayed.**

The breakdown in primary ear health care when an immediate need is identified highlights:

- **delays and lost opportunities to access treatment at earliest instance**
- **pressure on available primary health resources**
- **lack of primary health resources**
- **inefficiencies with communication and management of onward specialist referral**
- **unsuccessful effort or lack of resources to contact family to follow-up for treatment**
- **inadequate local management**
- **inefficient communication between agencies**
- **client/family not pro-actively following up on own needs**

Scenarios observed in different communities when timely and opportunistic primary ear health care broke down include:

- Hearing assessment of children at school and advice in person to family afterwards to visit medical clinic for treatment. Assumes families follow through.
- Assessment at clinic and treatment indicated. Two locum nurses on duty but busy with other patients. Nurses manage to see some patients referred for treatment if timing right but other patients left clinic, indicating would return later or on another day.
- Patient referred directly to doctor at clinic – doctor already working through lunchtime with considerable workload for day. Patient left clinic, indicating would return another day (doctor based at clinic most days).

- Small remote clinic – visiting doctor who attends on weekly basis. Doctor busy, client couldn't wait and doctor driving out that afternoon. Healthworker based in community but not available.
- Healthworker not available – away for a few days. Nurses busy with other patient needs. No doctor on site. Patients indicated would return.
- Reports sent to clinic indicating patient needs. Apparent at return visit that no opinion for treatment occurred as suggested.
- Inefficient manual systems – clinic behind in scanning and processing previous correspondence recommending treatment and in-tray overloaded with paperwork to be processed.
- Recommendations for ENT referrals not managed. Review of clinic's ENT list identified names not previously added. Reports overlooked, not acted on or inefficient manual system and communication.
- Families advised to seek medical opinion for treatment but not possible on day. Clients/families subsequently moved and reviewed in different community with no treatment having occurred.

If primary ear health workers with appropriate scopes of practice were to be introduced, the role of secondary and tertiary hearing service providers would need review. Issues for them to consider include their flexibility in service delivery to contribute to primary health care, how to be funded appropriately for primary health services delivered and how continue to manage their original prime objective (where existing resources often also high in demand).

The facts at present though are quite clear and in the context of current reviews of health management between States and the Commonwealth governments:

- **we continue to struggle with chronic ear health management within indigenous communities**
- **if chronic ear disease was better managed at the earliest opportunities with effective treatments, the longer term benefits would be better ear health and better hearing, thus less demand for secondary/tertiary services**
- **we need to consider new ideas to address indigenous health and improve health outcomes**
- **we need to be more flexible and have the capacity to deliver better healthcare**

Yours sincerely,

Paul Hickey