Committee Secretary
Senate Community Affairs References Committee
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Dear Colleagues

Inquiry into Hearing Health in Australia

Thank you for the opportunity to contribute to the current inquiry into hearing health in Australia. You have requested information 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
e. specific issues affecting Indigenous communities.

As an audiologist with clinical and research experience in the field of professional practice, I am contributing mainly to points c) and d) listed above, but note that there is considerable overlap across these five nominated areas.

Hearing healthcare in Australia has an admirable history. In order to ensure that services remain comparable to those offered in the rest of the world, a review of current practices is required. This is a vast area for discussion. However, three main areas for change are very obviously needed in the hearing healthcare industry:

1. **Registration of Audiology as a profession**, distinct from audiometry, nurse audiometry and medical specialties such as Ear Nose and Throat.

2. **Allocation of Medicare item numbers associated with hearing assessment Audiologists**, allowing them to work independently.

3. **Office of Hearing Services to revise renumeration polices to reward Audiologists for professional services**, not just device provision.

Audiologists are professionals trained at postgraduate university level to provide diagnostic and rehabilitative hearing services to people of all ages. However, at present, anyone is Australia is allowed to offer hearing services to members of the public. Under Medicare, medical practitioners may employ staff (not necessarily formally trained) to undertake hearing assessments on their behalf. Medicare, reimburses patients or pays medical practitioners directly for such hearing tests. In some cases, medical practitioners employ trained Audiologists to undertake this work. Medicare does not allocate item numbers for hearing and balance assessments to Audiologists. Audiologists are only recognised by Medicare as independent professionals for limited work undertaken as part of an enhanced primary care plan, and for audiology services offered within a limited scope to Aboriginal and Torres Strait Islander people.

To ensure that the Australian public has access to hearing services by fully trained Audiologists who are capable of interpreting and integrating all aspects of the assessment, Medicare should assign item numbers for audiological assessments to Audiologists. This form of recognition will raise the standard of hearing care and will ensure that all patients who access Medicare funding for audiology are attended to by trained professionals.

The **recognition of Audiologists as the primary provider of hearing services** need not negate the role of others who contribute to the field, such as audiometrists (trained at Tafe), nurse audiometrists (trained in hospitals) and the like. However, Audiologists need to be recognised for their unique role and knowledge gained by a minimum of five years of university training. Audiometrists and nurse audiometrists with far lesser training and limited scope of practice should work under the guidance and supervision of Audiologists. The contribution from those technically trained audiometrists would thus continue to be valuable, but would be differentiated from the contribution of Audiologists to the overall hearing service.

Recognising the professional role of Audiologists in diagnostic and rehabilitative audiology for all ages, and the supervisory role of Audiologists over technically trained audiometrists and nurse audiometrists, will ensure that a high standard of hearing services can be achieved for Australia.

Associated with the recognition of Audiologists as primary providers of hearing services is the need to recognise **hearing rehabilitation as involving counselling, communication skills training, support for family members and others, and the use of hearing aids and other assistive devices**. To date the focus of hearing rehabilitation in Australia has been on devices (hearing aids and implantable technologies). Evidence for the device focus is seen in the fees paid for devices and the top up policy that is in place for OHS, and pricebundling of fees and devices that takes place in the private sector.

Whilst OHS has always allowed patients to opt for counselling instead of a hearing device, such counselling is limited and restricts access to devices. The counselling option results in only a small fee being paid to the service provider. OHS does not currently allow any gap fee for *services*, only for *devices* under the top of scheme, making the offering of counselling services a less financially viable option to serviced providers.

Recently OHS introduced “Rehab plus” which is payment to audiologists for counselling sessions that *follows* the fitting of hearing aids. Whilst this is an improvement on past practices, it does not go far enough to ensuring that patients have access to comprehensive audiological services.

Firstly, the restriction to just two sessions suggests that all patients will have sufficient support with very limited time with the audiologist.

Secondly, the counselling is only paid for by OHS when sessions follow the fitting of a device, a policy which ignores many patients’ needs for counselling in order to *prepare* them for effective use of hearing devices. The counselling option is also available only to patients who receive fully subsidised hearing aids.

Those who “top up” within the OHS scheme are not eligible for Rehab Plus, a policy which reinforces the incorrect notion that hearing aids that are paid by patients achieve better outcomes. The strong message that this sends to patients and professionals alike is that currently the OHS scheme is a device driven programme, that devices are the solution to hearing loss, and that more expensive devices result in better outcomes. There is no room in this scheme for recognising the role of the Audiologist in addressing psychosocial issues, a widely recognised aspect of hearing rehabilitation that influences the outcome of rehabilitation, including how effectively devices are used.

A review of the way OHS operates is required in order to shift OHS policy to truly embrace rehabilitation and adopt a *service* orientation.

Audiologists in Australia need to be renumerated for time spent with patients in addressing the effects of their hearing loss on inter and intrapersonal functioning.

The counselling and communication training that Audiologists offer their patients needs to be recognised as valuable, as contributing to improved outcomes for patients, and as integral to hearing aid use.

Further, the skills needed to recognise the difficulties that patient face in coping with hearing loss as associated with other mental health and health issues requires knowledge and insight built up over years of study of psychology and communication.

Audiologists, with a minimum of 5 year of university study (that incorporates psychology, communication disorders, linguistics, auditory anatomy and physiology, language, auditory pathology, Deaf studies, child development, geriatric studies, paediatric audiology and geriatric audiology)**, are suited to undertake this level of intervention for those with hearing loss.** Audiometrists, with their training at Tafe level, do not have the background to undertake this complex clinical activity.

Audiologists who spend considerable professional time and skill in offering counselling to their patients ought earn a **reasonable professional fee** for their services. A reasonable fee is one that that covers the basic cost of running a practice and earning a comparable salary to other professionals

with postgraduate training. Each clinic has different running costs. This has so far not been recognised by OHS policy.

A **restructure of OHS to recognise *service* as well as *devices*** should lead to fees being either bulk billed or a gap fee could be charged, at the discretion of the Audiologist. This would give patients access to hearing rehabilitation, not just hearing technologies, as is currently the case. Research conducted in Australia and elsewhere has shown clearly that counselling improves the quality of life and overall outcome of intervention for those with hearing loss. It is now time for OHS to put that research into practice in its policies.

A prerequisite for this revision is the **differentiation within the scheme between Audiologists and audiometrists,** as discussed above. Over the past year OHS has sought to narrow the gap between these two groups of hearing service providers through offering audiometrists training in aspects of audiological service provision. However, the amount of time and depth of training has not been comparable to that included in university Masters level programmes. In my opinion, the attempt to narrow that gap through offering short courses to audiometrists to "upskill" has undermined the complexity of hearing loss and its effects on individual functioning. Hearing loss causes complex language, processing, and mental health effects that impact on every aspect of the lives of affected individuals. **A deep understanding of the impact of hearing loss on psychosocial functioning thus underpins all audiological decisions.** The short courses offered to audiometrists cannot compare to university level training over many years. Yet, the current scheme does not differentiate between audiologists and audiometrists in their ability to carry out this work.

It is clearly time for a distinction between service providers who offer rehabilitation (Audiologists) and those who are technicians (audiometrists) is required, to be made within the OHS scheme. Technically trained audiometrists have a role to play in hearing service delivery, but one that is different to that of university trained Audiologists.

In writing this submission, I have assumed that the reader will have knowledge of the OHS scheme, Medicare regulations, OHS terminology, and differences in training to qualify as an Audiologists and audiometrists. However, should further clarification be needed on any of the points raised above, I would be happy to discuss this further at any level.

Thank you once again for the opportunity to raise relevant concerns to this committee.

Yours sincerely

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