Audiology Australia Response to the Senate Inquiry into Hearing Health in Australia

Summary:

There is no doubt that Australia is a world leader in the provision of hearing healthcare services, and in hearing healthcare research, but there is so much more that can be done, and ***needs*** to be done, to support those with hearing loss acquired from a wide range of origins, as well as focusing on preventing the fastest growing area of hearing loss – noise induced hearing loss!

One in six Australians is affected by hearing loss, with one in five Australians over the age of 15 affected – that's 20% of the population – and of this 20%, less than 30% is doing anything about it!

Prevalence rates for hearing loss are associated with increasing age, rising from less than 1% for people aged younger than 15 years to ***three in every four people aged over 70 years***.

With an ageing population, hearing loss is predicted to increase to 1 in ***every*** 4 Australians by 2050.

Hearing loss is second only to arthritis in its physical impact and second to depression in its emotional and social impact, but less than 1% of the ***TOTAL*** expenditure on the National Health Priority areas goes to any aspect of hearing health care!

A 'womb to tomb' strategy should be developed and implemented to provide access to the highest standards of hearing healthcare management for this growing sector of the Australian community, be they babies, young children, adolescents, Gen X, Gen Y, Baby Boomers and those family and friends who are affected wherever there is a lack of support!

It is vital that hearing loss is identified as early as possible so Universal Newborn Hearing Screening (and provision of appropriate diagnostic support to manage the hearing loss of those identified) should be the right of every newborn babe.

Access to timely hearing assessment services in all regions, rural or remote, for young children to manage later onset of hearing loss and as they progress beyond 21 to support their significant needs as socio-economic contributors to Australian society.

Access to informed educational environments where hearing and hearing related conditions become secondary to the young person's valuable and valued educational experience because education professionals have the necessary training, skills and resources to offer the same level of enlightened and extended education opportunities as their peers! And their parents don't have to grovel, beg, cajole and fund-raise to ensure ***THEIR*** offspring gets a fair go!

Where age-related hearing loss doesn't diminish the quality of life of the very people who have given so much so that we younger Australians can enjoy the standard of living we have come to expect and make provision for the highest standards of health care (and Hearing health care) future ageing generations in return.

In order that all Australians have access to the right health care clinical services at the right time, in the right location, provided by the right health professional, we must ensure that appropriate, quality, ongoing clinical education is available, supported and mandatory for all health professionals, and in this specific context, for all hearing healthcare professionals.

Thank you for the opportunity to submit the views of the Audiological Society of Australia (trading as Audiology Australia) to the Senate Community Affairs References Committee Inquiry into Hearing Health Care in Australia.

Part 1. Preamble

When this Inquiry was announced, as CEO of Audiology Australia, it became my task to manage the development of our submission and to invite ASA members to contribute individually to the Inquiry, as well as to provide their thoughts and issues to us as their professional body, so that we could compile a comprehensive document for the Senate Committee's consideration of current and future priorities for hearing health care in Australia.

As promoting hearing health care, and our members as hearing health care professionals, is a significant focus of my role leading the peak professional body for audiologists, I had no difficulty identifying the numerous achievements of the Society and the 98% of the profession of audiologists who make up its membership.

There is much to be proud of in the way hearing health care is supported and developed in Australia. Our clinicians and researchers have been the initiators of many of the now standard approaches to assessing hearing loss and identifying individual goals for hearing rehabilitation (eg the COSI developed by NAL and used worldwide). The work of our National Acoustic Laboratories researchers exploring the way forward for hearing loss management by delving into areas which include:

- Hearing loss assessment
- Prevention of hearing loss,
- Hearing rehabilitation devices,
- Hearing rehabilitation procedures,

under the guidance of Professor Harvey Dillon (an ASA Fellow).

The highly acclaimed work emanating from the Hearing CRC lead by Associate Professor Robert Cowan (an ASA Past President) where an internationally unique consortium of research, clinical and industry organisations (including Audiology Australia) have been brought together to the common purpose of 'creating sound value' through research and education – to prevent and better remediate the lost productivity resulting from hearing loss in children and adults.

'Listen Hear! The Economic Impact and Cost of Hearing Loss in Australia' report was carried out by Access Economics at the behest of the Hearing CRC and VicDeaf to inform future research and clinical practice. This report has become the prime source of data on the prevalence and economic impact of hearing loss. The Hearing CRC's research contributes directly and principally to the national research priority:–

'***Promoting and Maintaining Good Health'*** through its goals of:

- A healthy start to life
- Ageing well, ageing productively
- Preventative healthcare
- Strengthening Australia's social and economic fabric.

The groundbreaking work in implantable devices which have revolutionised the options for those with hearing loss is exemplified by the work of many around Australia including those at the Sydney Cochlear Implant Centre through the leadership of Professor Bill Gibson and his Clinical

Manager, Sharan Westcott (ASA's Past President), and the Royal Victorian Eye and Ear Hospital's Cochlear Implant team lead by Dr Robert Briggs and Professor Richard Dowell (an ASA Fellow).

The list is endless identifying our members at the leading edge of hearing healthcare research in every State and Territory working tirelessly to support those with hearing loss and to promote hearing loss prevention – suffice to say that many of these highly regarded professionals have submitted their responses to this Inquiry for the Committee's consideration but as I read those that had also been copied to us at the Society I was struck by how large the spectre of hearing loss looms for those affected by it and how, even though there has been has been significant advancement and support to date, there is so much more that needs to be done, and can be done, if there is to be a <u>*PLANNED, SYSTEMATIC and NATIONAL APPROACH*</u> to effectively support those with identifiable hearing loss and to educate the community in hearing loss prevention.

"Hearing loss reduces the capacity to communicate, and this in turn impacts on a person's life chances through the reduced opportunity to equitably participate in education, to gain competitive skills and employment, and to participate in relationships. The Listen Hear study reports that 'Hearing loss ranks with asthma, diabetes and musculoskeletal diseases in terms of burden of disability' and should be considered as a national health priority".

(A/Prof Robert Cowan quoted from the Listen Hear! Media Release May 2006.)

Part 2.

Audiology Australia's response to the 'Hearing Health in Australia' Inquiry 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.

There are recurring themes that emerge from all parts of Australia as each of these criteria has been explored within the membership of Audiology Australia - as well as more fully identified in the submissions received and copied to us. I will endeavour to summarise these issues and have attached a number of individual submissions where further evidence is contained and demonstrated.

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

- Universal Newborn Hearing Screening – early detection is vital but regional inequities due to lack of qualified staff and equipment limits effectiveness and extent of availability of the program, as specific testing conditions are required to ensure accurate results.
- Social impact? Second only to depression in its social and emotional impact
- Physical impact? Second only to arthritis in its physical impact!
- <1% of funding on National Health Priorities goes to hearing!
- Detection of hearing loss - can impact at various times for mixed reasons:
    - Tinnitus
    - Noise Induced Hearing Loss
    - Neonatal issues
    - Congenital – hereditary issues
    - Age related – hearing loss is affecting younger people too
- Mental health issues – affect capacities to lead a socially and economically effective life.

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

- Limited employment options – hearing is a major requirement for effective communication in the workplace and reduced access to expensive devices and rehabilitation can prevent an individual from attaining their maximum potential.

- Social impact? Second only to depression in its social and emotional impact

- Physical impact? Second only to arthritis in its physical impact!

- Stigma associated with hearing loss – most deny the presence or effect.

- Data is gained only from those willing to identify as hearing impaired but what of the other 70% (of the 20% of Australians) with hearing loss who are doing nothing about it?

- Detection of hearing loss - can impact at various times for mixed reasons:
    - Tinnitus – Australia has some of the world experts on Tinnitus – individuals need to be able to access these clinicians and treatments at cost effective rates.
    - Neonatal – universal newborn hearing screening for all but with ongoing hearing assessments encouraged as hearing loss can develop for other reasons.
    - Congenital – researchers continue to investigate hereditary health issues.
    - Age related – but as more suffer hearing loss earlier this can become a huge burden on the Australian community's resources.
    - Preventable hearing loss - Noise Induced Hearing Loss is fastest growing area of hearing loss but it is PREVENTABLE!
    - Rehabilitation – aim towards optimal reinstatement of capacities – best opportunities rather than be treated as a burden or worse, a malingerer!
    - Compensation – must be adequate, regularly reviewed and aimed
    - Workplace responsibilities under legislation

- Mental health issues – hearing loss can cause mental anguish! Confusion aligned with ageing creates communication issues. Incorrect assessments, misdiagnosis, failure to recognize impact of hearing loss on communication abilities – professionals often ignore the presence of hearing loss in day to day contact eg turning their back as they talk, walking away from the client mid-conversation.

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

- Medicare access for audiological services – unlike many other areas of health care hearing services provided by audiologists are not supported by Medicare other than within the specific Item Numbers allocated to Chronic Disease Management or 'for and on behalf' of a Medical Practitioner.

- Audiology services around Australia have developed on an ad hoc basis – where equipment has been funded there is no recurring funding for staffing – where there ***is*** equipment there is rarely funding for the expensive calibration and maintenance costs to ensure this equipment can operate at the highest standards for accurate testing and diagnostic assessments.
- Closure of audiology departments as centres try to balance dwindling/reduced budgets.

- Staffing issues – access to appropriately qualified staff is difficult which in turn makes it impossible to plan for staff development, advancement, retirements etc. As with most of the health sector, audiology has an ageing workforce.

- Recruitment to regional, rural and remote locations is difficult – need to consider the 'Medical Incentives Model' to encourage greater take-up of these positions.

- Private Health Insurance is device focused therefore there is significant pressure to push lucrative hearing aids as this is almost the only aspect of hearing health care that is rebated by the Health Funds. It is very rare to find Health Funds that rebate consultations.

- The Community Service Obligation & the over 21s – these young people are already disadvantaged by hearing loss – they experience even further disadvantage once they are no longer eligible for Australian Hearing services due to cost of accessing the necessary level of hearing support to enable them to ***enter*** the workforce - let alone stay there!

- There are 'bigger picture' impacts on access to hearing healthcare. Many hospitals provide very limited access to operating theatres for implantable devices which in turn prevents many clients from accessing timely surgical interventions!

- Funding limitations imposed in many jurisdictions compound access to appropriate surgical interventions – nowhere near enough surgical opportunities are available for the number of eligible children who would benefit from a cochlear implant.

- There are significant costs involved in setting up hearing clinics with the appropriate equipment to provide for the necessary diagnostic testing to effectively assess hearing loss. Equipment is costly to invest in, costly to maintain, and costly to update. The investment required to operate a hearing healthcare clinical setting requires an appropriate access to a fee structure that acknowledges the overheads and recompenses fairly and respectfully the infrastructure investment required in every hearing healthcare clinical setting. It is inappropriate for government agencies such as OHS and Workcover to seek to contract extensive clinical conditions for a minimal financial arrangement which fails to acknowledge the financial realities of these audiological services.

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

- There are **hearing health programs** such as the government Voucher program offered to pensioners through the Office of Hearing Services (OHS).

- There are **research programs** such as those already mentioned at NAL and the Hearing CRC, but also at universities and private research institutions. There are also hearing aid manufacturers who invest significantly in hearing research.

- There are **education programs in schools** for children and young people with hearing impairment – most of which suffer from a lack of assured recurrent funding and adequate professional development resourcing for teachers and hearing health practitioners to ensure those in their care receive the best hearing healthcare education and support available. Most still have to supplement existing funding models by a program of extensive fundraising activities just to provide the necessary programs, equipment and special needs equipment for everyday education activities. Any suggestion of enhanced or aspirational experiences is fantasy for most hearing education settings.

- **Community education and hearing awareness programs** are rarely in receipt of significant long term funding arrangements so again much of this work is done by volunteers from the hearing impaired community. While **Hearing Awareness Week** is promoted every year in the last week in August, its success and reach is usually limited by the extent of available resources. States and Territories provide ad hoc funding but nothing that allows the ongoing development of effective hearing education programs or

campaigns that would affect community beliefs, attitudes, or behaviours about hearing health care management and prevention.

- **Community awareness of hearing loss in a sound oriented environment** - providing an understanding of communication limitations affecting the hearing impaired through awareness training in the travel, hospitality and communication industries to ensure that there are non-aural information alternatives available such as signage and diagrams to complement broadcast announcements for hearing impaired travelers etc.

- But where does **acquisition of qualifications** and a program of **continuing professional development** necessary for those professionals working in hearing healthcare to remain professionally and clinically current fit it? There needs to be appropriate consideration of the ways and means for these professionals to stay abreast of research and current evidence-based practice to ensure that those who seek their care and advice are assured of the highest levels of current professional knowledge applied to their needs. So it is vital that this area of professional need is also considered to ensure the hearing healthcare professionals are able to access timely, appropriate and affordable professional education and that provision for this is mandated in all employment arrangements.

- Many employers require their staff to have **clinical certification** to enable their businesses to offer specific hearing healthcare services but do not see it as their responsibility to support or even contribute to staff-members' clinical currency needs to retain clinical certification by providing access to professional development leave arrangements or even setting up a training budget to support the expenses involved in remaining clinically current..

- **HECS & PELS debt** forces practitioners into making career decisions to manage debt when most would prefer to follow their health instincts to assist the hearing impaired – HECS relief schemes exist to encourage medical practitioners to work in regional, rural and remote locations thereby assuring these communities of access to doctors but couldn't this same model be developed to support greater access to hearing healthcare practitioners and other health professionals?

and

e) specific issues affecting Indigenous communities:

There have been significant clinical and organisational learnings that have evolved out of the **Australian Government Intervention** program that shouldn't be lost – many principles implemented with consequent positive outcomes in NT may also apply just as well to low socio-economic communities and mainstream Australian hearing health (and other health) needs.

- Building family and community participation essential for rehabilitation of children with hearing disability is really difficult to provide in remote communities/ homelands and further research and effort is required to meet associated challenges
- Audiologists are required to work outside the usual scope of practice when providing services to Indigenous people in the NT including diagnosing middle ear conditions, removing wax and pus from ear canals
- Remote Indigenous Audiological practice represents a specialised area that requires specific training particularly in the area of otoscopy, diagnosis and treatment of otitis media and Indigenous cultural competency

- Neonatal hearing screening in the Northern Territory that targets significant permanent hearing impairment will detect approximately three newborns each year. Infant hearing screening that targets Indigenous chronic ear disease will detect approximately 100 newborns in the first year of life with significant hearing impairment.
- Ear disease in Indigenous populations is attributed to high bacterial load of pathogens and is established in the first weeks of life in almost all remote Indigenous children (90%). It is a complex disease and early identification with a view to preventing chronic conditions requires 'expert skills' that are not a component of mainstream training for most health and allied health practitioners.
- Population based hearing initiatives such as ear health promotion and sound field amplification in classrooms have an important role
- New information technologies that enhance coordinated hearing care require investment to improve case management capabilities, provide telemedicine and satellite rehabilitation support opportunities, assist with agency and organisational data sharing, and evaluate initiatives.
- Further research and standardisation of infant hearing screening pathways and early intervention programs that address significant hearing loss associated with chronic ear disease Indigenous children is strongly recommended

Summary:

There are many further issues that have been raised in the submissions attached – some of which have been submitted already.

Those ASA members who have submitted responses to this Senate Inquiry are among the most ethical clinicians working in hearing health care. Their views are considered, realistic and full of empathy for the plight of their clients and the entire hearing impaired community.

When these high integrity clinicians highlight the shortcomings of the system they do it in the hope that things will change for the better.

These are views from every State and Territory in Australia providing a cross section of metropolitan, regional, rural and remote hearing health perspectives.

It takes a very special kind of human being to take an active role in health care and the hearing health care sector has its own rewards and challenges – every one of these writers is committed to the highest standards in hearing healthcare! They work in this area and know the realities!

They are not naïve supplicants seeking to advantage themselves, but eternal optimists who want to believe that a Senate Inquiry might actually bring about change:–

- ***change to the burden that the hearing impaired community has to bravely and stoically bear;***
- ***change to community attitudes towards protecting their hearing***
- ***and most of all change to the level of resourcing required for those who provide the support and those in need of hearing health care support***.

Part 3.

AUDIOLOGY AUSTRALIA – who we are, what we do and why we believe audiologists are best placed to manage Australia's hearing healthcare

AUDIOLOGY AUSTRALIA (ASA/the Society)

- ASA was founded in 1968, and has a current membership of nearly 1800 member audiologists, which represents approximately 98% of the profession.

- ASA Full Membership requires evidence of a Master of Clinical Audiology degree (or equivalent) with a major in Audiology, and minimum one year of supervised postgraduate clinical practicum – the (Graduate) Clinical Internship - (G)CI. After completing their practicum, Full Members are eligible to apply for the ASA's Certificate of Clinical Practice (CCP). ASA members have agreed to practise audiology in accordance with the ASA Code of Ethics and Professional Standards of Practice. ASA membership is restricted to audiologists, and does not include other professionals as members.

- ASA is recognised by Australian Commonwealth and State Governments, Medicare, Private Health Funds and providers of Professional Indemnity-related insurances as the peak organisation representing professional audiologists across all sectors of audiological practice, including private practice, hospital settings, community services and agencies, Australian Hearing Services, Universities and research.

- Full and CCP (Certificate of Clinical Practice) status is accepted by all the above as the benchmark in the absence of licensing or registration. We are an inaugural member of the National Alliance of Self-Regulating Health Professions – the body formed to inform and liaise with those bodies involved in COAG's National Registration and Accreditation Implementation Project.

- ASA is a member of Professions Australia (formerly the Australian Council of Professions), the Allied Health Professions of Australia, the International Society of Audiology, the Australian Deafness Forum, the Australian Health Care Reform Alliance (AHCRA), and the National Primary Health Care Partnership.

- ASA is recognised internationally as the peak professional association representing audiologists in Australia. ASA is the official Australian International Affiliate for the Alexander Graham Bell Association for the Deaf, and is the Australian member association to the International Society of Audiology, and to Hearing International. ASA was selected by the International Society of Audiology to host the 2002 World Congress of Audiology in Melbourne (and will host it again in Sydney in 2014), and the 7th International Tinnitus Seminar in Perth, March 2002.

About Audiologists

- Audiologists have postgraduate university qualifications in hearing science and specialise in assessment, prevention and management of hearing loss and related conditions, including tinnitus and balance disorders.

- Audiologists master skills and knowledge from their university study and clinical application of acoustics, acoustic phonetics, psychoacoustics, anatomy and physiology of auditory and vestibular systems, speech and language development, communication and auditory behaviours over the lifespan, hearing loss prevention and screening, diagnostic assessment, intervention, auditory re/habilitation, audiological service delivery and other aspects of professional practice.

- Using their specialist skills and knowledge, audiologists primarily assess how people of all ages hear. With the application of technology, re/habilitation and therapy, audiologists help people with hearing loss and related disorders. This extends to tinnitus and balance disorders.

- Audiologists provide clinical services through hospitals, community health clinics, government funded agencies, hearing aid clinics, cochlear implant clinics, private practice, university clinics, medical practices, ENT and otology clinics, occupational hearing conservation programs, programs for compensation of occupational noise injury, community awareness and consumer advocacy.

- Research and evidence based practice are important cornerstones of audiology. Audiologists provide research which adds to the knowledge base. Research often results in innovations and new developments in assessment procedures, hearing aid and implantable technologies, hearing health therapies and re/habilitation programs.

- Audiologists are the only non-medical hearing health practitioners who provide services across the lifespan, from newborn babies to the elderly. Specialist programs and services support the audiological needs of neonates, hearing impaired and deaf school aged children, indigenous communities, disabled persons and the frail and elderly.

- Audiologists have an important role as the professional leaders in hearing health care. Through a team approach and in liaison with others including GPs, ENTs, nurses, allied health professionals and educational professionals, audiologists meet the hearing needs of individuals and the community.

For Australia's health care needs, audiologists are the primary health practitioners for people with hearing loss and related disorders.

Audiologists provide full diagnostic hearing assessment and determine the individual's need for medical and/or rehabilitative intervention. Audiologists have considerable knowledge and expertise to:

- identify medical indicators from client self-reports or test results
- ascertain and manage the likely effectiveness of hearing rehabilitation and
- are able to make independent decisions about whether to proceed with medical referral and/or hearing rehabilitation

Audiologists are responsible for the full diagnosis of hearing loss and management of patients requiring hearing re/habilitation, including hearing aids, cochlear implants and other implantable technology.

Audiometrists have a role in hearing health care, working alongside or under the direction of audiologists, to perform basic hearing tests and fit hearing aids. ENTs and otologists specialise in the medical diagnosis, treatment and management of ear, hearing and related disorders.

Diagnosis of Hearing Disorders

An initial assessment requires complex decision-making processes including how to conduct each test to provide required information. The initial assessment determines whether further assessment is required or whether hearing rehabilitation may proceed. The interpretation of the clinical findings requires in-depth integration of the presenting history, the audiometric information and observations about the client's behaviours.

Knowledge of, and the skill and expertise to provide, a comprehensive test battery is required to appropriately conduct an audiological assessment of the client's needs and presenting symptoms.

No single audiometric test can provide sufficient information to determine the site-of-lesion, the magnitude of the impairment, impact on an individual's ability to recognise speech and impact on communication needs. The types of tests undertaken within an initial assessment may be relatively standard for each initial assessment. However, there are a number of decisions and evaluations that the practitioner must make throughout this assessment. Only audiologists are able to provide this independently.

Hearing Rehabilitation

Hearing device technology has advanced since the 1980s, even more so since the late 1990s. There has been an accompanying belief that hearing loss can be "fixed" by the application of appropriate technology. However, evidence based research shows that hearing devices alone do not produce satisfactory rehabilitation outcomes for many people.

Fortunately, research also shows that strategies other than device fitting (such as counseling, communication training and group rehabilitation) enhance performance for many clients.

Appropriate rehabilitation cannot and should not be provided by a formulaic approach as it needs to be highly individualised. Audiologists have the professional skills and knowledge to manage this with the application of current evidence based tools and methodologies, and through their thorough understanding of the psychosocial impacts of hearing loss on the individual and their family.

Role of Audiology in Primary Healthcare

GPs and primary healthcare providers seek the skills and knowledge of audiologists to assist them in primary medical care of hearing loss and related disorders. This assists medical practitioners to identify underlying medical pathologies and plan appropriate medical investigation or intervention. Audiology Australia is developing clinical presentations and educational support materials for GPs which will include:

- differential diagnosis of conductive hearing loss, sensorineural or mixed hearing loss

- otitis media and otitis externa
- recurrent ear infections
- differential diagnosis of otitis media with effusion by determining extent and nature of hearing loss and middle ear condition (difficult to diagnose by otoscopy alone)
- speech and language developmental delay
- behavioural changes in children
- inconsistent or poor response to sound
- frequent or occasional request for repetition
- increasing TV or radio volume
- not consistently hearing telephone ring or doorbell
- difficulty listening over the telephone
- learning difficulties
- poor educational progress
- differential diagnosis of hearing loss and autism
- lack of clarity in conversation
- difficulty listening in groups and background noise
- poor attention and concentration
- not following instructions or conversation appropriately
- sensitivity to loud noises
- investigation for acoustic neuroma or other retrocochlear pathology
- sudden or rapidly changed hearing loss
- fluctuating hearing loss
- unilateral or asymmetrical hearing loss
- unilateral tinnitus
- sudden or significantly changed tinnitus
- reported sensation of blockage or fullness in ear
- balance problems or clumsiness
- chronic dizziness or vertigo
- newly apparent or confirmed perforation
- persistent pain, discomfort or tenderness in the ear
- chronic discharge or ear infection
- ear trauma – physical trauma, acoustic trauma, barometric trauma
- reported facial numbness, weakness or asymmetrical facial movements
- reported distortion in clarity of telephone or headphone listening on one side in otherwise symmetrical hearing

Audiologists provide clinical results and indicators to help GPs formulate an opinion on when to refer for further ENT advice and/or if rehabilitation by an audiologist is appropriate.

Secondary or tertiary health services and agencies, hospitals, university clinics or private practices are available to manage specialised audiological services. Contact with a local practice or agency would determine specialty service provided:

- Electrophysiological or electroneurography assessment
- Assistive listening devices – fitting, advice and management
- Auditory rehabilitation and counselling
- Hearing aid fitting and re/habilitation
- Cochlear implant management and re/habilitation
- Other implantable technology eg bone anchored hearing aids
- Tinnitus counselling

- Vestibular and balance disorders
- Central auditory processing disorders
- Audiometry for aviation medicals (Civil Aviation Safety Authority standards)
- Pre-employment audiometry
- Hearing conservation programs
- Occupational and workers compensation
- Acoustic shock trauma or hypersensitivity
- Review of client needs or significant change in communication ability with existing hearing devices
- Information on consumer groups and support groups for additional resources

Audiology in Complex Chronic Conditions and Disabilities

The Australian Government identified through its National Chronic Disease Strategy seven National Health Priority Areas which contribute significantly to the burden of illness and injury and which have potential for health gains and reduction in the burden of disease: arthritis and musculoskeletal conditions, asthma, cancer, cardiovascular health, diabetes mellitus, injury prevention and control, and mental health.

"Listen Hear! The economic impact and cost of hearing loss in Australia" (Access Economics, 2006) reports:
Hearing loss has been described as an under-estimated health problem (Wilson et al,1992). Adult hearing loss shows a comorbidity and association with an increased risk for a variety of health conditions including:

- diabetes (Wilson et al, 1992; Mitchell, 2002);
- stroke (Mitchell, 2002);
- elevated blood pressure (Wilson et al, 1992);
- heart attack, particularly those rating their hearing as poor (Hogan et al., 2001);
- psychiatric disorder, particularly those rating their hearing as poor (Hogan et al.,
- 2001);
- affective mood disorders (Ihara, 1993; Mulrow et al, 1990);
- poorer social relations (Mulrow et al, 1990);
- higher sickness impact profiles (physical and psycho-social (Bess et al, 1989);
- reduced health related quality of life, particularly those with more severe hearing loss (Wilson, 1997).

Hearing loss and deafness may co-exist with other sensory and physical disabilities (including visual impairment and blindness, cerebral palsy, developmental delay) or be one feature of specific syndromes (syndromic deafness e.g. Usher syndrome, Branchiootorenal syndrome).

Appropriate care of individuals with chronic conditions and other disabilities should extend to an evaluation of communication and hearing needs with a referral to an audiologist as required.

Audiology in Injury Prevention, Preventative Care and Health Promotion

Injury prevention would include people working in high risk occupations or high risk recreational activities where excessive noise levels are a hazard for healthy hearing.

Initiatives and programs to identify hearing loss and prevent or minimise risk or impact of ear disease include:

Universal neonatal hearing screening
Baby wellness clinics
Healthy kids checks
Preschooler health checks
Indigenous ear health programs
Hearing conservation programs
High risk occupational and recreational noise management
Men's and women's health programs
Over 40s health checks
Over 75s and older Australians health checks

Healthy hearing promotion includes awareness of

- typical auditory behaviour of good hearing in babies and young children
- typical speech and language milestones
- early warning signs of otitis media
- early warning signs of acquired or fluctuating hearing loss
- communication strategies with hearing impaired and deaf
- awareness of public facilities for deaf and hearing impaired
- awareness of importance of good building design and acoustics for optimal listening
- facilities for deaf and hearing impaired
- where to seek advice and help if hearing loss suspected

Hearing loss if not identified nor managed appropriately can result in speech and language delay, lack of academic performance, deterioration in inter-personal relationships, loss of opportunity for employment, stress, depression, feelings of isolation and frustration.

Clinical observations alone of gross auditory behaviour in quiet consulting rooms or clinics are not sensitive to accurately identify hearing loss nor does match a patient's experience in noisier environments at home, school, socially or at work.

An audiological evaluation should be arranged if indicated from parental concern, self reports or screening tools. The earlier hearing loss at any age is identified and managed, the better the outcome.

Audiology in Aged Care

The prevalence of hearing loss increases significantly with older generations (three in every four people aged over 70 years).

Patients considered for aged care programs and residents in aged care facilities would typically have an appropriate care plan formulated. A differential diagnosis of hearing loss from onset or deterioration of cognitive decline or state of confusion is important.

Professionals administering cognitive and behavioural assessments need to be aware of any hearing loss that may affect outcomes of assessment. Due consideration should be given with respect to possible or previously identified hearing loss ie how a test is administered, under what conditions assessments performed, how clinical setting where test conducted compares to day-to-day communication environment, if person has previously diagnosed hearing loss, if person is using previously fitted and functioning hearing devices and technology.

For residents admitted to aged care, it is likely that their communication needs may differ from previous living arrangements. A review of communication and hearing needs with the resident, their family and care professionals is recommended at earliest opportunity and regularly reviewed.

An individual's care plan should include communication and hearing recommendations with respect to any hearing loss, hearing devices, specific needs and the resident and their family's preferences. Communication strategies become even more important in aged care facilities and care professionals and families need to understand how to modify their communication appropriately.

As well as individual communication and hearing plans, aged care facilities should consider a facility plan with respect to use and care of personal hearing devices, technology that would assist group communication, awareness of acoustics and facility design limitations that may impact on effective communication, use of general communication strategies, easy identification of specific residents with individual needs, and staff training.

Aged care facilities in conjunction with residents and their families, need to manage the individual audiological needs of residents as required. In addition, facilities should have an overall facility plan addressing communication and hearing needs.

Audiology in Hearing Loss Compensation and Rehabilitation

Excessive and prolonged occupational and workplace noise is a contributing factor towards acquired hearing loss (industrial deafness or work-related hearing loss).

Hearing conservation programs manage hearing screening and monitoring, noise level measurements, management of appropriate hearing protection and education of workers and employers. An established baseline of hearing levels prior employment is important.

State and Commonwealth government legislation addresses occupational health and safety. Each State and Territory has programs for prevention, compensation and rehabilitation of occupational and workplace injuries, including hearing loss. Claims for hearing loss compensation includes audiological and ENT assessments.

People employed in high risk occupations for excessive or prolonged noise exposure, who report hearing damage or who are being compensated or rehabilitated for hearing injury should be referred to an audiologist. Employees and employers must be aware of responsibilities under relevant occupational health and safety legislation and guidelines.

Audiology in Indigenous Healthcare

Australia's indigenous population has a higher incidence of ear disease (particularly otitis media) and subsequent hearing loss than the normal population. Indigenous individuals may choose to access services available through public, private or Aboriginal or Torres Strait Islander community controlled health services.

Indigenous communities in urban, rural and remote areas need access to hearing and audiological services delivered in the context of local needs and culturally appropriate protocols.

An inter-disciplinary team approach with effective consultation, communication and support from the community and medical, health and educational workers is important. A commitment to an ongoing sustainable program with adequate resources is required.

Audiologists may work in liaison with or be directly employed by Aboriginal community controlled health services. Team members may include indigenous healthworkers, ear health workers, ENTs, paediatricians, medical and nursing professionals, clinic or hospital allied health professionals and staff, teachers, specialist teachers. The client or patient and their family or caregivers should be central to being involved in decision making, formulating an ongoing management plan and sharing responsibility in outcomes.

Hearing and ear health programs may include:

- Needs assessment
- Hearing screening of all ages
- Tympanometry and otoscopy screening – opportunistic checks for babies and young children
- Diagnostic audiology
- Medical management
- Self management – minimise impact of ear discharge (tissue spears), reduce risk of ear infection, healthy living, breathe-blow-cough program, access to medical services, compliance with medication, follow-up
- Appropriate hearing technology fitted for individuals
- Appropriate hearing technology or amplification in educational settings and classrooms
- Re/habilitation
- Health promotion including nutrition, hygiene, housing, medical services
- Training and transfer of skills and knowledge within community
- Education and communication
- Advocacy and collaboration
- Research and evaluation

More information available in *'General Guidelines for Audiological Practice with Indigenous Australians'* (Audiology Australia, June 2001).

Audiologists have a pivotal role within indigenous hearing health. Indigenous clients at risk of or experiencing ear and hearing problems should be referred to appropriate services and programs with audiological assessment as required. All health and educational professionals are encouraged to be vigilant through identification and referral of anyone with ear and hearing problems at any age.

Audiology in the Paediatric Population

Australian studies show a prevalence of pre-lingual (0-4 years) hearing loss of 1.2/1,000 live births and of child acquired loss (4-14 years) as 3.2/1,000 live births.

From the *Australian Consensus Statement on Universal Neonatal Hearing Screening* (Ratified by the Australian National Hearing Screening Committee, November 2001; Adopted by Audiology Australia):

> *Significant bilateral hearing impairment, if undetected, will impede, and can have profound effects on speech, language, and cognitive development, and thus emotional and social well-being. Unilateral and mild hearing impairments can also have significant educational impacts.*
>
> *Current international research indicates that babies whose permanent bilateral hearing impairment is diagnosed before the age of six months, and who receive appropriate and consistent early intervention, have significantly better language levels than those children identified after the age of six months.*
>
> *Prompt audiological assessment must be achieved for all neonates identified by hearing screening, and prompt, effective intervention must follow for those in whom the impairment is confirmed.*
>
> *Effective universal neonatal hearing screening will not replace the need for vigilance and for continued surveillance of hearing behaviour and language development to detect hearing impairment in children who have not received neonatal screening or who develop permanent hearing loss at a later age.*
>
> *A program of universal neonatal hearing screening should be introduced across all states and territories in Australia in order to detect children with hearing loss at the earliest possible age.*
>
> *The Australian federal government should work together with state and territory governments to establish a coordinated screening program.*
>
> *A universal hearing screening program must be sufficiently resourced to enable high quality monitoring and evaluation.*

Audiologists have an important role in the establishment, management, delivery and research of neonatal hearing screening programs. Audiologists provide diagnostic assessments for babies and young children. Where indicated, audiologists provide subsequent hearing aid and cochlear implant re/habilitation, counselling with families, ongoing audiological management, educational support and research.

Intermittent, fluctuating and chronic conductive hearing loss associated with childhood otitis media may affect speech and language development, educational progress and learning, behaviour and social well-being.

Otitis media with effusion may be difficult to diagnose in the medical clinic given absence of other acute symptoms and difficult to diagnose through otoscopy alone. Tympanometry, audiometry and diagnostic otoscopy are important to make a differential diagnosis and for appropriate management.

Sensorineural (permanent) hearing loss and deafness may also be acquired during childhood. Intermittent and fluctuating conductive hearing loss may present during childhood. Central auditory processing disorders may become apparent in which children do not have any problem with hearing sensitivity, but compared to normal age group may not be able to process sound and speech which is more complex or expected to be processed in more adverse listening environments.

Although an individual child may have had a hearing screening at birth, ongoing vigilance should be maintained with due consideration of parental concern, delayed speech and language, learning problems, teacher concern, educational sub-performance, and auditory behaviour. Audiological assessment and management should be arranged as required.

Audiology and Other Professionals

Audiologists work in conjunction and frequently liaise with other professionals as required to help manage the health needs of individuals. These include:

- Medical professionals
- ENTs and otologists
- Paediatricians
- Nursing professionals
- Speech pathologists
- Psychologists
- Social workers
- Teachers
- Educational specialists – teachers-of-the-deaf
- Occupational therapists
- Physiotherapists

Liaison and collaboration with audiologists also includes early intervention agencies for deaf and hearing impaired babies and children, support services for visually impaired and blind, support services for physical and intellectual disabilities, indigenous health services and healthworkers, and aged care facilities.

Audiologists are hearing specialists who manage Australia's hearing health.

Audiology Australia members actively advance Hearing Health Care Outcomes

- Current hearing health care research and evidence based practice informs clinical practice in the work of our members and provides the basis of ASA's Professional Practice Standards.

- **The Hearing CRC** – ASA is a Supporting Partner of the Hearing CRC and benefits from this interactive involvement flow through to an individual client's management of hearing loss

- **National Acoustics Laboratories** – this research facility is world renowned and ASA supports its NAL members in many ways including providing CPD credit to encourage clinicians to engage in research activities in the field.

- ASA members are world leaders in their fields including (but not limited to):
  - Tinnitus,
  - Central Auditory Processing Disorder (CAPD),
  - Hearing Amplification Sciences
  - Rehabilitation and Habilitation

- **Universities** – ASA works closely with the 5 Schools of Audiology both as the Accreditation Body for recognition of their university programs and as a link between those educating the audiology professionals and the workplace.

- **Humanitarian** – ASA endeavours to support humanitarian audiology within Australia and internationally by encouraging active engagement in humanitarian roles promoting improved hearing health care outcomes where they may otherwise not be available.

- **Office of Hearing Services** – Audiology Australia maintains a productive relationship with OHS to support the needs of its members and to foster the highest standards of hearing health care for the Australian community.

- **Professional Relationships** – ASA endeavours to support the hearing industry and has contributed to the development of curriculum and qualifications for hearing aid audiometrists, has lead the development of clinical accreditation for the hearing industry, and has an 'in principle' agreement with the Hearing Aid Audiometrist Society of Australia (HAASA) to actively support the professional development of HAASA members via inclusion and access to ASA CPD programs.

- **Allied Health Professions Australia** – ASA is a member of AHPA's Management Team and Board of Directors whereby the broader issues that affect the allied health professions are negotiated, reviewed and represented to all levels of government.

- **Professions Australia** – to ensure that the Society remains abreast of issues beyond the health sector, ASA is actively involved in the peak body for the Professions in Australia, Professions Australia. Dr Robert Cowan was named 'Professional of the Year' in 2006 and Dr Catherine McMahon was named 'Young Professional of the Year' in 2008. ASA was a recipient of the 2008 Australia-Japan Foundation Travel Scholarship to promote professional practice between Australian and Japanese hearing health care practitioners.

PART 4

SUBMISSION TO SENATE INQUIRY INTO HEARING HEALTH IN AUSTRALIA.

Author: Dr Jenny Rosen

a) Extent, causes and costs of hearing impairment in Australia.

Extent. Hearing loss is the second most prevalent chronic disabling disorder, after musculo-skeletal disorders such as arthritis. As such, it is more prevalent than any of the other national health priorities.

Causes. Hearing loss can occur at any age. Pre-natal causes of hearing impairment include in-utero infections and genetic elements, with hearing loss either partial or complete at birth and/or stable or progressively deteriorating over time. Post-natally, hearing impairment can result from accidents, illness, drug toxicity and excessive noise exposure. Such losses will also vary in degree and stability of hearing levels.

Costs. Costs vary with age and management requirements. However, early identification and appropriate management of hearing impairment at any age is highly cost-effective in minimising secondary effects. When identification and management are both early and appropriate, the need to provide remedial programs for avoidable secondary problems will be reduced or even eliminated.

Despite the above, health expenditure on hearing loss is less than 1% of the total expenditure on the national health priority areas (*Access Economics 2006*).

b) Implications of hearing impairment for individuals and the community.

Individual implications. The impact of hearing impairment varies with degree of loss, age of onset, and provision of timely and appropriate management. At any age, time is of the essence. If identification and management is delayed in infants, delays in language acquisition can be expected. For older children, there may be educational delays. For young adults, with educational achievement low compared with potential, there will be consequent limitation to employment and career opportunities. For older adults, enforced early retirement is common. In yet older adults, hearing impairment can be, and too often is, misdiagnosed as confusion or dementia with subsequent incorrect, inappropriate, and costly, management decisions frequently made.

Community implications. For each hearing impaired individual, hearing loss will impact on relationships not only with family members but also with others in various social and vocational relationships with them. With respect to the wider community, the implications of hearing loss also need to be considered in terms of community cost. Throughout life, at any age, delayed identification and poor and/or delayed management will result in totally avoidable costs. For example, well-managed and supported hearing impaired children who achieve age-appropriate language skills can be educationally mainstreamed and subsequently, employed to their appropriate potential, saving significantly at all of these levels. In our ageing population, up to one third of people over the age of sixty five will demonstrate a significant hearing loss. With prevalence and severity increasing with increasing age, we clearly cannot afford unnecessary early retirements, or mismanaged older folk who are confused not by dementia, but rather by not hearing adequately. From the community perspective, investment in timely and

appropriate individual hearing management programs is clearly an economic, as well as a moral, imperative.

c) **Adequacy of access to hearing services, including assessment and support services and hearing technologies.**

Assessment services.

Australia has been fortunate in its unique nationwide Commonwealth-funded Hearing Services Program with its clearly defined responsibility for children under the age of 21 years who need hearing devices, and for means tested pensioners. With few exceptions, for the remainder of the population, hearing health is presently a state responsibility. Given Australia's vast and varied geographic spread and scattered population, any state-wide hearing health guidelines must be based on adequate area-by-area demographic detail, and should remain sufficiently flexible to adapt to the differing needs of the various health regions. This pre-supposes appropriately located, staffed, equipped and funded audiology units to identify, manage and where appropriate, refer on to other appropriate services, people of all ages and abilities from their surrounding community, for whom hearing is a question.

Unfortunately, this is a model yet to be attained. In fact, it appears to be going backwards rather than forward. For example, in the 1970's, Victoria established a state-wide demographically-based network of audiology units of this nature. In NSW audiology units were situated more by happenstance, with fewer in country areas. More recently, however, in both NSW and Victoria, instead of augmenting these services, audiology units providing unique identification and non-medical hearing management services for all ages and abilities for local communities where no alternatives exist in either the public or the private sector, have progressively been closed. These closures are occurring in both metropolitan and rural areas. As noted in the sections above, despite apparent short-term cost-savings, this has major economic implications in terms of delayed identification and of subsequent increased management costs.

Support services. At any age, appropriate services are clearly essential to ensure that newly diagnosed individuals and/or parents of young hearing impaired children are supported in selecting the rehabilitation/habilitation services most appropriate to their need, and also to ensure that such devices as cochlear implants and hearing aids are fully and appropriately utilized. As such, these services are extremely cost-effective. Adequacy of support services presently varies widely from excellent to non-existent.

However, it is obviously NOT cost-effective to have to provide support services for remediation of unnecessary secondary handicaps that may well result from delays in initial identification of hearing impairment and in subsequent delayed commencement of appropriate management.

Hearing technologies. Australia is fortunate in having access to a full range of hearing technologies. International hearing aid companies are well represented, and Australia's pre-eminence in cochlear implant technology is well known. An appropriate range of assistive listening systems while perhaps not widely enough known and used, is also available.

The question of affordability of hearing devices for those not eligible for the Commonwealth Hearing Services Program remains problematic. For example, the unique Australian Hearing CSO hearing services program provides (and appropriately

encourages reliance on) hearing devices for hearing impaired children resident in Australia from birth/age of identification until they reach 21 years of age. Subsequently, this group in particular tends to be totally dependent on such aids to remain employed tax-paying citizens, yet purchasing new aids can be prohibitive. It is in both their interest, and the economic interest of the community at large, that an appropriate way to address this dilemma is devised and introduced as soon as possible.

Another area requiring to be addressed is communications access. Captioning on television and in cinemas is increasingly available. While this is commendable, there are too many other areas where despite the existence of disability laws, 'disabled access' requirements are considered to have been met when there are ramps installed for wheelchairs. Unfortunately, ramps do nothing to assist participation for hearing impaired people. Technology to provide communications access such as induction loops and CART (Computer Assisted Realtime Captioning) is not new, but is still far too seldom available.

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

<u>Hearing health and research programs</u>. Australia is fortunate to have the world-renowned National Acoustic Laboratories programs contributing to research across the range of hearing health issues. For thirty years, world-leading cochlear implant research has emanated from the Bionic Ear Institute and the University of Melbourne. Increasingly, universities around Australia, in particular those offering post-graduate professional training in audiology, are contributing to this body of knowledge.

<u>Education and awareness programs.</u> With regard to the general community, there is still much that needs to be done. Hearing loss is widely known as 'the invisible handicap'. The need for communications access is noted above and community education regarding this is essential. Too often, lack of education and awareness leads to underutilisation of installed systems which is not only unfortunate for those missing out on the benefits they can provide, but can lead to their removal. Too frequently, installed systems such as induction loops are not maintained, and when needed, found to be non-functioning. Community education programs for managing hearing issues particularly in older populations, and in potentially noise exposed populations (either leisure or work-related) are also very much needed. To be successful however it is essential that these must be evidence based. Presently, there is some work being done in these areas. If any real progress is to be made there needs to be more work done, both in developing Australian programs, and in evaluation for their suitability in the Australian context, of programs developed overseas.

e) <u>Specific issues affecting indigenous communities .</u>

Indigenous communities have their own unique problems. Hearing problems in these communities will not be resolved independently of many other health and lifestyle issues. To be successful, programs must be developed in consultation with appropriate community members.

Ref: Access Economics (2006): *LISTEN HEAR! The Economic Impact and Cost of Hearing Loss in Australia.* Access Economics www.accesseconomics.com.au

Submission to inquiry into Hearing Health in Australia from The University of Melbourne, Audiology and Speech Sciences

Prepared by Professor Richard C. Dowell BSc MSc DipAud PhD FASA(CC)
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Royal Victoria Eye and Ear Hospital

Preamble: Professor Dowell has 30 years of experience in research, teaching and clinical services in the hearing health field. The University of Melbourne and the Royal Victorian Eye and Ear Hospital employ over 35 audiologists in a range of clinical, teaching and research activities across the spectrum of hearing health care. The University of Melbourne has an international reputation in the Cochlear Implant Field as the original developer of the cochlear implant technology, commercialized by Cochlear Ltd, that has become standard treatment around the world for severe and profound hearing loss.

A. The extent causes and costs of hearing loss in Australia.

In 2006, the Cooperative Research Centre for Cochlear Implant and Hearing Aid Innovation (now the Hearing CRC) along with VICDEAF commissioned a report from Access Economics to document the economic impact and cost of hearing loss in Australia (LISTEN HEAR!) This document provides a comprehensive investigation of these issues and I refer the Reference Committee to this report regarding issues of extent and costs of hearing loss. The study concluded that the real financial cost of hearing loss in Australia was $11.75 billion in 2005, with a further $11.3 billion in terms of "loss of well-being".

It is worth highlighting that the direct health care costs amount to only 6% of the real financial cost. There would appear to be a persuasive argument for additional spending in the research and health care areas related to hearing as long as such spending is targeted to produce measurable outcomes in terms of improved productivity and well-being.

As to the causes of hearing loss, the two risk factors of noise exposure and age account for a very large proportion of all significant hearing losses. Legislation already seeks to protect employees in Australia from exposure to dangerous levels of noise but there remain problems in the implementation and acceptance of hearing protection and the susceptibility to noise damage appears to vary widely across the population. Research into the susceptibility to noise damage and into pharmacological protection of the ear could have a large impact on this area. In addition, smarter forms of hearing protection may provide more acceptance by employees and have less impact on communication in the work place. Recreational

noise exposure tends to generate a lot of discussion and in recent years has tended to focus on the use of Ipods and other portable music devices. It is clear that recreational noise exposure reaches levels that are known to be dangerous. It is not well-established how much this recreational exposure is contributing to significant hearing loss in later life and the burden of disease and economic costs. Other recreational activities such as shooting, motor sport and the use of power tools may also be contributing to the levels of hearing loss in the community. Long term population-based research is needed in this area to really understand the extent of the problem.

B. The effects of hearing loss on individuals and the community

It did not surprise me when the Access Economics report put a figure of over $11 billion per annum on the cost of hearing loss as I have observed first-hand the effects that significant hearing loss has on people's lives over a long period. In our modern society, communication is almost everything. How many people do not have a mobile phone? How many job descriptions do not have a criterion relating to "excellent communication skills". Even mild hearing losses may be limiting in the vocational arena where every nuance of a meeting or negotiation could be critical. Once a hearing loss reaches the severe level (a point where people are unlikely to be able to use the telephone successfully), the effects on vocational, social and educational activities are often truly devastating.

In the main, the effects of hearing loss are hidden from view. It is not obvious that someone has a hearing disability as it would be for physical or visual handicap. People with hearing loss tend to withdraw from activities that involve spoken communication (virtually all activities if you consider this for a moment), and therefore become invisible to the general population. The most devastating effects of hearing problems occur with significant congenital hearing loss. For children born deaf they may never learn to speak intelligibly and often do not develop language skills to a level beyond early primary school. This is again a hidden deficit as it is quite obvious when someone's speech is difficult to understand but not obvious at all when they have not developed the language structures that all of our more abstract cognitive abilities are built on.

This is the real educational problem for hearing impaired children – their language skills lag continually behind their hearing peers. This gap grows over time such that very few are in a position to gain an adequate secondary education. Studies of the language progress of children with significant hearing impairment show growth rates between 0.4 and 0.6 compared with normal. The practical significance of this simple result is that a child entering secondary school at 12 years of age will have the reading ability of a first grader. There are exceptions to this rather dismal average result for children educated through both visual methods (sign language) and oral methods (spoken language), and there is much debate about which approach is best, but until recently the prospect of normal educational and vocational opportunities for congenitally deaf people has been remote.

The last two decades have revolutionized audiology and provided us with the tools to provide near normal opportunities for 80% of deaf children. The development of

cochlear implants, the improvement in hearing aid technology and the ability to diagnose hearing loss at birth have changed the field dramatically. The latest research indicates that with three components in place, most children born deaf can look forward to near normal opportunities in life.

1. Identify significant hearing loss accurately within the first month of life
2. Fit appropriate hearing devices (conventional hearing aids or cochlear implants) as early as possible (but definitely before 12 months) and make sure these are operating every minute of every day.
3. Make sure that Mum, Dad and teachers talk to the child as often as possible providing a meaningful spoken language model.

Although this sounds simple, it is being achieved in less than 50% of cases in Victoria due to failures at 1, 2, 3 or a combination. To improve the situation, we need to ensure that hearing screening programs are rolled out across all states and regions, and are monitored carefully. We need to make sure that appropriate hearing aids and cochlear implants are available to all children who need them and that follow-up is in place to deal with technical problems, maintain comfort and ensure consistent use. Finally, we need an approach to early intervention based on evidence rather than philosophical beliefs or tradition.

C. The adequacy of access to hearing services, including assessment and support services, and hearing technologies;

There are a number of major issues in Australia that lead to inequities for hearing-impaired people and inappropriate management of hearing loss. Australia potentially has the best services for hearing-impaired people of any country in the world, but historical traditions in health care, inadequate, complex or contradictory models of funding and a failure to recognize the importance of rehabilitative services makes it extremely difficult to run a viable patient-focused comprehensive hearing clinic, something we have been striving for nearly 30 years. I believe the main issues worthy of attention and action are:

1. FUNDING OF DIAGNOSTIC AUDIOLOGY

Medicare funding for audiology services in Australia is controlled by medical practitioners who, in most cases, have no training in the practicalities of modern audiology testing or the interpretation of results. Furthermore, there is no requirement that trained audiologists perform the diagnostic services, although these days most of the services are provided by appropriately trained practitioners (I hope). The fact that under Medicare, a medical practitioner with very limited knowledge of hearing assessment can be funded for complex diagnostic tests performed by an untrained technician is simply ridiculous, and provides no assurance for patients that their hearing problem will be managed appropriately. In addition, the scheduled fees for various assessments tend to drive some decisions as to what tests are performed, not necessarily in the best interests of solving a patient's problems. Services attracting a low fee (or none) will tend to be rushed through or left out, despite sometimes being the most important for achieving an effective patient outcome. There are also

ludicrous differences in funding schemes where, for instance, the same activity billed via Medicare will attract a payment of ~$50 and if billed through the Office of Hearing Services will attract ~$120. Within the various State Health systems, there will be yet another funding rate for this type of service.

The Medicare funding schedule and regulations for audiology services should be completely overhauled and updated with input from experienced audiologists. Particular issues are the requirement for audiological qualifications for those performing these tests, a more comprehensive range of tests being available, and a careful consideration of the scheduled fees to prevent the financial incentives for over and under servicing. Oversight and responsibility for these services should rest with trained audiologists rather than medical practitioners.

Due to inadequate and outdated provisions of Medicare it has been almost impossible to run a viable, comprehensive, diagnositic audiology service and maintain the level of quality and patient outcomes expected within the audiology profession. This is a major factor that is preventing access to good quality hearing care in Australia.

2. INEQUITIES IN THE PROVISION OF AUSTRALIAN HEARING SERVICES

Provision of hearing technology for children and pensioners through Australian Hearing (AH) has been one of the excellent initiatives in Australia that is unique in the world in terms of the consistency and quality of audiological services. There are, however, some substantial inequities that come about through AH's current "rules of engagement". Patients in most need of support are those born with significant hearing loss or those who become deaf early in life. This group is well looked after by AH until they are 21 years of age, but are then on their own in a financial sense. Those with the most severe hearing problems are those who will have the largest financial burden to maintain their hearing technology (particularly cochlear implant users). This group will also the most affected by hearing loss with perhaps decreased educational and vocational opportunities. I would suggest that AH's scope of service be extended to adults who have had significant levels of bilateral hearing loss from early in life. An additional inequity arises for adults with severe hearing loss. If they reach a stage where they are considered for a cochlear implant, this ~$50,000 procedure will be funded almost completely by private health insurance or public funding. If you are not quite bad enough for a cochlear implant, your hearing aids (up to $10,000 every 4-5 years) have to be financed by the patient in most cases. This actually creates a strange "false economy" situation where an occasional patient will exaggerate their hearing loss to try to qualify for a cochlear implant because they feel they cannot afford new hearing aids. There would seem to be scope for providing AH services to all adults who reach a certain level of hearing loss.

3. EVIDENCE-BASED, GOAL DRIVEN EARLY INTERVENTION

Early intervention and educational management for hearing-impaired children is crucial for successful outcomes, particularly in the pre-school years. This field, however, is driven by philosophy and beliefs rather than science and evidence.

There is a widely held belief that additional resources provided for pre-school early intervention programs for hearing-impaired children will assist in providing improved outcomes. There is also some good evidence to support this notion, however, early intervention programs must be held accountable for the progress and outcomes of children in their care. The concept of consistent measurement of progress against norms and goals is not well accepted in the sector and it is likely that a shift to an evidence based approach will need to be mandated and linked to funding, preferably at a national level. Without this shift in approach, we are likely to continue to see tragic cases where children are placed in inappropriate educational programs and remain there until it is too late to do anything about it.

4. FAMILY SUPPORT FOLLOWING DIAGNOSIS OF HEARING LOSS

There is a current gap in the clinical pathway for families of children with diagnosed hearing loss. The diagnosis itself is often a devastating and emotional experience and families are often left grieving while they are given sometimes conflicting advice from up to seven agencies or professionals that may claim part "ownership" of the case. Many countries have established a family support scheme where a case-manager becomes the main point of contact and helps coordinate the necessary assessments and consultations until a degree of stability is reached. It is generally agreed that this is a service that needs to be established in the Australian context. Not many will agree, however, about who or how it should be achieved. The debate centres mainly on the degree of bias towards one approach or another that an individual case-manager may bring to the situation. Again, a focus on evidence-based and family centred practice should be able to assist in bringing families to a level of stability and empowerment suitable for clear decision-making.

D. THE ADEQUACY OF CURRENT HEARING HEALTH AND RESEARCH PROGRAMS, INCLUDING EDUCATION AND AWARENESS PROGRAMS

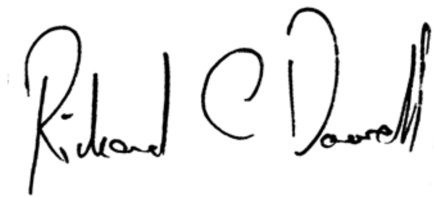
Australia has a good record in hearing research, and could perhaps claim a premier position given the work that has come out of NAL on hearing aid fitting and the development of the cochlear implant. Despite these successes, there is an urgent need for more research, particularly to inform early intervention programs, to understand the reasons for non-use of hearing devices, to understand and prevent the more common types of hearing loss and to increase awareness of the importance of hearing health and the services available. Less than 20% of adults who could benefit from hearing devices, actually access these services. Less than 10% of people who could benefit from cochlear implants actually seek this form of treatment.

E. SPECIFIC ISSUES AFFECTING INDIGENOUS COMMUNITIES

It is well-documented that the rate of hearing loss due to middle ear disease in indigenous communities can be as high as 80%. The reasons for this major problem are not completely clear but it is likely that they relate mostly to the general standard health and hygiene encountered in indigenous communities. The raising of this standard has remained a frustrating issue over many years and I don't believe I can offer any simple solutions. Despite some concerted efforts to treat middle ear disease, there is limited success due to lifestyle issues and the failure to improve the general standard of living within these communities. It is possible that hearing loss in indigenous children is a major cause of educational under-achievement. Given that in the short-term there does not appear to be an effective way to reduce the incidence of middle ear disease, a novel approach to the educational problem has been suggested by Dr Harvey Dillon from the National Acoustics Laboratories. He has proposed that the hearing loss issues could be overcome in the classroom by installing sound field systems in every classroom. This is a simple amplification system whereby the teacher's voice is raised in level using a wireless microphone. I believe this is an ingenious suggestion well worth considering in indigenous communities at least as a pilot program.

Thank you for considering this submission to the inquiry,

Yours sincerely,



Richard C Dowell
Professor of Audiology and Speech Sciences
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Submission: Senate Inquiry into Hearing Healthcare in Australia

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Summary:
Ready access to quality hearing services in the southwest region of WA is dismal and limited to those who can afford it. The public services available in the South West Region have declined in the last 10 years and hearing health services appear to have been over looked in health planning in the region. What services are available are so oversubscribed that medical practitioners give up on referring to them. One in 6 Australians is hearing impaired, the cost to individuals and the community is far reaching, but is incredibly appears to have been overlooked in public health planning in the region.

Background

I am an Audiologist who has been in private practice in the region for 16 years before selling my business, South West Audiology to a national company, Connect Hearing. During my time in the South West I have seen a decline in the hearing services publically available to residents of the region and there has not been an increase in public or Health fund support for these residents to seek private services.

I make no apologies for charging for our audiological services which has been necessary to establish a quality, sustainable "Full service" Audiology centres. Our company has a "hub and spoke" model of service delivery, with two permanent centres in Bunbury and Busselton and three visiting centre in Australind, Margaret River and Augusta.

We provide diagnostic, rehabilitative and preventative services to children as young as 12 hours old through to industrial clients and geriatrics.

Our services include:

- Otoacoustic emissions assessment
- Diagnostic and site of lesion assessment.
- Industrial hearing assessments and monitoring
- Balance Assessment
- Tinnitus Assessment and management
- Paediatric Assessment – visual response audiometry , central auditory processing assessment.
- Hearing aids and assistive devices
- Cochlear and bone implantable device and rehabilitation.
- Hearing Protection
- Communication training and counseling

- Community hearing awareness programs

Education
We also provide clinical supervision and training for Audiologists from the University of WA Audiology, Masters Program and Audiometrists from the NSW OTEN course. We are also involved in exposing Student Medical Practitioner to audiological services during their rural placements.

Eligibility
Our service is available to people of all ages on a private pay for service basis and we have a contract with the office of hearing services to provide free or subsided rehabilitative services for eligible pensions and Veterans.

Fees and Who gives rebates?
One of the major causes of inaccessibility of hearing care is the lack of rebates from Private Health funds or Medicare.

Our fees are based on $230/hour and the will depend on the duration of the services provided. Hearing aids range from Free under the OHS program and from $1000-$5000 each for fee paying customers. Cochlear implants and processors cost approximately $30 000 each for the prosthesis only.

Most Health funds will pay a portion of the hearing aid fee and will pay all of the implant prosthesis fee if you have the right level of cover. Very few health funds, i.e. Army Health and Goldfields medical pay anything toward a visit to an Audiologist for an assessment which normal costs around $115 and Cochlear Implant rehabilitation is closer to $300.00.

Medicare rebate is only available if the client is on an agreed Medicare Care Plan and the client can receive $50.00 from Medicare. Recently we reached agreement with one of our ENTs
To have a Medicare arrangement where by we supply the services on his behalf, the other ENT is worried about being responsible for debt collection and is weary about doing the same.

Telethon Speech and Hearing Centre
Connect Hearing supports the TSH Centres neonatal screening program in the SW with facilities and expert support for the screening staff. An Ear bus for aboriginal children in the area is also offered by the centre.
Neonatal screening is offered in to all new mothers at St John of God hospital for a fee of $80. It is optional, not universal! NOTE: This service is provided Free to all new mothers in public hospitals in Perth.

Implant Services and New technologies
The state government provided for 2 publicily funded cochlear implants a year in our region. At present that quota has been used up and there are two people waiting until funding is available. They have both recently become completely deaf.

No allowance is made for the rehabilitation for people with implants. The rehabilitation takes many visits and will cost the fee paying client at least $1200 minimum. There is a Medicare number for programming but it is only accessible if we have a Medicare relationship with the surgeon and we perform the work on his behalf.

Cochlear Implants and bone implantable hearing aids and products have been approved in most advanced country for many years. In Australia they are treated as New and rare but they are becoming accepted and regular treatment for the management of hearing loss in this country. There is a need for funding and policy to keep abreast of the technological advances.

The cost of providing a quality Comprehensive Hearing Health Service.

Due to the fact that hearing aids have health fund rebates there has been a proliferation of hearing aid dispensing centres that do not provide any other service. Be aware that not all hearing centres have the technical capability to provide comprehensive services to the community.

Equipment

The usual overheads of running a building and business apply but a fully equippend hearing centre required a great deal of space to house the acoustic booths. A paediatric centre requires a sound field which is can occupy a space of over 3m x 3 metre and is very expensive to have moved. The booths cost around $70 000 installed. Smaller adult size booths are $5000.

A standard diagnostic audiometer costs $20 000 our centres have 9 of these alone. An auditory brainstem response system costs $90 000 and there are many other diagnostic and rehabilitation devices required to run a comprehensive service.
Booth require calibration every 5 years equipment and sound field require calibration annually. A standard calibration fee for one instrument is $300.

Clinicians

A fully qualified Audiologist with a clinical certificate commands a minimum wage package of $85-$130 000. There is a shortage of fully qualified audiologists in the Australian market and they are very difficult to attract to regional areas. It is very likely that these wage expectations prevent audiologist from taking on government positions. Clinicians must have on going education to keep up certification and skills and the cost of education and associated is in top of salary.

Present problems in South West,WA. (in my personal opinion)

No Public Audiology Service for adults:

There is a gap in service provision in the region, whereby people who not on a pension have no public Audiology service. Even those who have private health insurance must pay for their services in most cases as their funds do no cover hearing services.

Suggestion: Improve access to Audiological services by improving Health fund rebates.

Australian Hearing: Children must have a **confirmed hearing loss** before they can be eligible for the services of AH. I believe AH has moved away from its community responsibilities and focused on dispensing hearing aids to pensioners and veterans in attempt to become commercially competitive.

Suggestion: AH eligibility should be increased to include free assessment of children under 21 with GP referral. AH should be providing more accessible services to local Aboriginal children, it is dreadful that a Charity (TSH) has to provide a service that should be provided by the government. This would greatly relieve the burden on the local state health system and greatly improve access to hearing care for children in the region.

ENT Services:
Our local ENT surgeon is so busy that local and regional general practitioners routinely refer patients to Perth ENT surgeons to by pass the waiting list. The current wait list of 4 months is not a true reflection of the massive demand in the area. The local ENT cannot attract another ENT to join him in the practice as there are insufficient operating hours available at the Bunbury Hospital campus to make another ENT position viable.

Our local ENT is new and has inherited an in house audiometerist who has no formal training or qualifications. Yet the audiometrist assesses the hearing of small children and adults and the fee is covered by Medicare.

Suggestion: Increase the availability of operating hours in Bunbury, perhaps support the establishment of a day surgery in the region.
Encourage/fund a regular visit to Bunbury and Busselton from a Perth ENT or Registrar from Fremantle hospital to relieve the pressure on the local ENT and reduce the cost for families to attend ENT clinic.
Please consider making the OTEN audiometry course the minimum requirement for persons doing work on or behalf of Medical Practitioners to prevent, untrained and unqualified personnel from performing assessments which may well be inaccurate and lead to misdiagnosis and poor outcomes. This will also improve the worth and status of qualified personnel and encourage greater take up of the profession.

<u>Health Fund Rebates</u>
One of singularly easiest ways to improve accessibility is to improve health fund rebates.

Suggestion: Lobby Health funds to provide realistic rebates for clinical and rehabilitative services provided by audiologists, not just for the prosthesis. I can get a rebate for a massage but not a hearing assessment…go figure!

Medicare
Most of the Medicare services listed under Otolaryngology cannot be provided by the ENT as they neither have the training or the diagnostic equipment to do so, yet the services are essential to the correct diagnosis and appropriate management of the patient. Therefore they have to be provided by an Audiologist who is the most qualified professional to do so.
When I was "self employed" Allied health professional it was made very clear to me that I could not use the Medicare system to do work on behalf of a Medical practitioner and this is stated in the schedule. Medical Practitioners are very cautious about setting up Medicare relationships with Audiological services for fear of professional and legal liability as well as the ever present threat of being accused of fraud. They also do not want the burden of debt collection.

Suggestion: Make Medicare items numbers for Audiological Services available for direct billing by the suitably qualified Audiological service provider.

Make the procedure for Audiologists providing services "on behalf of" a medical practitioner under the Medicare program "crystal clear" so there is no chance of misinterpretation and latter accusations of fraudulent behaviors arising in the future.

Health Partnerships:
The expense of setting up a comprehensive Audiological service and keeping it continuously manned with qualified Audiologists will be an on going battle in the South West.
Suggestion: Greater utilisation of existing private services by government agencies would result in greater accessibility, reduced costs, greater continuity of quality hearing services. A sharing of resources may be advantageous.

Concerns for the future of Audiology and Hearing services
There is a risk that in with the proliferation of Hearing aid dispensing centre in the market will result in a reduction in viability of comprehensive centres. As a result opportunities to learn and develop higher level scientific and diagnostic skills will be lost. There will be no opportunities for clinical placement for audiologists or general practitioners.
Suggestion:
Implement policy to support the viability of comprehensive audiological services in WA.
Hearing services available in the South West of WA.

Services	Services provided	Waiting time	Clinicians	Eligibility
Connect Hearing Permanent clinics: Bunbury, Busselton	• Otoacoustic emissions assessment • Diagnostic and site of lesion assessment. • Industrial hearing assessments and	Same day	5	Open to all ages fee paying Eligible Pensioners and Veterans

Visiting: Australind Margaret River Augusta	monitoring • Balance Assessment • Tinnitus Assessment and management • Paediatric Assessment – visual response audiometry , central auditory processing assessment. • Hearing aids and assistive devices • Cochlear and bone implantable device and rehabilitation. • Hearing Protection			
Australian Hearing Permanent clinics: Bunbury, Visiting: Collie Augusta	Adult and Paediatric rehabilitation centre. Hearing aid dispensers.	Same week	2.5 Pediatric specialist audiologist visits from Perth.	Eligible Pensioner and Veterans Free or subsidised services. Children under 21 years with **confirmed** hearing loss.
State Health Bunbury Hudson Road Community Centre	Children's Diagnostic centre. • Otoacoustic emissions assessment • Diagnostic and site of lesion assessment. • Visual response audiometry • Play audiometry	0-4 years- high priority under 4 months wait. Over 4 months wait for school aged	1 part time Audiologist 2 days a week Possibly back to 3 days by the end of 2009.	Children only Free service

National Hearing Bunbury	Hearing Aid dispensers only.	Same week	1 Part time Audiologist	Open to all Adults- fee paying and Eligible Pensioners and Veterans
Mr Latif Kadhim ENT Bunbury Visting: Katanning	Ear, Nose and Throat Surgeon.	4 months For non - urgent referral. CI 2 Implants a year	1 ENT 1 Unqualified audiometrist	Fee paying Medicare rebatable service.
Mr Ian Wallace Cottesloe	ENT surgeon – Cochlear Implants only.	Assists with public implant patients and will implant private clients with 6 weeks.	ENT Relies of private audiologists services.	Fee Paying Assists with public clients.
Telethon Speech and Hearing Centre	Neonatal screening Travelling Ear Bus for aboriginal children with screening and some ENT services.	Daily all new mothers	Train nurse screener.	Offered to all new mothers in Private Hospital for approx: $80.00 Advertised to public mothers as a fee paying service.

SUBMISSION TO SENATE INQUIRY INTO HEARING HEALTH IN AUSTRALIA.

Author: Mrs Jenny Wimberger

I tender the following submission in the following context:

- I am a Clinical Audiologist of 23 years' experience.
- I am a Full Member of the Audiology Society of Australia, and hold a current Certificate of Clinical Practice.
- I have worked in the areas of rehabilitative and diagnostic audiology, and with patients / clients aged from newborn infants to elderly pensioners and veterans.
- I am currently working part-time at a public hospital and at a private practice.

My area of speciality and expertise has focussed over the last few years primarily in the *diagnostic audiology of school-aged children – specifically Central Auditory Processing Disorders.*

I address the Inquiry specifically in relation to point c): "the adequacy of access to hearing services, including assessment and support services, and hearing technologies".

Central Auditory Processing is known as "what we do with what we hear", and involves a complex series of neurological functions which begin at the ear level and end in the brain. It is not as simple as being able to hear tones or repeat back speech on a basic hearing assessment. To obtain a full picture of one's Central Auditory Processing ability an extensive battery of tests must be undertaken. This is *only* correctly administered and interpreted by an *Audiologist*.

In view of the current concern regarding the recent statistics on the literacy and numeracy level of our children, this support service and diagnostic tool is particularly important.

Central Auditory Processing disorders are recognised by Paediatricians, Speech Pathologists, Psychologists and Educators as a critical factor in the success or otherwise of a child's educational, social and behavioural development. There is a constant stream of referrals requesting such assessment, which on average takes 1.5 – 2.0 hours, plus interpretation and report writing time. Personally, results from my assessments have impacted on the development of children's Individual Education Plans (IEPs), remedial Speech Pathology regimes, diagnoses of behavioural, learning or autistic spectrum disorders, and general planning of educational placements.

<u>Very few</u> Audiology practices offer this service, for the following reasons:

- It is lengthy.
- It involves patients / clients with *normal hearing* (and therefore no prospect of a hearing aid sale).
- It is a specialty which requires extra study and experience for the Audiologist to administer and interpret correctly (and cannot be done so by an Audiometrist).
- The multitude of test materials required is expensive to obtain.

- The follow-up with other professionals and the recommendation of other assistive listening devices is complex and time-consuming.

For those of us who recognise the importance of delivering this service, we are currently hamstrung by the following facts:

- Central Auditory Processing Assessment currently does not have a Medicare item number.
- Audiologists in Private Practice do not have Medicate access equitable with Optometrists.
- Children with normal hearing but learning delays or behavioural issues who require this assessment are NOT being referred by their GP under an EPC.
- Very few Private Health Insurance companies offer any rebate to Audiology, and those who do so provide inadequate "consultation" rebates, yet other Allied Health services such as Speech Pathology, Physiotherapy and Psychology are rebated more satisfactorily.

I have previously corresponded with the Office of the Minister for Health and Ageing, Ms Roxon, regarding this matter. On 8th of April 2009 I received a reply from the Hon Justine Elliot MP's office stating:

"Under the Australian Government Hearing Services Programme.....Australian Hearing receives fixed funding to provide hearing services to all children who have, or are at risk of having, hearing loss that may impact on communication, educational and / or social development. Services are not dedicated to evaluating educational or language disturbances that are not related to hearing loss.
Since children with Central Auditory Processing Disorders (CAPD) have normal hearing on pure tone audiometry, Australian Hearing does not provide the type of assessments that are used to diagnose CAPD, nor does it provide hearing and communication improvement programs to children who have CAPD.
There is currently no Medicare Benefits Schedule item for Central Auditory Processing assessment."

This reply simply reiterated my points and confirmed a lack of recognition of the importance of the diagnosis and management of children with Central Auditory Processing issues.

In conclusion, the current situation clearly demonstrates an inadequacy of access to this hearing service. Patients whom attend Private clinics are paying the cost with no fair rebate from either the private or public health insurance system. Patients whom cannot afford to attend privately are being placed on lengthy waiting lists at public hospitals. Once again very few of them offer this service anyway.

I can say that at the present time I am one of only three audiologists at the only public hospital Audiology Department in Queensland that even offers Central Auditory Processing assessments!

To improve access to all Australian families I would urge The Committee to consider the following points:

- Provide Medicare access to fully qualified Audiologists to ensure Australians have access to a professional and thorough diagnostic hearing assessment (and not just a “free hearing screen” aimed at securing a hearing aid sale).
- Pressure the Private Health Insurance companies to rethink their narrow perception of Audiology. They have told me they do not rebate hearing tests because people can get them for free. A child with chronic glue ear who needs regular assessments is not going to be serviced adequately by a local hearing aid sales audiometrist! There are thousands of Australian families who pay private health insurance premiums, but will never need to claim on a hearing aid. However to have their child’s hearing or Auditory Processing assessed they have to pay out with no rebate or sit on a public hospital waiting list. Private Insurers claim to be “proactive in health prevention” but as far as audiology is concerned this is certainly not the case.

“Hearing Health” is not just about the prevention or management of hearing *loss.* It is also about the diagnosis and management of *what we do with what we can hear*, and the management and remediation of children and adults who have a disorder in their auditory processing ability.

Thank-you for the opportunity to present this submission.

Mrs Jennifer Wimberger
September 20th, 2009.

SUBMISSION TO SENATE INQUIRY INTO HEARING HEALTH IN AUSTRALIA.

Issues raised by **ASA members in Queensland** in response to the 5 criteria:

- Medicare rebates for hearing tests performed by Audiologists. Especially for those who are from low socioeconomic areas and can't afford a hearing test - the waiting lists at the hospitals can be quite long.

- Private health funds - recognition of hearing tests where Medicare doesn't offer a rebate or if clinics need to charge a higher fee. Improved PHI rebates for the cost of hearing devices, including hearing aids, assistive listening devices, FM systems, ear plugs, batteries and repairs.

- A rebate for hearing tests is an obvious shortfall in our health system (the fact that clinics resort to offering "free" hearing tests just to get people in the door really irks!). The OHS voucher system needs a simpler process for clinics, but more importantly for clients.

- Pensioners could simply present their pension card and a clinic could quickly ascertain their eligibility etc? Clinics should be able to charge a gap fee when they provide, and their clients want, a higher level of service – such as home, Nursing Home visits, extra rehab etc.

- Private clients should also be eligible for some level of subsidy from Medicare for both hearing tests and hearing aids. Children in particular should be able to see any audiologist for a test and have most of the costs rebated.

- Having a fairer fee structure for services *actually* provided will help the rehab audiology industry move away from having to rely on hearing aids as the major source of income (and hopefully help reduce the cost of hearing aids!). I'd love to see the day when we don't have to bundle all our costs into the cost of the hearing aid to make ends meet!

A diagnostic audiologist in private practice (as well as also providing a public service at a major hospital) has the following queries:

- Why do private health insurance companies not rebate on diagnostic hearing assessment? Consultations for fellow allied health providers such as physiotherapists, speech pathologists, occupational therapists and psychologists are rebated, but not audiologists.

- Private health insurance companies cover part cost of hearing aids, but not the cost of the assessments required before a hearing aid can be considered and accurately prescribed and fitted. Only a relatively small percentage of people with a diagnosed hearing loss actually go on to benefit from a hearing aid.

- This rebate is totally useless and irrelevant in the case of families with young children who suffer recurrent middle-ear infections (up to 75% of children below age 7). They are able to obtain medical treatment through their GP or ENT specialist but the families and schools cannot manage their social and educational needs without accurate and recent hearing assessment.

- Similarly, children with learning and / or behavioural difficulties who pass a hearing screen most commonly have a Central Auditory Processing disorder, which can only be fully and accurately diagnosed by an audiologist. The outcomes of such assessments are implemented by families, teachers and therapists to improve the educational and language

development of the child. There is no rebate through health insurance or a Medicare item number for this type of assessment. I am astounded and wonder why not.

- Princess Alexandra Hospital runs the only **Hearing Aid Bank** in Queensland – this service allows people to be fitted with second hand hearing aids if they do not qualify for the Government Hearing Services Program or if they are financially unable to purchase hearing aids privately. We are only able to fit approx 2 people per month and we have a 12-15 month waiting list which has remained fairly constant for many years. Our clientele consist of the 'working poor' - of which there are plenty when the cost of a single hearing aid starts at about $2000 (and most people need 2!). We see many people who cannot obtain employment because of their hearing loss. The Commonwealth Rehabilitation Service used to be able to provide services for some of these clients, however, this is no longer the case as their services have been significantly reduced. It is a vicious circle when you can't earn a living because of your hearing loss and because you have no job, you cannot afford to buy hearing aids! Some people have financial assets tied up as part of their property (e.f. farmers) who have very little by way of finances to pay for hearing aids. We also see a large number of people who have come to Australia as refugees (e.g. from Sudan) – these people are not entitled to hearing aids or hearing services from the government. They often have English as a second language and cannot start to learn the language because of their hearing loss. We also see people who were clients of Australian Hearing or the OHS program and lose their eligibility – and cannot afford hearing aids.

- There is a BIG gap in Hearing services for the 'working poor', people who have property assets (e.g. farms) but not enough money to pay for hearing aids, people who have entered the country as refugees or migrants, and people who were clients of Australian Hearing or the OHS program and lose their eligibility.

- **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. 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.

- 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.

- 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 access 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 Chronic Disease Management 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!

- Child 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 and well presented, however, it is unfortunate that hearing which is critical for the development of literacy and numeracy, rates no mention in the set of thirty two cards. Ideally with all literacy and numeracy information there could be a dot point about the importance of a hearing check, especially if the child is believed to have "selective hearing".

- 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 arise 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, is a common cause for delay in acquisition of 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.

- Compensation for noise induced hearing loss needs to be addressed so that people are adequately compensated where this is due to workplace negligence and is given to ***<u>8Khz</u>*** to at least cover the speech range. Current compensation is only up to 4kHz.

e) **Specific issues affecting Indigenous communities.**

While there has been a long term problem with the ear health in communities, there are simple strategies that may have been overlooked in the medical model of care. These would help reduce the problems that currently require surgical interventions and there are likely to be corresponding improvements in literacy levels.

- 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!
- 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 mp3 sharing adaptor - 5 Headphones can be run for $100

To summarise:

- The cost of hearing loss is significantly more than what is spent to address the issue.
- To improve service in rural areas (incentives similar to those for doctors are needed) and the general population.
- Audiologists should be entitled to claim the existing Medicare rebate structure in line with ENT's for hearing assessment and balance/vestibular testing, with the addition of auditory processing and otoacoustic emission testing to be consistent with Medicare access available to 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 quite simple, cost effective measures are already available.

SUBMISSION TO SENATE INQUIRY INTO HEARING HEALTH IN AUSTRALIA.

Author:
Barbara Nudd (Audiologist at Wyong Hospital, NSW)

Thank you for implementing this inquiry into hearing health in Australia. Unmanaged hearing loss is a major issue in Australia and your interest may help to address some current inequities in service provision. I am an audiologist of 30 years experience, 4 years with Australian Hearing, the Commonwealth funded Audiology service, and the rest within the NSW public health system. I have seen the cycle of growth and fall of Community Health within NSW Area Health Services, predominantly due to funding issues. This has had a significant impact on NSW public audiological services. I have had some short blocks of employment recently in the NT working in Aboriginal communities through the Commonwealth Intervention funding, but my main expertise is in the NSW Health service as a paediatric specialist audiologist in a community health setting.

My submission is not to be seen to represent the views of my employer, but my personal views as an audiologist.

a) <u>The extent, causes and costs of hearing impairment in Australia</u> have been well documented in the Access Economics Report (2006) *Listen Hear – The Economic Impact and Cost of hearing loss in Australia* Canberra.

ABS census data gives some indication of the extent of hearing loss in the community, but this is from people who are willing to identify as hearing impaired.

b) <u>The implications of hearing impairment for individuals and the community</u>
Note that there is still a major stigma for most people to acknowledge that they have a hearing loss. When I ask families whether there is a family history of hearing loss, most people will laugh and say: well he hears what he wants to…he just doesn't want to hear…he switches off etc. There is very little understanding from the general public of the impact of a hearing loss on a person's life, on their speech and language learning, their education and later employment. It impacts heavily on people's confidence, social interaction, and communication. It is a silent invisible handicap. Parents with small children are often unaware of normal developmental milestones for speech and hearing and miss a hearing loss in their child for considerable time.

Voluntary self-help groups such as Better Hearing Australia and Self Help for Hard of Hearing People do a great job in assisting people with hearing loss to live a 'normal' life, but not all people with a hearing impairment are aware of these organisations.

Any submissions from Self Help groups and Deafness Forum, the peak body for Deafness and Hearing Impairment will give you a realistic indication of the impact of hearing loss on people's lives and areas of assistance. But again, note that members of self –help groups are the people who are dealing with their hearing loss. There are

many people out there trying to ignore their difficulties and this results in a significant impact on their social relationships, education and employment. This is also well covered in the Access Economics Report cited above.

c) The adequacy of access to hearing services, including assessment and support services, and hearing technologies:

Access to hearing services in NSW:

Audiologists are post graduate allied health professionals with a range of skills of diagnosis and the non-medical management of hearing impairment and vestibular problems. Different work settings require different skills. There is considerable counselling and support required when a hearing loss is diagnosed. This is necessary for families of young children whose hearing impairment has just been detected, but also crucial for teens and adults who develop a hearing loss.

NSW public Audiology services have developed on an ad-hoc basis since the late 1960s– there is no requirement from NSW Health that every Area Health Service should provide a certain level of hearing services.
NSW Health introduced an excellent newborn infant hearing screening program (State Wide Infant Screening-Hearing 'SWISH') in December 2002. This has been appropriately funded and equipped from NSW Health funds, not Area Health funds. So babies **born** with significant hearing loss are now diagnosed at a very early age, and are accessing rehabilitation services (devices, investigation of etiology, counselling for families, early education and speech interventions etc).

However Area Health Audiology departments depend on money from their Area Health Services, and this is dwindling rapidly as Area Health services try to manage their deficits. This has resulted in the closure of a number of Sydney metropolitan Community Health Audiology services when their audiologists have resigned or retired. Most recently this has been Mona Vale and Hornsby Kuringai Hospitals. Previously we have lost departments at Sydney Hospital, Canterbury Hospital and Lidcombe Hospital.

The reduction in NSW Area Health Audiology departments has increased the inequity of access to publicly funded Audiology for NSW residents. Assessing the hearing of babies, toddlers and young preschoolers requires special skills from the audiologist, in a purpose built facility with appropriate equipment. At present the 2 audiologists in the Central Coast sector of Northern Sydney Area Health Service provide the only public audiology service for children from birth to age 4 for the region from the Harbour Bridge to Lake Macquarie. Families may access private audiology clinics for assessment on the North Shore but in most cases must pay for services. Few of these clinics have facilities for the hearing assessment of young children or employ specialist paediatric audiologists which both Mona Vale and Hornsby Hospitals previously employed. Both these departments are still equipped and functional, but not staffed.

Keep in mind that hearing loss can develop after birth, and may be permanent or 'temporary' – medically/ surgically treatable once detected.

The other problem resulting from the lack of publicly funded Audiology services is the difficulty experienced by older children and adults in accessing comprehensive audiological diagnostic assessment and counselling. Hearing aid companies may employ audiologists but a basic hearing test only is usually provided. Adults are often concerned they may be pressured into purchasing a hearing aid. They require an independent professional assessment of their hearing, with appropriate explanation of results, rehabilitation options and counselling.

If all health funds provided adequate rebates for audiology services – assessment, rehabilitation and counselling (rather than simply hearing aid purchase) or if audiologists had appropriate Medicare item numbers, private audiologists would be more able to provide a comprehensive service.

The other option is to fund Community Health Audiology services specifically from a State or Commonwealth budget. Newborn infant hearing screening is to be rolled out Australia wide. It is imperative that appropriate services to follow up and manage the children diagnosed and to detect the children with later onset hearing loss are also provided.

As mentioned above this can be a publicly funded service, or more private practice audiologists could be encouraged to provide a full range of audiological services if there were Medicare item numbers assigned to cover some of the costs to the public.

<u>Equipment and facilities</u>

Gosford and Wyong Hospitals (NSW Central Coast) opened new purpose built audiology facilities in 2005. The facilities and all equipment were provided through NSW State Govt funding as part of the hospitals' re-development. The departments were designed and equipped to the audiologists' specifications, to meet Australian standards, for 5 audiologists in total. Unfortunately the funding was only for building and equipment. As staffing is a recurrent expense and the budget is in deficit, the Area Health Service has the current staff of 2 audiologists only to manage the 2 departments. It appears that targeted funding would be required to keep current adequately equipped audiology departments fully staffed.

Audiologists frequently have to depend on charities and fundraisers to provide new equipment for their public audiology departments. Many are working with equipment that is more than 15 to 25 years old. An ongoing problem is the cost of the annual calibration of equipment, to ensure that assessments meet Australian standards. At this stage there is no forward planning for equipment replacement, or facility upgrades. There is also no succession planning to maintain audiologists in the present positions.

NOTE: that at present there is a very different situation in the NT where money from the NT Emergency Response (NTER) has been spent to provide infrastructure of new equipment and test facilities (sound booths) built into shipping containers. 17 of these have been installed in Aboriginal communities across the NT. This now allows visiting audiology teams to assess babies through to adults in conditions that meet Australian standards.

Access to Hearing Technologies:
Young Australians with permanent hearing loss are fortunate to have free hearing devices and audiological services provided to them until the age of 21(through Australian Hearing's federally funded community service obligation).

Supply of free devices and services stop after the age of 21 unless the person has a pensioner concession card. For a person who is still studying or breaking into the workforce, the sum required to replace a lost or broken hearing aid or cochlear implant processor is great. This is also an issue for families on a low income if either parent requires amplification. Even if they are unemployed there is no access to Office of hearing services vouchers unless the person has a pensioner concession card. The tax concession for a hearing aid as a 'medical' expense is minimal. Health fund rebates for people with ancillaries cover are very limited.

In the past there were interest free Government loans (GIO). Could this be implemented again?

d) Education and awareness programs
There is little or no financial assistance at present from the NSW Area Health Services for audiologists to maintain and update their professional skills by attending seminars and conferences. Most attend at their own expense and often in their own time.

Public education and awareness programs.

Some types of hearing loss are preventable. Noise damage to hearing in particular. We need to make this an issue of national concern through awareness raising.

f) specific issues affecting indigenous communities

Some issues affecting the hearing health of indigenous Australians also affect other low income Australians. Poor diet, poor access to medical services and medication with adequate follow up, & the lack of audiological input can result in long term hearing problems. Some of these hearing losses could be reversed if detected and managed early. The problem is to determine the best management strategy. The NT health workers have years of experience in trying different strategies. Please carefully consider their research and findings. Management of chronic middle ear disease with perforation is not easy. I do not have knowledge of the situation in other States. The note above on the NT Intervention funding is copied here:

NOTE: In the NT money from the NT Emergency Response (NTER) has been spent to provide infrastructure of new equipment and test facilities (sound booths) built into shipping containers. 17 of these have been installed in Aboriginal communities across the NT. This now allows visiting audiology teams to assess babies through to adults in conditions that meet Australian standards.

This is a model that could be implemented in other rural and remote areas of Australia to address the lack of appropriate audiology services. This would provide equity in service provision across Australia.

INQUIRY INTO HEARING HEALTH IN AUSTRALIA.

Author: Melissa Dourlay

I am an Audiologist with 15 years of experience as a paediatric, diagnostic Audiologist in public hospitals in Victoria. I have worked in both Victorian country and Melbourne metropolitan services during this time. My current role is to oversee the running of the Audiology Department at Southern Health in Victoria. This is the largest public paediatric diagnostic services in the state providing almost 8000 occasion of audiological services per year.

There is a strong body of evidence that indicates the diagnosis of significant, permanent hearing loss and early intervention should occur at 6 months or younger for best long term outcomes. Universal Neonatal Hearing Screening (UNHS) is operating in various forms across Victoria in an attempt to diagnose permanent, significant hearing loss at the earliest possible opportunity. Evidence suggests that permanent, congenital, significant hearing loss effects between 1-5 in 1000 infants. Current evidence suggests hearing loss in childhood that remains undiagnosed and untreated will result in significant adverse social, emotional and educational outcomes resulting in significant burden and cost the families, communities and government. Paediatric services therefore have a strong focus on the early detection and appropriate intervention of permanent, significant hearing loss in infants. Additionally, paediatric audiology services provide audiological assessment and management to a wide variety of referrers including General Practioners, Ear Nose and Throat surgeons, Paediatricians, Maternal and Child Health Nurses, Teachers and families for a wide range of reasons including ear infections, pre and post operative assessments, speech delay, developmental delay, suspected autism etc.. Hence paediatric audiological services tend to have a wide variety of referrers and reasons for referral.

In my opinion, there is an insufficient supply of quality, paediatric, diagnostic audiological services in Victoria. Southern Health based at Clayton, for example, provides paediatric diagnostic services to the entire south east of Victoria as there is no other public paediatric unit in the region. For most paediatric diagnostic services, resources are insufficient to meet community demand. Insufficient resources to meet demand include space, sound proof rooms, diagnostic equipment and trained staff. And therefore:

- Paediatric diagnostic services generally have 6-10 week waiting periods for first assessment. This is unsatisfactory for families with new babies failing hospital hearing screening and for children with urgent medical issues.

- Paediatric diagnostic services have been unable to adopt new technologies to fit with best practice standards. There has been significant technological advancement in the field of audiology and most paediatric clinics are unable to adopt new technologies to fit in with best practice due to insufficient resourcing.

Audiological services in Victoria (and indeed across Australia) are being asked to support Universal Neonatal Hearing Screening (UNHS) without ANY funding for the diagnostic component. Currently newly born babies are screened for hearing loss in hospitals and for those that do not pass screening, are referred for full diagnostic follow up. The screening component is fully funded by the state of Victoria. The follow up diagnostic component receives no funding and public audiology clinics support this important initiative without any provision of resources. In my opinion this is unsatisfactory.

There is a dearth of complete public, paediatric audiological service in regional Victoria. In the past few years Victoria has seen the closure of regional audiological public services at Warrnambool, Ballarat, Traralgon and Bendigo. This has resulted in:

- Additional pressures on already stretched metropolitan, paediatric audiological service providers

- The need for families to travel great distances to access paediatric audiological services. Local services are patching with varying degrees of quality.

- Regional and metropolitan services will be compromised further with the rollout of VIHSP in the near future.

In summary, Victorian paediatric audiological services have large demands, are insufficiently resourced, support UNHS without appropriate allocation of resources and are considerably stretched by these increasing demands.

Yours sincerely

Melissa Dourlay,

Author: Nick Modrovich – Tasmania

Inquiry into Hearing Health in Australia submission

In reply to the request for written submissions into the Senate inquiry into Hearing Health in Australia, I would like to submit my opinion, with particular reference to Point c) – the adequacy of access to hearing services, including assessment and support services and hearing technologies.

Here in Tasmania, it is not unusual for a small percentage of hearing care providers to decide not undertake government hearing aid work, ie, they are not accredited to provide hearing services as part of the Office of Hearing Services(OHS) voucher program. All of these providers appear to be audiometrists able to fit hearing aids and provide hearing care to all clients who call on their services. My concern stems from the fact that these providers are able to fit hearing aids yet they make no distinction between government clients (ie.OHS eligible clients) and private clients when fitting hearing aids. These providers will charge private hearing aid fees for all clients they see, meaning that potential OHS clients will be made to pay for their hearing aids when in fact they should have been given the option of a government subsidy using their OHS voucher or the offer of government subsidized free to client hearing aids. Private hearing aid charges usually range from $3000 for a pair upwards which is a substantial amount of money for someone on a pension. Coupled with this issue is the OHS contract for accredited providers, which is quite specific about the type of advertising that accredited providers can and cannot undertake, which non-OHS providers are not bound by. Therefore non-OHS providers are apparently answerable to nobody when it comes to hearing aids fitted or advertising claims. I would like to see some uniformity in the quality of providers that fit hearing aids with a code of ethics they are required to uphold. I feel registration for all hearing aid practitioners would be the best way to go to stop non OHS accredited providers maligning the quality of government provided hearing aids and services.

Another matter that I would like to bring to attention is the situation with Complex clients in the OHS voucher program. At present, if a client of the voucher program is deemed to be “complex”, that is they have hearing thresholds above 80dB in both ears or they have other mental or physical impairments that require more time for the hearing aid fitting process, the client is referred to Australian Hearing (AH) which receives funding by the Federal Government to provide hearing services. If the degree of hearing loss is the main reason for the referral to AH, then AH will be able to fit them with FM hearing systems, which have been proven to be the best option to improve communication for this cohort, provided they have the wherewithal to manage them. I feel that in the interests of client continuity, the private hearing aid fitting market (ie. All providers other than AH) should be given the opportunity to fit FM systems to complex clients. There are many skilled audiologists in the private sector who have the ability to provide support for clients fitted with FM systems and there are many FM systems now on the market which work with a range of hearing aids, either as wireless FM transmitter receiver combo’s or T-loop systems.

In my more than a decade in the hearing industry, I have noticed a particular lack of direction and preparation with clients who received hearing aids as a child through the AH system and carried AH services through to their 21st year. After the age of 21, they are told to find a private provider, and if necessary purchase hearing aids. My concern stems from the fact that the majority of people in this situation are at university or in their first job and therefore will rely heavily on their hearing aids to function in the workday world. When a hearing aid breaks down and can no longer be repaired or is at the end of its useful life, the person is left to procure a new device, which can range from $1500 upwards. I would like to see some thought given to this cohort to give them the means necessary to be able to purchase good quality hearing aids.

Maybe extending the OHS voucher program further or providing financial information to prepare them for adult life after AH would benefit.

Lastly, down here in Tasmania, it is extremely difficult to recruit clinical audiology staff to work and live in the state. For some reason, graduates are not attracted to the city-rural lifestyle of this beautiful state, leading to a lack of services in areas away from the large towns of Hobart and Launceston. Given its decentralized population, weekly travel to visiting sites is a part of the work requirements of a clinician, which seems to be a determining factor when choosing a place of employment. Some form of government based rural incentive, similar to that in place for GP's, could help graduates make the decision to live and work in this great state.

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Accessing Hearing Services in SA

October 2007

Reviewed 2009

Discussion Paper by:
David May (Tinnitus SA; Adelaide Hearing Consultants; ASA – SA Branch), Maureen McGrotty (Hearing Solutions), Julie LePage (CICADA), Melissa Phillips (DECS), Tracy Schirripa (Can Do for Kids), Grace Macri (Sensory Directions), Alex Crawford (Can Do for Kids)

On behalf of:

HIDKON
(Hearing Impaired & Deaf Kindred Organisation Network)

Organisations represented at HIDKON meetings

- Adelaide Hearing Consultants
- Audiological Society of Australia (SA Branch)
- Australian Hearing
- Cora Barclay Centre for Hearing Impaired Children
- Cochlear Implant Group (CICADA)
- Can Do for Kids
- Deaf Blind Association
- Deaf SA
- Department of Education & Children's Services (DECS)
- Farm Noise & Hearing Project
- Hearing Solutions (SA Govt Funded Service)
- Royal Adelaide Hospital – Audiology Department
- Sensory Directions (SA Govt Funded Service)
- Tinnitus SA (SA Govt Funded Service)

Background

Hearing loss has been identified as one of the most common physical impairments occurring in our community (Ries 1982; Wilson et al 1998; Wilson et al 1992). Hearing loss causes communication difficulties, resulting in reduction to one's quality of life. Affected are the social, emotional and general health and well being of the individual, their family and the community at large. The aim of this paper is to highlight poor access to funding and professional services for people with hearing related issues in South Australia.

Incidence of hearing loss & community impact

A 1998 South Australian Health study found that hearing loss occurs in approx one in five adults (Wilson et al 1998). It was also noted in this research that the incidence increasing sharply with age. This is significant consideration in regards to future planning for the aging population.

It is commonly known that noise exposure is a significant risk factor of hearing loss. Financially occupational noise induced hearing loss costs the Australian industry around $35 million annually in compensation (workcover 2000). Noise & hearing loss is one of the most preventable injuries in our community.

Also, it is commonly known that Tinnitus becomes a major issue for many people with hearing loss

- Approximately 50% of people with hearing loss have tinnitus
- Approximately 10% of people with noise induced tinnitus are severely affected (ie: 5% of people with NIHL have severe tinnitus)

It is well documented that hearing loss is closely linked with increased episodes of poor health. People with hearing loss experience 3 times more psychological disturbance than the general population. This includes increased incidence of depression, anxiety, isolation and loneliness, increased stress and fatigue (Wilson et al 1992; Hindley et al 1994; Vernon et al 1993; Knutson et al 1990). Increased episodes of poor general health results in increased contact with medical practitioners and the health system as a whole.

The Rising Incidence and Cost of Hearing Loss

More recent figures show that one in six Australians is affected by hearing loss. Prevalence rates for hearing loss are associated with increasing age, rising from less than 1% for people aged younger than 15 years to three in every four people aged over 70 years. With an ageing population, hearing loss is projected to increase to 1 in every 4 Australians by 2050. 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. 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.

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.. The productivity cost arises due to lower employment rates for people with hearing loss over 45 years and subsequent losses in earnings (The Economic Cost and Impact of Hearing Loss in Australia. A Report by Access Economics Pty Ltd, February 2006)

Summary of Issues:

1. ***Hearing loss is a significant issue in the community.***

2. ***Hearing loss is a rising issue in our community due to the increasing aged population.***

3. ***Hearing loss affects communication, social wellbeing & relationships with others.***

4. ***Due to its hidden nature the effects of hearing loss is often under estimated, with increased chance of mental health issues and associated conditions.***

Accessing hearing services
The following outlines access, including entry funding and possible issues, to public and private hearing services in South Australia:

Assessment at Public Hospitals
- Audiology department
- Full auditory assessment
- Metro area only
- Free to members of the public (adults and children)
- Some private Audiologists visit country hospitals which may attract fee for service
- Hospitals do not fit hearing devices / aids

Assessment by an ENT (Ear Nose & Throat Surgeon)
- Medicare rebates (gap payments may apply)
- Requires GP referral
- Access to this service is for options regarding medical treatment of active ear condition – not usually for a routine hearing assessment
- Do not fit external hearing devices / aids

Assessment by Audiologists or Audiometrists
1. Adults:
1.1 Pensioners
- Eligible Pensioners (Commonwealth Government Pension Card - does not include Government “benefits” or “allowances” – Aged and Disability) can obtain a Commonwealth Government hearing services voucher
- Present their voucher with an accredited contracted provider
- Voucher funds a full audiological assessment every 2 years which is free to client

1.2 Non Pensioners / Private Clients
- “free hearing screening” at private hearing practices (can be useful *but may end in fee for service)*
- Medicare rebates do not apply unless under an “Enhanced Care Plan” with an accredited Audiologist
- Some private health funds provide rebates for assessment (but rare)

2. Children:
- Public Hospitals

- Child & Youth Health – screening of children
- Child & Youth Health – State wide screening and diagnostic of infants (newborn)
- Australian Hearing – usually once hearing loss has been identified
- Long waiting lists. Reality GP to ENT to WCH – many cases

Other:
- Some GP centers do provide screening audiometry (?gap payments)

Summary of Issues:

1. ***Basic hearing assessment is available for adults and children across several funding areas.***

2. ***Access hearing evaluation through the public system in rural areas is limited and qualitatively questionable.***

Country SA

Hearing loss does not only target the urban population. It is commonly known that farmers use noisy equipment, machinery, workshop tools and firearms. They are often exposed to noise for long periods of time. They are also exposed to intense work commitments at certain times of the year. That is, seeding and harvest seasons. On rural properties noise is often both continuous (tractor) and / or impulse/impact (workshop & firearms). As discussed, there is a significant incidence of hearing loss in the community. The Farm Noise and Hearing Network (FNHN) has studied the impact of noise and hearing loss on farmers across rural South Australia. A specific study conducted at the Northern Yorke Peninsula Field Days (Paskeville) investigated the impact noise has on farmers. This study found almost 56% of presenting farmers suffered from some form of hearing loss and close to 50% reported tinnitus (Williams, Forby-Atkinson, Purdy, Gartshore 2002). Also, noise exposure over a period of time has a major impact on the health of the auditory system. To make this scenario more complex many farmers are somewhat isolated due to physical location on rural properties and have a casual attitude to health, especially at a prevention level.

Farm Noise and Hearing Project:
Since 1993, the Farm Noise and Hearing Network has been conducting hearing tests on farmers at Field Days held across the state. The Farm Noise and Hearing Network is made up of a volunteering group of farmers and health professionals that aim to promote noise reducing practices and subsequently reduce hearing loss caused by noise exposure in those working on the land. This involves hearing screenings and information provision at rural field days, country shows and events. This much needed project has been stretched to breaking point. Currently this much needed primary prevention project is on the brink of folding due to poor absence of funding and Government and Regional Community Health support.

In country SA many rural centres have limited hearing health access / services. Audiological services are usually in the form of visiting private services. There are no state funded audiological positions in Local Community Health Services in country SA and local primary hearing prevention initiatives are often limited and poorly funded

Valid and reliable hearing assessment can only be performed under controlled acoustic conditions. The suitable acoustic conditions for testing are defined by Australian Standard 1269.0-1998 for maximum acceptable background noise levels. Such conditions are readily

available in metropolitan locations in the private and public sector but are not routinely available in rural and remote settings.

Currently, there is no portable hearing testing resource in South Australia. In many instances hearing health programs that conduct hearing assessments are doing so in facilities or rooms that are difficult and costly to maintain or are not acoustically adequate.

In the past the Farm Noise and Hearing Network (FNHN) has accessed a hearing testing van which was owned by the Department of Industrial Affairs and administered through the Northern Yorke Peninsula Community Health Service (NYPCHS). This van was maintained on a small grant obtained from Bernafon Australia, a private hearing aid company. In recent years the ongoing maintenance and administration costs have stretched the goodwill of private grants and the NYPCHS.

The FNHN hearing testing van lost its roof on the way to Paskeville Machinery Field Days in September 2003. This facility is no longer usable.

It should be noted that there are several different programs that fund hearing services to the indigenous communities in SA & NT. Outside of the indigenous consumer group the provision of hearing services to people from Non English speaking (NES) backgrounds or who are linguistically diverse and who live in country areas, is questionable.

Summary of Issues:

1. ***No government funding allocated for audiological positions in country SA for <u>non pensioners</u> and <u>those who are not of aboriginal descent</u>. Therefore, no funded hearing services for community members over 21 years and not on a pension.***

2. ***Lack of signing interpreters in rural area.***

Hearing aid and device funding
The following outlines issues related to hearing aid and device funding in SA:
- No Medicare rebates for hearing aids
- Providers include Audiologists & Audiometrists and are located in metro and rural areas. Most rural providers are of a visiting nature.
- Hearing aids are expensive to purchase privately. Costs vary depending on the chosen devices (between $1400 - $6000 per device)
- Private health funds can provide rebates (minimal when considering overall cost approx $400 - $800 per aid). There are many conditions (ie rebates every 3 years)
- Approved claims for hearing injury at work can seek funding for hearing services under Workcover.

1. Pensioners & children under 21 years
- Hearing aids are funded through the Commonwealth Hearing Services scheme (current hearing services voucher required) for pensioners with aged and disability status. Pensioners choose a hearing service provider.
- Children under the age of 21 are seen by Australian Hearing and do not require voucher application.

- The Commonwealth Government provides additional funding to Australian Hearing for children under the age of 21 years and of Aboriginal and Torres Strait Islander descent and device and rehabilitation provision for pensioners who have "complex" needs. This funding is separate to the voucher scheme.
- Pensioners have the option of either bulk billed devices (free to client) or "top up" devices (gap payment required) as per government device listing schedule.
- Under the voucher scheme pensioners are cared for by the chosen provider under a 12 month contracted period – a small yearly fee is charged (approx $35-00) to the pensioner. This covers hearing aid battery supply and hearing aid care/maintenance.

2. Non Pensioners (over 21 years & not on a pension)
This is primarily the key working age and members of the community within this age bracket are either involved in employment or are seeking employment. This group of consumers is significantly disadvantaged. They rely on private health insurance to provide rebates for hearing aids. Not all of this patient group is able to access private health insurance. For those who can afford private health insurance, rebates for hearing aids are small in comparison to the required financial outlay.

Currently there is no level of government funding for hearing devices for this age group. People of low income are extremely disadvantaged. In most cases do not have access to private health insurance and are unable to afford the cost of private hearing aid fitting. Thus they are unable to access hearing services in this state.

- Employment services can provide small one off funding to assist individuals to gain employment. However, funding does not cover cost of hearing devices, resulting in out of pocket expense. To be seeking employment under these schemes would usually illustrate a picture of financial hardship and private hearing aid purchase is not achievable.

- Commonwealth Rehabilitation Service (CRS) can seek a Commonwealth Hearing Services Voucher (similar to pensioners) but the individual must be accepted for a rehabilitation program under their charter. Hearing loss alone is not an entry point to this service.

Summary of Issues:

1. ***Pensioners and children under the age of 21 years are able to access free hearing aids and basic hearing services.***

2. ***People eligible for hearing aids under Workcover are cared for under this scheme.***

3. ***People over the age of 21 and do not hold pensioner or Workcover (Key group of community members seeking employment) rely on private health insurance.***

4. ***A gap exists in government funding. There is no government funding for hearing devices for people over the age of 21 and not on a pension.***

5. ***People with low income are severely disadvantaged and are unable to afford private hearing aid purchase.***

6. ***Those who do not have private health insurance for hearing services have <u>no</u> level of financial assistance.***

Cochlear Implantees

- The cochlear Implant is a surgically implanted device to people with severe to profound hearing loss.

- Surgery holds rebates under Medicare & private health.

- Significant auditory rehabilitation is required. Audiological services are funded through private health or CI funding provided to hospitals.

Service access:

1. Public – Flinders Medical Centre (adults); Women's & Children's (paediatric)

2. Private – Rehab: SA Cochlear Implant Centre (SACIC)
   Surgery: Range of private hospitals

Service issues:

1. Waiting lists – originally 3; 5; now 9 public patients per year for adults.
   a. Children also have waiting lists
   b. FMC waiting lists recently cut

2. Accessing private CI centres with appropriate audiological support.

3. Travel and costs associated with the work up prior to implantation.

4. Ongoing rehabilitation costs such as remapping (reprogramming device), replacement parts, cords, batteries, coils etc.

5. Breakdown and replacement of devices (DBR). Young individuals implanted some years back are reaching the end life of their speech processors.

6. Ongoing appointments and costs (accommodation etc for country patients).

7. Inconsistent approach of private health funds when considering rebates for CI.

8. Processors – Many people are unable to afford to have speech processors replaced / upgraded. Without adequate speech processor function the implant is useless, leaving the individual with a total hearing loss in that ear.

Issues related to hearing services in SA - General Summary

- There is a definite need for hearing services in the community. Incidence and aging population highlights this.

- Hearing related conditions attract a high co morbidity of mental health issues and associated conditions.

- A range of avenues are available for consumers to seek basic funding for hearing assessment, hearing aid fitting and hearing support services for pensioners and those under the age of 21 years.

- However, over 21 and not on a disability or aged pension there is no available funding for hearing aids and cochlear implants.
    - This raises issues for low income community members
        - Purchase of devices
        - Maintenance / replacement of devices

- Limited government funded hearing services in rural areas.

- There is a need for a project officer to be appointed to further define this need.

Summary of issues identifying gaps in service requiring further action / planning:

1. ***Access to hearing evaluation through the public system in rural areas is limited and qualitatively questionable.***

2. ***No government funding allocated for audiological positions in country SA for non pensioners and those who are not of aboriginal descent.***

3. ***People over the age of 21 and do not hold pensioner or Workcover (Key group of community members seeking employment) rely on private health insurance. (limited options for people seeking employment and of low income)***

4. ***A definite gap exists in funding of basic hearing care. There is no funding available for hearing devices for people over the age of 21 and not on a pension.***

5. ***People with low income are severely disadvantaged and are unable to afford private hearing aid purchase and associated rehabilitation (country & metro).***

6. ***Those who do not have private health insurance for hearing services have no level of financial assistance. Private health rebates provide limited financial assistance for device only. Private health insurance does not rebate hearing assessment.***

Individual cases scenarios highlighting community issues.

Case 1:

Adult who is 5 years post implant, his speech processor is DBR just through normal wear & tear, and he has no funding or ability to purchase a replacement processor. There is no funding for replacement speech processors for adults. However, through the state government funding, this man was given the wonderful opportunity to hear again via a CI and now 5 years down the track he is more disadvantaged.

Professional concern / response to this case:
This scenario will become more and more common as the base of publicly implanted patients grows and as the children who have been funded for replacements & upgrades, move into the adult program. The government's response to this situation has been:

- **People could have private cover – can't afford it**
- **People should insure their speech processors – doesn't cover normal wear & tear**
- **People can purchase a new processor and get a tax rebate – can't afford and the low income levels of these patients mean that there are no tax breaks.**

Case 2:

28 year old male. Severe to profoundly deaf. Low income. Works casually in a winery. Job is not in jeopardy, therefore not eligible for CRS (??if he ever would be anyway). Fitted with hearing aids as an under 21 year old. Hearing aids are now at the end of their working life (usual wear and tear). Aids now 12 years old. Can afford to purchase new devices. No level of funding available to asssit.

Case 3:

42 yo single mother. Medical treatment caused her to lose hearing and vision***. In need of urgent amplification due to her total sensory deprivation.*** NO financial assistance to obtain hearing devices, not even temporary devices. Therefore, due to the tragic nature of this case provider (audiologist) funded the devices from his own pocket. Took 2 months to obtain disability pension and eligibility for hearing services. Significant issues arise with the deprivation of hearing and vision across a two month period. Much confusion, anxiety and emotion. We don't shut people in quiet dark room and deprive them of any input for two months…why do it to people with hearing and vision loss!

Case 4:

I am finally getting my new Freedom upgrade – I have now had my implant 7 years so Mutual have finally agreed to pay and a copy of their agreement has gone in with my claim for $8050. It still hurts that I was advised to get an upgrade earlier but my Benefits would not pay where other Benefits pay out each 3 years (if I had had surgical intervention – replacement or gone bilateral there would not have been any problem).

Case 5:

One 23yr old male who lives in rural (Victor Harbour) with his cochlear repair/update issues.

- my cochlear is now broken, it doesnt work anymore, I knew the time was coming soon and it has so im totally deaf at work, home, everywhere so its very different.

- went to FMC (flinders medical centre), where my cochlear is being held at the moment, had to re apply for a new Hearing Service Card coz mine has expired and is still classified as a 'child' not as a adult.
- came home, booked an appoinment with my GP to fill the application form out
- post that off
- now I have to wait until it return in my mail with a voucher
- as I get that voucher I have to ring Victor Harbour hearing service centre, coz they only do cochlear implants on a friday every fortnight, to book an appoinment, pay 34 bucks for a new member and explain that i dont need a hearing test. I just need my cochlear to be repaired.
- as i have paid, I have to contact FMC to say that I have a new card, and paid for it, then she will finally send it off, then it may be a month wait who knows!!
- waiting for the mail and the voucher, say if its not ready or being fixed by July 14th, bad luck
- I will contact FMC before I leave and she may mention me to go with the cochlear that I have on loan.
- without the Cochlear, my mind becomes more worried or something like that too.
- also work isnt looking good also, having trouble fitting in, they have been pushing me over the edge, so im working faster and harder so this comes to pressure and stress, i get snapped at (even though i cant hear them) so i lose distraction in what im doing on my job and not finishing properly

Case: 6

21yr old female who has worn hearing aids pretty much all her life and through recent changes in her hearing loss (now profound in left ear and severe to profound in right ear) she can only wear one hearing aid in right ear in which she is finding hard to still hear much these days (she did only have a moderate to severe in her left ear which was once her better ear). She has a case of en enlarged vestibular aquduct syndrome in which may still further reduce her hearing levels to become profound in both ears in future. She has been going thru various assessments, and testing through FMC to try approving for a cochlear. She has a major appt end of Oct (29th) to gather all docs, audiologist, ENT, along with all reports to further discuss if she's go ahead with receiving a coclear and if so when she could possibly receive it (on the waiting list - but for how long??) She has relied on hearing aids all her life for hearing, but now that the hearing aids cannot provide enough support with hearing/listening she is persistent to continue to hear provided she can access the cochlear. She is currently doing cert 4 at TAFE (community services - family support) and struggles with communication and lectures. She does use some interpreting when they can provide it with enough funding (at this stage she gets one full class time out of 7 or 8 classes for interpreting). She uses more oral than AUSLAN in her everyday life and rather choses to continue communication this way. The concern here is a young adult (over 18yrs age bracket) who urgently needs a cochlear for everyday communciation because she is now limited to using the phone to communicate wit families, her partner, and friends because she cannot hear them, and struggles to have conversations in noisy environments even in cafes, TAFE, working environments in the past like retail stores or supermarkets.

Professional concern/response:

There continues to be an ongoing battle for our youths (21 and over) whom if they continue to lose more hearing or need to update their cochlear or hearing aids, do not have the funding or money available to pay for it alone, and are either placed on the waiting list or become disheartened by the un affordable costs. And if they have no choice but to pay for it then they miss out as most cannot afford to pay for the device alone (looking at figures up and over a couple of thousands for 2 aids or more for a

cochlear). Therefore they then become deaf without their aids/device and try finding other ways to communicate like AUSLAN so they do not have to keep missing out on some communication throughout their lives. This is quite sad that this limits their opportunity to be something more, and have more choices in how they wish to communicate provided they can access devices, equipments and aids to continue supporting them throughout their life cycle which includes having a family, employment, social networks, travelling, playing sports, and doing everyday things to choice them in living life. Unfortunately some clients deaf/hearing impaired are on low incomes (who are not eligible for DSP), and struggle to find the full finance (and find suitable employment without being discriminated against because they lack communication or cannot participate fully as a employable worker due to their hearing impairment impacting their rights to work in that job) to pay for aids, devices etc. These are the ones we need to continue supporting because they want to continue to have communication and have a part of life trying to do everything like a hearing individual has opportunities to do, but with the extra support.

Case 7:

I am 35 years old and live in rural SA. Farming is a tough slog at the moment. I cant hear well due to the years I have been around farm machinery. It has damaged my hearing. I have significant tinnitus which impacts on my communication and state of mind. I can concentrate to do the BAS and my hearing loss means that I have difficulty when attend lectures to learn how. My GP sent me to an ENT, I had to drive 3x to Adelaide all for him (in an arrogant way!!) to say there was nothing he could do. This left me on the shelf. After a time I was told that was cause he was a surgeon and I didn't qualify for surgery. I tired to do the right thing and I have investigated hearing aids and after paying for a another hearing test (cause the community health doesn't do it!!) I found out they would cost a couple of thousand dollars – at a minimum. Ive gone down hill in the past year. Im now on antidepressants and antianxiety medication. I feel like Im giving up. I don't go to meetings any longer, don't attend church and avoid social situations cause I cant hear. Communication with my family is very difficult and I know it is causing relationship breakdown. Sometimes it would be easier to end it all. I don't get why government cant give some financial assistance through the community health to support us farmers and their hearing health. Several of my neighbours and mates report the same. We are isolated casue we live some 2 – 3 hours from the city. We cant get basic hearing help under the community health. But they can run seminars for diabeties. I think hearing cause it is hidden it is avoided. My community health and GP say there is no funding. My audiologists really wanted to help but there was no funding for him to seek. He did his best, looked at all options, even waived charging me. I learnt a few years back at a field day about noise and hearing loss and now wear ear muffs all the time to protect them. But its too late. I have since heard that the field days are becoming so commercial that the hearing project cant afford to come…cause they were all volunteers.

I hope my story helps. I am happy to assist in any way I can to help others if needed.

Case 8:

Dear Sir/Madam,

I live in a small town in SA. I have general good health now, but in the years gone by have undergone chemo for cancer. Subsequently I have a hearing loss. My oncologist reported that it may relate to the treatment. Hearing is down, but at least Im still here. I am amazed at the lack of rural assistance for people with hearing loss. My GP has no idea! The hospital has a ENT who visits, but he just does surgery (and doesn't communicate very well!). I need hearing

rehabilitation, the same as a physio gives someone with an injured back. I have an injured ear. There are visiting hearing people that come here but I don't get any financial assistance. Nothing. I don't have private health. I can't even get a hearing test through community health. I can get my blood pressure checked and the moles looked at on my back. My aged mother (who had a stroke) even got speech pathology from the hospital and physio through her private health. I don't understand it. Hearing is a basic sense and the government doesn't provide basic hearing health care. Im amazed and appalled at what I have found out since my hearing loss started.

I hope this email helps to raise awareness with the government.

Case 9:

I don't like to travel to the city. I can get a hearing test when someone visits from the city, but it is a free screening test. Im tired of free screening tests. I want to move forward, but I cant cause I have no money. I tried the hospital and no one knows anything about hearing except the fellow that visits. I thought I could go to the hospital and have a basic hearing test and get some hearing aids. Im only 55 therefore I don't get the aged pension. I just stay home now and keep my garden. I don't go out cause I cant hear. I feel a bit sad about it really.

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Senate Inquiry into Hearing Health

Author: Kathy Currie

I provide the following comments as an Audiologist member with 13 years of Indigenous Hearing Health experience across the NT.

- Building family and community participation essential for rehabilitation of children with hearing disability is really difficult to provide in remote communities/ homelands and further research and effort is required to meet associated challenges
- Audiologists are required to work outside the usual scope of practice when providing services to Indigenous people in the NT including diagnosing middle ear conditions, removing wax and pus from ear canals
- Remote Indigenous Audiological practice represents a specialised area that requires specific training particularly in the area of otoscopy, diagnosis and treatment of otitis media and Indigenous cultural competency
- Neonatal hearing screening in the Northern Territory that targets significant permanent hearing impairment will detect approximately three newborns each year. Infant hearing screening that targets Indigenous chronic ear disease will detect approximately 100 newborns in the first year of life with significant hearing impairment.
- Ear disease in Indigenous populations is attributed to high bacterial load of pathogens and is established in the first weeks of life in almost all remote Indigenous children (90%). It is a complex disease and early identification with a view to preventing chronic conditions requires 'expert skills' that are not a component of mainstream training for most health and allied health practitioners.
- Population based hearing initiatives such as ear health promotion and sound field amplification in classrooms have an important role
- New information technologies that enhance coordinated hearing care require investment to improve case management capabilities, provide telemedicine and satellite rehabilitation support opportunities, assist with agency and organisational data sharing, and evaluate initiatives.
- Further research and standardisation of infant hearing screening pathways and early intervention programs that address significant hearing loss associated with chronic ear disease Indigenous children is strongly recommended

Kathy Currie

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 cannot 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)

Re: Inquiry into Hearing Health in Australia

Thank you for the opportunity to contribute to the current inquiry into hearing health in Australia. We respond to the requested information with particular reference to:

- the extent, causes and costs of hearing impairment in Australia;
- the implications of hearing impairment for individuals and the community;
- **the adequacy of access to hearing services, including assessment and support services, and hearing technologies;**
- **the adequacy of current hearing health and research programs, including education and awareness programs;** and
- specific issues affecting Indigenous communities.

As Audiologists, **members of the Audiological Society of Australia (ASA) and members of the ASA NSW branch**, we are contributing mainly to points c) and d) listed above but note that there is considerable overlap across the five nominated areas.

Hearing healthcare in Australia has an admirable history. In order to ensure that services remain up to date and 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, four main areas for change are most pressing in the hearing healthcare industry:

1. **Registration/self-regulation of Audiology as a profession**, distinct from Audiometry, Nurse audiometry and medical specialties such as Otolaryngology.

   Audiologists are professionals trained at postgraduate university level to provide diagnostic and rehabilitative hearing and balance services to people of all ages, from newborn to the elderly. At present in Australia, anyone (even those with no qualifications) is allowed to offer hearing services, thereby exposing members of the public to the risks of inadequate provision of hearing and balance care. For example, as audiologists we have come across in our clinical work, patients who have not been referred to medical specialists when required, been inappropriately fitted with hearing aids, or insufficiently tested. Registration or Self Regulation of Audiologists will ensure that the population accesses appropriately qualified and skilled professionals. Audiology Australia is a founding member of the ***National Alliance of Self Regulating Health Professions.***

2 **Allocation to Audiologists of Medicare item numbers: 11024, 11027, 11205, 11300, 11303, 11306, 11309, 11312, 11315, 11318, 11321, 11324, 11327, 11330, 11332, 11333, 11336, 11339, which are the items for diagnostic tests of hearing and balance disorders.**

   Audiologists are the professionals who are university trained at a Masters degree level to perform the diagnostic test procedures described in the Medical Benefits List of Procedures by the above item numbers. At present, these items are performed by qualified and non-qualified personnel and charged to Medicare through

the provider number of medical specialists. Audiologists do currently have provider numbers, but currently that allows only very limited access to Medicare items. Access to the above mentioned item numbers will allow Audiologists to exercise their area of expertise as independent professionals, providing a reliable, direct and accessible service in hearing and balance care to the population.

Currently Audiologists are eligible to a Medicare provider number which only accesses item numbers 10952 and 81310, for limited work undertaken as part of the enhanced primary care plan (EPC) for patients with chronic conditions and to Aboriginal people, and Torres Strait Islander people.

Assignment of those item numbers (listed above), which are currently allocated to medical specialists. but which cover the diagnostic assessment of hearing and balance, to Audiologists, will ensure public access to hearing and balance tests performed by properly qualified professionals. This will promote growth of the Audiology profession, one which the government supports at the university training level through offering courses, but which is not currently supported at the level of service delivery through Medicare.

With access to item numbers relevant to the practice of audiology, Audiologists will be able to work in collaboration with, but independent of, medical specialists. Such changes have the potential to significantly reduce the current overload of Audiology departments in public hospitals, as more Audiologists will be able to set up private audiology practices that incorporate diagnostic services, making them available to the population Australia, not just those covered by the Office of Hearing Services (see below).

3 Office of Hearing Services (OHS) to revise remuneration policies for audiological services and to facilitate clients' access to hearing health care.

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 not only the use of hearing aids. To date the focus of hearing rehabilitation in Australia has been device driven.

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 attracts only a small fee for the service provider. OHS does not currently allow any gap fee for *services*, only for *devices* under the top up scheme. This makes the offering of the very relevant counselling services a less financially viable option to serviced providers. It is proposed that a revision of the OHS schedule of fees is made so that fees are related to services offered and professional time, and that the Medicare model is adopted whereby providers are allowed to charge a gap on top of the scheduled fees for services *and* devices.

Were OHS to operate along the principles of Medicare, as suggested above, implantable devices such as cochlear implants and bone anchored hearing aids could be offered to those with hearing loss, within a single hearing services scheme that incorporated both the diagnostic aspects currently allocated to Medicare, and the rehabilitative aspects currently covered in part to some members of the population, though OHS. Such a development in the field will assist those who are deaf and rely on

audiological rehabilitation, to achieve independence in their daily functioning, including access to education and employment.

4 Adequacy of state funded hospital services – comment on NSW

There has been a reduction in the number of Public (State funded) Audiology Departments in NSW. The erosion of these departments has been occurring for some time and include the Audiology Departments of Canterbury Hospital, Lidcombe Hospital and more recently Hornsby Hospital and Mona Vale Hospital.
This has left NSW depleted of State run Audiology services particularly on the North Shore of Sydney. In this region there are no public hospitals that cater for the assessment of young children. Families are able to access private hearing aid clinics for assessment but must pay for services. Most of these clinics have not been set up for assessment of young children.

The Federally funded service, Australian Hearing, has in the last few years changed its practice with an emphasis toward rehabilitative services rather than diagnostic services. Diagnostic services have now largely become the responsibility of the now depleted (as shown above) State funded hospitals. Unfortunately, there has been no increase in staffing levels to State run hospitals with this increase in patient population. The result of this is increasing waiting times.

Audiology is a highly technical field. There has been a rapid increase in technology. Most Audiology Departments are functioning with antiquated equipment, some of which may be twenty years old. There is heavy reliance of donations for new equipment. We would need a review of this and replacement of equipment within a reasonable time span.

There are inadequate measures within the Public Health system to ensure the continued education of Audiologists. Staff members take responsibility for ongoing education, but there is no financial assistance to attend courses or conferences. There is a heavy reliance on the good will of staff. This situation must be reviewed if State run Audiology Departments are to exist as centres of excellence.

We trust that these comments will be helpful to the current investigation in hearing services in Australia, and that they will be taken into consideration. We will be happy to further discuss them at an open forum.

Yours sincerely

Dr Louise Collingridge (ASA NSW Secretary)
Ms Joanne Maritz (ASA NSW Committee member)
Ms Celene McNeill (ASA FEC representative for NSW)
Ms Barbara Nudd (ASA NSW Committee member)
Ms Sue Slack (ASA NSW Committee member)
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Senate Inquiry into Hearing Health in Australia

Author: Genelle Cook

3. The adequacy of access to hearing services, including assessment and support services, and hearing technologies

Assessment services

- Since the advent of newborn hearing screening programs, there seems to be less support of other hearing screening programs. Since newborn hearing screening will only identify approximately one third of children who will eventually require hearing aid fitting it is essential that access to primary hearing screening services be readily available. As a high proportion of children are identified around ages 5-6 years it would be highly beneficial if the school hearing screening program was reinstituted or if the child health check undertaken at age 4 years included an objective hearing assessment rather than a set of questions that the GP asks the family.
- Additionally, creation of a national database that contained the records of children diagnosed with hearing loss, and children who have received hearing habilitation would minimise the number of children lost to follow-up after diagnosis.
- It can be difficult to access diagnostic hearing services. These services were mostly available through hospital audiology clinics. A number of hospitals have decided to not fill audiology positions eg Hornsby hospital and Mona Vale hospital which reduces access to this important service. Private audiology services are not routinely set up to accommodate the needs of young children.
- Australian Hearing have changed their focus from a diagnostic service to a habilitative service requiring initial assessments to be carried out elsewhere.

Access to services by Culturally and Linguistically Diverse Clients

There is no provision for people who do not speak English to have the cost of an interpreter covered for their appointment with an audiologist or teacher.

Using family members as interpreters is not appropriate for accessing a health related service.

If an accredited interpreter is provided, the agency has to cover the cost. This arrangement does not encourage providers to offer an equitable, accessible service to multicultural clients.

Access to hearing technologies

Deaf or hearing impaired adults on low incomes who do not meet the eligibility requirements of the Australian Government Hearing Services Program are often forced to wear very old devices which become impossible to maintain over New devices are too expensive. This may mean the person is not able to maximise the use of their residual hearing which in turn may impact on their ability to communicate and reduce the opportunity to participate equitably in education and training; to attain employment or career advancement and can lead to social isolation and depression.

Some hearing impaired people who were fitted with hearing aids as children stop using their hearing aids after their lose eligibility for services from Australian Hearing due to the cost of batteries, repairs and new devices which is contrary to the aim of the previous 21 years where the focus has been on early intervention and the promotion of consistent hearing aid use.

It is recommended that adults on low income be given access to more affordable hearing services.

Cochlear implants

A number of individuals who have obtained a cochlear implant through a publicly funded program will be unable to afford to replace the speech processor when it is lost or unable to be repaired. . Recently Cochlear LTD announced the obsolescence of four models of cochlear implant speech processors. Cochlear implantees who rely upon these devices will need to purchase a replacement once their processor is deemed beyond repair, at a cost of $8000 – 12,000. If the person cannot afford a new device they will be rendered profoundly deaf and unable to resume use of a hearing aid in the implanted ear.

Classroom amplification systems

Classroom acoustic considerations (reverberation and noise from internal or external sources) limits the ability of many children to properly understand instruction given by teachers. This can apply to any child, but is particularly a problem for children who have any of the following disadvantages. Some Indigenous children will have all of these disadvantages.

- Have conductive hearing loss, which is extremely common in Aboriginal and Torres Strait children;
- Have a mild or unilateral hearing loss. (Children with a greater hearing loss, who will usually also be wearing hearing aids, will also benefit. A recent study (Wake et al, 2006) has indicated that 11% of children in Primary School in Victoria have a hearing loss of some type in one or more ears at any given time);
- Have an auditory processing disorder which may be a result of chronic middle ear infection during their infancy;
- Speak English as a second language.

Sound-field amplification systems are able to significantly enhance communication in the classroom. The system consists of a wireless microphone/transmitter worn by the teacher, a wireless receiver/amplifier, and a loudspeaker in each corner of the room. The system increases the teacher's voice level, and just as importantly decreases the distance from each child to a reverberation-free source of the teacher's voice. Some systems have a second transmitter for use by students in interactive discussions, or for use by assistant teachers, such as occurs in some Indigenous classrooms.

Teachers experience voice disorders at approximately twice the rate of the general population (Roy et al, 2004; Inserm, 2007) due to the strain of making themselves heard in the classroom. A valuable side benefit of sound-field amplification is that teachers report fewer problems with voice strain and voice fatigue (Crandell, Smaldino and Flexer, 1995).

Research undertaken by the National Acoustic Laboratories showed that use of the system resulted in a hugely significant 41% increase in the rate of attainment of educational indicators during the terms the systems were installed (averaged across all children in the classes and across reading, writing and number skills) (Massie and Dillon, 2006a, 2006b).

There is no single authority, state or federal, education or health, that has responsibility to ensure that classrooms with a high proportion of Indigenous children have been acoustically treated or had sound field systems installed.

Genelle Cook

Author: Paul Hickey

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

Inquiry into Hearing Health in Australia

Author: Jane MacDonald.

I work at Mildura Base Hospital as the only paediatric audiologist for a 400km radius, and also work in aural rehabilitation in my own clinic. As such, I encounter many frustrations concerning limited access for clients to services.

Hearing loss at birth is one of the highest incidents of birth defects. Because of this, many states within Australia provide hearing screening to babies after birth. In Victoria, the Victorian Infant Hearing Screening Program has been underway in metropolitan Melbourne, and there are plans to roll this out to regional areas in the future. I am concerned about access to follow-up diagnostic audiological services to babies in country areas, and because of this I was involved with the Audiological Society of Australia (ASA) in writing a submission to government for dedicated diagnostic paediatric audiology funding to public hospitals. Currently audiology is funded as part of a global allied health budget, making it possible for hospital management to reduced audiology services and shift money to other allied health areas. This submission was presented to Maxine Morand, and Daniel Andrews.

It is imperative that babies born with significant hearing loss are diagnosed early, provided with auditory rehabilitation and early intervention to improve their acquisition of speech and language, and to enable them to maximise their outcomes for education, thus improving their employment prospects later in life, and significantly enhancing their quality of life. An area lacking in rural areas is the support services offered to parents after their baby is diagnosed as hearing-impaired. There are often no community parent advisers available in rural areas, however they are available in metropolitan areas.

Access to community audiological services is often affected by regional hospitals being unable to attract audiological staff. There is a great disparity between audiology salaries offered by hospitals and the private sector, whereby a new graduate audiologist can be paid two and a half times as much working for a private hearing aid company than a hospital. This all results in some regional areas of Victoria having no paediatric audiological services, and others having long waiting lists.

The extent, causes and cost of hearing impairment in Australia was highlighted in the "Listen Hear" Report, which is available on the ASA website. (www.audiology.asn.au)

In my local area, I do have exposure to clients whose deafness impacts on their employment prospects. Some of these people have been helped by accessing free hearing aids through the Commonwealth Rehabilitation Services via Centrelink.

There is a significant indigenous community in and around Mildura. They are able to access paediatric audiology as a free service at Mildura Base Hospital. Private access has been made more affordable with the recent inclusion of Medicare rebates for audiology for ATSI clients. The absence of this cover for non-ATSI Australians disadvantages those who are unable to afford to pay for these services. The only other Medicare rebates for audiology services are available if these tests are billed under a doctor's provider number. Currently it is only pensioners and veterans who are entitled to government-funded testing via the Office of Hearing Services scheme. I observe many people in my local community who are ineligible for free or government rebated testing and due to current economic difficulties are unable to afford to pay privately.