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

RE: Inquiry into Hearing Health in Australia

Dear Community Affairs References Committee,

The Senate has referred the following matter to the for inquiry and report by the last sitting day in February 2010:

Hearing Health in Australia with particular reference to:

a) the extent, causes and costs of hearing impairment in Australia;

b) the implications of hearing impairment for individuals and the community;

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

d) the adequacy of current hearing health and research programs, including education and awareness programs; and

RE: a) **extent, causes and costs of hearing impairment in Australia**

one in six Australians has some form of hearing impairment, and this is projected to increase to one in four by 2050 (from Access Economics (2006) *Listen Hear � The Economic Impact and Cost of hearing loss in Australia* Canberra, you can view this online at http://www.accesseconomics.com.au/publicationsreports/showreport.php?id=71&searchfor=2006&searchby=year

The main thrust of the report is that " In 2005, the real financial cost of hearing loss was **$11.75 billion or 1.4% of GDP**." Yet the **Direct health system costs** are expenditures incurred in the health system for the diagnosis, treatment and management of hearing loss. These costs are estimated at **$674 million** in 2005, **(including hearing aids and cochlear implants)** and account for less than 6% of total financial costs.

RE: b)) **the implications of hearing impairment for individuals and the community**;

Hearing impairment leads to social withdrawal and isolation, frustration, embarrassment, depression, dementia. The costs to the health system are enormous and could be reduced with early effective rehabilitation.

RE c) **The adequacy of access to hearing services, including assessment and support services, and hearing technologies;**

Unfortunately due to the medical centric health system, the skills of allied health practitioners are under utilised. This means that many people who could be directly treated by audiologists are having to wait to see a General Practitioner, who due to their lack of training, either fails to address the issue or just refers to an ENT where there is a further wait. The most straightforward way is to have audiologists with direct medicare acces to align with optometrists and dentist along with referral rights to ENT doctors and the prescription rights for mild antibiotics and antifungal medication to help with otitis media.

Doctors have also unfortunately often been an impediment to appropriate, timely and accurate information about aural rehabilitation, this has led to people waiting far too long before taking action through assessment and rehabilitation. Motivation is a key factor in successful aid use and it is important that when people decide they would like help, the application process needs to be fast, straight forward and widely available. It is especially important that applications are available to providers and practitioners to enable the motivated client to achieve entry to the program in one step. The wait to see a GP or ENT saps motivation and places undesired cognitive strain and stress on vulnerable people.

The irony of the current system is that audiologists who do the testing, write the reports and diagnose the problems for ENT or GPs to fix yet are not recognised for their services.

Emerging technologies such as otoacoustic emission testing and the whole range of auditory processing assessments are areas that can only be done by audiologists and there should be medicare funding for them .

While there is access through enhanced primary care plans- 5 appointments per year spread across the many allied health providers is inadequate and the referrals required are too complicated so GPs don't bother referring.

Access for pensioners and Veterans is excellent and a strength, however the same can't be said for private health insurers. Most private health insurers don't go close to matching what the Government pays for devices, and they rarely pay for audiological services. They seem to believe hearing aids fit themselves when over a 5 year period the Government will pay up to $860 for audiological assessment, rehabilitation assessment, hearing aid fitting and follow up services and ongoing reviews on top of the up to $880 for devices and $900 to maintain and repair the devices. Compare $2640 over 5 years with the $400 every 5 years that one of the major private health insurers pays for devices and no payment for services or repair!

Support services are available yet hearing is often not mentioned when it comes to numeracy and literacy an example is from Early Childhood Literacy and Numeracy Cards from the Office of Early Childhood Education and Child Care. They are an excellent idea presented well however hearing critical for the development of literacy and numeracy, unfortunately there was no mention of hearing in the set of thirty two cards.

While most children are screened for hearing loss at birth, there is a burgeoning misconception that because they passed the initial screen, there will be no hearing difficulty later on. This belies the fact that chronic middle ear infections are one of the most common chronic conditions in children. The fluctuation in hearing due to conductive hearing problems, caused by the ear infections causes, is a common cause for delay in literacy and numeracy skills. Unfortunately due to the increasing number of children in childcare and a lack of access to general practitioners for time poor parents, these children are not being diagnosed effectively. Hopefully the Government will in their wisdom give primary care access through Medicare to audiologists to help alleviate the access difficulty and to provide effective solutions.

Ideally with literacy and numeracy, to have a dot point to have a hearing check, especially if the child is felt to have "selective hearing".

E: D- **the adequacy of current hearing health and research programs, including education and awareness programs;**

and compensation need to be addressed so that people are adequately compensated and that compensation is given to 8Khz to at least cover the speech range. Current compensation is only up to 4kHz.

RE: e) **specific issues affecting Indigenous communities.**

While there has been a long term problem with the ear health in communities, I feel there is some simple strategies that have been overlooked in the medical model of care . The simple strategies would help reduce the problems requiring surgical care and there would be a corresponding improvement in literacy levels.

Step one; for those communities that have pools, there is a way to have automated control of the pool that does away with the need for chlorine. This would mean that the pools can be set to be isotonic and therefore will not cause irritation of the nasal, Eustachian, and middle ear for those children that tympanic membrane perforations. These pools use an anode system and were developed by Don Tallon in Brisbane.

Nose clips: stop water entering the nasal passages and irritating the Eustachian tube or causing acute Otitis media.

Otovents: an Otovent is a simple device where a balloon is inflated by blowing out one nostril at a time, this is fast, effective, easy to use, fun and cheap! See below.

OTOVENT

The only clinically effective, non surgical, drug free treatment for glue ear

What is Otovent

Otovent autoinflation treatment is a clinically effective glue ear treatment designed to reduce the need for surgical intervention. It's convenient, increases chances of a shorter recovery time from glue ear and is the only effective non-invasive glue ear treatment for use during the 'watchful waiting' period.[1]

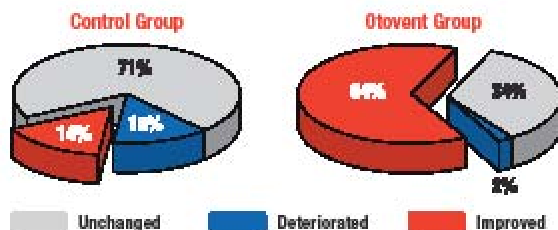
Otovent may reduce ENT referrals for Glue Ear by up to 50%.
Otovent is listed on the drug tariff under Appliances: Autoinflation Device: Otovent
PIP Code 102889

NICE guidelines on Autoinflation

NICE recommends that GP's should offer autoinflation during the active observation period to children with OME who are likely to cooperate.[2]

Proven Success in Clinical Study[3]

Tympanometry[4] after 2 weeks of Otovent treatment



About Glue Ear

Glue ear is a very common condition that affects 80% of children at some point during their childhood - 200,000 per year in the UK. Also known as secretory otitis media, otitis media with effusion or serous otitis media, more than 7 in 10 children have at least one episode of glue ear before they are 4 years old, and boys are more commonly affected than girls (source: Zeilhuis).

1 The time period between the first examination by the GP through to a grommet operation.
2 Quick reference guide. Issue date: February 2008. Surgical management of otitis media with effusion on children.
3 S-E Stangerup M.D., J. Sederberg-Olsen M.D., V. Balle M.D. Autoinflation as treatment of Secretory Otitis Media. Arch Otolaryngol Head Surg 1992; 118: 149-152.
4 The measurement of the outer and middle ear's ability to accept and conduct sound.

Chewing gum – – aids Eustachian function, research in the USA demonstrated 40% reduction in otitis media and Eustachian tube dysfunction if used at least 3 times per week — have chewing gum that includes Multivitamins and use as a reward for school attendance and good behaviour! Combine it with isotonice nasal sprays and the Otovent for all kids and there would be a huge improvement in hearing health for little cost and effort.

headphones for TV so adequate volume English is heard from an early age to improve literacy - can either be cordless or for a more cost effective option run a set of computer speakers and an mp3 sharing adaptor so 5 Headphones can be run for $100

To summarise, the cost of hearing loss is significantly more then what is spent to address the issue. To improve service in rural areas(incentives like for doctors needed) and the general population, audiologists should be included and entitled to claim the existing Medicare rebate structure in line with ENT for hearing assessment and balance/vestibular testing with the addition of auditory processing and otoacoustic emission testing to be consistent with optometrists. Private health insurers need to pay for audiological services and to increase the rebates for hearing aids. With Indigenous health, much more work on prevention needs to done and as explained, quite simple and cost effective measures are available.

Yours sincerely,

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