20 October 2009

Committee Secretary

Senate Community Affairs Reference Committee

Po Box 6100

Parliament House

Canberra ACT 2600

RE: HEARING HEALTH IN AUSTRALIA – SENATE SUBMISSION

Dear Mr Humphrey

On behalf of Attune Hearing Pty Ltd (Attune), we are writing in response to the *Inquiry into Health in Australia* with reference to *Hearing Healthcare in Australia - Terms of Reference*.

Jenny Stevens spoke to Christine McDonald on 7 October 2009, who kindly granted an extension of time to make this submission.

1. BACKGROUND TO ATTUNE

1.1. Attune, formally Queensland Hearing, was founded over 20 years ago by a group of Brisbane ENT surgeons to ensure reliable and readily available diagnostic services to support their ENT practices and the referring medical community. The view then, which remains today, is that the public health system cannot provide diagnostic audiology services in a sufficiently timely manner.

1.2. Attune provides a comprehensive range of (complex) diagnostic, rehabilitation and hearing aid services to urban and regional Queensland including Townsville , Mackay, and Hervey Bay, Nambour and Ipswich. To accommodate demand, Attune has recently opened a full service audiology clinic in St Leonard's Sydney, with plans to open similar, full service clinics in NSW and beyond.

1.3. Attune's 'full service" capacity includes paediatric assessment ,central auditory processing assessment for children with learning disabilities, vestibular function assessment, electrophysiological testing, hearing assessments for adults with retrocochlear and cochlear pathology, an adult cochlear implant program and tinnitus assessment, treatment and management. Hearing aid assessment services are provided privately and to clients on behalf of the Office of Hearing Service.

2. HEARING HEALTH IN AUSTRALIA

2.1. **Reference: The extent, causes and costs of hearing impairment in Australia**

As addressed in detail and summarised below from the Access Economics' 2006 report "Listen Hear! The Economic Impact and Cost of Hearing Loss in Australia":

Prevalence

- **One in six** Australians is affected by hearing loss.
- The prevalence rates for hearing loss is influenced by increasing age, rising from less than 1% for people aged younger than 15 years to **three in every four people aged over 70** years of age .
- With an ageing population, hearing loss is projected to increase to an average of **1 in every 4 Australians by 2050**.

- Evidence suggests hearing loss is the second highest ranked disability for men in Australia representing an average 5.7 years of life with a disability. For every Australian woman an average of 2.6 years of life.

Causes

The most common causes include:

- Age related hearing loss driven by the ageing Australian population.
- Noise related hearing loss due to hazardous noise exposure within the workplace.

Costs

- In 2005, the real financial cost of hearing loss was **$11.75 billion or 1.4% of GDP**.
- This figure represents an average cost of **$3,314 per person** per annum for each of the **3.55 million Australians who have hearing loss or $578 for every Australian.**
- Costs are conservatively based on prevalence of a hearing loss in the better ear.
- Costs conservatively do not include costs of otitis media, which may be substantial in some sub-populations, such as Aboriginal children.
- The financial cost does not take into account the net cost of the loss of wellbeing (disease burden) associated with hearing loss, which is a further **$11.3 billion.**
- The largest financial cost component is **productivity loss, which accounts for well over half (57%) of all financial costs ($6.7 billion**).
- Nearly half the people with hearing loss are of working age (15-64 years), and there are an estimated 158,876 people not employed in 2005 due to hearing loss.

3. Reference to: "The implications of hearing impairment for individuals and the community"

3.1. Consequence of hearing loss

- Associated poor quality of life including reduced capacity to communicate, affecting independence, socialisation and interpersonal relationships.
- Reduced ability to listen and respond to speaking; the ability to speak is lost or impaired.
- Reduced communication ability impacts on a person's life through the reduced opportunity for employment. As a group, individuals with hearing loss have reduced income and thus pay less in taxation and rely heavily on social welfare benefits.
- Adverse health effects associated with hearing loss include anxiety and depression.
- Leads to a greater reliance on community support and aged care facilities.
- Cost to administer the welfare benefits to hearing impaired.
- While interventions such as hearing aids and cochlear implants enhance a person's ability to communicate, the majority of people with hearing loss (85%) do not have such devices.
- Health system costs for the identification, diagnosis, treatment and management of hearing loss.
- Costs associated with the hearing device both privately and Commonwealth funded (OHS).
- Costs associated with education and awareness programs for individuals with hearing loss.
- Costs associated with Workcover claims.

4. Reference to: "The adequacy of access to hearing services, including assessment and support services, and hearing technologies"

4.1. Hearing Services – Assessment

Comment

- The hearing industry today is vastly different to what it was 3-5 years ago. A once small, privately owned 'audiology' industry has been replaced by a corporately consolidated, hearing aid product driven industry.
- The majority of hearing industry providers in Australia are now owned by European or US hearing aid manufacturers (which have vertically integrated into retail to protect their supply chain) or large public or private equity companies. We have no complaint about current industry ownership or the consolidation which has occurred.

- We do however make the following observations about the effect of consolidation on the matters about which the Committee has invited submissions:

  1. Diagnostic audiology is a dying profession. The majority of audiologists have either sold to hearing aid retailers or ceased doing more complex diagnostic work because it cannot be done cost effectively. Diagnostic services are arguably the most important part of the audiology professional service.

  2. The majority of (at least initial) hearing assessments are now performed by untrained and unskilled staff. The initial tests are usually quick, and free, with the objective of achieving a hearing aid sale.

  3. Similarly, the majority of (at least initial) hearing assessments are done in poor sound environments which do not meet Australian and New Zealand Standards for testing.

  4. Emphasis is on the hearing aid sale, not counselling and rehabilitation.

  5. Post sale, ongoing support services are poor and often non existent.

- From one perspective, access to quick and free hearing screens is a good thing for relevant stakeholders. Conversely, there is evidence that –

  1. At great cost to the Commonwealth, many consumers have been fitted with hearing aids in circumstances where they will never benefit from them.

  2. Consumers have not been properly, diagnostically examined, such that serious medical indicators have been missed with resulting serious medical consequences for the patient.

  3. Consumers often do not maintain use of hearing aids because they did not receive adequate professional counselling prior to fitting, or adequate follow up service or support (if any).

  4. A lack of disclosure exists regarding professional qualifications, credentials and standards and the "real" difference between the skill set of audiology professionals and untrained/unskilled hearing aid fitters.

  5. Hearing screening services without adequate follow up diagnostic assessment risk the lack of identification of underlying medical pathologies.

  6. Severe to profound hearing loss identified in children who are subsequently fitted with hearing aids or an implantable device, after the age of 21, have no subsidised, ongoing rehabilitation program until they reach pension eligibility. These recipients have reduced employment opportunities and fall into the lower socio-economic group.

Recommendations

The hearing services industry should be properly regulated, with the introduction of accreditation, including standards, and a quality framework, to ensure that:

1. Hearing aid assessments are conducted by qualified and credentialed audiology professionals, or at the very least, by trained people who at all times work at 'elbow's length' to an audiology professional. Full disclosure of professional or non professional qualifications should be mandatory so that consumers can make informed decisions.
2. Hearing aids should not be dispensed until the consumer has been fully diagnostically examined in sound proofed environments which comply with Australian and NZ standards. This is not to say that initial screening could not be done in other environments; but a follow up, full examination, by a qualified audiology professional, in sound proofed environments, should be mandatory, prior to hearing aid fitting.
3. Without these requirements, many people will continue to be fitted with hearing aids that provide no benefit. Of more concern, serious medical indicators will continue to be missed. Both outcomes will continue to burden the Commonwealth with considerable and unnecessary cost.
4. Additional financial assistance should be provided for diagnostic audiology services. The 'gap' is currently too high, such that many consumers cannot afford to pay for them.
5. While Medicare does contribute to "mapping costs" a program to assist recipients of implantable devices who are unable to afford ongoing related repair, service, parts, replacement, rehabilitation and maintenance costs should be considered. Implantable devices need to be replaced every 5 years.
6. Due to the inconsistency of professional standards across the industry develop an accredited standards framework and adopt quality, safety and clinical practice standards for implementation by hearing health services. Assess the performance of hearing services in meeting these standards and make recommendations for improvement.

4.2 **Hearing Services – Support Services**

Comment

- Support services such as pre and post hearing aid fitting rehabilitation programs, are not adequately provided, partly due to poor (if any) remuneration for the audiology professional in providing such on going support.
- Hearing Healthcare must be *service and not product* driven.
- Education to prevent avoidable hearing loss especially in the younger population and in the workforce will help reduce and prevent hearing damage.
- Following a period of extensive consultation, representative members of the broader hearing industry met in July 2009 to discuss the Clinical Pathway for OHS recipients. Minutes of the meeting are attached for ease of reference. It was agree that :

  1. The medical practitioner should remain at the entry point to the pathway.
  2. Improved communication between the GP and hearing practitioner, specifically reporting and referring, will facilitate better outcomes for clients.
  3. The fitting of hearing aids forms only one small part of the professional skills of the audiology professional.

Recommendations

1. Any outcomes of the Senate Enquiry should be consistent with those which have already been agreed to by industry representatives in the context of discussions about the OHS Clinical Pathway.
2. Increased focus on prevention of hearing loss by providing educational programs which are focused on preventative care, including support for healthy hearing lifestyles at home and in the workplace.
3. Through the delivery of community awareness programs inform the client of the high quality after care service which is mandatory to enhance positive outcomes of device fitting.
4. Introduce an accreditation system including standards and a quality framework for the hearing industry.
5. A strong professional working relationship between all healthcare and education professionals associated with the care of patients with hearing disabilities should be encouraged and assisted.

4.3 **Hearing services - Hearing Technologies**

Comment

- An increase of on-line hearing service provision has lead to hearing aids may now be purchased on the internet with no professional “face to face” consultation. This practice will continue to grow due to the reduced prices for these devices, which is due to limited “on the ground” support services by these suppliers.
- As hearing tests become more automated, untrained and unskilled staff are being used to provide assistance.
- The future will be characterized by rapidly evolving technology in which the line between hearing care and consumer products has become increasingly blurred. As the size of the hearing loss population booms new businesses will try to capture clients through non traditional channels ie. on-line internet sales and other future telecommunications technologies (Bloggs, Twitter,etc).
- Awareness of access to hearing devices is driven by “social marketing” which leads the consumer, into believing there is “no real choice.”
- Cheaper hearing devices and regular upgrades in technology mean that patients are less concerned with extended warranties.
- Service v Product. Ideally, management of a hearing loss should not be product driven but also consist of a rehabilitation service that assists the patient in optimising the efficiency of the hearing device. The patient's progress should be monitored during scheduled visits to evaluate success allowing for appropriate modifications to both service and device.
- In the last few years large manufacturers of hearing assistive devices have purchased existing clinics or alternatively opened direct to consumer retail outlets to ensure their supply of devices within the retail sector is ensured in an increasingly competitive market. This significant corporate consolidation has seen monopolies forming with the consolidation of the industry.

- The consequences of this consolidation may include the following the risks for health sector in the future:

  (1) Closure of smaller clinics and loss of *true* diagnostic services to the medical community.

  (2) Reduced client choice for service.

  (3) Provision of a "full diagnostic service" audiology model providing comprehensive audiology services including those services (Auditory processing, tinnitus management, vestibular and balance assessments, paediatric hearing tests, implantable devices) which are poorly remunerated but supported by hearing aid services, will not be sustainable and be lost to the private sector.

  (4) Increased waiting times for the public health sector.

  (5) Declining diagnostic audiology skills among audiologists.

  (6) Loss of services to rural and remote areas resulting in poor outcomes for these communities.

Recommendations

1. Client satisfaction is not only tied to fitting and aftercare but is closely linked to the appropriate evaluation of the hearing, realistic expectations and the explanation. Clients requirements need to be identified and understood and recommendations for amplification are reflected in a personal needs for lifestyle. As this cannot and would not be performed through internet sales public awareness programs to alert potential consumers to the lack a "value added service" and potential poorer outcomes is recommended.
2. Due to the increased use of the internet by the aging population consumers initial introduction to hearing rehabilitation is the hearing aid device. With advancing age and the associated cognitive emotional and social changes this population is open to exploitation and inappropriate outcomes.
3. Consistency in marketing material, limitations of the device and realistic outcomes should be provided by all providers of hearing devices.

5. <u>Reference to: "The adequacy of current hearing health and research programs, including education and awareness programs"</u>

Comment

- Consumers are not sufficiently informed to understand that hearing aids do not, by themselves, provide a complete solution to their hearing difficulties.
- There is a lack of awareness in the community of the *true value* of additional counselling and rehabilitation services provide, in ensuring better outcomes for device fitting.
- As evidenced by the *2006 Access Economic Report*, the productivity loss consequences of hearing impairment in Australia are enormous. OHS provides financial support to young and older Australians who will benefit from hearing aids, but no Commonwealth assistance is provided to working people with hearing loss, or their employers.
- The Australian Government through the National Acoustic Laboratory, supports research in regard to hearing loss, rehabilitation and prevention.
- Recognising the importance of *The Blue Mountains Study* and *Access Economics Listen and Hear Research* 2006, given the ageing population, hearing health is underfunded, uncoordinated, and under researched, given that hearing impairment affects 50% of the Australian population.

Recommendations

1. A coordinated research program should be commissioned, with a firm empirical platform for both development and continuing evaluation, receiving data from all stakeholders regarding "total hearing care" across all sectors in audiology.
2. The Department of Health and Ageing has, through a number of initiatives, raised the importance of the Healthy Ageing concept. Thus more attention needs to be given to the reliable diagnosis, identification and appropriate treatment of hearing loss within the aging population.
3. Working Australians and their employers should receive tax benefits or other concessions for both hearing assessments and hearing aids. Naturally, safeguards would have to be implemented to ensure the integrity of the system. For example, evidence should be required that the employee and employer would benefit if hearing services and products were provided. The accreditation framework referred to earlier in his paper would greatly assist to ensure that the right balance is achieved for the employee, the workplace and the Commonwealth.

6. **Reference to specific issues affecting Indigenous and rural communities.**

Comment

- Shortage of consistent follow up programs for prevention and treatment.
- Delay in time appropriate services.
- Inadequately trained, inexperienced, predominately young staff to deal with complex issues in predominately isolated locations.
- Lack of current and appropriate equipment.
- Lack of consistent multi- disciplinary teams working in a co- coordinated approach for long term sustainable benefits to the communities.
- Recognition of the impact hearing loss has on education, employment and social consequences.
- While many audiology professionals would like to devote more time to servicing indigenous and rural communities, the reality is that that under current funding arrangements, these services simply do not pay. Having said that, many audiologists continue to perform these services, but on a part time, philanthropic basis. As a consequence, the services are inadequate to meet the genuine needs which exist.

Recommendations

1. The Commonwealth should support organisations which are attempting to provide consistent and specific programs and services to rural and indigenous Australians, in an attempt to reduce inequity in service delivery.
2. The Commonwealth should support a multi disciplinary, team based approach for hearing care in rural and indigenous communities.

SUMMARY

In summary, introduction of an accredited standards framework will produce a better and more cost effective outcome for consumers, employees, workplaces, the Commonwealth and hearing service providers.

Yours Sincerely,

Jenny Stevens DipTeach,BEd,MEd,DipAud,MAudSA(CCP)

CLINICAL DIRECTOR

Patrick Gallagher BA/LLB

EXECUTIVE CHAIRMAN

Attachment 1: Minutes of OHS ACP meeting 13 July 2009

ATTACHMENT 1

DEPARTMENT OF HEALTH AND AGEING

MINUTES OF MEETING

Subject Clinical Pathway and Rehabilitation Plus **Date** 13 July 2009
Location Stamford Plaza (Sydney Airport)

Attendees

Gina Mavrias, Australian Hearing
Janette Thorburn, Australian Hearing
Monica Persson, Audiological Society of Australia
Jim Brown, Audiological Society of Australia
Sarah Love, Audiological Society of Australia
Dr Peter Ford, Australian Medical Association
Dr Brian Williams, ASOHNS (The Australian Society of Otolaryngology Head and Neck Surgery)
Mark Carmichael, ASOHNS
Nina Quinn, The Neurosensory Unit
Donna Staunton, Hearing Care Industry Association
Patrice Lockwood, Hearing Care Industry Association
Jan Pollard, Hearing Care Industry Association
Nicole Lawder, Deafness Forum
Sharan Westcott, Deafness Forum
Gayle Dicieri, Australian College of Audiology
Ian Mawby, Australian College of Audiology
Bill Vass, Australian College of Audiology
Dr John Aloizos, Royal Australian College of General Practitioners
Steve Sant, Rural Doctors Association of Australia
Gerry Taniane, Hearing Aid Audiometrist Society of Australia
Matthew O'Neil, Hearing Aid Audiometrist Society of Australia
Anne Plohberger, Hearing Aid Audiometrist Society of Australia
Jenny Stevens, Attune Hearing

Office of Hearing Services (OHS)
Richard Bartlett, National Manager
Chris Jennings, Director, Clinical Support Section
Lynne Clune, A/g Director, Quality Assurance Section
Stephanie Isaacson, Assistant Director, Quality Assurance Section
Catriona Macivor, Audiologist, Clinical Support Section

Apologies
Teri Snowdon, Royal Australian College of General Practitioners

Item 1 Clinical Pathway – a way forward

1.1 Entry Point

There was general consensus for the medical practitioner to remain at the entry point to the pathway (as the multidisciplinary care team leader).

1.2 Referring and reporting

It was agreed that improved communication between the GP and hearing practitioner, specifically reporting and referring, will facilitate better outcomes for clients.

For a more streamlined approach, medical practitioners would prefer to use the *New Clients Hearing Services Voucher Application Form* to certify and refer clients. However, the current form does not clearly spell out what the medical practitioner is certifying nor does it provide capacity for referral.

The medical practitioner requires a report of the client's outcomes. However, due to potential medical indemnity implications, medical bodies oppose any "unsolicited" reports and will only accept reports on referred clients.

Hearing practitioners need to know the name of the referring medical practitioner, particularly where clients assessed with medical indicators need referral for medical assessment. Currently, they currently do not have access to this information.

ACTIONS

Representatives from medical groups and professional bodies will be sought to form a working group:

- To develop reporting templates for:
  - information sharing; and
  - alignment with e-health developments.

1.3 Medical and non-routine indicators

The meeting agreed to a review of medical indicators that prevent the fitting of a hearing device, noting that some clients may have medical indicators which do not preclude the fitting of a hearing device.

1.4 Audiolink and 610/810 items

There was mixed response to the effectiveness of the audiological referral with some participants favouring its removal from the Program.

ACTION

Volunteers will be sought to form a working group:

- To review medical and non-routine indicators.
- To review the Audiolink function and viability of the 610/810 items in relation to a "second opinion".

1.5 Medical education

The meeting agreed that medical practitioners, particularly GPs, would benefit from further education on hearing assessment and clinical decision making.

ACTION

Representatives from medical and professional bodies will be sought to form a working group:

- To develop appropriate training tools for GPs.

1.6 OHS Administrative processes

There was general consensus that OHS administrative processes need streamlining.

> ***ACTION***
> OHS will review administrative processes with the aim of streamlining the processing of new client application and return voucher forms.

1.7 Proposed pathway

The meeting agreed that some modification to the current pathway, other than major change, would improve the safety and quality of hearing services for clients. A final model would incorporate:

- the medical practitioner at the entry point
- better reporting mechanisms
- revised non-routine and medical indicators
- a "second opinion".

> ***ACTION***
> Key bodies will provide OHS with comments on a preferred final model by 31 July 2009.

Item 2 Minimum Hearing Loss Threshold (MHLT)

The 2009-10 Budget Measure of a hearing threshold of 3 FAHL of 23dB will be introduced on 1 July 2010. Prior to implementation, OHS will work with service providers and professional groups to identify tests, to ensure that patients who can get a clinical benefit from having a hearing aid fitting are not denied under the threshold measure. Tests under consideration include:

- high frequency tests for 2, 3 and 4KHz
- 23dB at 5(1,2 hertz)
- client motivation measurement tests
- tools for predicting outcomes.

> ***ACTIONS***
> OHS will work with key bodies
> - To develop guidelines to assist medical and hearing practitioners in the application of the MHLT.
> - To develop a letter (sent with the *New Clients Hearing Services Voucher Application Form*) describing the implementation of the MHLT.

Item 3 Rehabilitation Plus

The meeting noted that although Rehabilitation Plus would more effectively be implemented through mixed groups of new and return clients, it is currently restricted to new clients.

Solutions to consider include:

- training appropriate people, such as representatives of the Deafness Forum, to provide rehabilitation; and
- Promote Rehab Plus within client goals.

> ***ACTIONS***
> OHS will work with key bodies to develop guidelines to assist hearing practitioners in using Rehabilitation Plus.

Item 4 Other issues raised

- Home visits – practitioner paid the same amount as a centre visit, although the associated costs are much higher.
- Funding for interpreters (available under the Program prior to 1997).

Item 5 Summary of Actions

1. Volunteers will be sought to form working groups:
   - 1.1 To review and amend the *New Clients Hearing Services Voucher Application Form* for the purposes of:
     - certification of the client;
     - referral of client for hearing rehabilitation services;
   - 1.2 To develop reporting templates for the purposes of:
     - information sharing; and
     - alignment with e-health developments.
   - 1.3 .To review medical and non-routine indicators
   - 1.4 To review the Audiolink function and viability of the 610/810 items in relation to a "second opinion".
   - 1.5 To develop appropriate training tools for GPs.
   - 1.6 To review OHS administrative processes for more streamlined processing of new client application and return voucher forms.
2. Key bodies to provide OHS with comments on a preferred final model by 31 July 2009.
3. OHS will work with key bodies:
   - 3.1 To develop guidelines to assist medical and hearing practitioners in the application of the MHLT.
   - 3.2 To develop a letter describing the implementation of the MHLT(sent with the *New Clients Hearing Services Voucher Application Form*) describing the implementation of the MHLT.
4. OHS will work with key bodies to develop guidelines to assist hearing practitioners in using Rehabilitation Plus.