

PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA

# Still waiting to be heard...

*Report on the Inquiry into the Hearing Health and Wellbeing  
of Australia*

House of Representatives Standing Committee on Health, Aged Care and  
Sport

September 2017  
CANBERRA

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# Chair's Foreword

Hearing is intrinsic to the lives of most Australians; it underpins the conversations that form the basis of our relationships and social lives, it gives us access to the beauty of music, and it can warn us of approaching danger. Hearing seems so natural that is not until it is gone or affected in some way that we realise how much we have taken it for granted. In Australia, 3.6 million people are affected by some form of hearing impairment and, by 2060, it is estimated that this will increase to 7.8 million.<sup>1</sup>

In so many respects Australia is a leader in supporting those with a hearing loss. Universal newborn screening, the Community Service Obligations overseen by Australian Hearing, our voucher scheme for people over 65 to access hearing aids, and the incredible work of our medical researchers, health care providers and organisations working with children are world-class. An enduring example of Australian research and innovation is the invention of the Cochlear implant.

Yet there is much more that can be done to support the needs of those with hearing loss.

In 2010, the Senate Community Affairs References Committee tabled a significant report, *Hear Us: Inquiry into Hearing Health in Australia*. While some of its recommendations have been implemented, many have not. Seven years on, this inquiry of the House Standing Committee on Health, Aged Care and Sport heard similar evidence and drew similar conclusions. There was a sentiment of frustration among those with hearing loss or in the medical and support community that bipartisan recommendations had not been implemented – hence the title of this report.

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<sup>1</sup> Deloitte Access Economics, Exhibit 18: *An Update of the Social and Economic Cost of Hearing Loss and Hearing Health Conditions in Australia*, July 2017, pp 3-4.

Most notably, hearing health must be treated as a national health priority and we must do so much more to respond to Indigenous hearing health. It is no exaggeration to describe Indigenous hearing health as at a crisis.

The Committee is very grateful to the individuals who, during the inquiry, relayed their experiences of living with hearing loss and balance disorders and the impact that this has on those closest to them; their family, friends, and work colleagues. Challenges recounted by individuals with hearing impairment and/or a balance disorder included negative impacts on: self-esteem, personal relationships, and the ability to cope in education and employment situations.

Hearing impairment does not just impact those immediately affected. On a broad scale, it has been estimated that hearing loss costs the Australian economy \$33.3 billion, comprised of \$15.9 billion in financial costs and \$17.4 billion in lost wellbeing for individuals. The economic impact of balance disorders is less certain but one estimate suggested that their cost for hospital emergency departments alone could be as high as \$148 million per year.<sup>2</sup>

Two key issues relating to hearing services for children were repeatedly raised during the inquiry: the implementation of the National Disability Insurance Scheme (NDIS); and the rate of otitis media, middle ear, infections among Aboriginal and Torres Strait Islander children.

The future framework underpinning hearing health services is the implementation of the NDIS. The NDIS is expected to introduce competition into the market for children's hearing services which will require parents of children recently diagnosed with hearing impairment to navigate through a multitude of service providers.

For a young child even a small delay in the diagnosis and treatment of hearing impairment can result in a life-long reduction in their language and communication skills. Concerns were raised that emotionally vulnerable parents are less likely to be equipped to rapidly make an informed decision about the future healthcare needs of their child.

While there are many laudable elements of Australia's system of providing hearing health care for children there is also one area where it is clearly failing. The prevalence of otitis media infections among Aboriginal and Torres Strait Islander children is at crisis point. At any time 90 per cent of children in remote communities will be experiencing an otitis media infection. While the problem is most severe in remote communities, Aboriginal and Torres Strait Islander children

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<sup>2</sup> Dr Daniel Brown, *Submission 100*, p. 2.

in urban and regional areas also experience otitis media at much higher rates than most children. Repeated otitis media infections in childhood can result in permanent hearing damage and have been found to have a detrimental impact on life opportunities that can stretch well into adulthood. For a child with otitis media the constant struggle to hear at school may leave them frustrated and disengaged and unlikely to reach their full potential in education.

Preventing hearing damage and providing support for hearing impaired Australians of working age was also raised during the inquiry. Many hearing impaired Australians in the workforce are reliant on a hearing device to maintain their employment. Yet, due to the high cost of hearing devices, hearing impaired working Australians may not be able to afford to replace a broken or outdated hearing device. In addition, the cost of hearing devices may cause people in their fifties or sixties whose hearing is deteriorating to simply struggle on, or turn to early retirement, instead of seeking treatment.

Hearing loss is particularly prevalent among older people affecting three out of every four Australians over 70 years of age. An issue of particular concern is the potential for financial exploitation of vulnerable older Australians due to the use of commissions in the hearing aid clinic industry. Older Australians entering a hearing aid clinic should be able to trust that the advice they receive will be based solely on their healthcare needs. The use of commissions creates an incentive for clinicians to instead provide advice based on the potential for personal financial gain. This is clearly unacceptable. The Committee has recommended that Australian Hearing cease the use of commissions as soon as is feasible and that the Department of Health takes steps to phase out their use by private providers.

While associated with hearing health, balance disorders do not receive a lot of attention but their effects on sufferers can be debilitating. Balance disorder sufferers can experience unexpected attacks of dizziness that are accompanied by intense nausea and a loss of balance so acute that those affected are unable to stand. Acute attacks, and the anxiety of not knowing when they will occur, can make everyday activities, such as working or driving a car, difficult or impossible. The causes of balance disorders are not well understood and there is a need for more research, which may result in the development of new treatment options.

The evidence is clear, regardless of the age or background of the people they affect, hearing impairment and balance disorders have significant social and economic impacts. These impacts can be lessened, however, if they are diagnosed and treated as early as possible.

In recent years, hearing health issues have been the subject of investigations by Senate Committees, the Australian National Audit Office, the Australian

Competition and Consumer Commission, and Deloitte Access Economics. This suggests a growing recognition that hearing impairment, a condition affecting 3.6 million Australians, should be a government priority.

The Committee strongly believes that hearing health requires greater recognition and prioritisation by government and that implementing the actions recommended in this report will improve the hearing health and wellbeing of Australia.

My thanks to the organisations, agencies, and individuals who participated in this inquiry, especially those hearing impaired and deaf Australians who provided the Committee with accounts of their personal experiences. Thank you also to the Auslan interpreters who assisted with interpretation at public hearings. I would like to thank my fellow Committee colleagues for their commitment and constructive contributions during this inquiry – inquiries such as this show parliament working at its best. Finally I would like to thank the Committee staff who have collated the evidence, run the hearings and assisted in the preparation of this report. The Committee has been exceptionally well-served by its Secretariat.

**Mr Trent Zimmerman MP**

**Chair**

# Contents

Chair's Foreword .....	iii
Members .....	xiii
Committee Secretariat .....	xv
Terms of Reference .....	xvii
Abbreviations .....	xix
Recommendations .....	xxiii

## The Report

<b>1 Introduction.....</b>	<b>1</b>
Background.....	1
About the Inquiry .....	2
Objectives and Scope .....	2
Inquiry Conduct .....	3
Previous Inquiries and Reports into Hearing Health.....	4
Access Economics Reports on the Economic Impact of Hearing Loss .....	4
Senate Inquiry into Hearing Health in Australia (2010).....	5
Audit Report of Community Service Obligations Program (2014).....	6
Senate Inquiry into Australian Hearing (2015).....	7
Australian Competition and Consumer Commission Report (2017) .....	8
Current Inquiries and Investigations into Hearing Health .....	9

	Inquiry into Hearing Services under the National Disability Insurance Scheme.....	9
	Report Structure.....	10
<b>2</b>	<b>Current Approaches.....</b>	<b>11</b>
	Overview.....	11
	Hearing Impairment in Australia.....	12
	Types and Causes of Hearing Impairment.....	12
	Prevalence of Hearing Impairment .....	15
	Current and Future Cost of Hearing Impairment .....	16
	Impact on the Development of Communication Skills in Children .....	16
	Links to Other Health Conditions.....	18
	Stigma and Social Impact of Hearing Impairment.....	19
	Balance Disorders and Other Ear Health Issues in Australia .....	22
	Types and Causes.....	22
	Prevalence of Balance Disorders and Other Ear Health Issues .....	23
	Economic Cost of Balance Disorders and Other Ear Health Issues .....	24
	Impact of Balance Disorders and Other Ear Health Issues .....	24
	Current Provision of Hearing Services and Treatment.....	25
	Universal Newborn Hearing Screening .....	25
	Early Intervention Programs .....	26
	Hearing Services Program .....	27
	Programs for Aboriginal and Torres Strait Islanders and Other At-Risk Populations .....	29
	Auslan Interpretation and Other Communication Support .....	32
	Support for Balance Disorders and Other Ear Health Issues.....	33
	Concluding Comment.....	35
<b>3</b>	<b>Hearing Health in At-Risk Populations .....</b>	<b>37</b>
	Overview.....	37
	Aboriginal and Torres Strait Islander People .....	37
	Prevalence of Otitis Media and Hearing Loss.....	37

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	Impact of Otitis Media and Hearing Loss.....	43
	Prevention and Treatment of Otitis Media.....	48
	People from Culturally and Linguistically Diverse Backgrounds .....	55
	People Living in Rural and Regional Areas.....	58
	Aged Population.....	59
	Veterans.....	63
	Concluding Comment.....	65
<b>4</b>	<b>Research and Prevention of Hearing Loss .....</b>	<b>71</b>
	Overview.....	71
	Noise Induced Hearing Loss.....	71
	Occupational Noise Induced Hearing Loss.....	72
	Recreational Noise Exposure.....	78
	Public Awareness of Hearing Health Issues.....	81
	Hearing Health Awareness in Australia.....	81
	Effects of Limited Awareness of Hearing Health Issues .....	82
	Education and Awareness Programs .....	83
	Research into Hearing Impairment .....	85
	Cochlear Implant Technology .....	85
	Genetics and Stem-Cell Research.....	86
	Longitudinal Studies.....	88
	Research into Balance Disorders and Other Ear Health Issues .....	89
	Innovation in Hearing Service Delivery.....	90
	Concluding Comment.....	92
<b>5</b>	<b>Provision of Hearing Devices .....</b>	<b>97</b>
	Overview.....	97
	Structure of the Hearing Aid Clinic Industry.....	97
	Role of Australian Hearing.....	99
	Cost of Hearing Aids and Available Subsidies.....	101
	Hearing Aid Clinic Sales Targets and Commissions .....	108

	Sales Practices .....	111
	Methods of Regulating Sales in Hearing Aid Clinics.....	114
	Post-Sales Support.....	115
	Alternatives to Using Hearing Aids .....	118
	Training, Registration, and Skills Shortages in Audiology and Audiometry.....	119
	Regulatory Settings in Hearing Health Professions .....	119
	Skills Shortages – Audiology and Audiometry .....	122
	Concluding Comment.....	124
<b>6</b>	<b>Future of Hearing Services in Australia .....</b>	<b>129</b>
	Overview.....	129
	National Disability Insurance Scheme.....	129
	Contestability in the Community Service Obligations Market .....	131
	Early Intervention Services in the NDIS .....	134
	Policy Options for Young Children .....	139
	Hearing Screening Programs .....	140
	Improvements to Universal Newborn Hearing Screening Programs .....	140
	Additional Hearing Screening for Children .....	141
	Hearing Screening for Adults.....	145
	Availability of Auslan Interpreters .....	146
	Ownership of Australian Hearing.....	147
	National Health Priorities.....	149
	Concluding Comment.....	150
	<b>Appendix A. Submissions .....</b>	<b>157</b>
	<b>Appendix B. Exhibits .....</b>	<b>163</b>
	<b>Appendix C. Hearings and Witnesses .....</b>	<b>167</b>
 <b>List of Tables</b>		
	Table 1.1 Public Hearings Held .....	3

## List of Textboxes

Box 2.1	Experiences of Hearing Impairment .....	20
Box 3.1	Otitis Media .....	39
Box 4.1	Noise Induced Hearing Loss and Farmers.....	76
Box 4.2	Preventing Recreational Noise Induced Hearing Loss: The HEARsmart Campaign .....	80
Box 5.1	Cost of Hearing Devices.....	107



# Members

## *Chair*

Mr Trent Zimmerman MP

## *Deputy Chair*

Mr Steve Georganas MP

## *Members*

Hon Damian Drum MP

Dr Mike Freeland MP

Mr Andrew Laming MP

Mrs Lucy Wicks MP

Mr Tim Wilson MP

Mr Tony Zappia MP



# Committee Secretariat

Ms Stephanie Mikac, Committee Secretary

Mr Timothy Brennan, A/g Inquiry Secretary

Ms Caitlin Cahill, Senior Research Officer

Ms Carissa Skinner, Officer Manager



# Terms of Reference

Taking into consideration the significant percentage of Australians experiencing hearing loss and the related social and economic impact of hearing impairment to the long term health and wellbeing of Australia, the Standing Committee on Health, Aged Care and Sport will inquire into and report on:

1. The current causes and costs of hearing loss, and ear or balance disorder to the Australian health care system should existing arrangements remain in place;
2. Community awareness, information, education and promotion about hearing loss and health care;
3. Access to, and cost of services, which include hearing assessments, treatment and support, Auslan language services, and new hearing aid technology;
4. Current access, support and cost of hearing health care for vulnerable populations, including: culturally and linguistically diverse people, the elderly, Aboriginal and Torres Strait Islanders and people living in rural and regional areas;
5. Current demand and future need for hearing checks and screening, especially for children (12 years and younger) and older Australians at key life stages;
6. Access, availability and cost of required drugs, treatments and support for chronic ear and balance disorders sufferers;
7. Best practice and proposed innovative models of hearing health care to improve access, quality and affordability;
8. Developments in research into hearing loss, including: prevention, causes, treatment regimes, and potential new technologies;

9. Whether hearing health and wellbeing should be considered as the next National Health Priority for Australia; and
10. Any other relevant matter.

# Abbreviations

ACAud	Australian College of Audiology
ACCC	Australian Competition and Consumer Commission
ACT	Australian Capital Territory
AHPRA	Australian Health Practitioner Regulation Agency
AIOH	Australian Institute of Occupational Hygienists
AMA	Australian Medical Association
AMS	Aboriginal Medical Service
ANAO	Australian National Audit Office
ANHSC	Australasian Newborn Hearing Screening Committee
AOM	Acute Otitis Media
ASOHNS	Australian Society of Otolaryngology Head and Neck Surgery
ASORC	Australian Society of Rehabilitation Counsellors
BPPV	Benign Paroxysmal Positional Vertigo
CAPD	Central Auditory Processing Disorder
CICADA	Cochlear Implant Club and Advisory Association
COAG	Council of Australian Governments
CRC	Cooperative Research Centre
CSO	Community Service Obligations
CSOM	Chronic Suppurative Otitis Media
dB	Decibels

DSQ	Deaf Services Queensland
DVA	Department of Veterans' Affairs
EAF	Employment Assistance Fund
ENT	Ear, Nose and Throat
FM	Frequency Modulation
GP	General Practitioner
HAASA	Hearing Aid Audiometrist Society of Australia
HBA	Hearing Business Alliance
HCIA	Hearing Care Industry Association
HGSA	Human Genetics Society Australasia
HPC	Health Professionals Council
HSP	Hearing Services Program
IAA	Independent Audiologists Australia
IAG	Indigenous Affairs Group
LOCHI	Longitudinal Outcomes of Children with Hearing Impairment
MoUs	Memorandums of Understanding
NABS	National Auslan Interpreter Booking and Payment Service
NAL	National Acoustic Laboratories
NAPLAN	National Assessment Program – Literacy and Numeracy
NASRHP	National Alliance of Self Regulating Health Professions
NCFH	National Centre for Farmer Health
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NHPA	National Health Priority Area
NRHA	National Rural Health Alliance
NRS	National Relay Service
NSW	New South Wales
NT	Northern Territory
NT COGSO	Northern Territory Council of Government School Organisations

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OHS	Occupational Health and Safety
OME	Otitis Media with Effusion
PBS	Pharmaceutical Benefits Scheme
QAIHC	Queensland Aboriginal and Islander Health Council
Qld	Queensland
RACS	Royal Australasian College of Surgeons
RAP	Rehabilitation Appliances Program
RIDBC	Royal Institute for Deaf and Blind Children
SHHH	Self Help for Hard of Hearing People
SA	South Australia
SMS	Short Message Service
SRC	Safety, Rehabilitation and Compensation
TAFE	Technical and Further Education
UK	United Kingdom of Great Britain and Northern Ireland
Vic	Victoria
WHS	Work Health and Safety



# Recommendations

## **Recommendation 1**

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3.119 The Committee recommends that the Department of Health, in collaboration with Australian Hearing, the Department of the Prime Minister and Cabinet, states and territories, Aboriginal and Torres Strait Islander health organisations, and local communities, develop a national strategy to improve hearing health in Aboriginal and Torres Strait Islander communities aimed at:

- coordinating Commonwealth, state and territory services to ensure they are complementary and delivered in a coordinated manner;
- developing a nationally consistent data reporting framework to record data on the prevalence of ear health conditions and the provision of services, including a treatment outcomes tracking method;
- regular monitoring and evaluating of programs to ensure they are meeting their objectives; and
- funding further research into Aboriginal and Torres Strait Islander hearing health issues.

## **Recommendation 2**

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3.120 The Committee recommends that the Department of Health and Australian Hearing significantly increase the resources devoted to providing hearing health services in regional and remote Aboriginal and Torres Strait Islander communities. The mobile outreach services of the Deadly Ears Program should serve as a best practice example for national implementation. This

program should focus on expanding access to hearing health services in regional and remote locations and reducing the waiting lists for Aboriginal and Torres Strait Islander children requiring hearing health treatment.

### **Recommendation 3**

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3.121 The Committee recommends that the Department of Health together with the Department of Education and Training create a hearing health support fund for Aboriginal and Torres Strait Islander students. This fund should:

- be responsible for the progressive installation of soundfield amplification systems in the classrooms of all regional, rural, and remote schools with a significant Aboriginal and Torres Strait Islander student population; and
- provide support to deaf Aboriginal and Torres Strait Islander children to learn sign language and access interpreters where necessary.

### **Recommendation 4**

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3.122 The Committee recommends that the Department of Social Services include audiology and audiometry as eligible services for access to the Free Interpreting Service, delivered by the Translation and Interpreting Service.

### **Recommendation 5**

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3.123 The Committee recommends that the Office of Hearing Services review the provision of hearing services to residents in aged care facilities. This review should consider issues including:

- the use of assistive listening devices for aged care residents;
- service provision for deafblind Australians in aged care facilities; and
- the education of aged care facility staff.

### **Recommendation 6**

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4.81 The Committee recommends that the Department of Health, in consultation with state and territory counterparts and key stakeholder groups, develop and implement an education and awareness raising campaign focussed on national hearing health. The campaign should:

- Promote safe noise exposure practices in the workplace. (The department, in partnership with Safe Work Australia, should focus on encouraging businesses to enact measures to eliminate or isolate sources of noise rather than relying on personal hearing protection.)
- Build on existing projects such as HEARsmart and Know Your Noise to promote safe listening practices in the music industry and among young people.
- Encourage people who may be experiencing hearing loss to seek assistance and encourage general practitioners and other relevant medical practitioners to actively enquire about the hearing health of their patients, particularly those aged 50 years and over.
- Include messaging aimed at destigmatising hearing loss and educating the public on the challenges faced by deaf and hearing impaired Australians.

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### **Recommendation 7**

4.82 The Committee recommends the Department of Health develop a national hearing loss prevention and treatment program for agricultural communities. Effective interventions piloted in the National Centre for Farmer Health's *Shhh Hearing in a Farming Environment* project should serve as the basis for the development of the program. Specifically, the program should include:

- The provision of education on farm-based sources of noise exposure and how the risks to hearing health from these noise sources can be minimised.
- Hearing screening services targeted at workers in agricultural industries and referrals to treatment services for people found to have a hearing loss.
- The promotion of communication techniques to assist people with hearing loss regardless of whether they choose to use hearing devices.

### **Recommendation 8**

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- 4.83 The Committee recommends that the Hearing Services Program and the National Acoustic Laboratories prioritise funding for research which focuses on:
- The causes of balance disorders and potential treatment options;
  - Genetic and stem-cell based treatments for hearing impairment; and
  - Longitudinal research on the experiences of adults undergoing treatment for hearing impairment.

### **Recommendation 9**

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- 4.84 The Committee recommends that the Australian Government add hearing health services delivered via the internet to the Medicare Benefits Schedule. These services should include: audiology; ear, nose, and throat consultations; early intervention listening and spoken language therapy; and speech pathology.

### **Recommendation 10**

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- 5.119 The Committee recommends a review be undertaken of Australian Hearing's commercial operations to ensure it is undertaking a competitively neutral approach to its participation in the Hearing Services Program Voucher Scheme.

### **Recommendation 11**

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- 5.120 The Committee recommends that the Community Service Obligations program be extended to provide hearing services to hearing impaired Australians aged 26 to 65 years on low incomes or who are unemployed and qualify for lower income support or the Low Income Superannuation Tax Offset.

### **Recommendation 12**

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- 5.121 The Committee recommends the Australian Government's Hearing Services Program prohibit the use of commissions or any other similar sales practices likely to undermine the ability of audiologists and audiometrists to provide independent and impartial clinical advice. The Committee also recommends that:

- Australian Hearing cease the use of commissions and similar sales practices as soon as is feasible.
- The Department of Health amends contracts with service providers operating under the Hearing Services Program Voucher Scheme to prohibit the use of commissions and similar sales practices as soon as is feasible.
- If necessary, changes be made to the *Hearing Services Administrative Act 1997* (Cwlth), and any other relevant legislation or regulation, to enable the prohibition of commissions and similar sales practices as described above.

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**Recommendation 13**

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5.122 The Committee recommends that the Australian Government pursue the registration of the audiology and audiometry professions under the Australian Health Practitioner Regulation Agency framework with the Council of Australian Governments.

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**Recommendation 14**

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6.108 The Committee recommends that audiological services for children aged zero to five years remain under the Department of Health's Community Service Obligations program, with Australian Hearing retaining its role as the sole provider of these services.

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**Recommendation 15**

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6.109 The Committee recommends that the Office of Hearing Services fund the creation of a national 'guided pathway' system, based in Australian Hearing, to assist parents in choosing expert early intervention services for their children.

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**Recommendation 16**

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6.110 The Committee recommends the Council of Australian Governments:

- establish a universal hearing screening program for children in their first year of school, with the aim of having all children tested within the first 60 days of the school year; and

- investigate the use of an evidence based online screening program, to deliver a cost effective screening process.

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### **Recommendation 17**

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6.111 The Committee recommends the Department of Health establish a system of automatic referral to a paediatric audiologist, which can be bulk billed, following identification of a hearing impairment at a school screening program.

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### **Recommendation 18**

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6.112 The Committee recommends that states and territories be required to report against the 'National Performance Indicators to Support Neonatal Hearing Screening in Australia', and that the Standing Committee on Screening coordinates the monitoring and reporting in this area.

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### **Recommendation 19**

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6.113 The Committee recommends that the National Disability Insurance Agency undertake modelling to determine the likely demand for Auslan interpretation services following the introduction of the National Disability Insurance Scheme, and the capacity of existing services to meet this demand.

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### **Recommendation 20**

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6.114 The Committee recommends the Government work with states and territories to ensure that Auslan interpretation services are available for interactions with medical, law and other essential services.

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### **Recommendation 21**

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6.115 The Committee supports the decision not to privatise Australian Hearing and recommends that Australian Hearing be retained in government ownership.

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### **Recommendation 22**

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6.116 The Committee recommends that hearing health is made a National Health Priority Area.

# 1. Introduction

## Background

- 1.1 Approximately 3.6 million Australians experience hearing loss and, with Australia's growing ageing population, the prevalence of hearing loss is expected to more than double by 2060. Currently, approximately three in every four Australians over the age of 70 experience hearing loss.
- 1.2 In 2017, hearing loss is expected to cost the Australian economy approximately \$33.3 billion, of which the loss of wellbeing to individuals is valued at \$17.4 billion.
- 1.3 For some individuals, the impact of hearing impairment may include: reduced self-esteem, difficulties finding and maintaining employment, reduced social interaction, and a higher likelihood of a range of associated mental and physical conditions.
- 1.4 In addition, hearing impairment is having a profoundly negative impact within Aboriginal and Torres Strait Islander communities. As many as 90 per cent of Aboriginal and Torres Strait Islander children in some remote communities have otitis media (middle ear) infections at any time. Reoccurring or persistent ear infections can result in permanent hearing damage and are linked to the delayed development of communication skills and reduced educational attainment.
- 1.5 Despite these issues in rural and regional Aboriginal and Torres Strait Islander communities, Australia is considered to be a world leader in the provision of hearing services to children. This system includes universal hearing screening for babies, the fitting of free hearing devices through Australian Hearing, and the provision of communication support and therapy through multidisciplinary early intervention services.

- 1.6 With the expected future rise in the number of people who will require assistive hearing devices, developments in assistive technologies, their availability, and cost is a major consideration now and into the future. A recent Australian Competition and Consumer Commission report has drawn attention to sales practices within the hearing aid clinic industry and concerns have been raised that often vulnerable older Australians are being coerced into purchasing more expensive hearing aids than required.
- 1.7 Framing the current status of hearing health in Australia is the Australian Government's National Disability Insurance Scheme (NDIS). The NDIS is aimed at providing an improved source of support and assistance for eligible deaf and hearing impaired Australians. The NDIS is expected to result in changes to the way some services are funded and delivered. How the NDIS will affect and support those already receiving and yet to receive hearing health services was a major issue of concern raised during the Hearing Health and Wellbeing Inquiry.

## About the Inquiry

### Objectives and Scope

- 1.8 On 2 November 2016, the then Minister for Health, Aged Care and Sport, the Hon Sussan Ley MP, referred the *Inquiry into the Hearing Health and Wellbeing of Australia* (the Inquiry) to the Standing Committee on Health, Aged Care and Sport (the Committee).
- 1.9 As part of the Inquiry the Committee reviewed the current state of hearing health in Australia. More specifically the Committee examined:
  - The prevalence of hearing impairment in Australia and the costs that hearing impairment imposes both on individuals and on the broader Australian community.
  - The state of hearing health within at-risk population groups. In particular, the impacts of otitis media infections among Aboriginal and Torres Strait Islander children and specific issues relating to access to services and treatment for people from culturally and linguistically diverse backgrounds, people living in rural and regional areas, and older Australians.
  - Programs to encourage Australians, particularly young Australians, to take action to protect their hearing health and programs to increase awareness of the benefits of seeking treatment for hearing loss.

- Sales practices within the hearing aid clinic industry, including the payment of commissions and incentives to clinicians to encourage the sale of hearing aids.
- The introduction of the NDIS and its impact on the delivery of hearing services.

## Inquiry Conduct

- 1.10 On 9 November 2016, the Committee issued a media release announcing the Inquiry and calling for submissions to be received by 23 December 2016. The Committee also invited submissions from: government agencies, peak industry and professional organisations, community advocacy and support groups, hearing health providers, universities and research organisations.
- 1.11 The Inquiry received 150 submissions and 20 exhibits, which are listed at Appendix A and B respectively.
- 1.12 The Committee subsequently held 11 public hearings as outlined in the table below. The Committee also conducted two inspections in Sydney and Darwin.

**Table 1.1 Public Hearings Held**

<b>Date</b>	<b>Place</b>
15 November 2016	Sydney, NSW
6 April 2017	
14 February 2017	Canberra, ACT
3 March 2017	
23 March 2017	
16 June 2017	
21 April 2017	Brisbane, Qld
1 May 2017	Melbourne, Vic
2 May 2017	Shepparton, Vic
3 May 2017	Adelaide, SA
7 June 2017	Darwin, NT

## Previous Inquiries and Reports into Hearing Health

### Access Economics Reports on the Economic Impact of Hearing Loss

- 1.13 In February 2006 Access Economics released the report entitled *Listen Hear! The Economic Impact and Cost of Hearing Loss in Australia*. The report, commissioned by the Cooperative Research Centre for Cochlear Implant and Hearing Aid Innovation and the Victorian Deaf Society, provided a quantitative analysis of the ‘financial cost and the loss of wellbeing from hearing loss in Australia’.<sup>1</sup>
- 1.14 Access Economics found that one in six Australians (a total of 3.55 million people), was affected by hearing loss in 2005.<sup>2</sup> Taking into consideration Australia’s growing ageing population, by 2050, the prevalence of hearing loss is projected to rise to one in four Australians.<sup>3</sup> In addition, Access Economics estimated that, in 2005, the real financial cost of hearing impairment was \$11.75 billion, equal to 1.4 per cent of Australia’s Gross Domestic Product.<sup>4</sup>
- 1.15 The Access Economics report and its findings were quoted widely in submissions, including submissions from: the Department of Health<sup>5</sup>, Australian Hearing<sup>6</sup>, Better Hearing Australia<sup>7</sup>, the Deafness Forum of Australia<sup>8</sup>, the Northern Territory Government<sup>9</sup>, Audiology Australia<sup>10</sup>, the Shepherd Centre<sup>11</sup>, Independent Audiologists Australia<sup>12</sup>, and the Australian Society of Otolaryngology Head and Neck Surgery<sup>13</sup>.

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<sup>1</sup> Access Economics, *Listen Hear! The Economic Impact and Cost of Hearing Loss in Australia (Listen Hear!)*, February 2006, p. 5.

<sup>2</sup> Access Economics, *Listen Hear!*, February 2006, p. 5.

<sup>3</sup> Access Economics, *Listen Hear!*, February 2006, p. 5.

<sup>4</sup> Access Economics, *Listen Hear!*, February 2006, p. 5.

<sup>5</sup> Department of Health, *Submission 16*, p. 3 and p. 5.

<sup>6</sup> Australian Hearing, *Submission 58*, p. 1.

<sup>7</sup> Better Hearing Australia, *Submission 83*, p. 4, p. 7 and p. 16.

<sup>8</sup> Deafness Forum of Australia, *Submission 17*, pp 33- 34.

<sup>9</sup> Northern Territory Government, *Submission 93*, p. 5.

<sup>10</sup> Audiology Australia, *Submission 49*, p. 4.

<sup>11</sup> The Shepherd Centre, *Submission 19*, p. 6.

<sup>12</sup> Independent Audiologists Australia, *Submission 20*, p. 6.

- 1.16 In 2017 the Hearing Care Industry Association commissioned Deloitte Access Economics to update the 2006 *Listen Hear!* report. The updated report estimated the financial cost of hearing loss at \$15.9 billion,<sup>14</sup> with the associated value of the loss of wellbeing being \$17.4 billion.<sup>15</sup>

## Senate Inquiry into Hearing Health in Australia (2010)

- 1.17 On 10 September 2009, the Senate referred an *Inquiry into Hearing Health in Australia* to the Senate Community Affairs References Committee (the Community Affairs Committee).
- 1.18 On 13 May 2010, the Community Affairs Committee presented to the Parliament its report *Hear Us: Inquiry into Hearing Health in Australia*.

### Key Issues

- 1.19 The 2010 Senate report found that the:
- ... single issue most raised by submitters to the inquiry was that of eligibility to Australian Hearing services, and especially the cut off age of 21 years. At a time in their lives when they are studying, or not yet established in their careers, young Australians find themselves without the excellent care they have received to date, and often without the means to replace that care, or their hearing devices, in the private sector.<sup>16</sup>
- 1.20 In particular, the report highlighted the barriers to accessing appropriate treatment for hearing impairment. These barriers included the very high cost of hearing devices for individuals who are not eligible for support from the Hearing Services Program, and the lack of hearing assessment and support services in regional and remote parts of Australia.<sup>17</sup>
- 1.21 In addition, another issue highlighted was the high rate of ear disease among Aboriginal and Torres Strait Islander people, which was described as a crisis. The report found that the onset of childhood hearing loss 'can be

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<sup>13</sup> The Australian Society of Otolaryngology Head and Neck Surgery, *Submission 24*, p. 7.

<sup>14</sup> Deloitte Access Economics, *Exhibit 18: An Update of the Social and Economic Cost of Hearing Loss and Hearing Health Conditions in Australia*, July 2017, pp 4-5.

<sup>15</sup> The estimation of the loss of wellbeing was made using a 'disability adjusted life years' approach which quantifies the impact of diminished quality of life and premature death. *Exhibit 18*, p. 60.

<sup>16</sup> Senate Community Affairs References Committee, *Hear Us: Inquiry into Hearing Health in Australia*, May 2010, p. xiv.

<sup>17</sup> Senate Community Affairs References Committee, *Hear Us: Inquiry into Hearing Health in Australia*, Canberra, May 2010, p. xiv.

devastating for Indigenous Australians. [Due to hearing loss] their capacity to access education—arguably the best way out of the poverty cycle—is limited.<sup>18</sup>

### ***2010 Report Recommendations***

1.22 The 2010 Senate report made 34 recommendations in relation to hearing health in Australia, in the areas of:

- access and services;
- education and learning;
- awareness raising and research;
- criminal justice; and
- recreational hearing loss among young people.

### ***Government Response***

1.23 On 30 May 2011 the Australian Government in its response to the Committee's report, accepted a number of recommendations in principle, while noting others were the responsibility of state and territory governments.<sup>19</sup> The majority of the recommendations are yet to be adopted.<sup>20</sup>

1.24 Subsequently, in 2011-12, the maximum age of eligibility for young adults to receive services under the Hearing Services Program was raised from 21 years of age to 26 years of age.<sup>21</sup>

### **Audit Report of Community Service Obligations Program (2014)**

1.25 Following the Senate Inquiry, in 2014, the Australian National Audit Office (ANAO) conducted a performance audit to 'assess the effectiveness of the Department of Health's and Australian Hearing's administration of the Community Service Obligations (CSO) program for hearing services'.<sup>22</sup>

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<sup>18</sup> Senate Community Affairs References Committee, *Hear Us: Inquiry into Hearing Health in Australia*, Canberra, May 2010, p. xv.

<sup>19</sup> The Australian Government's response can be viewed at [http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/Completed\\_inquiries/2008-10/hearing\\_health/index](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2008-10/hearing_health/index)

<sup>20</sup> Hearing Care Industry Association, *Submission 30*, p. 1.

<sup>21</sup> Australian Government, *Response to the Senate Community Affairs References Committee Report, Hear Us: Inquiry into Hearing Health in Australia*, May 2011, p. 5.

<sup>22</sup> ANAO Audit Report No.32 2013–14, *Delivery of the Hearing Community Service Obligation*, p. 14.

1.26 The ANAO found that ‘overall, the CSO program [was] being effectively administered’, but recommended that:

... the Department of Health establish a methodology, in consultation with Australian Hearing, for measuring performance against the projected service targets and other outcomes for eligible client groups from 2011–12 to 2014–15.<sup>23</sup>

## Senate Inquiry into Australian Hearing (2015)

1.27 On 17 September 2015, the Senate Select Committee on Health, as part of its remit, presented its third interim report entitled *Australian Hearing: Too Important to Privatisise*.

1.28 The Senate Select Committee examined whether the Government should act on the recommendation of the National Commission of Audit 2014 to privatise Australian Hearing.

1.29 As the title of the Senate Select Committee report suggests, broadly it recommended that Australian Hearing should not be privatised.<sup>24</sup>

1.30 The Senate Select Committee report included the concerns raised by stakeholders regarding the proposed privatisation of Australian Hearing. These related to:

- maintaining access to hearing services, particularly for parents of deaf children, very young children, and babies;
- maintaining standards of service in the CSO program if Australian Hearing were privatised, particularly in rural and remote areas and Aboriginal and Torres Strait Islander communities; and
- whether a competitive market would have any incentive to provide the types of services and ongoing research currently provided by Australian Hearing and the [National Acoustic Laboratories].<sup>25</sup>

1.31 The Senate Select Committee also recommended that:

... the government provide clarity around the work already done on the transition of the Hearing Services Program to the National Disability Insurance Scheme. Any 'blueprint' or implementation plan should be made public as soon as it is finalised, so as to reassure stakeholders that the quality

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<sup>23</sup> ANAO Audit Report No.32 2013–14, *Delivery of the Hearing Community Service Obligation*, p. 24.

<sup>24</sup> Senate Select Committee on Health, *Third Interim Report: Australian Hearing: Too Important to Privatisise*, Canberra, September 2015, p. xi.

<sup>25</sup> Senate Select Committee on Health, *Third Interim Report: Australian Hearing: Too Important to Privatisise*, Canberra, September 2015, pp 23–24.

services provided by Australian Hearing continue to be available in order to ensure that hearing impaired Australians can live the life they deserve.<sup>26</sup>

### ***Government Senators' Dissenting Report***

1.32 Coalition Senators on the Select Committee released a dissenting report to the Committee's recommendations. In relation to the Committee's recommendation against privatising Australian Hearing, the dissenting report advocated that:

Given the Government has not made a decision on the ownership of Australian Hearing and the consultation is ongoing, the Committee should not pre-empt the outcome. Therefore, Coalition Senators reject Recommendation 1.<sup>27</sup>

1.33 In relation to Recommendation 2, which urged the Australian Government to provide more clarity around the work done on the transition of the Hearing Services Program to the NDIS, the dissenting report stated that the Government had provided 'ample information and clarity' about the transition.<sup>28</sup>

### **Australian Competition and Consumer Commission Report (2017)**

1.34 In 2015 the Australian Competition and Consumer Commission (ACCC) conducted a survey focussing on 'consumer protection issues in the hearing clinic industry. In 2017, the ACCC released its findings in its report entitled *Issues around the Sale of Hearing Aids: Consumer and Clinician Perspective*.<sup>29</sup>

1.35 The ACCC found that within the hearing aid clinic industry 'sales commissions and incentives are commonly used to motivate clinicians to sell hearing aids, particularly in clinics run by major operators.'<sup>30</sup>

1.36 The ACCC found that sales in hearing aid clinics 'may be driven by commission and other incentives rather than consumer need.' The ACCC

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<sup>26</sup> Select Committee on Health, *Third Interim Report: Australian Hearing: Too Important to Privatisise*, Canberra, September 2015, p. xi.

<sup>27</sup> Senate Select Committee on Health, *Third Interim Report: Australian Hearing: Too Important to Privatisise*, Canberra, September 2015, p. 45.

<sup>28</sup> Senate Select Committee on Health, *Third Interim Report: Australian Hearing: Too Important to Privatisise*, Canberra, September 2015, pp 45.

<sup>29</sup> Australian Competition and Consumer Commission (ACCC), *Issues Around the Sale of Hearing Aids: Consumer and Clinician Perspective*, 3 March 2017, p. 1.

<sup>30</sup> ACCC, *Issues Around the Sale of Hearing Aids: Consumer and Clinician Perspective*, 3 March 2017, p. 1.

also outlined issues relating to the 'cost and performance of hearing aids' and the 'treatment of vulnerable consumers'.<sup>31</sup>

- 1.37 The ACCC stated that it had contacted industry participants and requested that they 'review their incentive programs and performance measures to ensure that they do not create a conflict between independent healthcare advice and sales.'<sup>32</sup>

## **Current Inquiries and Investigations into Hearing Health**

### **Inquiry into Hearing Services under the National Disability Insurance Scheme**

- 1.38 On 30 November 2016, the Joint Standing Committee on the National Disability Insurance Scheme (NDIS Committee) commenced an inquiry into the provision of hearing services under the NDIS. The NDIS Committee was originally due to report to the Parliament by 23 March 2017 but its reporting date was, subsequently, extended.<sup>33</sup>

- 1.39 The inquiry's terms of reference are to inquire into and report on:
- The eligibility criteria for determining access to, and service needs of, deaf and hearing impaired people under the NDIS;
  - Delays in receiving services, with particular emphasis on early intervention services;
  - The adequacy of funding for hearing services under the NDIS;
  - The accessibility of hearing services, including in rural and remote areas;
  - The principle of choice of hearing service provider;
  - The liaison with key stakeholders in the design of NDIS hearing services, particularly in the development of reference packages;
  - Investment in research and innovation in hearing services; and

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<sup>31</sup> ACCC, *Issues around the Sale of Hearing Aids: Consumer and Clinician Perspectives*, 3 March 2017, p. 1.

<sup>32</sup> ACCC, *Issues around the Sale of Hearing Aids: Consumer and Clinician Perspective*, 3 March 2017, p. 4.

<sup>33</sup> Joint Standing Committee on the National Disability Insurance Scheme, *Current Inquiries*, [http://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/National\\_Disability\\_Insurance\\_Scheme](http://www.aph.gov.au/Parliamentary_Business/Committees/Joint/National_Disability_Insurance_Scheme), Accessed 10 July 2017.

- Any other related matters.<sup>34</sup>

## Report Structure

- 1.40 Chapter 2 outlines hearing impairment and balance disorders in Australia, including: the types, causes, and prevalence of these conditions; the economic costs; and the impacts of these conditions on individuals. Chapter 2 also outlines the current approaches used to provide services and support for Australians with hearing impairments and balance disorders.
- 1.41 Chapter 3 discusses hearing health in at-risk populations, including: Aboriginal and Torres Strait Islanders; people from culturally and linguistically diverse backgrounds; the elderly; people living in rural and remote communities; and others.
- 1.42 Chapter 4 considers the extent and causes of noise induced hearing loss and programs aimed at reducing preventable hearing loss. Chapter 4 also outlines research and innovation in the treatment of hearing impairment and balance disorders.
- 1.43 Chapter 5 discusses the provision of hearing assistance devices, including: the structure of the hearing clinic industry; the role of Australian Hearing; the cost of hearing devices and available subsidies; the use of commissions and other sales practices in the hearing services industry and potential models for regulating these practices; post-sales support for recipients of hearing devices; alternatives to hearing devices; training, registration, and skill shortages in audiology and audiometry.
- 1.44 Chapter 6 considers the future of hearing services in Australia, including: the introduction of the National Disability Insurance Scheme; hearing screenings; the availability of Auslan interpreters; ownership of Australian Hearing; and hearing health and wellbeing as a National Health Priority Area.

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<sup>34</sup> Joint Standing Committee on the National Disability Insurance Scheme, Hearing Services Terms of Reference, [http://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/National\\_Disability\\_Insurance\\_Scheme/HearingServices](http://www.aph.gov.au/Parliamentary_Business/Committees/Joint/National_Disability_Insurance_Scheme/HearingServices) 10 July 2017.

## 2. Current Approaches

### Overview

- 2.1 Hearing impairment is a condition estimated to affect one in seven Australians including as many as three out of four people over 70 years of age. Hearing impairment may impact a person's self-esteem and mental health as well as their ability to fully participate in social and employment activities.
- 2.2 The effects of hearing impairment among children can include delays in the development of language skills and can have a long term impact on educational achievement. Among older people hearing loss can increase social isolation and the risk of cognitive decline and dementia. This chapter discusses these costs and impacts as well as the ongoing effects of the social stigma related to hearing loss.
- 2.3 The impact of hearing impairment is also significant for the Australian economy and includes the direct costs of providing hearing services, productivity losses due to reduced workforce participation, and the impact of reduced wellbeing for individuals.
- 2.4 In addition to issues around hearing health, the Inquiry received evidence on balance disorders. Balance disorders can result in attacks of acute dizziness that can increase the risk of falls and have a detrimental impact on a person's work and social life. In addition, this chapter outlines the prevalence and impact of balance disorders, while acknowledging there is some uncertainty regarding whether balance disorders are common in Australia. This chapter also discusses programs serving Australians with hearing impairment or balance disorders.

# Hearing Impairment in Australia

## Types and Causes of Hearing Impairment

2.5 Experiences of hearing loss can vary depending on: what part of the ear is affected, whether it impacts one ear (unilateral) or both ears (bilateral), the severity of the hearing loss, and whether it was present at birth or acquired at a later stage. There are three types of hearing impairment:

- **Conductive hearing loss** is caused by a blockage or damage to the outer or middle ear which stops sound reaching the hearing nerve.<sup>1</sup> It is often seen with ear infections, but can also have genetic causes.<sup>2</sup> Conductive Hearing Loss can be temporary but can also cause long term hearing impairment.<sup>3</sup> Conductive Hearing Loss can be corrected medically, surgically, or remediated with the use of hearing devices.<sup>4</sup>
- **Sensorineural hearing loss** is due to problems in the cochlea or auditory nerve which disturbs the sound signals being sent to the brain, and is usually permanent.<sup>5</sup> This form of hearing loss can be caused by genetics, ageing, noise damage or disease.<sup>6</sup> Sensorineural hearing loss is most commonly addressed through the use of hearing devices, such as hearing aids or cochlear implants.<sup>7</sup>
- **Mixed hearing loss** involves a combination of hearing problems in the middle and inner ear.<sup>8</sup>

2.6 The severity of hearing loss is classified as mild, moderate, severe or profound, with prevalence rates decreasing as the severity increases.<sup>9</sup> The

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<sup>1</sup> Department of Health, *Submission 16*, p. 4.

<sup>2</sup> Dr Timothy Makeham, Private Capacity, *Official Committee Hansard*, Canberra, 14 February 2017, p. 2.

<sup>3</sup> Government of South Australia, *Exhibit 10a: An Aboriginal Ear Health Framework for South Australia*, p. 7.

<sup>4</sup> The HEARing Cooperative Research Centre (CRC), *Submission 59*, p. 6.

<sup>5</sup> Department of Health, *Submission 16*, p. 4.

<sup>6</sup> Dr Timothy Makeham, Private Capacity, *Official Committee Hansard*, Canberra, 14 February 2017, p. 2.

<sup>7</sup> The HEARing CRC, *Submission 59*, p. 6.

<sup>8</sup> Department of Health, *Submission 16*, p. 4.

<sup>9</sup> The HEARing CRC, *Submission 59*, p. 6.

Department of Health advised the following grades are used in Australia to classify hearing impairment:

- 0-20 decibels (dB) — normal hearing — no effects in good listening environment;
- 21-45 dB — mild — understanding speech can be difficult especially in a noisy environment;
- 46-65 dB — moderate — has trouble hearing and understanding in ideal conditions;
- 66-90 dB — severe — unable to hear normal speech, depends on visual clues such as speech reading or sign language;
- Over 91 dB — profound — may hear some loud sounds but does not rely on hearing as the primary channel for communication.<sup>10</sup>

2.7 Hearing loss can be present at birth (congenital) or occur later in life (acquired). Causes of congenital hearing loss include genetic factors; physical development issues; pre-natal rubella<sup>11</sup> and cytomegalovirus<sup>12</sup>; and birth trauma and prematurity.<sup>13</sup> The Human Genetics Society of Australasia stated that approximately 50 per cent of cases of congenital hearing loss are genetic, 25 per cent are not genetic with cytomegalovirus a 'major cause' of hearing impairment in this group, and 25 per cent have no established cause.<sup>14</sup>

2.8 Acquired hearing loss in adults is commonly caused by ageing and/or excessive exposure to noise.<sup>15</sup> The Human Genetics Society of Australasia

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<sup>10</sup> Department of Health, *Submission 16*, p. 4.

<sup>11</sup> Rubella is also known as German Measles. If contracted during the first trimester of pregnancy, it can affect the pregnancy and lead to congenital rubella syndrome at birth, a characteristic of which is deafness. Department of Health, '8.4 Rubella', <http://www.health.gov.au/internet/publications/publishing.nsf/Content/clinical-practice-guidelines-ac-mod1~part-b-maternal-health-screening~rubella>, Accessed 9 August 2017.

<sup>12</sup> Cytomegalovirus is a virus which, if passed from a mother to child during pregnancy, can have adverse effects on the developing baby including impaired hearing. New South Wales Department of Health, 'Cytomegalovirus (CMV) and pregnancy fact sheet', <http://www.health.nsw.gov.au/Infectious/factsheets/Factsheets/cmv.pdf>, Accessed 9 August 2017.

<sup>13</sup> Australian Hearing, *Submission 58*, pp. 1-2.

<sup>14</sup> Dr Matthew Hunter, Member, Human Genetics Society of Australasia (HGSA), *Official Committee Hansard*, Canberra, 14 February 2017, p. 7.

<sup>15</sup> Access Economics, *Listen Hear! The Economic Impact and Cost of Hearing Loss in Australia*, February 2006, p. 17.

advised that while these forms of acquired hearing loss are based in part on environmental factors, ‘increasingly we are understanding that there are susceptibility genes which predispose a person to developing age-related hearing loss or susceptibility to noise induced hearing loss.’<sup>16</sup>

- 2.9 Otitis media, or middle ear disease, refers to inflammation and infection of the middle ear, and causes conductive hearing loss.<sup>17</sup> Mild otitis media is common among children, the majority of whom will recover with no long term damage.<sup>18</sup> If the otitis media is recurrent or becomes chronic, however, it can cause permanent hearing loss.<sup>19</sup> Aboriginal and Torres Strait Islander children experience severe and persistent otitis media at much higher rates than non-Indigenous Australians.<sup>20</sup> This is discussed in further detail in Chapter 3.
- 2.10 As well as ageing, noise exposure and chronic middle ear disorders, Australian Hearing advised that other causes of acquired hearing loss or later onset hearing loss include: genetic factors or malformations in the inner ear; disease including meningitis; Meniere’s disease; injury; consequences of cancer treatment including use of ototoxic medication; and Otosclerosis (a hereditary thickening of the bones in the ear).<sup>21</sup>
- 2.11 Central Auditory Processing Disorder (CAPD) is a dysfunction of the brain rather than the ear that can make it harder ‘to understand speech when there is background noise present.’<sup>22</sup> Sound Scouts Australia advised that the causes of CAPD are ‘largely unknown but include protracted conductive hearing loss during the first five years of life.’<sup>23</sup> Australian Hearing stated that children with recurrent middle ear disease are more likely to have Spatial Processing Disorder, a type of CAPD which ‘interrupts a person’s

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<sup>16</sup> Dr Matthew Hunter, HGSA, *Official Committee Hansard*, Canberra, 14 February 2017, p. 7.

<sup>17</sup> Department of Health and the Menzies School of Health Research, *Exhibit 10: Recommendations for Clinical Care Guidelines on the Management of Otitis Media in Aboriginal and Torres Strait Islander Populations (April 2010)*, p. iii.

<sup>18</sup> Department of Health and the Menzies School of Health Research, *Exhibit 10*, p. iii.

<sup>19</sup> Department of Health and the Menzies School of Health Research, *Exhibit 10*, p. iii.

<sup>20</sup> Department of Health and the Menzies School of Health Research, *Exhibit 10*, p. iv.

<sup>21</sup> Australian Hearing, *Submission 58*, p. 2.

<sup>22</sup> Sound Scouts Australia, *Submission 41*, p. 2.

<sup>23</sup> Sound Scouts Australia, *Submission 41*, p. 2.

ability to learn in a noisy environment, such as the classroom'.<sup>24</sup> The HEARing Cooperative Research Centre (CRC) stated that children with CAPD are often misidentified as having reading disorders.<sup>25</sup> The HEARing CRC further stated that if CAPD is 'properly detected, remediation can be effective in improving communication and educational outcomes.'<sup>26</sup>

## Prevalence of Hearing Impairment

- 2.12 Australian Hearing stated that approximately one (1.1) in every thousand babies is born each year with a moderate or greater bilateral hearing impairment, and almost one (0.6) in every thousand babies is born with a moderate or greater unilateral hearing impairment.<sup>27</sup> First Voice advised that by the age of school entry, the rate of hearing loss increases to approximately three in every thousand children, due to a number of factors including: a failure to detect a hearing loss at birth, progressive hearing loss, or trauma, infections and childhood diseases.<sup>28</sup>
- 2.13 The prevalence of hearing loss continues to increase with age. The Department of Health advised that 'less than one per cent of people under the age of 15 are affected by hearing loss compared to three out of every four people over the age of 70 years'.<sup>29</sup>
- 2.14 A 2017 Deloitte Access Economics report commissioned by the Hearing Care Industry Association estimated that there were 3.6 million people in Australia with hearing loss in the better ear,<sup>30</sup> which equated to 14.5 per cent of the total Australian population.<sup>31</sup> Hearing loss was found to be more common among males than females, with 2.2 million males and 1.4 million females with hearing loss in 2017.<sup>32</sup> The Deloitte Access Economics report

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<sup>24</sup> Australian Hearing, *Submission 58*, pp 2-3.

<sup>25</sup> HEARing CRC, *Submission 59*, p. 11.

<sup>26</sup> HEARing CRC, *Submission 59*, p. 11.

<sup>27</sup> Australian Hearing, *Submission 58*, p. 1.

<sup>28</sup> First Voice, *Submission 28*, p. 5.

<sup>29</sup> Department of Health, *Submission 16*, p. 5.

<sup>30</sup> Deloitte Access Economics measured this as '25 decibels (dB) or worse loss in the better hearing ear'. Deloitte also stated that using better ear measures provides 'conservative estimates'.  
Deloitte Access Economics, *Exhibit 18: An Update of the Social and Economic Cost of Hearing Loss and Hearing Health Conditions in Australia*, pp 3, 10.

<sup>31</sup> Deloitte Access Economics, *Exhibit 18*, p. 3.

<sup>32</sup> Deloitte Access Economics, *Exhibit 18*, p. 3.

stated that the prevalence of hearing loss is 'expected to more than double to 7.8 million by 2060.'<sup>33</sup>

## Current and Future Cost of Hearing Impairment

- 2.15 The 2006 Access Economics *Listen Hear!* report found that, in 2005, the real financial cost of hearing impairment was \$11.75 billion.<sup>34</sup> In the 2017 update of the *Listen Hear!* report, the financial cost of hearing loss was revised up to \$15.9 billion.<sup>35</sup> The largest component of this cost was lost productivity (\$12.8 billion), most of which was due to the reduced employment of people with hearing loss.<sup>36</sup> Health system costs accounted for \$881.5 million, 76 per cent of which was attributed to the Australian Government, largely through the Hearing Services Program.<sup>37</sup> The remaining financial costs included informal care costs (\$141.6 million), deadweight losses (\$1.6 billion), and other financial costs (\$480.3 million).<sup>38</sup>
- 2.16 The 2017 report also stated there was a further \$17.4 billion cost associated with lost wellbeing.<sup>39</sup> Loss of wellbeing includes the 'pain, suffering and premature mortality' associated with hearing loss.<sup>40</sup> Combined with the financial costs, Deloitte Access Economics found that the total cost of hearing loss in 2017 was \$33.3 billion.<sup>41</sup>

## Impact on the Development of Communication Skills in Children

- 2.17 The Department of Health found that hearing loss in children can lead to 'delays in language and psychosocial development' and 'also impact on educational achievements and employment opportunities.'<sup>42</sup> The South

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<sup>33</sup> Deloitte Access Economics, *Exhibit 18*, p. 3.

<sup>34</sup> Access Economics, *Listen Hear! The Economic Impact and Cost of Hearing Loss in Australia*, February 2006, p. 5.

<sup>35</sup> Deloitte Access Economics, *Exhibit 18*, p. 3.

<sup>36</sup> Deloitte Access Economics, *Exhibit 18*, p. 4.

<sup>37</sup> Deloitte Access Economics, *Exhibit 18*, p. 34.

<sup>38</sup> Deloitte Access Economics, *Exhibit 18*, p. 4.

<sup>39</sup> Deloitte Access Economics, *Exhibit 18*, p. 75.

<sup>40</sup> Deloitte Access Economics, *Exhibit 18*, p. 60.

<sup>41</sup> Deloitte Access Economics, *Exhibit 18*, p. 75.

<sup>42</sup> Department of Health, *Submission 16*, p. 5.

Australian Department for Education and Child Development stated that 'hearing begins operation in the last trimester of pregnancy ... so, if you are born without hearing, you have already missed some period of development.'<sup>43</sup>

2.18 Cochlear Limited outlined four ways hearing loss can affect a child's development:

- 1 It causes delay in the development of receptive and expressive communication skills (speech and language).
- 2 The language deficit causes learning problems that result in reduced academic achievement.
- 3 Communication difficulties often lead to social isolation and poor self-concept.
- 4 It may have an impact on vocational choices.<sup>44</sup>

2.19 The Shepherd Centre highlighted that while children with bilateral hearing loss have 'the most profound deficits in speech, language, literacy and social inclusion', children with unilateral hearing loss 'also suffer significant impacts.'<sup>45</sup> Hear for You expressed similar sentiments, stating that '30 [to] 40 per cent of students with mild or unilateral hearing losses experience difficulty with one or more of: speech production, speech and language proficiency, [and] psychosocial outcomes.'<sup>46</sup>

2.20 Australian Hearing also advised that 'approximately one quarter of children with permanent hearing loss have at least one other disability,' which can have a 'significant impact' on the progress of a child with hearing loss.<sup>47</sup>

2.21 The Shepherd Centre stated that risks to language, speech and academic development can be minimised if a child with hearing loss is:

1. accurately diagnosed;
2. effectively fitted with appropriate assistive hearing devices (hearing aids, cochlear implants, etc; depending if spoken language communication is selected by the parents); and

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<sup>43</sup> Mr Quenten Iskov, Senior Advisor, Disability Policy and Programs, Department for Education and Child Development, *Official Committee Hansard*, Adelaide, 3 May 2017, p. 21.

<sup>44</sup> Cochlear Limited, *Submission 91*, p. 12.

<sup>45</sup> Shepherd Centre, *Submission 19*, p. 5.

<sup>46</sup> Hear for You, *Submission 64*, p. 3.

<sup>47</sup> Australian Hearing, *Submission 58*, p. 2.

3. enrolled in a specialist early intervention service.<sup>48</sup>

2.22 The Shepherd Centre added that these steps must be ‘rapidly completed, without loss to follow up between them, to ensure each child has a reasonable opportunity to achieve successful outcomes.’<sup>49</sup>

## Links to Other Health Conditions

2.23 Hearing loss was identified as being related to a range of cognitive and physical health conditions, particularly in older Australians.<sup>50</sup> Australian Hearing stated that ‘untreated age-related hearing loss can not only link to brain shrinkage but also increase the likelihood of cognitive decline, dementia, falls and social isolation.’<sup>51</sup>

2.24 The Hearing Care Industry Association added that hearing loss is associated with an ‘increased risk of heart disease, other cardiovascular diseases including peripheral arterial disease ... depression, other psychiatric disorders, poorer social relations, higher sickness impact profiles and reduced quality of life’.<sup>52</sup>

2.25 The Australian Society of Rehabilitation Counsellors stated that people with impaired hearing:

- use [general practitioners] up to three times more often than other members of the community;
- are three times more likely to consume prescription medicines;
- are 1.5 times more likely to [have been] hospitalised in the last 12 months; and
- are four times more likely to require home support services.<sup>53</sup>

2.26 Dr Elaine Saunders advised that there is ‘strong evidence that hearing loss decreases [the] ability to self-manage chronic conditions, seek effective treatment, or be reached by public health campaigns.’<sup>54</sup>

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<sup>48</sup> Shepherd Centre, *Exhibit 1: Appearance at the House Standing Committee on Health, Aged Care and Sport Inquiry into the Hearing Health and Wellbeing of Australia*, p. 3.

<sup>49</sup> Shepherd Centre, *Exhibit 1*, p. 3.

<sup>50</sup> Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS), *Submission 24*, p. 2.

<sup>51</sup> Australian Hearing, *Submission 58*, p. 14.

<sup>52</sup> Hearing Care Industry Association (HCIA), *Submission 30*, p. 3.

<sup>53</sup> Australian Society of Rehabilitation Counsellors, *Submission 23*, p. 8.

<sup>54</sup> Dr Elaine Saunders, *Submission 53*, p. 3.

2.27 As well as being related to other health conditions, high rates of hearing loss in older Australians can make interactions with the medical system difficult.<sup>55</sup> Better Hearing Australia advised that due to older Australians making up the majority of hospital admissions:

... almost four in every ten hospital admissions will have some form of hearing loss — more than double the prevalence in the general population. This all too often causes communication difficulties between a patient and the hospital medical and nursing staff, to the patient's disadvantage.<sup>56</sup>

## Stigma and Social Impact of Hearing Impairment

2.28 The Department of Health outlined the social and psychological effects of hearing loss as including 'isolation, depression, anxiety, paranoia, stress, loss of concentration, frustration, irritation, perceived inferiority, and anger.'<sup>57</sup> The department added that 'hearing impairment will affect a person differently depending on when the hearing loss occurred and the severity of the hearing loss.'<sup>58</sup>

2.29 The Telethon Kids Institute outlined social difficulties faced by children and young people with hearing loss and stated:

Peer stigmatisation is common among children and adolescents with hearing loss, particularly children who use assistive devices such as hearing aids and cochlear implants.<sup>59</sup>

2.30 Hear for You stated that there is evidence that over 40 per cent of deaf adolescents experience mental health problems.<sup>60</sup> In addition, deaf adolescents may experience isolation and social stigma due to their hearing impairment.<sup>61</sup> In a survey of its deaf and hearing impaired teenage membership base, Hear for You found that prior to seeking support, many

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<sup>55</sup> Better Hearing Australia, *Submission 83*, p. 5.

<sup>56</sup> Better Hearing Australia, *Submission 83*, p. 5.

<sup>57</sup> Department of Health, *Submission 16*, p. 5.

<sup>58</sup> Department of Health, *Submission 16*, p. 5.

<sup>59</sup> Telethon Kids Institute, *Submission 44*, p. 9.

<sup>60</sup> Hear for You, *Submission 64*, p. 3.

<sup>61</sup> Mrs Olivia Andersen, Founder and Director, Hear for You, *Official Committee Hansard*, Sydney, 6 April 2017, p. 60.

of the teenagers felt ‘embarrassed, angry, frustrated, sad, lonely, shy, withdrawn and weird.’<sup>62</sup>

2.31 A Year 10 student, Olivia Barnes, described her experience of starting high school as a deaf teenager before she sought support from Hear for You:

I struggled with the pace, rushing from class to class, and trying to hear was exhausting. Trying to keep up with conversations at recess and lunchtime was almost impossible. I fell behind socially. I was not being included. I was not getting any invitations to social events. It was very hard.<sup>63</sup>

2.32 William Demant Holding stated that ‘unlike spectacles or dental devices, hearing devices are still judged negatively by many in the community.’<sup>64</sup>

2.33 Australian Hearing stated that as well as having an impact on the affected individual, hearing loss can impact on the individual’s family. This is known as a ‘third party disability’.<sup>65</sup>

2.34 A report by Better Hearing Australia and the Institute of Governance and Policy Analysis at the University of Canberra outlined that impacts on partners and carers of people with hearing loss can include ‘reduced self-esteem, a loss of intimacy, stress and tiredness due to communication-based conflicts and a reduced social life because their partner does not wish to socialise.’<sup>66</sup>

### Box 2.1 Experiences of Hearing Impairment

A number of submissions from people with hearing impairment described the impact of their hearing loss on their everyday lives:

- ‘I’ve stopped going to public spoken-word occasions such as drama and talks and many community events because I too often can’t hear the speakers. I often can’t hear when I try to listen to podcasts or YouTube videos online. I want to be able to participate in and contribute to community organisations. I do not feel confident that I would any longer

<sup>62</sup> Hear for You, *Submission 64*, p. 4.

<sup>63</sup> Miss Olivia Barnes, Mentee, Hear for You Mentorship Program, Hear for You, *Official Committee Hansard*, Sydney, 6 April 2017, p. 61

<sup>64</sup> William Demant Holding, *Submission 52*, p. 6.

<sup>65</sup> Australian Hearing, *Submission 58*, p. 3.

<sup>66</sup> Better Hearing Australia, *Exhibit 11: A Fairer Hearing – Enhancing the Social Inclusion of People with Hearing Loss*, p. 11.

be able to take on voluntary or paid work.<sup>67</sup>

- 'I find it distressing that I am often treated as being 'daft' when I am just deaf.'<sup>68</sup>
- 'I am at a point where my hearing loss is affecting my work life and my personal relationships so I plan to purchase a hearing aid for my affected ear. There is still a social stigma associated with hearing aids, however, so I plan to purchase one that will be largely invisible to others. This, of course, is a more expensive option but important to my self-confidence.'<sup>69</sup>
- 'I had lots of instances when I was in meetings and I gave the wrong answer to a question because I misheard, and I sometimes felt that people thought I was a little bit mentally deficient because of that.'<sup>70</sup>
- 'In my experience, hearing loss still cannot be openly discussed amongst the corporate and social communities and many people still refuse to wear hearing aids because of the stigma attached.'<sup>71</sup>
- 'As a young teenager in secondary school, he [my son] began to feel conscious of wearing the hearing aids in term of his appearance. He wanted to feel what he perceived as being "normal" and he subsequently refused to continue to wear the hearing aids. I observed that without the hearing aids, he could not hear conversations properly.'<sup>72</sup>
- 'I know of many older men who have worked in the building industry (my husband is a plumber) who by 60 years old are not yet able to retire but have such poor hearing and often other associated mental health issues that they cannot effectively work.'<sup>73</sup>

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<sup>67</sup> Mr Anthony Ferguson, *Submission 9*, p. 1.

<sup>68</sup> Name Withheld, *Submission 11*, p. 2.

<sup>69</sup> Ms Bronwyn Fletcher, *Submission 95*, p. 4.

<sup>70</sup> Mrs Christine Hunter, President, Self Help for Hard of Hearing People (Australia), *Official Committee Hansard*, Canberra, 16 June 2017, p. 33.

<sup>71</sup> Mr Andrew Swindell, *Submission 101*, p. 1.

<sup>72</sup> Name Withheld, *Submission 2*, pp 1-2.

<sup>73</sup> Ms Erica Smith, *Submission 26*, p. 1.

# Balance Disorders and Other Ear Health Issues in Australia

## Types and Causes

- 2.35 The Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) described most balance disorders as being:
- ... chronic medical conditions that derive from dysfunction of the balance (“vestibular”) organs within the inner ear, central (brain) vestibular processing or the integration of information across the senses of vision, balance and body position.<sup>74</sup>
- 2.36 The Whirled Foundation stated that ‘chronic ear and balance disorders are common, however, the causes often remain unexplained.’<sup>75</sup> The ASOHNS listed conditions that cause balance disorders as including ‘benign paroxysmal positional vertigo (BPPV), Meniere’s disease, vestibular migraine, drug injury to the inner ear (ototoxicity) or infection, or sudden loss of function of the inner ear (labyrinthitis or vestibular neuronitis)’. The ASOHNS added that imbalance could also be a symptom of a stroke or heart problems.<sup>76</sup>
- 2.37 Meniere’s disease is a condition of the inner ear with symptoms including fluctuating hearing loss, a ringing and/or feeling of fullness in the ears, dizziness and balance problems.<sup>77</sup> While the cause of Meniere’s disease is unknown, the Deafness Forum of Australia (Deafness Forum) advised that the build-up of excess fluid in the inner ear plays an important part in creating the symptoms.<sup>78</sup>
- 2.38 Tinnitus is a ‘hearing condition where people hear noises that have no external source’, and is often described as a ‘ringing in the ears’.<sup>79</sup> The Deafness Forum stated tinnitus could be caused by sudden or prolonged exposure to loud sounds, as well as underlying hearing conditions such as Meniere’s disease, hyperacusis or hearing injuries. Further, the Deafness

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<sup>74</sup> ASOHNS, *Submission 24, Attachment A*, p. 2.

<sup>75</sup> Whirled Foundation, *Submission 77*, p. 15.

<sup>76</sup> ASOHNS, *Submission 24, Attachment A*, p. 2.

<sup>77</sup> Deafness Forum of Australia, *Submission 17*, p. 12.

<sup>78</sup> Deafness Forum of Australia, *Submission 17*, p. 12.

<sup>79</sup> Deafness Forum of Australia, *Submission 17*, p. 11.

Forum stated tinnitus has been linked to certain medications and medical conditions including high blood pressure and diabetes.<sup>80</sup>

## **Prevalence of Balance Disorders and Other Ear Health Issues**

2.39 Dr Daniel Brown stated that:

... as our population is ageing both hearing and balance disorders and the social and financial costs of those disorders is increasing. Particularly with balance disorders, the incidence increases quite significantly with age.<sup>81</sup>

2.40 The ASOHNS similarly stated that 'self-reported prevalence of dizziness and vertigo exceeds 36 per cent in Australians over the age of 50 years.'<sup>82</sup> The Whirled Foundation advised that Meniere's disease affects one in 600 Australians.<sup>83</sup>

2.41 The Bionics Institute of Australia stated that tinnitus affects 'approximately 18 per cent of Australians at some point in life', and that 'one to three per cent of people suffer from debilitating and chronic tinnitus.'<sup>84</sup> The Bionics Institute also advised that:

The prevalence of tinnitus is particularly high in people returning from military service, and is much higher in people with severe to profound hearing loss. Of growing concern is the overexposure of young people to recreational sounds, considered a key driver of hearing loss and tinnitus.<sup>85</sup>

2.42 The Whirled Foundation stated that 'the exact number of Australians affected by vestibular disorders is not known as the conditions are under-diagnosed and under-reported' and that there is a lack of research into the prevalence of these disorders in Australia.<sup>86</sup> The Whirled Foundation recommended the Government fund research into the prevalence and incidence of these disorders in Australia.<sup>87</sup>

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<sup>80</sup> Deafness Forum of Australia, *Submission 17*, p. 11

<sup>81</sup> Dr Daniel Brown, Senior Research Fellow, Sydney Medical School, University of Sydney, *Official Committee Hansard*, Sydney, 6 April 2017, p. 1.

<sup>82</sup> ASOHNS, *Submission 24, Attachment A*, p. 2.

<sup>83</sup> Whirled Foundation, *Submission 77*, p. 19.

<sup>84</sup> Bionics Institute of Australia, *Submission 27*, p. 3.

<sup>85</sup> Bionics Institute of Australia, *Submission 27*, p. 3

<sup>86</sup> Whirled Foundation, *Submission 77*, pp 18-19.

<sup>87</sup> Whirled Foundation, *Submission 77*, p. 18.

## Economic Cost of Balance Disorders and Other Ear Health Issues

- 2.43 Neurosensory advised that there has been ‘very little research and analysis of the economic impact of balance disorders in Australia’.<sup>88</sup> Despite this, Neurosensory stated that ‘the most likely outcome for untreated dizziness is a fall, and preventing falls could potentially have a very positive outcome on Australia's economy.’<sup>89</sup> Dr Daniel Brown estimated that the national cost of emergency department patients presenting with dizziness exceeds \$148 million annually.<sup>90</sup>

## Impact of Balance Disorders and Other Ear Health Issues

- 2.44 Neurosensory outlined the impact that dizziness and balance disorders could have on the lives of working aged people and stated:

... 27 per cent of patients with dizziness or balance disorders had to change jobs because of their balance problems, and a further 21 per cent gave up work entirely. 57 per cent of these patients also reported disruptions to their social lives, due to an inability to take part in outdoor activities and travel.<sup>91</sup>

- 2.45 Mr Stephen Spring described the impact Meniere's disease can have on a person's life, which can range from being a ‘minor nuisance’ to ‘completely devastating’ depending on the severity and stated:

Not only do you lose all your sense of who you are because you cannot communicate with the world; you lose your orientation because you cannot stand up. Having chronic imbalance means that you cannot walk on sand or drive a car. It means that you are too frightened to go down the street to pick up your groceries because, if you have a Meniere's attack whilst you are there, you are going to be on the ground, prostrate and throwing up. That is the kind of thing that people end up living with.<sup>92</sup>

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<sup>88</sup> Ms Shaunine (Nina) Quinn, Chief Executive Officer, Neurosensory, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 8.

<sup>89</sup> Ms Shaunine (Nina) Quinn, Neurosensory, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 8.

<sup>90</sup> Dr Daniel Brown, *Submission 100*, p. 2.

<sup>91</sup> Neurosensory, *Submission 63*, p. 4.

<sup>92</sup> Mr Stephen Spring, Private Capacity, *Official Committee Hansard*, Sydney, 6 April 2017, p. 57.

# Current Provision of Hearing Services and Treatment

## Universal Newborn Hearing Screening

- 2.46 All states and territories provide newborn hearing screening programs, under which all babies are screened for hearing loss at birth, at no cost to families.<sup>93</sup> Babies identified as being hearing impaired are referred to a diagnostic service within the hospital.<sup>94</sup> If a permanent hearing loss is diagnosed, a newborn is referred to Australian Hearing and/or the cochlear implant service.<sup>95</sup>
- 2.47 According to the Australasian Newborn Hearing Screening Committee (ANHSC) this early screening and referral pathway to services makes Australia a 'world leader in delivery of services for children with hearing loss.'<sup>96</sup> Australian Hearing stated that due to this 'very fast' process, 'a baby can be fitted with hearing aids within the first six weeks of life if diagnostic results are confirmed and the family agrees to proceed.'<sup>97</sup>
- 2.48 The ANHSC also advised that despite the universality of the screening programs, 'a lack of available data' means it can only state with certainty that 'more than 95 per cent of all children born in Australia are now screened for hearing loss at birth.'<sup>98</sup> The ANHSC suggested that babies who are missing out on screening are likely to: be from remote locations; be born outside the hospital system; have families which decline to participate in screening; or have families with a first language other than English.<sup>99</sup>
- 2.49 Australian Hearing advised that Aboriginal and Torres Strait Islander babies are screened and referred at the same rate as non-Aboriginal and Torres Strait Islander babies. The proportion of Aboriginal and Torres Strait Islander babies who go on to be fitted with hearing aids within the first year

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<sup>93</sup> Australian Hearing, *Submission 58*, p. 7.

<sup>94</sup> Ms Alison King, Principal Audiologist, Paediatric Services, Australian Hearing, *Official Committee Hansard*, Canberra, 3 March 2017, p. 13.

<sup>95</sup> Department of Health, *Submission 16*, p. 6.

<sup>96</sup> Professor Gregory Leigh, Chair, Australasian Newborn Hearing Screening Committee (ANHSC), *Official Committee Hansard*, Sydney, 6 April 2017, p. 5.

<sup>97</sup> Australian Hearing, *Submission 58*, p. 7.

<sup>98</sup> Professor Gregory Leigh, Chair, ANHSC, *Official Committee Hansard*, Sydney, 6 April 2017, p. 5.

<sup>99</sup> Dr Zeffie Poulakis, Secretary, ANHSC, *Official Committee Hansard*, Sydney, 6 April 2017, p. 6.

of life, however, is 'significantly lower'.<sup>100</sup> As a consequence, Australian Hearing stated that 'there is a need to develop an understanding of where and why families depart from the pathway and implementation strategies to address this.'<sup>101</sup>

## Early Intervention Programs

- 2.50 After referral to Australian Hearing, children with hearing loss receive audiological assessment and, if necessary, are fitted with a hearing device. If a child is found to have profound hearing loss, they may be referred to an Ear, Nose and Throat (ENT) surgeon for a cochlear implant.<sup>102</sup> Families are then directed to an online resource outlining options including early intervention services.<sup>103</sup>
- 2.51 Using this online resource, families may choose to engage a specialist provider of early intervention services for their child. According to the Shepherd Centre, the percentage of children with hearing loss accessing these services ranges from 'less than 50 per cent up to 90 per cent depending on the state or territory.'<sup>104</sup>
- 2.52 Early intervention hearing services are provided by a range of groups, including charities, non-government organisations and governments. For example, the Shepherd Centre provides early intervention services in New South Wales, the Australian Capital Territory and Tasmania, and receives a third of its funding from government grants<sup>105</sup>, with the remaining two thirds sourced through fundraising and donations.<sup>106</sup> Government provided services include an early intervention service for children from birth to school entry offered by the South Australian Department for Education and Child Development.<sup>107</sup>

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<sup>100</sup> Australian Hearing, *Submission 58*, p. 15.

<sup>101</sup> Australian Hearing, *Submission 58*, p. 15.

<sup>102</sup> Ms Alison King, Australian Hearing, *Official Committee Hansard*, Canberra, 3 March 2017, p. 14.

<sup>103</sup> Shepherd Centre, *Submission 19*, p. 7.

<sup>104</sup> Shepherd Centre, *Submission 19*, pp. 7-8.

<sup>105</sup> Dr Jim Hungerford, Chief Executive Officer, the Shepherd Centre, *Official Committee Hansard*, Sydney, 15 November 2016, p. 3.

<sup>106</sup> The Shepherd Centre, 'About Us', <http://shepherdcentre.org.au/about-us/>, Accessed 21 July 2017.

<sup>107</sup> Mr Quenten Iskov, Senior Adviser, Sensory, Disability Policy and Programs, Department for Education and Child Development, *Official Committee Hansard*, Adelaide, 3 May 2017, p. 22.

- 2.53 Early intervention services are usually provided by multidisciplinary teams of specialists including:
- ... certified auditory-verbal therapists, teachers of the deaf, speech pathologists, paediatric audiologists, psychologists, child and family counsellors, social workers, occupational therapists, specialist kindergarten professionals, and youth workers.<sup>108</sup>
- 2.54 For children with cochlear implants, a ‘cochlear implant program’ may be used in conjunction with the early intervention services. First Voice advised that this would include input from ‘cochlear implant surgeons, paediatricians, and other medical and health personnel.’<sup>109</sup>
- 2.55 The Australian Hearing Hub at Macquarie University commented that:
- ... Australia’s capacity for early intervention and sustained follow-up to ameliorate the effects of hearing loss in infancy is outstanding, both in terms of attrition (i.e. loss to follow up...) and in terms of easily accessible and identifiable pathways to secure hearing technology and assistive devices for children (e.g. through Australian Hearing Services, or providers of cochlear implant technologies and education services such as the Royal Institute for Deaf and Blind Children).<sup>110</sup>

## Hearing Services Program

- 2.56 The Office of Hearing Services administered Australian Government Hearing Services Program ‘provides access to subsidised hearing services and devices for eligible people, and supports research that assists with reducing the incidence and consequences of hearing loss in the community.’<sup>111</sup>
- 2.57 Hearing Services Program components include: the Community Service Obligations (CSO), a Voucher Scheme, and the funding of research. The Department of Health advised that for 2016-17, it expects Australian Government expenditure in the Hearing Services Program to be \$564.5 million.<sup>112</sup>

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<sup>108</sup> First Voice, *Submission 28*, p. 8.

<sup>109</sup> First Voice, *Submission 28*, p. 8.

<sup>110</sup> Australian Hearing Hub, *Submission 60, Attachment A*, p. 4.

<sup>111</sup> Department of Health, *Submission 16*, p. 12.

<sup>112</sup> Department of Health, *Submission 16*, p. 10.

## *Community Service Obligations Program*

2.58 Hearing services are provided to at-risk groups through the CSO component of the Australian Government's Hearing Services Program. These groups include:

- hearing impaired children and young adults aged 0 to 26;<sup>113</sup>
- adults who are eligible for the Voucher Scheme and have 'complex hearing or communication needs or live in remote areas';<sup>114</sup> and
- Aboriginal and Torres Strait Islanders with hearing impairment over the age of 50 or who are participating in an eligible government program.<sup>115</sup>

2.59 Australian Hearing is the sole provider of CSO services. Australian Hearing stated that:

The block funding of service provision, via the CSO, to children and adults with complex communication needs allows for the benefits of economies of scale for the purchase of devices as well as improved outcomes from maximising the training of staff, and the creation and maintenance of the expertise gained from servicing a high volume of clients with specialised needs.<sup>116</sup>

2.60 In 2015-16, Australian Government expenditure on the CSO program was \$65.3 million.<sup>117</sup> The Department of Health advised that in this year:

- 29 850 children or young adults under 21 received 67 864 services;
- 3628 young adults aged between 21-26 received 7736 services;
- 23 344 adults with specialised needs received 53 771 services;
- 4300 Indigenous people received 8256 services; and
- 578 cochlear implant speech processors were funded through the speech processor upgrade program.<sup>118</sup>

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<sup>113</sup> Department of Health, *Submission 16*, p. 14.

<sup>114</sup> Australian Hearing, *Submission 58*, p. 25.

<sup>115</sup> Eligible programs include: the Community Development Programme and the Community Development Employment Programme. Australian Hearing, *Submission 58*, p. 25.

<sup>116</sup> Australian Hearing, *Submission 58*, p. 9.

<sup>117</sup> Department of Health, *Submission 16*, p. 14.

<sup>118</sup> Department of Health, *Submission 16*, p. 15.

## *Voucher Scheme*

- 2.61 The Australian Government's Hearing Services Program includes a Voucher Scheme, which provides eligible adults with access to hearing services and devices from Australian Hearing and private providers. Pensioner Concession Card holders make up 85.7 per cent of Voucher Scheme clients.<sup>119</sup>
- 2.62 The Voucher Scheme subsidises services including hearing assessments and the fitting and ongoing maintenance of hearing devices. Fully subsidised hearing aids are available under the Voucher Scheme, and all hearing service providers must discuss the fully subsidised option with their clients.<sup>120</sup> A client can also choose to purchase a more expensive device with additional features (a 'top-up') and will pay the differential between this model and the voucher value from their own pocket.<sup>121</sup>
- 2.63 In 2015-16, Australian Government expenditure on the Voucher Scheme was \$406.3 million.<sup>122</sup> The Department of Health advised that in this year, 1.2 million services were delivered to nearly 700 000 Voucher Scheme clients.<sup>123</sup>

## **Programs for Aboriginal and Torres Strait Islanders and Other At-Risk Populations**

- 2.64 From 2013-14 to 2018-19 the Australia Government's Indigenous Australians' Health Program includes \$39.5 million for 'targeted ear health activities.'<sup>124</sup> These activities comprise:
- \$31.3 million over five years for clinical ear health services through the Healthy Ears – Better Hearing, Better Listening Program.<sup>125</sup> This Program 'improves access to ear and hearing health services [for Aboriginal and Torres Strait Islander children and youth aged up to 21] on an outreach

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<sup>119</sup> Department of Health, *Submission 16*, p. 13.

<sup>120</sup> Ms Emma Scanlan, Principal Audiologist, Adults, Australian Hearing, *Official Committee Hansard*, Canberra, 3 March 2017, p. 18.

<sup>121</sup> Dr Harvey Dillon, Director, National Acoustic Laboratories, *Official Committee Hansard*, Canberra, 3 March 2017, p. 18.

<sup>122</sup> Department of Health, *Submission 16*, p. 9.

<sup>123</sup> Department of Health, *Submission 16*, p. 13.

<sup>124</sup> Department of Health, *Submission 16.3*, p. 1.

<sup>125</sup> Department of Health, *Submission 16.3*, p. 1.

basis, with a focus on rural and remote locations nationally.<sup>126</sup> In 2015-16, 42 357 patients accessed care under this program.<sup>127</sup>

- \$1.9 million over three years to expedite access to ear surgery for Aboriginal and Torres Strait Islander children, particularly in rural and remote locations, through the Eye and Ear Surgical Support initiative.<sup>128</sup>
- \$2.6 million over five years for workforce training in ear and hearing assessment for Aboriginal health workers, general practitioners and nurses, including those in remote locations.<sup>129</sup>
- \$2.1 million over three years for ear health coordinators around Australia, who assist in streamlining referrals to services.<sup>130</sup>
- \$1.4 million over two years for the provision of ear and hearing health equipment at Australian Government funded Aboriginal and Community Controlled Health Services and health clinics.<sup>131</sup>
- Clinical guidelines to assist practitioners in the management of otitis media, which were ‘comprehensively revised’ in 2010.
- \$150 000 over two years for promotional ear health resources for children, women’s groups, teachers and other carers as part of the ‘Care for Kids’ Ears’ campaign.<sup>132</sup>

2.65 From 2012-13 to 2021-22 the Australian Government is providing \$33.4 million for ear health services in the Northern Territory, under the National Partnership on Northern Territory Remote Aboriginal Investment.<sup>133</sup>

2.66 The Northern Territory Department of Health advised that its ‘Healthy Under Five Kids’ program is an ‘integral component’ of the Northern Territory Hearing Health System.’ The program includes: ear examinations, developmental milestone checks for hearing and communication, and key prevention and health promotion messages. According to the Northern Territory Department of Health, the program serves as a ‘universal entry

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<sup>126</sup> This excludes Tasmania which declined to participate. Department of Health, *Submission 16*, p. 8.

<sup>127</sup> Department of Health, *Submission 16.3*, p. 1.

<sup>128</sup> Department of Health, *Submission 16.3*, p. 2.

<sup>129</sup> Department of Health, *Submission 16.3*, p. 2.

<sup>130</sup> Department of Health, *Submission 16.3*, p. 2.

<sup>131</sup> Department of Health, *Submission 16.3*, p. 2.

<sup>132</sup> Department of Health, *Submission 16.3*, p. 2.

<sup>133</sup> Department of Health, *Submission 16*, p. 8.

point for care planning ... and supports early identification and intervention'.<sup>134</sup>

- 2.67 Teleotology has been implemented in the Northern Territory to ensure remote communities have access to ENT services.<sup>135</sup> Teleotology involves nurses taking video or images of ear concerns and forwarding them to an ENT surgeon to review, diagnose and provide management recommendations.<sup>136</sup>
- 2.68 The Queensland Government has implemented the 'Deadly Kids, Deadly Futures' framework to address middle-ear disease and associated hearing loss in Aboriginal and Torres Strait Islander children across Queensland.<sup>137</sup> The framework provides a 'coordinated and effective response across the health, early childhood and education sectors.'<sup>138</sup> Implementation and development of the framework is led by the Deadly Ears Program, which also delivers 'outreach services and local capacity building to eleven locations around the state'.<sup>139</sup>
- 2.69 In Western Australia, the 'Earbus' service travels to remote communities to deliver ear screening and primary health care to Aboriginal and Torres Strait Islander children in schools, day care, kindergartens and playgroups.<sup>140</sup> The team that travels to the communities includes audiologists and primary health practitioners. Periodically, an ENT surgeon also attends visits.<sup>141</sup>

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<sup>134</sup> Northern Territory Department of Health, *Submission 93*, p. 11.

<sup>135</sup> Northern Territory Department of Health, *Submission 93*, p. 12.

<sup>136</sup> Mrs Maggie Allen, Audiologist, Deadly Ears Program, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 22.

<sup>137</sup> Mr Matthew Brown, Director, Deadly Ears Program, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 18.

<sup>138</sup> Mr Matthew Brown, Deadly Ears Program, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 18.

<sup>139</sup> Mr Matthew Brown, Deadly Ears Program, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 18.

<sup>140</sup> Western Australian Council of State School Organisations Inc, *Submission 55*, p. 6.

<sup>141</sup> National Rural Health Alliance, *Submission 13*, p. 5.

## *Veterans*

2.70 Veterans are entitled to hearing support services through the Hearing Services Program and, in addition, a number of additional support services. The Department of Veterans' Affairs advised that eligible veterans receive the following services at no cost:

- Hearing aids through the Hearing Services Program;
- An Assistive Listening Device from the [Rehabilitation Appliances Program];
- Maintenance of these devices;
- Access to medical and allied health specialists;
- Education and training; and
- Rehabilitation programs.<sup>142</sup>

2.71 The Rehabilitation Appliances Program (RAP) provides eligible veterans with devices to manage their hearing loss such as devices to assist with using the telephone or television, specialised alarms and response systems, microphone/FM listening systems, and tinnitus maskers and inhibitors.<sup>143</sup>

2.72 In 2015-16 approximately \$70 million was 'spent addressing the hearing needs of veterans and their dependents, including \$17.95 million on aids and appliances through the RAP and a further \$50 million through the [Hearing Services Program].<sup>144</sup>

## **Auslan Interpretation and Other Communication Support**

2.73 Deaf Australia advised that the Australian Government funds three Auslan services:<sup>145</sup>

- the **National Auslan Interpreter Booking and Payment Service** (NABS), which provides interpreters for medical appointments at no charge.<sup>146</sup>
- the **National Relay Service**, which is a telephone service for deaf and hearing impaired people using typing and reading, or video relay for

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<sup>142</sup> Department of Veterans' Affairs, *Submission 90*, p. 4.

<sup>143</sup> Department of Veterans' Affairs, *Submission 90*, pp. 6, 21.

<sup>144</sup> Department of Veterans' Affairs, *Submission 90*, p. 1.

<sup>145</sup> Deaf Australia, *Submission 82*, p. 17.

<sup>146</sup> The Deafness Forum of Australia, *Submission 17*, p. 17.

Auslan users.<sup>147</sup> The Conexu Foundation described this service as ‘a wonderful thing’ that is ‘used significantly’<sup>148</sup>. The Conexu Foundation, however, stated that while the typing and reading version of the phone service is available 24 hours a day, seven days a week, the video relay service for Auslan users is only ‘open from 7am to 6pm Monday to Friday’.<sup>149</sup>

- **Job Access**, which offers financial assistance through the Employment Assistance Fund for Auslan interpreting in the workplace and in job interviews, deafness awareness training and workplace adjustments and equipment.<sup>150</sup>

2.74 Deaf Australia stated that these services all require prior knowledge of Auslan,<sup>151</sup> and there is no government assistance for families to learn Auslan.<sup>152</sup> The National Disability Insurance Agency advised that ‘Auslan lessons may be considered “reasonable and necessary” in a [National Disability Insurance Scheme] plan’<sup>153</sup> and Auslan lessons for parents may also be included in the associated reference packages.<sup>154</sup>

## Support for Balance Disorders and Other Ear Health Issues

2.75 William Demant Holding stated that due to the multiple causes of balance disorders, ‘difficulty lies with determining who looks after the patient within the health care system, whether it be audiologists, ENT [surgeons], neurologists, physiotherapists or psychologists.’<sup>155</sup> The ASOHNS added that

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<sup>147</sup> National Relay Service, ‘Features of the Service’, <http://relayservice.gov.au/about/features-of-the-service/>, Accessed 21 July 2017.

<sup>148</sup> Dr Phillip Harper, Community Liaison Manager, Conexu Foundation, *Official Committee Hansard*, 21 April 2017, p. 42.

<sup>149</sup> Conexu Foundation, *Supplementary Submission 21.1*, p. 2.

<sup>150</sup> Job Access, ‘Employment Assistance Fund (EAF)’, <https://www.jobaccess.gov.au/employment-assistance-fund-eaf>, Accessed 21 July 2017.

<sup>151</sup> Deaf Australia, *Submission 82*, p. 17.

<sup>152</sup> Deaf Australia, *Submission 82*, p. 21.

<sup>153</sup> National Disability Insurance Agency, *Submission 45.1*, p. 2.

<sup>154</sup> Ms Anne Skordis, Expert Adviser, Mainstream Interface and Government Relations, National Disability Insurance Agency, *Official Committee Hansard*, Canberra, 16 June 2017, p. 13.

<sup>155</sup> William Demant Holding, *Submission 52*, p. 20.

‘there are few centres that bring together the multidisciplinary teams required to provide best-practice management plans.’<sup>156</sup>

- 2.76 The Whirled Foundation advised that ‘due to the lack of awareness and information on vestibular disorders in Australia, many Australians diagnosed with a vestibular disorder find that a correct diagnosis can take years, even decades, to achieve.’<sup>157</sup> The Whirled Foundation also stated that while there are a number of tests that can diagnose vestibular disorders, many ‘are expensive with minimal or no coverage by Medicare.’<sup>158</sup>
- 2.77 The Whirled Foundation stated that vestibular rehabilitation therapy is effective in treating vestibular dysfunction, while cognitive behavioural therapy has been ‘helpful to sufferers in coping with anxiety related symptoms (such as panic attacks and agoraphobia) and chronic disease management.’<sup>159</sup>
- 2.78 Some balance disorders respond to medication. Some of these medications, however, do not attract a Pharmaceutical Benefits Scheme (PBS) subsidy and the cost can ‘be a burden on those with balance disorders.’<sup>160</sup> The Whirled Foundation recommended certain medications be added to the PBS to treat symptoms of Meniere’s disease.<sup>161</sup>
- 2.79 The ASOHNS stated that ‘emotional and social support for balance disorder sufferers is often difficult to access’ and that ‘peer support groups are well placed to provide this.’<sup>162</sup>
- 2.80 Better Hearing Australia advised that ‘more than two million Australians currently suffer from tinnitus yet there is no strategy or support system in place to deliver effective intervention or even provide information and advice.’<sup>163</sup> Better Hearing Australia recommended the creation of a national community awareness campaign on tinnitus.<sup>164</sup>

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<sup>156</sup> ASOHNS, *Submission 24, Attachment A*, p. 2.

<sup>157</sup> Whirled Foundation, *Submission 77*, p. 20.

<sup>158</sup> Whirled Foundation, *Submission 77*, p. 21.

<sup>159</sup> Whirled Foundation, *Submission 77*, p. 21.

<sup>160</sup> ASOHNS, *Submission 24, Attachment A*, p. 3.

<sup>161</sup> Whirled Foundation, *Submission 77*, p. 22.

<sup>162</sup> ASOHNS, *Submission 24, Attachment A*, p. 4.

<sup>163</sup> Better Hearing Australia, *Submission 83*, p. 8.

<sup>164</sup> Better Hearing Australia, *Submission 83*, p. 8.

## Concluding Comment

### *Prevalence and Cost of Hearing Impairment*

- 2.81 Deafness and hearing impairment are significant public health issues, affecting 3.6 million Australians in 2017. As Australia's population ages, the prevalence of hearing impairment is expected to increase considerably. It has been estimated that by 2060, approximately 7.8 million Australians will have a hearing impairment.
- 2.82 The Committee acknowledges and is concerned by the significant cost of hearing impairment to the Australian economy. In 2017, the estimated financial cost of hearing impairment was \$15.9 billion. The largest contributor to this cost is productivity loss (\$12.8 billion), as people with hearing impairment tend to have lower levels of employment. The cost of lost wellbeing due to hearing impairment was estimated to be \$17.4 billion. It is expected these costs will increase as the prevalence of hearing impairment rises over time.

### *Impacts of Hearing Impairment*

- 2.83 While the costs of hearing impairment to the economy and health system are significant, the impacts of hearing impairment are felt most profoundly at the individual level. Hearing loss can impact on personal relationships, mental health and educational and employment opportunities. The Committee is grateful to the individuals who provided submissions and personally described the impact their hearing loss has had on their everyday lives. The Committee also notes the important role of advocacy groups who support people with hearing loss. These groups provide hearing impaired individuals with advice and assistance to improve their quality of life and, perhaps most importantly, connect them with other individuals facing similar challenges.

### *Hearing Services for Children*

- 2.84 The Committee was pleased to receive evidence that the timely and universal provision of hearing services to newborns in Australia is among the best in the world. Universal newborn hearing screening programs and rapid referral to Australian Hearing ensures newborns diagnosed with a hearing impairment are provided with treatment within their first year of life, and are given the best opportunity to develop communication skills at the same rate as their hearing peers.

2.85 The Committee also acknowledges the importance of early intervention services in supporting the development of children with hearing impairments, and the need to ensure all children with hearing impairments have access to these services. While the early detection of hearing impairment and provision of hearing devices is paramount, communication and developmental support is needed to ensure children are getting the most out of their hearing devices. Early intervention services also help children develop their speech, language, literacy and social skills, and if successful can have a positive lifelong impact on their educational and employment opportunities.

### *Hearing Impairment and Cognitive Decline*

2.86 Hearing loss disproportionately affects older Australians, with three out of four Australians aged over 70 years being affected by hearing loss. The Committee was concerned to receive evidence of an association between hearing loss and other serious health issues such as cognitive decline, dementia and depression. Earlier detection and treatment of hearing loss in older Australians may slow the progression of cognitive decline and associated health impacts, and help prevent social isolation by enabling older Australians to better communicate and participate in social situations.

### *Balance Disorders and Other Ear Health Issues*

2.87 As well as deafness and hearing impairment, the Committee acknowledges that balance disorders are a related and significant health issue. Balance disorders and other ear health issues can have a debilitating impact on a person's life, and support and understanding can be difficult to come by. Further adding to this burden, the causes of some balance disorders such as Meniere's disease are complex and not well understood, meaning a person with this disease may have to see numerous health professionals before they receive the help they need.

### *Programs for At-Risk Groups*

2.88 The Committee acknowledges the range of programs and supports targeting hearing loss in Aboriginal and Torres Strait Islander communities and other at risk populations. The Committee further discusses hearing issues that impact these groups in Chapter 3.

# 3. Hearing Health in At-Risk Populations

## Overview

- 3.1 Otitis media (middle ear) infections are more prevalent in Aboriginal and Torres Strait Islander children than any other population in the world. Many Aboriginal and Torres Strait Islander children experience chronic or reoccurring otitis media infections that can result in permanent hearing loss. These infections can disrupt a child's language development and ability to benefit from education. This chapter describes: the prevalence, causes, and effects of otitis media; its links to disadvantage later in life; and possible public health measures to reduce the prevalence of otitis media in Aboriginal and Torres Strait Islander communities.
- 3.2 Specific groups within the Australian community are at greater risk of losing their hearing, or face additional challenges accessing treatment for hearing loss. This chapter also discusses the hearing health of these groups, focussing particularly on people from culturally and linguistically diverse backgrounds, people living in rural and regional areas, the aged population, and veterans and defence personnel.

## Aboriginal and Torres Strait Islander People

### Prevalence of Otitis Media and Hearing Loss

- 3.3 The Indigenous Affairs Group in the Department of the Prime Minister and Cabinet stated there is 'a higher proportion of Indigenous Australians

experiencing hearing problems than non-Indigenous Australians across most age groups and across remote, rural and metropolitan areas.<sup>1</sup>

- 3.4 Australian Hearing confirmed that while Aboriginal and Torres Strait Islanders were known to have higher rates of ear disease and hearing loss, a lack of quality data in this area meant that it is difficult to accurately estimate prevalence at a population level.<sup>2</sup>
- 3.5 The ‘predominant cause of hearing loss’ in Aboriginal and Torres Strait Islander children is the contraction of otitis media, or middle ear, infections.<sup>3</sup> Box 3.1 provides information on the types and pathology of otitis media.
- 3.6 Professor Amanda Leach and Professor Peter Morris stated that the prevalence of otitis media among Aboriginal and Torres Strait Islander children is thought to be the highest of any group in the world.<sup>4</sup> In 2013, 90 per cent of Aboriginal and Torres Strait Islander children in remote Northern Territory communities were found to have some form of otitis media.<sup>5</sup>
- 3.7 While not as prevalent as in remote communities, the rate of otitis media among Aboriginal and Torres Strait Islander children living in urban and rural settings is still estimated to be around 40 per cent with two per cent having perforated eardrums.<sup>6</sup>
- 3.8 Dr Damien Howard and Jody Barney stated that ‘it has been estimated that Aboriginal children in Australia experience otitis media throughout their childhood for an average of 2.5 years, while the average for children in the mainstream Australian community is three months.’<sup>7</sup>
- 3.9 The Deadly Ears Program highlighted that in Aboriginal and Torres Strait Islander children otitis media ‘is characterised by:

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<sup>1</sup> Mr Brendan Gibson, Assistant Secretary, Health Branch, Indigenous Affairs Group, Department of the Prime Minister and Cabinet, *Official Committee Hansard*, Canberra, 3 March 2017, p. 29.

<sup>2</sup> Australian Hearing, *Submission 58*, p. 15.

<sup>3</sup> Northern Territory Council of Government School Organisations (NT COGSO), *Submission 97*, p. 3.

<sup>4</sup> Professor Amanda Leach and Professor Peter Morris, Menzies School of Health Research, *Submission 108*, p. 4.

<sup>5</sup> Professor Amanda Leach and Professor Peter Morris, Menzies School of Health Research, *Submission 108*, p. 4.

<sup>6</sup> Professor Amanda Leach and Professor Peter Morris, Menzies School of Health Research, *Submission 108*, p. 6.

<sup>7</sup> Dr Damien Howard and Jody Barney, *Submission 98*, p. 2.

- **Earlier onset** – Aboriginal and Torres Strait Islander babies and infants acquire the disease at a younger age than children of other Australians
- **Higher frequency** – the disease occurs often and repeatedly
- **Greater severity** – more Aboriginal and Torres Strait Islander children experience the severest forms of the disease
- **Persistence** – the disease lasts for longer periods of time.<sup>8</sup>

### Box 3.1 Otitis Media

#### *Definition*

The term otitis media includes ‘all forms of inflammation and infection of the middle ear.’ Otitis media is ‘nearly always associated with middle ear effusion (fluid in the middle ear space)’.<sup>9</sup>

The common types of otitis media include:<sup>10</sup>

- Acute otitis media (AOM): fluid behind the eardrum resulting in symptoms such as: a bulging or red eardrum, pain and fever, that last less than six weeks.
- Chronic suppurative otitis media (CSOM) with discharge: a persistent discharge through a hole in the eardrum lasting for more than six weeks. CSOM with discharge is also referred to as ‘runny ear’.<sup>11</sup>
- CSOM without discharge: a hole in the eardrum without evidence of discharge or fluid behind the ear.
- Otitis media with effusion (OME): middle ear fluid without signs of acute infection or a perforation of the eardrum. OME is also referred to as ‘glue ear’<sup>12</sup> and may be episodic or persistent.

<sup>8</sup> Deadly Ears Program, *Submission 62*, p. 1.

<sup>9</sup> Australian Institute of Health and Welfare, *Exhibit 15: Northern Territory Remote Aboriginal Investment: Ear and Hearing Health Program June 2012 to June 2016*, p. 49.

<sup>10</sup> Australian Institute of Health and Welfare, *Exhibit 15*, p. 49.

<sup>11</sup> Professor Amanda Leach and Professor Peter Morris, Menzies School of Health Research, *Submission 108*, p. 4.

<sup>12</sup> Professor Amanda Leach and Professor Peter Morris, Menzies School of Health Research, *Submission 108*, p. 4.

## *Pathology*

Otitis media is caused by bacteria and viruses that colonise the back of the nasal passages and 'access the middle ear space via the Eustachian tube.'<sup>13</sup> The build-up of fluid in the middle ear prevents the eardrum vibrating and conducting sound to the brain.<sup>14</sup>

Otitis media is a very common condition in young children, with estimates suggesting it affects 'over 90 per cent of children at least once before their second birthday.'<sup>15</sup> Non-Indigenous children often experience viral otitis media during winter and the condition tends to resolve naturally.<sup>16</sup> In Aboriginal and Torres Strait Islander children, however, otitis media is commonly bacterial and 'children under five years of age are the major carriers of these bacteria'.<sup>17</sup> Transmission of the bacteria occurs 'via human to human contact, spread of nasal secretions via cough, sneezing, kissing and hand contamination'.<sup>18</sup>

3.10 Aboriginal and Torres Strait Islander children in remote communities often contract the bacteria that cause otitis media in the first weeks of life.<sup>19</sup> Professor Amanda Leach stated that half the children she sees at 28 days of age already have these bacteria, and that the bacterial strains accumulate as the child gets older. Professor Leach explained:

they have one infection at one month, then they have another strain by two months and then another one the next time. Each strain is accumulating, so they are not eliminating those before they acquire the next. So you have a

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<sup>13</sup> Professor Amanda Leach and Professor Peter Morris, Menzies School of Health Research, *Submission 108*, p. 5.

<sup>14</sup> Professor Amanda Leach and Professor Peter Morris, Menzies School of Health Research, *Submission 108*, p. 5.

<sup>15</sup> Telethon Kids Institute, *Submission 44*, p. 4.

<sup>16</sup> Professor Amanda Leach and Professor Peter Morris, Menzies School of Health Research, *Submission 108*, p. 5.

<sup>17</sup> Professor Amanda Leach and Professor Peter Morris, Menzies School of Health Research, *Submission 108*, p. 5.

<sup>18</sup> Professor Amanda Leach and Professor Peter Morris, Menzies School of Health Research, *Submission 108*, p. 5.

<sup>19</sup> Northern Territory Government, *Submission 93*, p. 2.

multipathogen problem, and that is not happening for other children, who have one infection at a time.<sup>20</sup>

- 3.11 The Deadly Ears Program stated that in Queensland and in ‘many other jurisdictions’ the rate of CSOM among Aboriginal and Torres Strait Islander children is reducing.<sup>21</sup> Prevalence rates are still high, however, with recent studies in remote communities finding rates of CSOM with discharge at between 11 per cent<sup>22</sup> and 15 per cent<sup>23</sup>. The World Health Organisation defined a ‘prevalence of CSOM of above one per cent as an avoidable burden of disease, and anything above four per cent as indicative of a massive public health problem requiring urgent attention.’<sup>24</sup>
- 3.12 Chronic otitis media can have a lifelong impact on hearing. Dr Damien Howard and Jody Barney advised that ‘the damage caused by persistent ear disease leaves between 40 per cent (urban) and up to 70 per cent (remote) of Aboriginal adults with, mostly conductive, hearing loss.’<sup>25</sup>
- 3.13 The Northern Territory Government outlined the potential impact of otitis media on hearing ability:
- The degree and impact of hearing loss associated with otitis media varies according to the severity and frequency of episodes, but research suggests that three or more episodes before the age of three years may seriously affect auditory and language development.<sup>26</sup>
- 3.14 In 2015-16, hearing loss was present in 49 per cent of the 1976 Indigenous children and young people in the Northern Territory who received audiology services. Bilateral hearing loss accounted for 32 per cent of cases, while 17 per cent had unilateral loss.<sup>27</sup> Between 2012-13 and 2015-16, of the

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<sup>20</sup> Professor Amanda Leach, Director, Centre of Research Excellence in Ear and Hearing Health of Aboriginal and Torres Strait Islander Children, *Official Committee Hansard*, Darwin, 7 June 2017, p. 3.

<sup>21</sup> Mr Matthew Brown, Director, Deadly Ears Program, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 18.

<sup>22</sup> Australian Institute of Health and Welfare, *Exhibit 15*, p. 49.

<sup>23</sup> Professor Amanda Leach and Professor Peter Morris, Menzies School of Health Research, *Submission 108*, p. 4.

<sup>24</sup> Deadly Ears Program, *Submission 62*, p. 1.

<sup>25</sup> Dr Damien Howard and Jody Barney, *Submission 98*, p. 5.

<sup>26</sup> Northern Territory Government, *Submission 93*, p. 3.

<sup>27</sup> Australian Institute of Health and Welfare, *Exhibit 15*, p. 17.

Aboriginal and Torres Strait Islander children and young people in the Northern Territory who received audiology services, the proportion with hearing loss has 'fluctuated but decreased from 52 per cent to 49 per cent.'<sup>28</sup>

- 3.15 The Northern Territory Government further advised that there was 'substantial variance in prevalence [of hearing loss] across age ranges' in Aboriginal and Torres Strait Islander children.<sup>29</sup> In 2015-16, hearing loss was most prevalent among the three to five age group. Among Aboriginal and Torres Strait Islander children in this age group who received audiology services, 59 per cent had hearing loss.<sup>30</sup>
- 3.16 Dr Damien Howard and Jody Barney advised that the proportion of the Aboriginal and Torres Strait Islander community who are deaf is thought to be higher than in the rest of the Australian community (although the disparity is not as large as among the hard of hearing population).<sup>31</sup> The increased rate of deafness may be caused by cases of otitis media where infected fluid from the middle ear has entered the inner ear and caused sensorineural hearing loss. Recent research with Aboriginal and Torres Strait Islander women in custody has suggested a further cause could be women whose hearing loss has been exacerbated due to head injuries sustained through family violence.<sup>32</sup>

### *Causes of Otitis Media*

- 3.17 The Deadly Ears Program highlighted both the 'early colonisation of the nasopharynx with bad bacteria', which leads to infection and inflammation, and the health impacts linked to entrenched poverty as contributing factors to the prevalence of otitis media in Aboriginal and Torres Strait Islander communities. Deadly Ears added, however, that there is 'no clear answer' as to why the rates of otitis media in Aboriginal and Torres Strait Islander communities are the highest in the world.<sup>33</sup>

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<sup>28</sup> Australian Institute of Health and Welfare, *Exhibit 15*, p. 17.

<sup>29</sup> Northern Territory Government, *Submission 93*, p. 3.

<sup>30</sup> Australian Institute of Health and Welfare, *Exhibit 15*, p. 18.

<sup>31</sup> Dr Damien Howard and Jody Barney, *Submission 98*, p. 6.

<sup>32</sup> Dr Damien Howard and Jody Barney, *Submission 98*, p. 6.

<sup>33</sup> Mr Matthew Brown, Deadly Ears Program, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 23.

3.18 Professor Leach described otitis media as a ‘condition of disadvantage’<sup>34</sup>. Factors outlined in submissions as potentially contributing to the high levels of otitis media among Aboriginal and Torres Strait Islander children included:

- crowded housing, particularly where young children ‘have a lot of contact with other young children’;<sup>35</sup>
- low socioeconomic status;<sup>36</sup>
- a lack of access to medical practitioners in remote areas;<sup>37</sup>
- poor hygiene;<sup>38</sup> and
- ‘high carriage rates of bacterial pathogens and the prevalence of multiple bacterial strains’.<sup>39</sup>

### **Impact of Otitis Media and Hearing Loss**

3.19 The Deadly Ears Program described otitis media and associated hearing loss as the ‘most profound health and development issue for Aboriginal and Torres Strait Islander children’.<sup>40</sup>

3.20 Dr Damien Howard and Jody Barney observed that ‘when hearing loss commences early in life, it has a greater impact than the late onset of hearing loss’.<sup>41</sup> Unlike non-Indigenous Australians, who most commonly will experience hearing loss late in life, hard of hearing Aboriginal and Torres Strait Islanders will be impacted by hearing loss for most of their lives (an average of 72 years for women and 67 years for men).<sup>42</sup>

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<sup>34</sup> Professor Amanda Leach, Centre of Research Excellence in Ear and Hearing Health of Aboriginal and Torres Strait Islander Children, *Official Committee Hansard*, Darwin, 7 June 2017, p. 1.

<sup>35</sup> Professor Peter Morris, Chief Investigator, Centre of Research Excellence in Ear and Hearing Health of Aboriginal and Torres Strait Islander Children, *Official Committee Hansard*, Darwin, 7 June 2017, p. 2.

<sup>36</sup> Australian Institute of Health and Welfare, *Exhibit 15*, p. 1.

<sup>37</sup> Australian Institute of Health and Welfare, *Exhibit 15*, p. 1.

<sup>38</sup> Northern Territory Government, *Submission 93*, p. 2.

<sup>39</sup> Northern Territory Government, *Submission 93*, p. 2.

<sup>40</sup> Mr Matthew Brown, Deadly Ears Program, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 18.

<sup>41</sup> Dr Damien Howard and Jody Barney, *Submission 98*, p. 3.

<sup>42</sup> Dr Damien Howard and Jody Barney, *Submission 98*, p. 3.

3.21 The Northern Territory Government summarised how otitis media infections early in life can have ongoing and wide-ranging effects well into adulthood, stating otitis media in the first few months of life:

... contributes to multiple negative impacts ranging from delayed auditory, cognitive and psychosocial development, to permanent hearing loss. This can contribute to poor school performance, absenteeism, dropout rates and subsequent difficulties gaining employment. Psychosocial development is also hindered as poor hearing and educational performance can engender self-doubt, behaviour problems, social isolation, family dysfunction and increased interaction with correctional facilities.<sup>43</sup>

3.22 Dr Damien Howard suggested there was insufficient focus on the impacts of hearing loss in Aboriginal and Torres Strait Islander communities, stating ‘the consequences of hearing loss on communication is not something that has been adequately or even initially addressed’.<sup>44</sup> To illustrate, Dr Howard relayed a case where he had been approached to do some work on the impact of hearing loss on Aboriginal and Torres Strait Islander employment and was told the experts had ‘never heard of hearing loss impacting on Indigenous employment, so they [did] not believe it [was] actually a real issue’.<sup>45</sup>

### *Impact on Education*

3.23 Professor Amanda Leach and Professor Peter Morris described hearing loss as ‘the most prevalent barrier to educational attainment for Aboriginal and Torres Strait Islander children in the Northern Territory.’<sup>46</sup>

3.24 The Northern Territory Government observed that early onset otitis media impacts on a child’s ability to ‘learn and interact with others during the most critical years of development: infancy and young childhood.’<sup>47</sup> Specifically, children who experience multiple episodes of otitis media prior to the start of school are likely to have difficulties with ‘auditory discrimination, auditory processing, phonological awareness, short-term auditory memory,

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<sup>43</sup> Northern Territory Government, *Submission 93*, p. 1.

<sup>44</sup> Dr Damien Howard, Private Capacity, *Official Committee Hansard*, Darwin, 7 June 2017, p. 11.

<sup>45</sup> Dr Damien Howard, Private Capacity, *Official Committee Hansard*, Darwin, 7 June 2017, p. 11.

<sup>46</sup> Professor Amanda Leach and Professor Peter Morris, Menzies School of Health Research, *Submission 108*, p. 5.

<sup>47</sup> Northern Territory Government, *Submission 93*, p. 2.

and auditory sequential memory'. As a result it will be more difficult for these children to attain oral communication, literacy, and numeracy skills.<sup>48</sup>

3.25 The Northern Territory Council of Government School Organisations (NT COGSO) identified the following actions as being necessary to enable hearing impaired children to participate fully in the classroom environment:

- Classrooms with acoustics fitted to an approved national standard;
- Soundfield amplification systems in classrooms with Aboriginal and Torres Strait Islander children, and individual amplification devices for one-to-one and group learning;
- Community members employed in the classroom who are fluent in the local language and cognisant of local sign languages;
- Education and awareness for parents, teachers, and staff regarding conductive hearing loss;
- Audiology assessments for students with referral, and access, to audiology services where needed.<sup>49</sup>

3.26 The NT COGSO described the role of soundfield amplification systems in classrooms, explaining that the systems consisted of a small microphone worn by the teacher connected to speakers around the room. The speakers amplify the teacher's voice by a few decibels enabling it to be heard at a uniform volume throughout the room without it being too loud for hearing students.<sup>50</sup>

3.27 The NT COGSO stated that an eight week trial of soundfield amplification systems had been carried out in rural Queensland and that it had resulted in an increased level of communication between children and teachers, and among children, including an increased number of interactions initiated by the children.<sup>51</sup>

### ***Interactions with the Criminal Justice System***

3.28 Dr Damien Howard and Jody Barney advised that research had identified hearing loss as a key issue in the 'overrepresentation of Aboriginal people in the criminal justice sector.'<sup>52</sup> In the Darwin and Alice Springs correctional

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<sup>48</sup> Northern Territory Government, *Submission 93*, p. 3.

<sup>49</sup> Ms Tabitha Fudge, NT COGSO, *Official Committee Hansard*, Darwin, 7 June 2017, p. 15.

<sup>50</sup> NT COGSO, *Submission 97*, p. 5.

<sup>51</sup> NT COGSO, *Submission 97*, p. 5.

<sup>52</sup> Dr Damien Howard and Jody Barney, *Submission 98*, p. 5.

systems, 90 per cent of Aboriginal and Torres Strait Islander inmates have hearing loss.<sup>53</sup> Australian Hearing advised that a similar pattern could be found across Australia, as 'hearing loss is over-represented in Aboriginal prisoners in all jurisdictions'.<sup>54</sup>

3.29 The Council of Presidents of Medical Colleges drew attention to the youth justice system, stating that 'up to 60 per cent of children in youth detention centres are Aboriginal, of which approximately 80 per cent have ongoing significant hearing issues when tested.'<sup>55</sup>

3.30 The Australian Medical Association (AMA) commented that high rates of hearing loss among Aboriginal and Torres Strait Islander people contributes to communication difficulties and that 'this, in turn, exacerbates problems in regard to interactions with law enforcement and criminal justice'.<sup>56</sup> The AMA recommended that all criminal justice detainees should undergo a health assessment including a screening for hearing loss.<sup>57</sup>

### *Experiences of Deaf Aboriginal and Torres Strait Islander People*

3.31 Dr Damien Howard and Jody Barney advised that the majority of deaf Aboriginal and Torres Strait Islander people do not use Auslan. Dr Howard and Ms Barney further advised that 'in the Northern Territory there are approximately 55 Aboriginal signing systems, with about eight most commonly used systems.'<sup>58</sup>

3.32 The diversity of signing systems result in deaf Aboriginal and Torres Strait Islanders being reliant on particular people, often family members, with whom they are able to communicate. Separation from the person with whom 'an idiosyncratic signing system' has been developed, for example because of death or imprisonment, can lead to a situation of extreme isolation.<sup>59</sup> In other cases, the limited group of people the deaf person can

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<sup>53</sup> NT COGSO, *Submission 97*, p. 4.

<sup>54</sup> Australian Hearing, *Submission 58*, p. 18.

<sup>55</sup> Council of Presidents of Medical Colleges, *Submission 4*, p. 2.

<sup>56</sup> Australian Medical Association, *Submission 3*, p. 1.

<sup>57</sup> Australian Medical Association, *Submission 3*, p. 2.

<sup>58</sup> Dr Damien Howard and Jody Barney, *Submission 98*, p. 6.

<sup>59</sup> Dr Damien Howard and Jody Barney, *Submission 98*, p. 7.

communicate with leaves them vulnerable to 'exploitation and abuse by some family members, especially financial and sexual abuse'.<sup>60</sup>

- 3.33 In addition, 'using community signing systems away from "country" is often not culturally permitted, thus preventing deaf Indigenous people from teaching community signs to outsiders'. This 'linguistic isolation' results in deaf Aboriginal and Torres Strait Islanders having limited 'access to the support services provided to mainstream deaf Australians'.<sup>61</sup>
- 3.34 Dr Damien Howard and Jody Barney advised that deaf Aboriginal and Torres Strait Islanders identify with their local communities, rather than mainstream deaf advocacy groups, and so 'support has to be through and with local Aboriginal communities'.<sup>62</sup>
- 3.35 DeafNT stated that some deaf children in the Northern Territory 'grow up without any exposure at all to sign language'. DeafNT advocated that it was an 'imperative' that deaf children had the opportunity to learn sign language, as without it 'they have a very limited linguistic foundation' and would find it difficult to 'express themselves and to understand their own needs as well as expressing their needs to others'.<sup>63</sup>
- 3.36 DeafNT advocated for increased resources to support deaf children learn sign languages, including local Aboriginal and Torres Strait Islander sign languages.<sup>64</sup> DeafNT also highlighted the need for greater access to interpreters for medical services. DeafNT relayed the case of a deaf child who, unable to 'express to the nurses and medical staff through sign language what they were feeling' passed away due to an ear infection.<sup>65</sup>

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<sup>60</sup> Dr Damien Howard and Jody Barney, *Submission 98*, p. 7.

<sup>61</sup> Dr Damien Howard and Jody Barney, *Submission 98*, p. 7.

<sup>62</sup> Dr Damien Howard and Jody Barney, *Submission 98*, p. 7.

<sup>63</sup> Mrs Vanessa Adzaip, Auslan Coordinator and Tutor, Deaf Children Australia and DeafNT, *Official Committee Hansard*, Darwin, 7 June 2017, pp 6-7.

<sup>64</sup> Mrs Vanessa Adzaip, Deaf Children Australia and DeafNT, *Official Committee Hansard*, Darwin, 7 June 2017, p. 7.

<sup>65</sup> Mrs Vanessa Adzaip, Deaf Children Australia and DeafNT, *Official Committee Hansard*, Darwin, 7 June 2017, p. 7.

## Prevention and Treatment of Otitis Media

### *Vaccines*

3.37 Professor Amanda Leach commented on the use of vaccines to prevent otitis media, suggesting that although vaccine uptake is very high among Aboriginal and Torres Strait Islanders that:

... this is a complex disease, and the vaccines do not cover all of the pathogens. There are shifting sands, if you like: new strains are coming in, and we have come to a plateau with the vaccines ... [which means] we have ended up with an improvement in the worst category of ear disease but not an improvement in the proportion of children who have normal ears, and that is partly to do with this changing pathology.<sup>66</sup>

3.38 Professor Amanda Leach and Professor Peter Morris also observed that prevention and treatment strategies in Aboriginal and Torres Strait Islander communities have not been as effective as similar strategies delivered in 'affluent settings'. This reduced efficacy is 'partially due to the early age of onset, diversity and multiplicity of [otitis media] pathogens, and the density of bacterial infections.'<sup>67</sup> Professors Leach and Morris suggested that 'longer courses and higher doses of antibiotics' and the provision of vaccines as early as one month of age may be required.<sup>68</sup>

3.39 Australian Hearing stated that 'loss to follow up is a significant issue impacting the management of childhood hearing loss in Aboriginal and Torres Strait Islander communities'. Australian Hearing suggested that the key reasons for this included 'difficulties in service access, normalisation of ear disease and hearing loss, lack of knowledge of the wide-ranging impacts of hearing loss, and lack of faith that following the pathway will result in improvement'.<sup>69</sup>

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<sup>66</sup> Professor Amanda Leach, Centre of Research Excellence in Ear and Hearing Health of Aboriginal and Torres Strait Islander Children, *Official Committee Hansard*, Darwin, 7 June 2017, p. 2.

<sup>67</sup> Professor Amanda Leach and Professor Peter Morris, Menzies School of Health Research, *Submission 108*, p. 7.

<sup>68</sup> Professor Amanda Leach and Professor Peter Morris, Menzies School of Health Research, *Submission 108*, p. 7.

<sup>69</sup> Australian Hearing, *Submission 58*, p. 4.

### *Services in Remote Aboriginal and Torres Strait Islander Communities*

- 3.40 The Department of Health explained that Aboriginal Medical Service (AMS) clinics, which are ‘comprehensive primary health-care providers’,<sup>70</sup> are structured in a ‘hub-and-spoke’ model with a larger clinic based in a town supporting a number of smaller clinics in Aboriginal and Torres Strait Islander communities. The Department commented that some remote communities did not have local health services and instead relied on health coordinators and outreach services.<sup>71</sup>
- 3.41 The Queensland Aboriginal and Islander Health Council (QAIHC) supported the greater provision of hearing health coordinators, each with the responsibility for a region containing multiple AMS clinics. These coordinators could work with local AMS clinics to develop community engagement and health promotion campaigns. The QAIHC suggested that these campaigns should ‘start in the community from the beginning and discuss the problems and come up with solutions’.<sup>72</sup>
- 3.42 The Northern Territory Government described the challenge of delivering hearing health services in remote communities, stating:
- ... chronic otitis media needs to be tightly case managed as treatment or surgical interventions are required at critical times. This is confounded by remoteness and significant unmet need in primary health care, allied health (audiology and speech therapy) and specialist services (Ear, Nose and Throat surgeons, Clinical Nurse Specialists – ENT).<sup>73</sup>
- 3.43 Mr Jeff Cook, who manages an Aboriginal Community Controlled Health Organisation, explained that Australian Hearing visits the Laynhapuy Homelands (near Gove in the Northern Territory) four times per year and that the funding for these visits is provided by his organisation. Mr Cook advised that for a forthcoming visit Australian Hearing had a list of 50 people to see, but realistically it may only manage to see up to ten people. Mr Cook stated that the people who miss out ‘do not have access to services,

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<sup>70</sup> Ms Bobbi Campbell, First Assistant Secretary, Indigenous Health Division, Department of Health, *Official Committee Hansard*, Canberra, 3 March 2017, p. 9.

<sup>71</sup> Dr Wendy Southern, Deputy Secretary, National Program Delivery Group, Department of Health, *Official Committee Hansard*, Canberra, 3 March 2017, p. 9.

<sup>72</sup> Mr Mark Mitchell, Hearing Health Project Officer, Queensland Aboriginal and Islander Health Council (QAIHC), *Official Committee Hansard*, Brisbane, 21 April 2017, p. 27.

<sup>73</sup> Northern Territory Government, *Submission 93*, p. 1.

it is that simple, they do not have a level of access to services that they require, and we get used to that.<sup>74</sup>

- 3.44 In Queensland, the Deadly Ears Program provides services to 11 outreach locations. Deadly Ears sends a team consisting of audiologists, ear, nose and throat (ENT) staff, anaesthetists, and a broad mix of nursing staff, to each location for a week to conduct clinics and surgery. Postsurgical care plans for treated children are developed and passed to primary health providers to implement. Any children with conditions outside the scope of the Deadly Ears team are referred to specialist ENT services.<sup>75</sup>
- 3.45 The Deadly Ears Program was described as ‘an excellent program’ by Speech Pathology Australia<sup>76</sup> and one that does a ‘fantastic job’ by the QAIHC.<sup>77</sup> The Royal Australasian College of Surgeons (RACS) added that while Deadly Ears is ‘a really good program in the sense that it is a holistic care model ... there is a real, pertinent need for a national strategy, and [key performance indicators] that we can benchmark off each other.’<sup>78</sup>

### *Access to Specialist Audiology and Ear, Nose and Throat Services*

- 3.46 In the Northern Territory the prevalence of otitis media conditions has resulted in unmet demand for hearing health services. In June 2016, ‘3090 children and young people were waiting for audiology services and 1841 for ENT teletology services.’<sup>79</sup> Professor Peter Morris commented that although the Australian Government has ‘greatly increased funding for both primary health care and audiology services in the Northern Territory’ that ‘further investment is required’.<sup>80</sup>

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<sup>74</sup> Mr Jeff Cook, Arnhem Regional Representative, NT COGSO, *Official Committee Hansard*, Darwin, 7 June 2017, pp 15, 18-19.

<sup>75</sup> Ms Anette Smith, Nurse Unit Manager, ENT Outreach and Mrs Maggie Allen, Audiologist, Deadly Ears Program, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 22.

<sup>76</sup> Dr Chyrisse Heine, Board Director, Speech Pathology Australia, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 29

<sup>77</sup> Mr Mark Mitchell, QAIHC, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 26.

<sup>78</sup> Associate Professor Kelvin Kong, Indigenous Health Committee, Royal Australasian College of Surgeons, *Official Committee Hansard*, Sydney, 6 April 2017, pp. 68-69.

<sup>79</sup> Australian Institute of Health and Welfare, *Exhibit 15*, p. vii.

<sup>80</sup> Professor Peter Morris, Centre of Research Excellence in Ear and Hearing Health of Aboriginal and Torres Strait Islander Children, *Official Committee Hansard*, Darwin, 7 June 2017, p. 2.

- 3.47 The Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) advised that ‘surgical treatment for otitis media in young children is not prioritised on hospital waiting lists’ despite this being a ‘crucial time in their educational and social development’.<sup>81</sup> The ASOHNS proposed that incentives be provided to hospitals to ‘prioritise the medical and surgical treatment of Indigenous children with ear and hearing problems’.<sup>82</sup>
- 3.48 The Department of Health stated that it was not aware of any specific complaints related to the ability to access ENT services and that it had an outreach program to ensure once diagnoses are made, people in remote areas can access necessary treatment.<sup>83</sup>

### *Primary Health Care Services*

- 3.49 Watto Purrunga Aboriginal Health Service observed that because otitis media in Aboriginal and Torres Strait Islander children is often pain free, parents are often unaware their child has an ear infection. Watto Purrunga emphasised the importance of hearing screening programs in diagnosing children with hearing problems at a young age.<sup>84</sup>
- 3.50 The Deadly Ears Program recommended that routine health checks must include ear and hearing checks using otoscopy and tympanometry to pick up asymptomatic forms of otitis media.<sup>85</sup> The QAIHC recommended that a focus was needed on treating very young children, up to the age of four or five, as currently children are being picked up ‘only after the damage is done’.<sup>86</sup>
- 3.51 Professor Amanda Leach and Professor Peter Morris contended that primary health care services needed to be able to provide hearing health services to cover gaps in the provision of specialist hearing services. They stated that it was ‘critical that ear health services are available in Primary Health Care settings, for families to access regularly for diagnosis and follow-up –

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<sup>81</sup> The Australian Society of Otolaryngology Head and Neck Surgery, *Submission 24*, p. 4.

<sup>82</sup> The Australian Society of Otolaryngology Head and Neck Surgery, *Submission 24*, p. 6.

<sup>83</sup> Dr Wendy Southern, Department of Health, *Official Committee Hansard*, Canberra, 3 March 2017, p. 9.

<sup>84</sup> Ms Leanne Quirino, Coordinator of Under Eights Aboriginal and Child Health Checks, Watto Purrunga Aboriginal Health Service, *Official Committee Hansard*, Adelaide, 3 May 2017, p. 33.

<sup>85</sup> Deadly Ears Program, *Submission 62*, p. 6.

<sup>86</sup> Mr Mark Mitchell, QAIHC, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 26.

without being placed on impossibly long waiting lists for six-monthly audiology services.<sup>87</sup>

- 3.52 Dr Damien Howard suggested that ‘the training of all professionals who are likely to engage Indigenous people in their work needs to incorporate information on communication strategies around hearing loss.’<sup>88</sup>
- 3.53 The Deadly Ears Program drew attention to guidelines developed by the Commonwealth Department of Health and the Menzies School of Health Research to assist health practitioners apply best practice in treating otitis media – the *Recommendations for Clinical Care Guidelines on the Management of Otitis Media (Middle Ear Infection) in Aboriginal and Torres Strait Islander Populations 2010 (Clinical Guidelines)*<sup>89</sup>. The Deadly Ears Program commented that despite the development of Clinical Guidelines ‘alignment of practice with the recommendations remains ad hoc and inconsistent.’<sup>90</sup>
- 3.54 The Deadly Ears Program illustrated the potential value of primary health care workers by referring to the town of Eidsvold in Queensland. In Eidsvold the proportion of the children attending clinics who had otitis media dropped from 83 per cent to 12 per cent over a six year period.<sup>91</sup> The Deadly Ears Program stated that the impact of a health worker and general practitioners (GPs) who were dedicated to improving hearing health made it possible to get ‘on top of ear disease at an early stage and eliminated our need to provide a specialist ENT service to the community.’<sup>92</sup>
- 3.55 The Department of Health advised that it was in the process of training Aboriginal and Torres Strait Islander health practitioners to ‘make sure that they are aware of their clinical guidelines’ and stated in the first year this training involved around 1500 people across 80 locations.<sup>93</sup>

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<sup>87</sup> Professor Amanda Leach and Professor Peter Morris, Menzies School of Health Research, *Submission 108*, p. 7.

<sup>88</sup> Dr Damien Howard, *Official Committee Hansard*, Darwin, 7 June 2017, p. 11.

<sup>89</sup> Deadly Ears Program, *Submission 62*, p. 2.

<sup>90</sup> Deadly Ears Program, *Submission 62*, p. 2.

<sup>91</sup> Deadly Ears Program, *Submission 62*, p. 6.

<sup>92</sup> Ms Anette Smith, Deadly Ears Program, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 20.

<sup>93</sup> Dr Wendy Southern, Department of Health, *Official Committee Hansard*, Canberra, 3 March 2017, p. 8.

3.56 The Department of Health also explained that child health checks were currently the primary means of assessing hearing health in young Aboriginal and Torres Strait Islander children.<sup>94</sup>

### *Coordination of Programs Addressing Hearing Health*

3.57 The ASOHNS suggested that the 'short-term nature' of programs focussed on Aboriginal and Torres Strait Islander hearing health results in 'a lack of coordination between the states and the Commonwealth'. The ASOHNS added that it strongly believes 'that there should be a nationally coordinated approach to the treatment of Indigenous children'.<sup>95</sup> The RACS and ASOHNS added that the national approach should 'build upon existing community approaches and programs, drawing upon programs that are working well and establishing national benchmarks for service delivery'.<sup>96</sup>

3.58 Australian Hearing agreed that a national approach is required to 'bring about the closure of the gap in ear health and hearing outcomes at the broad population level'.<sup>97</sup>

3.59 The Telethon Kids Institute suggested addressing the effects of otitis media on Aboriginal and Torres Strait Islander communities would require a 'multisectoral approach' with input from organisations involved in 'housing, health, education, child development, and corrective services'.<sup>98</sup>

3.60 The QAIHC stated that in November 2016 RACS convened a roundtable of stakeholders to discuss hearing health in Aboriginal and Torres Strait Islander communities. The representatives at the roundtable recommended the development of a National Aboriginal and Torres Strait Islander Hearing Health Taskforce and embedding hearing health in the Closing the Gap targets.<sup>99</sup>

3.61 The RACS and ASOHNS suggested that the taskforce should evaluate:

- the efficacy of existing services;

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<sup>94</sup> Ms Bobbi Campbell, Department of Health, *Official Committee Hansard*, Canberra, 3 March 2017, p. 7.

<sup>95</sup> Professor Stephen O'Leary, Member, Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS), *Official Committee Hansard*, Sydney, 6 April 2017, p. 45.

<sup>96</sup> Royal Australasian College of Surgeons (RACS) and ASOHNS, *Submission 46*, p. 4.

<sup>97</sup> Australian Hearing, *Submission 58*, p. 5.

<sup>98</sup> Telethon Kids Institute, *Submission 44*, p. 5.

<sup>99</sup> QAIHC, *Submission 57*, p. 2.

- community engagement in ear disease management and the views of Aboriginal and Torres Strait Islanders on how to address hearing health in their communities;
- approaches to culturally appropriate service delivery;
- funding of primary and specialist care;
- data and reporting practices; and
- the use and effectiveness of treatment guidelines.<sup>100</sup>

3.62 The RACS and ASOHNS also stated that the ‘absence of ear health from the Closing the Gap targets is a great concern.’<sup>101</sup> The RACS and ASOHNS added that:

... the prioritisation of ear health in the Closing the Gap strategy and the establishment of a taskforce to develop a best practice plan for a national approach to ear health ... can make a significant contribution to the health and wellbeing of Aboriginal and Torres Strait Islander Australians.<sup>102</sup>

3.63 The Indigenous Affairs Group (IAG) in the Department of the Prime Minister and Cabinet advised that there was not a specific Closing the Gap target focussed on hearing health, as the targets are not ‘disease-specific’. The IAG added that ‘it is not that we do not think that ear disease is important; it is just the way we would construct the Closing the Gap agenda is around those more holistic sorts of issues’.<sup>103</sup>

### ***Data Collection***

3.64 The QAIHC stated that there is an ‘absence of accurate and reliable data’ which ‘impedes health service planning and delivery’.<sup>104</sup> The QAIHC recommended the development of a nationally consistent process for collecting data. The QAIHC added that work already undertaken by groups including the Northern Territory Hearing Health program, the Australian Primary Health Care Research Institute, and the Aboriginal Health Council of Western Australia could form a foundation for a consistent dataset.<sup>105</sup>

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<sup>100</sup> RACS and ASOHNS, *Submission 46*, p. 4.

<sup>101</sup> RACS and ASOHNS, *Submission 46*, p. 4.

<sup>102</sup> RACS and ASOHNS, *Submission 46*, p. 4.

<sup>103</sup> Mr Brendan Gibson, Department of the Prime Minister and Cabinet, *Official Committee Hansard*, Canberra, 3 March 2017, p. 30.

<sup>104</sup> QAIHC, *Submission 57*, p. 3.

<sup>105</sup> QAIHC, *Submission 57*, p. 3.

- 3.65 The Deadly Ears Program agreed that data on the prevalence of otitis media and hearing loss is ‘inconsistent, patchy and unreliable and does not allow robust comparisons across jurisdictions.’<sup>106</sup> Australian Hearing expressed similar sentiments, describing the type, quality and consistency of data collected on Aboriginal and Torres Strait Islander hearing health as ‘inadequate’.<sup>107</sup> The Deadly Ears Program suggested that consistent data would help with targeting resources and that the data needed to be detailed enough to show whether the otitis media cases in a locality could be handled by GPs or whether an ENT surgeon would be needed.<sup>108</sup>
- 3.66 The Northern Territory Government is developing a digital hearing health record for the use of specialist hearing health practitioners such as ENT surgeons, audiologists, and specialist nurses. A related project being undertaken by the Northern Territory Government will provide hearing health data on individual students to teachers and will also be used to recommend amplification and other sound upgrades for classrooms.<sup>109</sup>

## People from Culturally and Linguistically Diverse Backgrounds

- 3.67 The Royal Institute for Deaf and Blind Children (RIDBC) advised that children from culturally and linguistically diverse backgrounds accounted for 30 per cent of the children in its programs.<sup>110</sup> The Shepherd Centre also identified that some of its centres had high numbers of children from culturally and linguistically diverse backgrounds and that it needed improved support from interpreting services in order to assist these clients. The Shepherd Centre stated:

Often at times we cannot get a face-to-face interpreter or we cannot get the same interpreter again and again, which is an ongoing issue for a family—

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<sup>106</sup> Deadly Ears Program, *Submission 62*, p. 2.

<sup>107</sup> Australian Hearing, *Submission 58*, p. 14.

<sup>108</sup> Mr Matthew Brown, Deadly Ears Program, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 21.

<sup>109</sup> Northern Territory Government, *Submission 93*, p. 10.

<sup>110</sup> Mr Bart Cavalletto, Director, Services, Royal Institute for Deaf and Blind Children (RIDBC), *Official Committee Hansard*, Canberra, 16 June 2017, p. 13.

particularly when we are trying to talk through medical terminology and go through implant procedures et cetera.<sup>111</sup>

3.68 The Can:Do Group described the need for ‘culturally appropriate information’ for culturally and linguistically diverse families of hearing impaired children, and the need to work with these communities to increase awareness of available services.<sup>112</sup> Can:Do stated that families from culturally and linguistically diverse backgrounds can have ‘their own cultural beliefs around hearing loss and what this means’, which may include ‘shame within their community’ around hearing loss or a reluctance to wear hearing aids.<sup>113</sup>

3.69 The Audiometry Nurses Association of Australia commented on an increase of vulnerable clients and refugees entering its clinics for hearing tests.<sup>114</sup> The Goulburn Valley Hearing Clinic also described the experience of refugees with hearing loss in their region and stated:

We see a lot of people in the refugee group who suffer traumatic hearing loss because of their experience in the country they left. We also see in the newborn population a higher incidence of hearing loss and birth defects ... It can be a disincentive to accessing services if people are not comfortable dealing with the professional people, and language is a key part of that. If they do not really understand what the process is and what is happening then it can be really confronting.<sup>115</sup>

3.70 Aussie Deaf Kids and Parents of Deaf Children recommended that ‘when non-English speaking parents and culturally Deaf adults need to make decisions that will impact on the future of their child, they must have access to appropriately qualified interpreters.’<sup>116</sup>

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<sup>111</sup> Ms Aleisha Davis, General Manager, the Shepherd Centre, *Official Committee Hansard*, Sydney, 15 November 2016, p. 7.

<sup>112</sup> Can:Do Group, *Submission 50*, pp 6-7.

<sup>113</sup> Can:Do Group, *Submission 50*, p. 6.

<sup>114</sup> Audiometry Nurses Association of Australia, *Submission 15*, p. 5.

<sup>115</sup> Mr Lindsay Symons, Senior Audiologist, Goulburn Valley Hearing Clinic (GVHC), *Official Committee Hansard*, Shepparton, 2 May 2017, p. 13.

<sup>116</sup> Aussie Deaf Kids and Parents of Deaf Children, *Submission 72*, p. 11.

- 3.71 Goulburn Valley Hearing Clinic described that, as a small business, it faces difficulties in finding funds for interpreters.<sup>117</sup> Goulburn Valley added that Office of Hearing Services contracts include an expectation that hearing clinics will provide interpreters, but that no funding is provided for this purpose and ‘it is really expensive.’ As a consequence, Goulburn Valley undertakes a lot of its ‘work with those vulnerable groups through the hospital’ in order to access interpreter support<sup>118</sup>.
- 3.72 The Deafness Forum of Australia (Deafness Forum) stated that as a result of the ‘significant cost’ of interpreters, ‘some providers are reluctant to accept clients ... who do not bring their own interpreter to appointments.’<sup>119</sup> The Goulburn Valley Hearing Clinic stated that ‘the provision of some sort of access for translation interpreting services through the Office of Hearing Services is something to consider.’<sup>120</sup>
- 3.73 The RIDBC also advised that culturally and linguistically diverse families who receive National Disability Insurance Scheme (NDIS) packages have not always had interpreting included as part of their package. The RIDBC stated:
- We are not really sure how we are supposed to work with families who do not speak English without an interpreter. So it is really important that, through those reference packages, that is considered as well’.<sup>121</sup>
- 3.74 The National Disability Insurance Agency (NDIA) advised that it ‘will fund interpreting (translation) for interaction with the NDIA but not with other providers or in the community.’<sup>122</sup>
- 3.75 Vicdeaf drew attention to its ‘Auslan for Deaf Migrants’ program, which teaches Auslan to deaf migrants. Vicdeaf stated that funding for this program is shifting to the NDIS, and ‘many of the course participants will be unable to participate in such programs in future, as many are presently ineligible for the NDIS.’<sup>123</sup> Vicdeaf recommended this program, along with

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<sup>117</sup> Ms Dierdre Robertson, Practice Manager, GVHC, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 11.

<sup>118</sup> Mr Lindsay Symons, GVHC, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 14.

<sup>119</sup> Deafness Forum of Australia, *Submission 17*, p. 21.

<sup>120</sup> Ms Dierdre Robertson, GVHC, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 11.

<sup>121</sup> Mr Bart Cavalletto, RIDBC, *Official Committee Hansard*, Canberra, 16 June 2017, p. 13.

<sup>122</sup> National Disability Insurance Agency, *Submission 45.2*, p. 3.

<sup>123</sup> Vicdeaf, *Submission 86*, p. 3.

other services for migrants, be funded to continue across Australia, and that access be given to people who are yet to meet the residency or visa requirements of the NDIS.<sup>124</sup>

- 3.76 The Deafness Forum advised that the Department of Social Services, under the Translating and Interpreting Service, 'provides free interpreting services to non-English speaking Australian citizens and permanent residents communicating with approved groups and individuals'.<sup>125</sup> Audiologists and audiometrists, however, are not included as an 'approved group' and cannot access this free service for their clients.<sup>126</sup> As such, the Deafness Forum recommended that 'hearing services providers be included in the Translation and Interpreting Service system of funded support.'<sup>127</sup>

## People Living in Rural and Regional Areas

- 3.77 Sounds Scouts Australia put the view that people living outside major cities are more likely to have hearing disorders than those who live in cities.<sup>128</sup> This was attributed to factors including the ageing of Australia's population outside of cities, and a greater potential for exposure to noise induced hearing loss, particularly in farming and mining.<sup>129</sup>
- 3.78 People with hearing impairment in rural and regional areas can face barriers to accessing hearing services. Country Hearing Care advised that there is an 18 month waiting list for the ENT surgeon in Mildura.<sup>130</sup> Country Hearing Care also commented that since 1990, despite a growing population, the audiologist position at Mildura Base Hospital has been reduced from a full-time equivalent to a one and a half day a week position.<sup>131</sup>
- 3.79 Goulburn Valley Hearing Clinic similarly stated that there is no ENT specialist in Shepparton, and 'there is a long waiting list to be seen as a

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<sup>124</sup> Vicdeaf, *Submission 86*, p. 4.

<sup>125</sup> Deafness Forum of Australia, *Submission 17*, p. 21.

<sup>126</sup> Deafness Forum of Australia, *Submission 17*, p. 21.

<sup>127</sup> Deafness Forum of Australia, *Submission 17*, p. 23.

<sup>128</sup> Sounds Scouts Australia, *Submission 41*, p. 8.

<sup>129</sup> Sounds Scouts Australia, *Submission 41*, p. 8.

<sup>130</sup> Country Hearing Care, *Submission 74*, p. 2.

<sup>131</sup> Mrs Jane MacDonald, Director and Senior Audiologist, Country Hearing Care, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 2.

public patient at the Goulburn Valley Health ENT clinic.<sup>132</sup> The Royal Flying Doctor Service added that ‘some remote and rural Australians with hearing loss will need to travel hundreds of kilometres to receive specialist hearing services.’<sup>133</sup>

3.80 The National Rural Health Alliance (NRHA) stated that for the delivery of hearing health services to children in rural and regional areas there was a need to ‘ensure access to an appropriately resourced, culturally competent multi-disciplinary team to identify, refer and treat ear health locally, supported by telemedicine and surgical intervention when necessary’.<sup>134</sup>

3.81 The NRHA identified GPs as a key component of the delivery of hearing health services to adults in rural and remote areas. The NRHA suggested that individuals often ‘prioritise other health issues above their hearing’ and that GPs should be encouraged to ‘raise hearing issues as part of regular primary health care checks’ to ensure hearing ‘is not lost in [the] competing priorities’.<sup>135</sup>

3.82 The Telethon Kids Institute identified telehealth, the provision of health services via the internet, as a valuable method for increasing access to hearing health services in rural areas.<sup>136</sup> Telehealth services are discussed in more detail in Chapter 4.

## Aged Population

3.83 Rates of hearing impairment increase with age, with most people over 65 years of age experiencing hearing loss.<sup>137</sup> Hearing impairment in older Australians is associated with communication difficulties, a decline in cognitive functioning and other health conditions.<sup>138</sup> Deafblind Australia stated that ‘the incidence of people with combined vision and hearing loss (deafblindness) will rise significantly as the population ages.’<sup>139</sup>

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<sup>132</sup> GVHC, *Submission 104*, p. 3.

<sup>133</sup> Royal Flying Doctor Service, *Submission 38*, p. 1.

<sup>134</sup> National Rural Health Alliance, *Submission 13*, p. 3.

<sup>135</sup> National Rural Health Alliance, *Submission 13*, p. 3.

<sup>136</sup> Telethon Kids Institute, *Submission 44*, p. 7.

<sup>137</sup> Speech Pathology Australia, *Submission 51*, p. 8.

<sup>138</sup> Speech Pathology Australia, *Submission 51*, p. 9.

<sup>139</sup> Deafblind Australia, *Submission 69*, p. 2.

- 3.84 Dr Timothy Makeham stated that older people are more likely to miss out on receiving treatment for hearing issues, as they have less ‘propensity to travel to seek out care’ and that this ‘depends on [the] support structure around them.’<sup>140</sup>
- 3.85 Issues regarding older Australians’ interaction with hearing aid providers and the cost of hearing aids are discussed in Chapter 5.

### *Older Australians in the Aged Care System*

- 3.86 The Deafness Forum advised that aged care residents are more likely to have hearing loss than older Australians living in the general community.<sup>141</sup> Australian Hearing stated that people living in aged care facilities are also ‘more likely to have other disabilities, including dementia, vision loss and physical impairments.’<sup>142</sup> These factors mean that ‘aged care residents require additional support to successfully use and manage devices and often rely on care home staff to access hearing services and maintain device usage.’<sup>143</sup>
- 3.87 Australian Hearing stated that it follows a ‘different client service pathway for many clients in residential care.’ This includes education of facility staff, the use of assistive devices, and involvement of carers in hearing improvement programs.<sup>144</sup>
- 3.88 The Deafness Forum advised that ‘the current model of delivering hearing services needs to be adjusted to better meet the needs of frail elderly clients living in an aged care facility.’<sup>145</sup> Adjustments recommended by the Deafness Forum include:
- using individual hearing and communication plans for clients with hearing impairments;
  - consulting and educating staff and carers on a client’s abilities and needs;

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<sup>140</sup> Dr Timothy Makeham, Private Capacity, *Official Committee Hansard*, Canberra, 14 February 2017, p. 3.

<sup>141</sup> Deafness Forum of Australia, *Submission 17*, p. 21.

<sup>142</sup> Australian Hearing, *Submission 58*, p. 14.

<sup>143</sup> Australian Hearing, *Submission 58*, p. 14.

<sup>144</sup> Australian Hearing, *Submission 58*, p. 14.

<sup>145</sup> Deafness Forum of Australia, *Submission 17*, p. 22.

- having a staff member coordinate services and support for clients with hearing care plans;
- the provision of advice to aged care facilities regarding any changes needed to enhance communication (such as amplification or captioning); and
- instituting evaluation mechanisms to gauge the success of treatment and support.<sup>146</sup>

3.89 Audiology Australia stated that the Australian Government should ‘facilitate audiologists to work together with the aged care workforce to meet the needs of care recipients.’<sup>147</sup> Audiology Australia considered that aged care recipients need access to audiologists who have training in providing services to clients with complex needs; and should only receive hearing aids if they are experiencing hearing difficulties that cannot be addressed through other means and can cope with using the device. Audiology Australia also stated that clarification was needed as to what personal and communication assistance should be provided by residential and home care services.<sup>148</sup>

3.90 Australian Hearing made the observation that ‘hearing aids are often used inappropriately by staff and residents in nursing homes and are frequently lost or damaged.’<sup>149</sup> Better Hearing Australia stated that it sends volunteers to nursing homes to help residents clean and maintain their hearing aids, and to train staff on how to carry out these tasks.<sup>150</sup> Better Hearing Australia recommended the Government provide funding to agencies that provide volunteers to perform these services.<sup>151</sup>

3.91 Deafblind Australia stated that services for people with deafblindness are currently inadequate.<sup>152</sup> Deafblind Australia recommended that adults with deafblindness in aged care facilities receive a referral from their aged care service provider to deafblind specific services.<sup>153</sup>

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<sup>146</sup> Deafness Forum of Australia, *Submission 17*, pp 29-30.

<sup>147</sup> Audiology Australia, *Submission 49*, p. 9.

<sup>148</sup> Audiology Australia, *Submission 49*, p. 9.

<sup>149</sup> Australian Hearing, *Submission 58*, p. 14.

<sup>150</sup> Better Hearing Australia, *Submission 83*, p. 12.

<sup>151</sup> Better Hearing Australia, *Submission 83*, p. 13.

<sup>152</sup> Deafblind Australia, *Submission 69*, p. 2.

<sup>153</sup> Deafblind Australia, *Submission 69*, p. 2.

### *Access to Interpreter Funding and Other Support*

- 3.92 Audiology Australia stated that there is ‘currently an option for a greater level of support under the NDIS than is available under the Hearing Services Program.’<sup>154</sup> Audiology Australia recommended the Australian Government ensure that hearing impaired older Australians are given the same level of access to the supports available under the NDIS, such as funding for hearing aid maintenance and specialist smoke alarms and television devices.<sup>155</sup>
- 3.93 The Coalition of Concerned Deaf Elders and Friends was similarly concerned that, unlike people eligible for the NDIS, deaf Auslan users over 65 years of age do not have access to Auslan funding packages to pay for interpreters.<sup>156</sup> The Can:Do Group stated that the lack of funded Auslan interpreting available for people aged over 65 years leaves them with ‘inequality of access, which is, essentially, a basic human right.’<sup>157</sup>
- 3.94 The Deafness Forum also questioned whether people aged over 65 years will have access to the National Auslan Interpreter Booking and Payment Service (NABS) over the long term, as funding for this service has moved to the NDIS. While the Government has confirmed people over 65 years of age can currently continue to access the NABS, the Deafness Forum stated that ‘this may change as the Government makes plans for the future of services like NABS’ and that ‘a lack of certainty in this area is a concern.’<sup>158</sup>

### *Access to Government Programs*

- 3.95 The Deafness Forum advised that the qualifying age for the pension is scheduled to increase to 67 years by 2023.<sup>159</sup> Further to this, the Deafness Forum stated that ‘access to the NDIS is limited to people under 65 years’.<sup>160</sup>

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<sup>154</sup> Audiology Australia, *Submission 49*, p. 8.

<sup>155</sup> Audiology Australia, *Submission 49*, p. 8.

<sup>156</sup> Ms Lorraine Mulley, Private capacity, through Ms Michelle Ashley, Auslan interpreter, *Official Committee Hansard*, Canberra, 16 June 2017, p. 24.

<sup>157</sup> Ms Heidi Limareff, Acting Chief Executive, Can:Do Group, *Official Committee Hansard*, Adelaide, 3 May 2017, p. 8.

<sup>158</sup> Deafness Forum of Australia, *Submission 17*, pp 17-18.

<sup>159</sup> Deafness Forum of Australia, *Submission 17*, p. 19.

<sup>160</sup> Deafness Forum of Australia, *Submission 17*, p. 19.

3.96 The Deafness Forum stated the change to the pension age may mean some people aged 65 to 67 years will not be able to access the NDIS or the Voucher Scheme<sup>161</sup> (the majority of Voucher Scheme recipients are pensioners<sup>162</sup>). To address this, the Deafness Forum recommended ‘that the age for accessing the NDIS be increased to 67 years at the same rate as access to the aged pension.’<sup>163</sup>

### *Eligibility for the Voucher Scheme*

3.97 National Seniors Australia suggested that the Voucher Scheme should be extended to Commonwealth Seniors Health Card holders.<sup>164</sup> National Seniors stated that ‘many older people do not qualify for free or subsidised hearing services, yet they also do not have the capacity to divert their income or savings to cover the out-of-pocket expenses associated with hearing services.’<sup>165</sup>

## **Veterans**

3.98 The Department of Veterans’ Affairs (DVA) advised that ‘hearing loss is very common in the veteran community and is a reflection of the exposures that veterans face as part of their service’.<sup>166</sup> In particular, the DVA identified ‘prolonged exposure to machinery noise or high intensity impulse munitions in a theatre of conflict’ as causes of hearing damage in veterans.<sup>167</sup>

3.99 The DVA stated that sensorineural hearing loss and tinnitus are the first and third most common accepted health conditions, respectively, among veterans of the Vietnam War. For veterans of more recent conflicts,<sup>168</sup> tinnitus and sensorineural hearing loss are the second and third most common accepted health conditions respectively.<sup>169</sup>

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<sup>161</sup> Deafness Forum of Australia, *Submission 17*, p. 19.

<sup>162</sup> Department of Health, *Submission 16*, p. 13.

<sup>163</sup> Deafness Forum of Australia, *Submission 17*, p. 19.

<sup>164</sup> National Seniors Australia (NSA), *Submission 79*, p. 7.

<sup>165</sup> Mr Ian Henschke, NSA, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 29.

<sup>166</sup> Department of Veterans’ Affairs, *Submission 90*, p. 1.

<sup>167</sup> Department of Veterans’ Affairs, *Submission 90*, p. 2.

<sup>168</sup> East Timor, Solomon Islands, Afghanistan, and Iraq.

<sup>169</sup> Department of Veterans’ Affairs, *Submission 90*, pp 2, 8-9.

3.100 In 2015-16, 194 434 DVA clients were registered under the Hearing Services Program. In the same year, 42 629 of these clients received hearing device fittings and approximately another 30 248 received other services such as maintenance or battery replacements.<sup>170</sup>

3.101 Arafura Audiology questioned whether it was appropriate for younger, recently returned veterans to be supported through the Voucher Scheme, which is predominantly aimed at pensioners. Arafura explained:

These are young ladies and men coming back from the Middle East or other war-torn areas with significant acoustic trauma incidents. They are broadly now lumped under the care of the Office of Hearing Services. They are provided with a device and/or a service that is the same as that provided to a retiree or a person with very different listening needs. They are potentially significantly limited in their capacity to reintegrate into the hearing world given they have had a significant workplace injury, but the decision was taken two years ago to limit the ongoing care in terms of the funding to applicable technology and services for these people.<sup>171</sup>

3.102 The Deafness Forum expanded on this issue by explaining that there has been a recent review of military compensation arrangements for veterans with hearing impairment. Previously, veterans eligible for support under the *Safety, Rehabilitation and Compensation Act 1988 (Cwlth)* (SRC Act) could receive high level hearing aids at no cost. Since the review, however, hearing support for these veterans has moved to the Hearing Services Program Voucher Scheme which provides a free base level hearing aid but requires a co-payment for higher level hearing aids.<sup>172</sup>

3.103 The Deafness Forum observed that these changes have resulted in veterans receiving less support than other people eligible for treatment under the SRC Act. The Deafness Forum stated:

It is unreasonable that veterans who sustained a hearing loss as a result of their military service should be disadvantaged in being able to access high level technology due to a change in administrative arrangements in the management of military compensation, whereas other claimants under the

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<sup>170</sup> Department of Veterans' Affairs, *Submission 90*, p. 5.

<sup>171</sup> Dr Matthew Callaway, Director, Senior Audiologist, Arafura Audiology, *Official Committee Hansard*, Darwin, 7 June 2017, p. 22.

<sup>172</sup> Deafness Forum of Australia, *Submission 17.2*, pp 1-2.

same Act, e.g. public servants, continue to receive high level devices at no cost.<sup>173</sup>

- 3.104 The DVA observed that the transfer to new arrangements of clients eligible for services under the SRC Act 'has caused some concerns'.<sup>174</sup> The DVA further added the hearing aids previously provided to these clients had often been 'in excess of what was required to manage their hearing loss, with the cost being borne by Government'. The DVA accepted that the changed arrangements had resulted in a 'perception that there has been a reduction in entitlements as there is a view that fully subsidised hearing aids are basic and insufficient for veterans with active lifestyles'.<sup>175</sup>
- 3.105 The DVA also stated that as 'a result of the concerns expressed in relation to hearing aids' it had recently undertaken a review of its hearing services in consultation with the Department of Health, the Ex Service Organisations Round Table,<sup>176</sup> and leading hearing industry experts.<sup>177</sup> As part of the outcomes of this review, the DVA was 'liaising with Comcare in clarifying the provision of devices for public servants with hearing impairment under the SRC Act'.<sup>178</sup>

## Concluding Comment

### *Aboriginal and Torres Strait Islander People*

- 3.106 The Committee is concerned by the crisis in Aboriginal and Torres Strait Islander hearing health. At any one time 90 per cent of the children in remote Aboriginal and Torres Strait Islander communities will be experiencing an otitis media infection. Sadly for many of these children frequent otitis media infections will result in permanent hearing damage.

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<sup>173</sup> Deafness Forum of Australia, *Submission 17.2*, p. 2.

<sup>174</sup> Department of Veterans' Affairs, *Submission 90*, p. 5.

<sup>175</sup> Department of Veterans' Affairs, *Submission 90*, p. 5.

<sup>176</sup> The Ex Service Organisations Round Table includes representatives from the Repatriation Commission and the Military Rehabilitation and Compensation Commission and a range of organisations representing veterans and their families. Department of Veterans' Affairs, 'ESO Round Table (ESORT)', <https://www.dva.gov.au/consultation-and-grants/consultation-ex-service-community/eso-round-table-esort>, Accessed 16 August 2017.

<sup>177</sup> Department of Veterans' Affairs, *Submission 90*, p. 5.

<sup>178</sup> Department of Veterans' Affairs, *Submission 90*, p. 7.

- 3.107 The Committee received evidence that, in comparison to other children, Aboriginal and Torres Strait Islander children experience otitis media infections that start at an earlier age and are more frequent, severe, and persistent. On average two and a half years of their childhood is spent with an otitis media infection. Even for those children who do not experience permanent hearing damage, the time spent struggling to hear can negatively impact their development and educational attainment.
- 3.108 Hearing impairment in early childhood can set off a chain of negative impacts that entrench disadvantage in Aboriginal and Torres Strait Islander communities. The unfortunate link between hearing loss and interactions with the criminal justice system can be seen in the Darwin and Alice Springs correctional facilities where 90 per cent of Aboriginal and Torres Strait Islander inmates have hearing loss.
- 3.109 The Committee is concerned by the limited access to hearing health services in regional and remote areas and the lengthy waiting lists for audiological services and ear, nose, and throat consultations in the Northern Territory. Given the negative impact of treatment delays on children's development, greater resources are needed to reduce these waiting lists.
- 3.110 The Committee was, however, pleased to see the example of the Deadly Ears Program which operates a mobile hearing health service travelling to outreach locations. The Committee believes it is important that successful programs, such as Deadly Ears, are continued and replicated.
- 3.111 Soundfield amplification in schools offers a practical means of assisting children with otitis media infections or mild hearing loss to remain engaged in the classroom. The 2010 Senate *Inquiry into Hearing Health in Australia* recommended the installation of soundfield amplification in classrooms but this has not been implemented. The Committee concurs with the findings of the Senate Inquiry regarding soundfield amplification in classrooms and reiterates this recommendation.
- 3.112 Many organisations referred to a lack of coordination between Commonwealth, state and territory programs focussed on Aboriginal and Torres Strait Islander hearing health. A strategic national approach is needed to address the crisis in Aboriginal and Torres Strait Islander hearing health. An important first step will be addressing the deficiencies in data collection regarding hearing loss and the provision of services in Aboriginal and Torres Strait Islander communities. Close cooperation between Commonwealth, state and territory agencies, health organisations, and local communities will be required.

### *People from Culturally and Linguistically Diverse Backgrounds*

- 3.113 Some hearing impaired children and adults from culturally and linguistically diverse backgrounds require access to interpreters when receiving treatment for their hearing loss. The Government already provides a free interpreting service to assist people from culturally and linguistically diverse backgrounds communicate with approved organisations and service providers, however audiologists and audiometrists are not eligible to use this service.
- 3.114 The Committee is of the view that hearing service providers should be added to the list of groups eligible to use this interpreting service. This will help to ensure people from culturally and linguistically diverse backgrounds are fully aware of their options for the effective treatment of hearing loss.

### *Older Australians*

- 3.115 Older Australians living in aged care facilities are more likely to have a hearing impairment, as well as a range of other health conditions. Effectively managing their hearing impairment may improve their quality of life and potentially slow cognitive decline. Using assistive listening devices in nursing homes, such as amplification devices and captioning, could make a difference to the everyday lives of residents. Educating staff, carers, and family members on how to best assist someone with a hearing impairment, including how to look after a hearing device, is also important.
- 3.116 The Committee received evidence that the introduction of the National Disability Insurance Scheme may result in a lack of services, particularly Auslan services, for people aged over 65 years. The Committee considers, given the high prevalence of hearing issues in people aged over 65 years, this cohort should be eligible for a similar level of care and support as those aged under 65 years. In particular, the Committee believes that the National Auslan Interpreter Booking and Payment Service should continue to be accessible to Auslan users over the age of 65 years.

### *Veterans*

- 3.117 Sensorineural hearing loss and tinnitus are among the three most common conditions experienced by veterans of recent international conflicts. The Committee is pleased that the Department of Veterans' Affairs provides additional hearing health support to Australia's veteran community.

3.118 The Committee is concerned by reports suggesting that a recent review of hearing health supports for veterans has resulted in a reduction in the quality of hearing aids available to veterans. The Department of Veterans' Affairs should ensure that, at a minimum, the quality of hearing devices provided to veterans is equal to that provided to other eligible government employees.

### **Recommendation 1**

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**3.119 The Committee recommends that the Department of Health, in collaboration with Australian Hearing, the Department of the Prime Minister and Cabinet, states and territories, Aboriginal and Torres Strait Islander health organisations, and local communities, develop a national strategy to improve hearing health in Aboriginal and Torres Strait Islander communities aimed at:**

- **coordinating Commonwealth, state and territory services to ensure they are complementary and delivered in a coordinated manner;**
- **developing a nationally consistent data reporting framework to record data on the prevalence of ear health conditions and the provision of services, including a treatment outcomes tracking method;**
- **regular monitoring and evaluating of programs to ensure they are meeting their objectives; and**
- **funding further research into Aboriginal and Torres Strait Islander hearing health issues.**

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**Recommendation 2**

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**3.120 The Committee recommends that the Department of Health and Australian Hearing significantly increase the resources devoted to providing hearing health services in regional and remote Aboriginal and Torres Strait Islander communities. The mobile outreach services of the Deadly Ears Program should serve as a best practice example for national implementation. This program should focus on expanding access to hearing health services in regional and remote locations and reducing the waiting lists for Aboriginal and Torres Strait Islander children requiring hearing health treatment.**

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**Recommendation 3**

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**3.121 The Committee recommends that the Department of Health together with the Department of Education and Training create a hearing health support fund for Aboriginal and Torres Strait Islander students. This fund should:**

- **be responsible for the progressive installation of soundfield amplification systems in the classrooms of all regional, rural, and remote schools with a significant Aboriginal and Torres Strait Islander student population; and**
- **provide support to deaf Aboriginal and Torres Strait Islander children to learn sign language and access interpreters where necessary.**

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**Recommendation 4**

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**3.122 The Committee recommends that the Department of Social Services include audiology and audiometry as eligible services for access to the Free Interpreting Service, delivered by the Translation and Interpreting Service.**

**Recommendation 5**

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**3.123 The Committee recommends that the Office of Hearing Services review the provision of hearing services to residents in aged care facilities. This review should consider issues including:**

- **the use of assistive listening devices for aged care residents;**
- **service provision for deafblind Australians in aged care facilities; and**
- **the education of aged care facility staff.**

# 4. Research and Prevention of Hearing Loss

## Overview

- 4.1 Exposure to noise is a major, and predominantly preventable, cause of adult onset hearing loss. Exposure to noise in the workplace has, in the past, been the primary source of noise induced hearing loss. While this remains a serious issue, in recent times recreational sources of noise have emerged as posing an additional significant risk to hearing health. This chapter will discuss occupational and recreational noise induced hearing loss, as well as education and awareness programs that aim to encourage people to protect their hearing and, if necessary, seek treatment for hearing loss.
- 4.2 In addition to considering how hearing loss can be prevented, this chapter discusses research into treatments for hearing loss and balance disorders including in emerging areas such as gene therapy. This chapter will also focus on how developments in communication technology are creating opportunities for new methods of delivering hearing treatment and support.

## Noise Induced Hearing Loss

- 4.3 Safe Work Australia stated that hearing can be damaged through exposure to a loud noise for a short period of time, or lower noise levels over a longer period.<sup>1</sup> In outlining how noise can affect hearing, the HEARing Cooperative Research Centre (CRC) stated that:

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<sup>1</sup> Safe Work Australia, *Submission 35*, p. 1.

... the impact is a result of the degree of insult (i.e. the loudness of the sound/noise), the length of the exposure, and the frequency of exposure, in addition to the factor of individual susceptibility.<sup>2</sup>

- 4.4 Noise induced hearing loss was described by the HEARing CRC as ‘the most significant contributor to the prevalence and degree of acquired hearing loss in adults’<sup>3</sup>. Deloitte Access Economics observed that it ‘can be difficult to distinguish between the effects of [noise induced hearing loss and age-related hearing loss], as they frequently co-exist.’<sup>4</sup> In 2006 Access Economics estimated that 37 per cent of hearing loss in adults was due to preventable causes.<sup>5</sup>
- 4.5 Deloitte Access Economics stated that while traditionally most cases of noise induced hearing loss have occurred through workplace activity (known as occupational noise induced hearing loss), there is an ‘increasing risk’ of recreational noise induced hearing loss. Activities associated with recreational noise induced hearing loss include: listening to personal music players at a high volume, and attending loud music concerts and nightclubs.<sup>6</sup>

## Occupational Noise Induced Hearing Loss

- 4.6 Safe Work Australia indicated that noise induced hearing loss is a ‘priority disorder for national action under the *Australian Work Health and Safety Strategy 2012-2022* because of the severity of the consequences and the estimated number of workers affected.’<sup>7</sup>
- 4.7 In 2011 Safe Work Australia developed model Work Health and Safety (WHS) Regulations, which:
- ... set out the requirements for noise control in the workplace ... The model WHS Regulations for noise have been implemented in all jurisdictions except

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<sup>2</sup> The HEARing Cooperative Research Centre (CRC), *Submission 59*, p. 7.

<sup>3</sup> The HEARing CRC, *Submission 59*, p. 6.

<sup>4</sup> Deloitte Access Economics, *Exhibit 18: An Update of the Social and Economic Cost of Hearing Loss and Hearing Health Conditions in Australia*, p. 31.

<sup>5</sup> Access Economics, 2006, *Listen Hear! The Economic Impact and Cost of Hearing Loss in Australia*, p. 7.

<sup>6</sup> Deloitte Access Economics, *Exhibit 18*, p. 31.

<sup>7</sup> Safe Work Australia, *Submission 35*, p. 1.

Victoria and Western Australia, where the regulations for noise control are dealt with in their occupational health and safety regulations.<sup>8</sup>

- 4.8 The model WHS Regulations include two standards for limiting noise exposure; a maximum of 85 dB for eight hours, and a maximum peak of 140 dB for short, loud noises.<sup>9</sup>
- 4.9 Safe Work Australia explained that noise in the workplace should be managed using a 'hierarchy of control' where the most effective control measures should be chosen wherever practicable. Safe Work Australia stated that the 'most effective control measure for noise is to eliminate the source of noise completely, for example by ceasing to use a noisy machine'.<sup>10</sup>
- 4.10 Where elimination of a noise source is not possible 'risks may be minimised by choosing one or more of the following measures:
- substitute the hazard with plant or processes that are quieter;
  - modify plant and processes to reduce the noise using engineering controls;
  - isolate the source of noise from people by using distance, barriers, enclosures or sound-absorbing surfaces.<sup>11</sup>
- 4.11 Where a risk remains it should be minimised using administrative controls and if a 'risk still remains, then suitable hearing protection must be provided and used.'<sup>12</sup>
- 4.12 Safe Work Australia stated that 69 481 workers' compensation claims for noise induced hearing loss were accepted between 2000-01 and 2014-15.<sup>13</sup> The majority of these cases (67 084 or 4472 per year) arose due to long term exposure to sounds, while the remainder (2048 or 136 per year) were due to exposure to a single, sudden sound.<sup>14</sup>
- 4.13 The rate of workers' compensation claims for noise induced hearing loss has not significantly reduced in the past 15 years. Safe Work Australia stated that analysis of trends in workers compensation figures was complicated by

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<sup>8</sup> Safe Work Australia, *Submission 35*, p. 3.

<sup>9</sup> Safe Work Australia, *Submission 35*, p. 3.

<sup>10</sup> Safe Work Australia, *Submission 35*, p. 4.

<sup>11</sup> Safe Work Australia, *Submission 35*, p. 4.

<sup>12</sup> Safe Work Australia, *Submission 35*, p. 4.

<sup>13</sup> Safe Work Australia, *Submission 35*, p. 1.

<sup>14</sup> Safe Work Australia, *Submission 35*, p. 2.

the potentially long period between noise exposure and the appearance of hearing loss. Safe Work Australia further stated it is difficult to determine 'whether hearing loss is work-related or due to age or non-occupational noise exposure'.<sup>15</sup>

- 4.14 Safe Work Australia advised that it had undertaken research indicating that noise was primarily controlled in workplaces through 'the use of personal protective equipment like ear plugs and ear muffs ... rather than putting controls in place to eliminate or minimise the noise at the source'.<sup>16</sup> The research also found that:

In addition to an over-reliance on personal hearing protectors ... barriers to effective noise control and [workplace noise induced hearing loss] prevention include infrequent and improper use of personal hearing protectors, lack of prominence of noise as a serious WHS issue, and lack of consideration of potential benefits of effective noise control.<sup>17</sup>

- 4.15 The Australian Institute of Occupational Hygienists (AIOH) recommended greater use of audiometric testing for people exposed to high levels of workplace noise. The AIOH suggested that providing personalised information for employees, rather than group presentations, would be more engaging. The AIOH explained that someone:

... saying: 'Those are your results. You are personally in danger here. This is not a theory; this is you.' It gives them an opportunity to take the preventative methods that are at work a bit more seriously.<sup>18</sup>

- 4.16 The Australian Society of Rehabilitation Counsellors advised that workers with noise induced hearing loss 'are not routinely offered either hearing rehabilitation or injury prevention services', and recommended the Government investigate the most appropriate and cost effective mechanisms for providing hearing services to this cohort.<sup>19</sup>

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<sup>15</sup> Safe Work Australia, *Submission 35*, pp 1-2.

<sup>16</sup> Safe Work Australia, *Submission 35*, pp 2-3.

<sup>17</sup> Safe Work Australia, *Submission 35*, pp 2-3.

<sup>18</sup> Mr Jeremy Trotman, Councillor and Executive Officer, Australian Institute of Occupational Hygienists (AIOH), *Official Committee Hansard*, Melbourne, 1 May 2017, p. 43.

<sup>19</sup> Australian Society of Rehabilitation Counsellors, *Submission 23*, p. 9.

## ***Ototoxins***

- 4.17 Ototoxins are chemicals that ‘may interact with noise’ to increase the risk of hearing loss.<sup>20</sup> They are found in some workplace chemicals including some painting, cleaning and degreasing agents.<sup>21</sup>
- 4.18 The AIOH commented that exposure standards have not been altered to indicate the increased risk to hearing health caused by the interaction of ototoxins and noise.<sup>22</sup> The AIOH advised that until standards are established Safe Work Australia recommended that workers exposed to ototoxins are not exposed to daily noise levels above 80 dB(A).<sup>23</sup>

## ***Hearing Loss in Specific Industries***

- 4.19 Safe Work Australia stated that the manufacturing and construction industry sectors have the highest number of workers’ compensation claims for noise induced hearing loss. The highest incidence rate, which is the number of claims per million employees, was in the mining sector.<sup>24</sup>
- 4.20 Safe Work Australia also identified a ‘sustained year-on-year reduction in [the] incidence rate’ for the Electricity, Gas, Water and Waste Services sector for the fifteen year period 2000-01 to 2014-15.<sup>25</sup> No other industry sectors displayed any clear trends regarding occupational noise induced hearing loss.<sup>26</sup>

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<sup>20</sup> Safe Work Australia, *Submission 35*, p. 1.

<sup>21</sup> Mr Jeremy Trotman, AIOH, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 43.

<sup>22</sup> AIOH, *Submission 54.1*, p. 1.

<sup>23</sup> AIOH, *Submission 54.1*, p. 1.

<sup>24</sup> Safe Work Australia, *Submission 35*, p. 2.

<sup>25</sup> Safe Work Australia, *Submission 35*, pp 2, 7.

<sup>26</sup> Safe Work Australia, *Submission 35*, p. 2.

### **Box 4.1 Noise Induced Hearing Loss and Farmers**

Noise induced hearing loss has been estimated to affect over 60 per cent of farmers.<sup>27</sup> The National Centre for Farmer Health stated that there is evidence that farmers develop hearing loss fifteen years earlier than the general population.<sup>28</sup> Farmers also have higher rates of social isolation, which can be exacerbated by hearing loss.<sup>29</sup>

Higher rates of hearing loss in farmers is largely due to occupational noise exposure, such as through the use of tractors and agricultural machinery.<sup>30</sup> Sound Scouts Australia stated that, in addition, 'people living in rural areas often make use of noisy recreational equipment such as power tools, firearms, motorcycles or quadbikes.'<sup>31</sup>

According to the National Centre for Farmer Health, hearing loss among the farming and agricultural population has become normalised and accepted.<sup>32</sup> This acceptance of hearing loss, as well as a culture of being 'strong and stoic', has meant that farmers do not always seek treatment for hearing issues.<sup>33</sup>

#### ***Shhh Hearing in a Farming Environment Program***

From 2012 to 2015, the 'Shhh hearing in a farming environment' program was conducted by the National Centre for Farmer Health at Deakin University, in partnership with the National Acoustic Laboratories and the University of Canberra, and funded by the

<sup>27</sup> National Centre for Farmer Health (NCFH), *Exhibit 9: Shhh Hearing in a Farming Environment: Parliamentary Inquiry Hearing Health and Wellbeing, May 2017*, p. 1.

<sup>28</sup> Associate Professor Susan Brumby, Director, NCFH, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 20.

<sup>29</sup> Associate Professor Susan Brumby, NCFH, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 18.

<sup>30</sup> Sound Scouts Australia, *Submission 41*, p. 8.

<sup>31</sup> Sound Scouts Australia, *Submission 41*, p. 8.

<sup>32</sup> Associate Professor Susan Brumby, NCFH, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 18.

<sup>33</sup> Associate Professor Susan Brumby, NCFH, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 20; NCFH, *Exhibit 9*, p. 1.

National Health and Medical Research Council.<sup>34</sup>

The program tested whether early intervention services tailored to farming families and agricultural workers would reduce the social impact of hearing loss on farmers, and successfully educate and empower farmers to reduce their exposure to noise.<sup>35</sup>

As part of this program the National Centre for Farmer Health: screened farmers for hearing loss, conducted on-farm noise audits, and introduced methods to reduce the social impact of hearing loss.<sup>36</sup> The on-farm noise audit tested farmers' exposure to noise over a 24 hour period. The results of the audits were characterised by Associate Professor Susan Brumby as 'alarming', with 51 per cent of participants being over their safe daily noise exposure limit.<sup>37</sup>

The research program found that as a result of the screening, farm audit and education about noise hazards and risks, 'most participants took action in reducing their noise and improving their psychosocial interactions—[becoming] more empowered to tell people they had a hearing loss and to be direct with how people communicated with them.'<sup>38</sup>

The research also identified that farmers preferred to learn techniques to manage their hearing loss instead of getting hearing devices. Techniques included meeting in quiet areas and being confident in asking people to use eye contact when speaking.<sup>39</sup>

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<sup>34</sup> NCFH, *Exhibit 9*, p. 1.

<sup>35</sup> NCFH, *Exhibit 9*, p. 1.

<sup>36</sup> Associate Professor Susan Brumby, NCFH, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 18.

<sup>37</sup> Associate Professor Susan Brumby, NCFH, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 19.

<sup>38</sup> Associate Professor Susan Brumby, NCFH, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 19.

<sup>39</sup> Associate Professor Susan Brumby, NCFH, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 22.

## Recreational Noise Exposure

- 4.21 According to HEARsmart and the HEARing CRC, 'excessive noise exposures from recreational sources, such as music venues, nightclubs, bars, sporting events and personal music players ... pose a risk to hearing.'<sup>40</sup> The HEARing CRC further stated that young adults in particular 'are at significant risk from leisure noise.'<sup>41</sup>
- 4.22 Personal music devices such as iPods may present a risk to hearing if the device is used for long periods of time and at a high volume.<sup>42</sup> The HEARing CRC presented the common scenario of people listening to music devices on public transport on their way to and from work. As public transport can be noisy, some people may listen to their devices at unsafe volumes, in order to hear over the background noise.<sup>43</sup> Can:Do Group also stated that up to 93 per cent of Australian children own personal music players, which may expose them to a risk of noise induced hearing loss at a young age.<sup>44</sup>
- 4.23 In contrast, Dr Timothy Makeham suggested that 'the intensity of the sound' from earphones is often 'not sufficient to cause long-term permanent damage'. As such, 'most people' are not at a high risk of permanent damage, as they are not listening at dangerously high volumes.<sup>45</sup>
- 4.24 The Hearing Care Industry Association (HCIA) stated that, in Australia, there is no required volume restriction on personal music players.<sup>46</sup> While the HEARing CRC agreed, it stated that it is not only the volume of sound but also length of time it is listened to that is important. As such, preventing

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<sup>40</sup> HEARsmart and the HEARing CRC, *Submission 32*, p. 1.

<sup>41</sup> HEARsmart and the HEARing CRC, *Submission 32*, p. 1.

<sup>42</sup> Professor Robert Cowan, Chief Executive Officer, the HEARing CRC and HEARsmart, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 14.

<sup>43</sup> Professor Robert Cowan, The HEARing CRC and HEARsmart, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 14.

<sup>44</sup> Can:Do Group, *Submission 50*, p. 2.

<sup>45</sup> Dr Timothy Makeham, Private Capacity, *Official Committee Hansard*, Canberra, 14 February 2017, p. 2.

<sup>46</sup> Ms Donna Staunton, Chief Executive Officer, Hearing Care Industry Association (HCIA), *Official Committee Hansard*, Adelaide, 3 May 2017, p. 18.

noise induced hearing loss is ‘not quite as simple as just legislating’ a maximum volume level.<sup>47</sup>

- 4.25 The HEARing CRC stated that young people who attend nightclubs are a ‘real at-risk population’<sup>48</sup> for hearing loss, and that ‘of those people who go to clubs, some 30 per cent end up with temporary threshold shifts, and, importantly, tinnitus as an outcome.’<sup>49</sup> Dr Makeham expressed similar concerns:

When you are at a nightclub or in a loud environment where you cannot hear conversation, the noise level is often at 100 decibels. At that point, the amount of time you can spend there without expecting to see irreversible damage is actually quite short—often less than an hour.<sup>50</sup>

- 4.26 Aboriginal and Torres Strait Islander communities may also experience high rates of noise induced hearing loss. The article *Dangerous Listening: The Exposure of Indigenous People to Excessive Noise* outlined recreational noise exposure risks in Aboriginal and Torres Strait Islander households, stating that:

Crowded housing, the high proportion of Indigenous people with conductive hearing loss and easier access to noise-generating entertainment equipment appear to result in an extreme noise exposure profile in many Indigenous households.<sup>51</sup>

- 4.27 The *Dangerous Listening* article also stated that there was ‘excessive noise exposure among quite young Indigenous children’, which can have lifelong consequences.<sup>52</sup> The article advocated that ‘urgent action’ was needed to prevent noise induced hearing loss in Indigenous communities, primarily through the provision of information on the dangers of excessive noise

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<sup>47</sup> Professor Robert Cowan, The HEARing CRC and HEARsmart, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 15.

<sup>48</sup> Professor Robert Cowan, The HEARing CRC and HEARsmart, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 14.

<sup>49</sup> Professor Robert Cowan, The HEARing CRC and HEARsmart, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 12.

<sup>50</sup> Dr Timothy Makeham, Private Capacity, *Official Committee Hansard*, Canberra, 14 February 2017, p. 2.

<sup>51</sup> Dr Damien Howard and Jody Barney, *Submission 98, Attachment A*, p. 7.

<sup>52</sup> Dr Damien Howard and Jody Barney, *Submission 98, Attachment A*, p. 7.

exposure, with a focus on ‘family based solutions’ and the engagement of Indigenous health workers.<sup>53</sup>

### **Box 4.2 Preventing Recreational Noise Induced Hearing Loss: The HEARsmart Campaign**

The HEARing CRC, observing that preventing hearing loss is ‘much more effective than remediation’,<sup>54</sup> partnered with the National Acoustic Laboratories (NAL) to launch HEARsmart. HEARsmart aims to ‘engage, inform and educate the public regarding the risk of developing hearing loss and tinnitus from excessive noise exposure’.<sup>55</sup>

HEARsmart identified young adults as being at ‘significant risk’ of experiencing hearing loss due to ‘noise levels in the music industry’.<sup>56</sup> To address this risk HEARsmart has been collaborating with the music industry to ‘promote healthy management of sound in live music venues’.<sup>57</sup>

HEARsmart installed sound management technology in a venue known to play particularly loud music. The results of the trial suggest that while the ‘musical integrity’ of performances at the venue were maintained the system produced safer levels of noise exposure for staff and patrons. Surveys suggest that the lower sound levels have also been appreciated by the venue’s patrons.<sup>58</sup>

Another HEARsmart project, the Know Your Noise campaign, aims to promote good hearing health among young people aged between 18 and 35. Know Your Noise is ‘focused on promoting simple actions to help keep sound doses safe (and importantly, not to be the ‘fun’ police)’.<sup>59</sup>

The Know Your Noise website features an online hearing test and a

<sup>53</sup> Dr Damien Howard and Jody Barney, *Submission 98, Attachment A*, p. 8.

<sup>54</sup> Professor Robert Cowan, The HEARing CRC and HEARsmart, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 12.

<sup>55</sup> HEARsmart and the HEARing CRC, *Submission 32*, p. 1.

<sup>56</sup> HEARsmart and the HEARing CRC, *Submission 32*, p. 1.

<sup>57</sup> HEARing CRC, *Submission 59.1*, p. 1.

<sup>58</sup> HEARing CRC, *Submission 59.1*, p. 1.

<sup>59</sup> HEARing CRC, *Submission 59*, p. 8.

noise risk calculator. The noise risk calculator (developed using NAL research data) asks users to enter information about their lifestyle and listening habits and provides them with a personalised assessment of their risk of exposure to dangerous levels of noise.<sup>60</sup>

Results from a survey of Know Your Noise users found that ‘following exposure to Know Your Noise, 43 per cent of young adults increased their motivation to take active steps to protect their hearing’.<sup>61</sup>

## Public Awareness of Hearing Health Issues

### Hearing Health Awareness in Australia

4.28 Despite the large number of Australians affected by hearing loss, many organisations suggested that the general public had a low level of knowledge surrounding hearing health issues. Reflecting this, Australian Hearing referred to hearing loss as the ‘hidden disability’.<sup>62</sup> Self Help for Hard of Hearing People Australia (SHHH Australia) further stated that there is ‘a general lack of awareness in the community of the many signs of deafness and ear and balance disorders as well as what to do about it and how it can be managed.’<sup>63</sup>

4.29 The Australian College of Audiology stated that in its view:

... the community is poorly informed about hearing health care choices. Many pensioners are not aware that they can obtain free hearing services from the Office of Hearing Services ... education around hearing loss is most often left to support groups instead of government agencies. Much of the promotion regarding hearing loss is more focussed on the fitting of hearing devices rather than general information about hearing loss and hearing conservation.<sup>64</sup>

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<sup>60</sup> HEARsmart and the HEARing CRC, *Submission 32*, p. 2.

<sup>61</sup> HEARing CRC, *Submission 59*, p. 8.

<sup>62</sup> Australian Hearing, *Submission 58*, p. 4.

<sup>63</sup> Self Help for Hard of Hearing Australia (SHHH Australia), *Submission 42*, p. 14.

<sup>64</sup> Australian College of Audiology, *Submission 94*, p. 2.

## Effects of Limited Awareness of Hearing Health Issues

- 4.30 The Royal Institute for Deaf and Blind Children (RIDBC) stated that despite efforts to 'educate Australians about hearing loss, it is estimated that around two thirds of all Australians with hearing loss still go untreated.'<sup>65</sup> In addition, the Deafness Forum of Australia (Deafness Forum) stated that on average there is a delay of seven years between 'the time the person becomes aware of a hearing problem to the time when they do something about it.'<sup>66</sup>
- 4.31 SHHH Australia suggested that a greater focus on hearing health issues would encourage people to seek treatment for hearing loss earlier, stating:
- ... by raising awareness of hearing loss and its consequences, the community will better understand that by addressing hearing loss earlier people can enjoy a better quality of life, avoid significant downstream health costs and help prevent cognitive decline particularly in the elderly.'<sup>67</sup>
- 4.32 Australia's hearing population also may not know how to assist hearing impaired people in their interactions. The Deafness Forum explained that:
- People generally do not know the strategies that can be applied to improve the communication with a hearing impaired person or how to change the environment to make it easier for a person with hearing loss to follow conversation.<sup>68</sup>
- 4.33 The HEARing CRC highlighted that even among general practitioners (GPs) awareness of hearing health issues may be low and this could, potentially, result in misdiagnoses.<sup>69</sup> The RIDBC suggested GPs needed greater knowledge of 'the implications of hearing loss and the services and strategies available to their patients and family members'.<sup>70</sup> Australian Hearing also highlighted that hearing technology is 'advancing at a rapid rate' and that medical practitioners need access to accurate information and

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<sup>65</sup> Royal Institute for Deaf and Blind Children (RIDBC), *Submission 48*, p. 7.

<sup>66</sup> Deafness Forum of Australia, *Submission 16*, p. 13

<sup>67</sup> SHHH Australia, *Submission 42*, p. 14.

<sup>68</sup> Deafness Forum of Australia, *Submission 16*, p. 13.

<sup>69</sup> Professor Robert Cowan, The HEARing CRC and HEARsmart, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 12.

<sup>70</sup> RIDBC, *Submission 48*, p. 7.

education so that their patients are provided with 'the most appropriate intervention for their needs'.<sup>71</sup>

- 4.34 Deafblind Australia stated that deafblindness was a 'unique and isolating sensory disability resulting from the combination of both a hearing and vision loss'<sup>72</sup> and that representatives of the health system were lacking in awareness of the needs of deafblind Australians. Deafblind Australia stated that there is an:

... extremely limited understanding among service providers of the complex needs of people with combined vision and hearing loss ... two key areas which require addressing urgently are awareness of National Disability Insurance Scheme planners and aged care services.<sup>73</sup>

## Education and Awareness Programs

- 4.35 There are currently two national awareness campaigns related to hearing health: the National Week for Deaf People, led by Deaf Australia, and Hearing Awareness Week, led by the Deafness Forum.<sup>74</sup> Both Deaf Australia and the Deafness Forum called for government funding to undertake further awareness raising and communications work.<sup>75</sup>
- 4.36 CICADA Australia suggested that Hearing Awareness Week 'is not widely advertised but could achieve much more with a national approach, better funding and professional marketing involvement.'<sup>76</sup> Goulburn Valley Hearing Clinic added that apart from the Hearing Awareness Week, 'most of the information and promotion about hearing loss and health care is coming from the retail sector in the form of advertising and direct marketing'.<sup>77</sup>
- 4.37 Deaf Services Queensland (DSQ) provides Deafness Awareness Training, which it described as 'crucial in workplaces to help co-workers understand how to work with someone who is deaf' and also beneficial to staff who may interact with deaf Australians in 'mainstream services' such as health and

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<sup>71</sup> Australian Hearing, *Submission 58*, p. 5.

<sup>72</sup> Deafblind Australia, *Submission 69*, p. 1.

<sup>73</sup> Deafblind Australia, *Submission 69*, p. 2.

<sup>74</sup> Mr David Brady, *Submission 65*, p. 3.

<sup>75</sup> Deaf Australia, *Submission 82*, p. 7; Deafness Forum of Australia, *Submission 17*, p. 14.

<sup>76</sup> CICADA Australia, *Submission 73*, p. 5.

<sup>77</sup> Goulburn Valley Hearing Clinic, *Submission 104*, p. 2.

education. The DSQ stated that funding for the training was being phased out with the introduction of the National Disability Insurance Scheme.<sup>78</sup>

4.38 Mr David Brady commented that there has been no government led national awareness campaign focussing on hearing health since at least the early 1990s.<sup>79</sup> Many organisations stated there is a need for the creation of a major nationally coordinated campaign. Organisations calling for such a campaign included: the Australian Hearing Hub<sup>80</sup>, Cochlear<sup>81</sup>, the Deafness Forum<sup>82</sup>, the HCIA<sup>83</sup>, the RIDBC<sup>84</sup>, and SHHH Australia<sup>85</sup>.

4.39 The HCIA stated that raising awareness about hearing health issues was 'part of its mandate'. The HCIA highlighted the impact of awareness campaigns in other areas of public health, stating:

We know from Australia's experience with previous public health campaigns such as the National Skin Cancer Campaign and the National Tobacco Campaign that awareness campaigns can and do lead to changes in knowledge, attitudes and ultimately in changed behaviour. In the area of hearing health, there is a glaring need for education and awareness programs.<sup>86</sup>

4.40 The RIDBC suggested that an awareness and education campaign should focus on encouraging Australians to:

- Become aware of hearing health;
- Understand the implications of high risk hearing behaviours;
- Implement preventative strategies to minimise behaviours that are damaging to hearing;
- Attend assessments at key life stages; and

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<sup>78</sup> Deaf Services Queensland, *Submission 113*, p. 3.

<sup>79</sup> Mr David Brady, *Submission 65*, p. 1.

<sup>80</sup> Australian Hearing Hub, *Submission 60*, p. 3.

<sup>81</sup> Cochlear, *Submission 91*, p. 5.

<sup>82</sup> Deafness Forum of Australia, *Submission 17*, p. 14.

<sup>83</sup> HCIA, *Submission 30*, p. 6.

<sup>84</sup> RIDBC, *Submission 48*, p. 7.

<sup>85</sup> SHHH Australia, *Submission 42*, p. 5.

<sup>86</sup> HCIA, *Submission 30*, p. 6.

- Understand the range of options available to assist in returning to optimal hearing health, and the pathways to seeking help.<sup>87</sup>

4.41 Life Unlimited, a New Zealand charitable trust which is funded by the New Zealand Ministry of Health to provide aural rehabilitation services, explained that the provision of a national education strategy on hearing health is part of its contract with the Ministry of Health. Life Unlimited stated that 10 to 15 per cent of its therapists' time was expected to be spent on community education and training. Life Unlimited recommended that the Australian Government investigate contracting a 'non-clinical, community-based' organisation to 'raise awareness and understanding of hearing loss ... and to educate people in the community on hearing loss prevention and management.'<sup>88</sup>

## Research into Hearing Impairment

### Cochlear Implant Technology

- 4.42 In the late 1970s the cochlear implant (also known as the bionic ear) was created by a team of researchers at the University of Melbourne led by Professor Graeme Clark.<sup>89</sup> The cochlear implant was then commercialised by Cochlear Ltd and has since been used to treat hearing loss in over 450 000 people worldwide.<sup>90</sup> Professor Clark also established the Bionic Ear Institute (now the Bionics Institute of Australia) to conduct further research in this area.<sup>91</sup>
- 4.43 The Bionics Institute of Australia (Bionics Institute) stated that significant technological advances were made to cochlear implant technology during the 1980s and 1990s but that 'relatively little progress has been made in the last 15 years'.<sup>92</sup> The Bionics Institute stated that this was due to 'a number of serious challenges' limiting technological developments in cochlear implants

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<sup>87</sup> RIDBC, *Submission 48*, p. 8.

<sup>88</sup> Life Unlimited, *Submission 70*, pp 2-4.

<sup>89</sup> The Bionics Institute of Australia (Bionics Institute), *Submission 27*, p. 1.

<sup>90</sup> Mr Dig Howitt, Chief Operating Officer, Cochlear Ltd, *Official Committee Hansard*, Sydney, 15 November 2016, p. 9.

<sup>91</sup> Bionics Institute, *Submission 27*, p. 1.

<sup>92</sup> Bionics Institute, *Submission 27*, p. 5.

and that it was engaged in research programs aimed at overcoming these challenges.<sup>93</sup> These research programs include:<sup>94</sup>

- Using new brain imaging techniques to study the role of brain reorganisation (neuroplasticity) in the variability in speech understanding among cochlear implant users.
- Development of a new automatic system for programming cochlear implants (this would be particularly valuable for children who are too young to provide verbal feedback during implant programming).
- Manipulation of the way electrical stimulation is presented to the cochlea to assist the understanding of speech in noisy environments.
- Brain imaging studies focussed on people who have difficulty understanding speech but do not have decreased hearing thresholds.

## Genetics and Stem-Cell Research

4.44 Genetic factors are responsible for approximately 50 per cent of the cases of children born with hearing impairment.<sup>95</sup> Diagnosis of the causes of genetic hearing impairment has recently been improved by advances in next-generation gene sequencing. The Human Genetics Society of Australasia linked these advances in gene sequencing to improved treatment outcomes stating:

... we are also starting to learn that some specific types of hearing loss, whose genetic basis one does need to identify, can be treated or have specific management recommendations. So while we may not be able to cure them we can actually prevent deterioration.<sup>96</sup>

4.45 Research into genetic and stem-cell based therapies could also, potentially, lead to new methods of treating and preventing noise induced or age related hearing impairment. The Human Genetics Society of Australasia stated that:

... recent advances in the molecular understanding of specific genes and conditions mean that new medications which are coming through and currently being tested in animals are able to restore hearing in the context of

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<sup>93</sup> Bionics Institute, *Submission 27*, p. 5.

<sup>94</sup> Bionics Institute, *Submission 27*, p. 5.

<sup>95</sup> Dr Matthew Hunter, Member, Human Genetics Society of Australasia (HGSA), *Official Committee Hansard*, Canberra, 14 February 2017, p. 8.

<sup>96</sup> Dr Matthew Hunter, HGSA, *Official Committee Hansard*, Canberra, 14 February 2017, p. 9.

noise-induced or age-related types of hearing loss after hearing has already been lost.<sup>97</sup>

4.46 The Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) stated that we are ‘moving into a time of pharmaceutical and regenerative medicine in hearing loss’.<sup>98</sup> The ASOHNS added that a drug which aimed to regenerate inner ear hair cells was about to begin clinical trials in Melbourne, but cautioned:

... we would be lucky if it works with the first iteration, but we are starting to move into a field where there may be more than devices and there may be medical treatments for hearing loss evolve over the next 10 to 20 years.<sup>99</sup>

4.47 Other research organisations undertaking research in similar fields include:

- The HEARing CRC, in conjunction with the Walter and Eliza Hall Institute, is researching ways to stop the apoptotic chain which results in the death of hair cells in the inner ear.<sup>100</sup>
- The Bionics Institute has undertaken stem-cell transplantation to rehabilitate the auditory nerve after deafness; and gene therapy to ‘re-program’ cells to function like inner ear hair cells.<sup>101</sup>

4.48 Several witnesses suggested that while new gene and stem-cell research had shown it was potentially possible to restore damaged hair cells, this research was still at a very early stage.<sup>102</sup> These techniques had been tested in animal studies but considerable further safety studies would be required before human trials could begin.<sup>103</sup>

4.49 Even if hair cells in the inner ear are able to be regenerated there may be additional challenges. The HEARing CRC explained that hair cells connect to nerves to convey particular sound frequencies and if lost hair cells are

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<sup>97</sup> Dr Matthew Hunter, HGSA, *Official Committee Hansard*, Canberra, 14 February 2017, pp 7-8.

<sup>98</sup> Professor Stephen O’Leary, Member, Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS), *Official Committee Hansard*, Sydney, 6 April 2017, p. 45.

<sup>99</sup> Professor Stephen O’Leary, ASOHNS, *Official Committee Hansard*, Sydney, 6 April 2017, p. 47.

<sup>100</sup> Professor Robert Cowan, The HEARing CRC and HEARsmart, *Official Committee Hansard*, Melbourne, 1 May 2017, pp 13-14.

<sup>101</sup> Bionics Institute, *Submission 27*, p. 6.

<sup>102</sup> Including: the Bionics Institute, the HGSA, The HEARing CRC.

<sup>103</sup> Professor Colette McKay, Leader in Translational Hearing Research, Bionics Institute, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 7.

regenerated 'we do not know if they are going to be connected in the same way'.<sup>104</sup>

## Longitudinal Studies

- 4.50 The NAL and the HEARing CRC have undertaken longitudinal research into the long term impacts of the early diagnosis and treatment of children with hearing impairment in the Longitudinal Outcomes of Children with Hearing Impairment (LOCHI) study. This study is considering 'whether universal newborn hearing screening and early intervention improve outcomes at a population level'.<sup>105</sup>
- 4.51 From 2002 to 2007 the LOCHI study recruited 453 hearing impaired newborn children in New South Wales, Victoria and Queensland and is following their development to the age of 12 to 15 years.<sup>106</sup> The LOCHI study found that 'early device fitting and early intervention do make a significant difference in terms of getting to peer-equivalent language ... by age five.'<sup>107</sup> Early intervention improved language outcomes for children fitted with hearing aids and those fitted with cochlear implants.<sup>108</sup>
- 4.52 The HEARing CRC stated that the results of the LOCHI study are:
- ... unequivocal in supporting the need for early identification through screening and early intervention. By far, the most significant factor in influencing outcomes is earlier age at hearing aid fitting or cochlear implantation. This is not feasible without universal newborn screening and comprehensive early intervention programs.<sup>109</sup>
- 4.53 Australian Hearing stated that an additional finding of the LOCHI study was that, in Australia, there was almost no loss of children between a referral from a newborn hearing screening to treatment from Australian

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<sup>104</sup> Professor Robert Cowan, The HEARing CRC and HEARsmart, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 14.

<sup>105</sup> The HEARing CRC, *Submission 59*, p. 10.

<sup>106</sup> The HEARing CRC, *Submission 59*, p. 10.

<sup>107</sup> Professor Robert Cowan, The HEARing CRC and HEARsmart, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 12.

<sup>108</sup> The HEARing CRC, *Submission 59*, p. 10.

<sup>109</sup> The HEARing CRC, *Submission 59*, p. 10.

Hearing. In contrast, in 'every country overseas' there was a problem with children failing a hearing screening but not going on to receive treatment.<sup>110</sup>

- 4.54 Better Hearing Australia recommended longitudinal research be undertaken on hearing impaired adults following intervention from a hearing services provider.<sup>111</sup> This recommendation was supported by the Bionics Institute, which was of the view that longitudinal research would help clinicians predict how clients would respond to rehabilitation and enable them to try to 'tailor the rehabilitation more precisely to the exact problem that the person is having'.<sup>112</sup>

### **Research into Balance Disorders and Other Ear Health Issues**

- 4.55 Dr Daniel Brown stated that Australian researchers had been successful in developing 'innovative tools and techniques for the diagnosis of hearing and balance disorders.' For example, Australian researchers developed 'head impulse goggles' that provided a 'very effective and much more accurate measure of the vestibule-ocular reflex' and allowed nurses to perform tests that previously required specialised neurologists.<sup>113</sup>
- 4.56 Dr Brown suggested that within the field of hearing impairment research there has been a move towards clinical research undertaken on human subjects, but that the same trend has not occurred for research into balance disorders. Dr Brown called for a commitment to increasing the amount of clinical research into balance disorders.<sup>114</sup>
- 4.57 Mr Stephen Spring agreed that there was a lack of funding for clinical research and that this was preventing promising outcomes of basic research being translated into marketable outcomes. Mr Spring stated that:

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<sup>110</sup> Dr Harvey Dillon, Director, National Acoustic Laboratories, Australian Hearing, *Official Committee Hansard*, Canberra, 3 March 2017, p. 20.

<sup>111</sup> Mr Andrew Bush, National Secretary, Better Hearing Australia, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 3.

<sup>112</sup> Dr Hamish Innes-Brown, Research Fellow, Bionics Institute, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 8.

<sup>113</sup> Dr Daniel Brown, Senior Research Fellow, Sydney Medical School, The University of Sydney (University of Sydney), *Official Committee Hansard*, Sydney, 6 April 2017, p. 3.

<sup>114</sup> Dr Daniel Brown, University of Sydney, *Official Committee Hansard*, Sydney, 6 April 2017, p. 2.

... it should not really be up to private individuals to scratch around [for funding], when the benefit for the community, if there is successful translational medicine, is going to far outweigh the initial investment.<sup>115</sup>

4.58 The Whirled Foundation stated that there was a need to fund research into balance disorders focussing on the causes of balance disorders and potential treatments.<sup>116</sup> Neurosensory advocated for research to be undertaken on the economic impact of balance disorders.<sup>117</sup>

## Innovation in Hearing Service Delivery

4.59 The growth in the use of the internet has enabled the development of new methods of accessing hearing health services and delivering real-time communication supports for deaf or hearing impaired people.

4.60 Telehealth<sup>118</sup> services enable metropolitan based medical practitioners to provide specialised health services to clients in remote locations via the internet. A telehealth model can be used to provide hearing health services including:

- Early intervention treatment and services for children;<sup>119</sup>
- Speech pathology services; and<sup>120</sup>
- Cochlear implant mapping.<sup>121</sup>

4.61 Speech Pathology Australia stated that there was 'a strong evidence base' for the efficacy of telehealth speech pathology services.<sup>122</sup> Hear and Say similarly drew attention to evidence for the value of early intervention telehealth services stating it had 'published a journal paper that looks at comparing the outcomes of our children who have therapy through

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<sup>115</sup> Mr Stephen Spring, Private Capacity, *Official Committee Hansard*, Sydney, 6 April 2017, p. 56.

<sup>116</sup> Whirled Foundation, *Submission 77*, p. 23.

<sup>117</sup> Ms Shaunine (Nina) Quinn, Chief Executive Officer, Neurosensory, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 8.

<sup>118</sup> Other names used to refer to particular health services provided remotely via the internet include: ehealth, telepractice, teleaudiology, and teleotology.

<sup>119</sup> Ms Emma Rushbrooke, Clinical Director, Hear and Say, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 3.

<sup>120</sup> Speech Pathology Australia, *Submission 51*, p. 19.

<sup>121</sup> Audiology Australia, *Submission 49*, p. 12.

<sup>122</sup> Speech Pathology Australia, *Submission 51*, p. 19.

[telehealth] versus face to face [consultations], and [it was found that] there is no significant difference.’<sup>123</sup>

- 4.62 The HEARing CRC advised that its research found that ‘95 per cent of cochlear implant recipients could have their speech processor appropriately mapped using remote connections’.<sup>124</sup>
- 4.63 Several organisations<sup>125</sup> observed that telehealth services are not eligible for Medicare rebates. The Telethon Kids Institute suggested that telehealth services will:
- ... considerably increase efficiency and access to diagnostic audiology in underserved areas in Australia. However, the primary barrier to these developments is the inability of audiologists to directly claim [Medicare benefits] for telehealth procedures.<sup>126</sup>
- 4.64 Vicdeaf advised that it provides a Video Remote Interpreting service which ‘enables interpreting access to those who are in settings in which Auslan interpreters are not readily available’.<sup>127</sup> In addition, hearing impaired Australians who use English can follow spoken content at live events using live captioning.<sup>128</sup>
- 4.65 The National Relay Service (NRS) has used technology to expand the range of services it supplies to deaf and hearing impaired Australians. The NRS now provides five types of services: the teletypewriter, which is a fixed keyboard device attached to a phone; SMS relay which can be used with braille for deafblind users; video relay for Auslan users to make calls; a captioned phone service; and a relay service for people with a speech impediment.<sup>129</sup>

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<sup>123</sup> Ms Emma Rushbrooke, Hear and Say, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 3.

<sup>124</sup> The HEARing CRC, *Submission 59*, p. 13.

<sup>125</sup> For example: Speech Pathology Australia, *Submission 51*, p. 9, Royal Institute for Deaf and Blind Children, *Submission 48*, p. 19, Cochlear, *Submission 91*, p. 6.

<sup>126</sup> Telethon Kids Institute, *Submission 44*, pp 7-8.

<sup>127</sup> Vicdeaf, *Submission 86*, p. 3.

<sup>128</sup> Mr Andrew Lyall, Chief Operations Officer, Vicdeaf, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 8.

<sup>129</sup> Dr Phil Harper, Community Liaison Manager, Conexu Foundation, *Official Committee Hansard*, Brisbane, Friday 21 April 2017, p. 43.

- 4.66 Deafblind Australia stated that deafblind Australians have ‘significant difficulty accessing telecommunication devices’.<sup>130</sup> Barriers to using telecommunications devices for deafblind people include: insufficient funds to purchase specialised equipment; a lack of training in using the equipment; and a lack of support staff trained in working with deafblind people.<sup>131</sup>
- 4.67 One communication service designed specifically for deafblind people is Able Link which aims to develop ‘digital literacy, including digital financial literacy skills of people with deafblindness’.<sup>132</sup> Able Link helps deafblind people access social media and engage in shopping, banking, and community based activities.<sup>133</sup>
- 4.68 Dr Elaine Saunders stated that her company, Blamey Saunders hears, was also using technology to provide hearing tests, in this case aimed at adults. Dr Saunders stated that this test can be undertaken at home or at a GP clinic and does not require a soundproof room or specialised equipment.<sup>134</sup>

## Concluding Comment

### *Noise Induced Hearing Loss*

- 4.69 Approximately one-third of all hearing loss in adults may be due to noise exposure. This represents a serious, and predominantly preventable, burden on the Australian community. The Committee was disappointed to discover that the rates of occupational noise induced hearing loss have not significantly reduced in the past 15 years. Workplaces appear to be relying on the use of personal hearing protection (such as ear plugs) rather than investing in methods of reducing noise levels at the source. Given the serious costs of hearing loss, both to the individual and to the economy, the Committee believes that efforts to prevent hearing loss in the workplace need to be re-invigorated.
- 4.70 Agriculture is an industry of particular concern. Farmers are developing hearing loss on average fifteen years earlier than the general population and as many as 60 per cent of farmers are experiencing hearing loss. The

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<sup>130</sup> Deafblind Australia, *Submission 69*, p. 7.

<sup>131</sup> Deafblind Australia, *Submission 69*, p. 5.

<sup>132</sup> Deafblind Australia, *Submission 69*, p. 5.

<sup>133</sup> Deafblind Australia, *Submission 69*, p. 5.

<sup>134</sup> Dr Elaine Saunders, *Submission 53*, pp 2-3; Dr Elaine Saunders, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 50.

Committee welcomes the work of the National Centre for Farmer Health in addressing hearing health issues in farming communities. A greater focus on providing education on preventing hearing damage among workers in agricultural industries is needed.

- 4.71 An emerging concern is the impact of recreational noise induced hearing loss on young people. In recent years there has been a rapid growth in the use of personal music players. The degree to which this is a danger to the hearing health of young people appears to still be a matter of debate. What is more certain is that some young people are being exposed to dangerously loud levels of noise at live music venues and nightclubs.
- 4.72 Live music venues need to do more to protect the hearing of their patrons and staff. The work of HEARsmart, a project formed by the HEARing Cooperative Research Centre and the National Acoustic Laboratories, offers a promising example of the benefits of collaboration between music venues and researchers. Whether focussed on changing practices in the music industry or on educating young people about hearing health, projects that can promote safe listening practices without compromising on the opportunities to enjoy music are likely to be the most effective.
- 4.73 The Committee was concerned to hear about the risk posed by high levels of noise within some Aboriginal and Torres Strait Islander homes. As discussed in Chapter 3, hearing loss is far too common in Aboriginal and Torres Strait Islander communities. Dangerous levels of noise caused by many hearing impaired people living together represents yet another risk to the hearing health of Aboriginal and Torres Strait Islander children and is a further reason why hearing loss in these communities needs to be addressed.

### *Hearing Health Awareness*

- 4.74 With 3.6 million Australians experiencing some form of hearing impairment it is surprising that public knowledge of hearing health issues remains relatively low. Addressing hearing loss early helps people maintain their quality of life, as well as prevent social isolation and cognitive decline. Despite this, on average people take seven years between realising they are losing their hearing and doing something to address it. As many as two-thirds of Australians with hearing loss may be going untreated.
- 4.75 Many of the organisations that contributed to the Inquiry called for a government led awareness campaign focussed on hearing health. A hearing health awareness and education campaign was also recommended by the 2010 Senate Inquiry into Hearing Health and in the intervening years the

need has not diminished. Despite the prevalence of hearing impairment it has never been the focus of a broad scale public health campaign like those that have targeted the prevention of skin cancer and quitting smoking.

- 4.76 The Committee believes that an education and awareness campaign focussed on promoting practices to prevent hearing damage, destigmatising hearing loss, and encouraging people experiencing hearing loss to seek treatment could have significant public health benefits.

### *Hearing Health Research*

- 4.77 The cochlear implant, one of the most important advances in the treatment of hearing loss and deafness, is a product of Australian hearing health research. The Committee was pleased to see that Australian researchers are continuing to make significant advances in understanding the causes of hearing impairment and developing successful treatment options. The Longitudinal Outcomes of Children with Hearing Impairment study is providing valuable long-term data on the effects of early intervention on children's development of communication skills. The Committee is also interested in the potential value of similar longitudinal studies focussing on hearing impaired adults.
- 4.78 The fields of genetics and stem-cell therapies appear to have the potential to offer a step-change in how hearing impairment is treated. While the research in these fields is at an early stage, it is possible that, one day, they will lead to new techniques that could prevent, or even reverse, hearing loss.
- 4.79 Balance disorders can have a devastating impact on those that suffer from them, and yet there appears to be significant uncertainty about their cause or how they might be treated. The Committee believes further research into the causes and possible treatment options for balance disorders is needed.

### *Innovation in Hearing Service Delivery*

- 4.80 Rapid development in telecommunications technology has been of great benefit for deaf and hearing impaired Australians. Services such as live captions and video Auslan translation assist deaf and hearing impaired people to participate in work, community, and social events. In addition, internet based telehealth services provide an opportunity to deliver hearing health services effectively to rural and remote regions. Changes to the Medicare Benefits Schedule should be made to allow providers to claim for the provision of telehealth services.

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**Recommendation 6**

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**4.81 The Committee recommends that the Department of Health, in consultation with state and territory counterparts and key stakeholder groups, develop and implement an education and awareness raising campaign focussed on national hearing health. The campaign should:**

- **Promote safe noise exposure practices in the workplace. (The department, in partnership with Safe Work Australia, should focus on encouraging businesses to enact measures to eliminate or isolate sources of noise rather than relying on personal hearing protection.)**
- **Build on existing projects such as HEARsmart and Know Your Noise to promote safe listening practices in the music industry and among young people.**
- **Encourage people who may be experiencing hearing loss to seek assistance and encourage general practitioners and other relevant medical practitioners to actively enquire about the hearing health of their patients, particularly those aged 50 years and over.**
- **Include messaging aimed at destigmatising hearing loss and educating the public on the challenges faced by deaf and hearing impaired Australians.**

### **Recommendation 7**

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**4.82 The Committee recommends the Department of Health develop a national hearing loss prevention and treatment program for agricultural communities. Effective interventions piloted in the National Centre for Farmer Health's *Shhh Hearing in a Farming Environment* project should serve as the basis for the development of the program. Specifically, the program should include:**

- **The provision of education on farm-based sources of noise exposure and how the risks to hearing health from these noise sources can be minimised.**
- **Hearing screening services targeted at workers in agricultural industries and referrals to treatment services for people found to have a hearing loss.**
- **The promotion of communication techniques to assist people with hearing loss regardless of whether they choose to use hearing devices.**

### **Recommendation 8**

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**4.83 The Committee recommends that the Hearing Services Program and the National Acoustic Laboratories prioritise funding for research which focuses on:**

- **The causes of balance disorders and potential treatment options;**
- **Genetic and stem-cell based treatments for hearing impairment; and**
- **Longitudinal research on the experiences of adults undergoing treatment for hearing impairment.**

### **Recommendation 9**

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**4.84 The Committee recommends that the Australian Government add hearing health services delivered via the internet to the Medicare Benefits Schedule. These services should include: audiology; ear, nose, and throat consultations; early intervention listening and spoken language therapy; and speech pathology.**

# 5. Provision of Hearing Devices

## Overview

- 5.1 The majority of hearing aids in Australia are purchased from hearing aid clinics contracted by the Australian Government's Hearing Services Program. This chapter discusses the structure of the hearing clinic industry, the cost of hearing aids, available subsidies and the possibilities for expanding assistance.
- 5.2 The recent release of a report by the Australian Competition and Consumer Commission has brought increased attention to practices used in hearing clinics to motivate clinicians to sell hearing aids. This chapter discusses the use of commissions and related sales practices and their potential impact on the advice provided by clinicians to clients. Also discussed is the provision of post-sale support and rehabilitation for hearing aid users, as well as the regulatory requirements for practicing audiologists and audiometrists.

## Structure of the Hearing Aid Clinic Industry

- 5.3 The Department of Health's Hearing Services Program (HSP) subsidises, or partially subsidises, approximately 80 per cent of the hearing aids sold in Australia, with Australian Hearing dispensing approximately a third of the subsidised devices.<sup>1</sup>
- 5.4 The HSP Voucher Scheme accredits approximately 300 private operators to provide subsidised hearing devices. Between Australian Hearing and the

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<sup>1</sup> Professor Harvey Dillon, Director, National Acoustic Laboratories, Australian Hearing, *Official Committee Hansard*, Canberra, 3 March 2017, pp 19-20.

private providers, Voucher Scheme devices are available at approximately 3700 locations across Australia.<sup>2</sup>

- 5.5 Large hearing clinic chains account for the majority of the hearing aid industry, with just six chains (including Australian Hearing)<sup>3</sup> responsible for 85 per cent of sales in the Voucher Scheme.<sup>4</sup> At the other end of the scale, Independent Audiologists Australia (IAA) represents more than 200 businesses across Australia that are at least 50 per cent owned by audiologists.<sup>5</sup>
- 5.6 Another business model is operated by Neurosensory, which runs 22 hearing and balance clinics across New South Wales, Queensland and Victoria and is jointly owned by 61 Ear, Nose and Throat Surgeons.<sup>6</sup>
- 5.7 Some of the major hearing clinic chains are owned, or part owned, by international hearing aid manufacturers. This is known as vertical integration. For example, Connect Hearing is part of the Sonova Group and Audioclinic is part of the William Demant Group.<sup>7</sup>
- 5.8 The Hearing Care Industry Association (HCIA) commented that ‘all of the vertically integrated HCIA members provide a full range of devices to suit every type of audible loss.’<sup>8</sup>
- 5.9 Country Hearing Care suggested that vertically integrated chains have ‘access to hearing aids at much reduced costs ... making competition for smaller independent clinics more difficult’.<sup>9</sup>

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<sup>2</sup> Department of Health, *Submission 16*, p. 12.

<sup>3</sup> The six chains are: Australian Hearing; Bloom; Connect Hearing; National Hearing Care; Bay Audio; and the chains owned by the William Demant Group. Hearing Business Alliance, *Submission 61.1*, p. 3.

<sup>4</sup> Mrs Jane MacDonald, Director and Senior Audiologist, Country Hearing Care, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 1.

<sup>5</sup> Dr Louise Collingridge, Executive Officer, Independent Audiologists Australia (IAA), *Official Committee Hansard*, Sydney, 6 April 2017, p. 49; IAA, *Submission 20*, p. 5.

<sup>6</sup> Neurosensory, *Submission 63*, p. 2.

<sup>7</sup> Hearing Care Industry Association (HCIA), *Submission 30, Attachment A*, pp 1-2.

<sup>8</sup> Mr Ashley Wilson AM, Chairman, HCIA, *Official Committee Hansard*, Adelaide, 3 May 2017, p. 16.

<sup>9</sup> Country Hearing Care, *Submission 74*, p. 3.

## Role of Australian Hearing

- 5.10 Australian Hearing provides free audiological services<sup>10</sup> to Community Service Obligations patients (the majority of whom are children and young people). Australian Hearing also operates in the Voucher Scheme market<sup>11</sup> on a commercial basis in competition with private providers.<sup>12</sup>
- 5.11 The IAA described Australian Hearing's practices in the Voucher Scheme market as 'aggressive' and stated that it was 'completely bizarre' that its members had to compete with a government agency.<sup>13</sup> The IAA stated that 'Australian Hearing ought to be a resource that we can all tap into rather than it be competing with us'.<sup>14</sup>
- 5.12 The IAA also drew attention to Australian Hearing's increasing profits, from \$4.2 million in 2013 to \$29.7 million in 2016, and stated that they have been:  
... achieved through increasing the number of voucher holders who select Australian Hearing as their preferred provider and by encouraging pensioners to select partially subsidised hearing aids so that top up fees can be collected.<sup>15</sup>
- 5.13 The Hearing Business Alliance (HBA) advised that many of its members believed Australian Hearing has a competitive advantage in the Voucher Scheme market, stating that 'no other hearing service providers competing with Australian Hearing in the [Voucher Scheme] market enjoy the significant taxpayer-funded promotions afforded to Australian Hearing'.<sup>16</sup>
- 5.14 The HBA contended that practices which provided Australian Hearing with a competitive advantage included:
- promotion on the Department of Human Services website;

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<sup>10</sup> These services can include fitting of hearing devices, communication training, and the provision of additional technologies such as remote microphone systems. Australian Hearing, *Submission 58*, p. 9.

<sup>11</sup> The Voucher Scheme serves nearly 700 000 clients, 89 per cent of these clients are aged over 65 years and 85 per cent are pensioners. Services in the Voucher Scheme are provided by Australian Hearing and approximately 300 private providers. Department of Health, *Submission 16*, pp 12-13.

<sup>12</sup> Department of Health, *Submission 16*, pp 12-14.

<sup>13</sup> Dr Louise Collingridge, IAA, *Official Committee Hansard*, Sydney, 6 April 2017, p. 53.

<sup>14</sup> Dr Louise Collingridge, IAA, *Official Committee Hansard*, Sydney, 6 April 2017, p. 52.

<sup>15</sup> IAA, *Submission 20.1*, p. 3.

<sup>16</sup> Hearing Business Alliance (HBA), *Submission 61.1*, p. 4.

- the automated delivery of HSP voucher applications directly from software commonly used by general practitioners (GPs) to Australian Hearing rather than providing the patient with the voucher application to take to a provider of their choice; and
- actively seeking partnerships with GP clinics and major pharmacy chains to encourage these clinics to direct Voucher Scheme clients to Australian Hearing.<sup>17</sup>

5.15 Australian Hearing responded to the comments relating to GP software systems and stated:

Australian Hearing has a commercial arrangement with Healthlink, an Online Health Directory and Booking System ... of all our referrals only about 10 per month come via this method (at this stage) ... paper GP referral remains the primary method [of referral].<sup>18</sup>

5.16 The Hearing Aid Audiometrist Society of Australia (HAASA) stated that it had learned about reports of Australian Hearing setting up hearing screening tests in Centrelink offices while private hearing service providers 'cannot even put a brochure in a Centrelink office'.<sup>19</sup>

5.17 National Hearing Care stated that it would be 'unfair' if, due to being a government agency, Australian Hearing is able to advertise on Centrelink's website and its offices.<sup>20</sup>

5.18 Australian Hearing advised that there are 'multiple mentions' of Australian Hearing on the Department of Human Services website due to the fact that Australian Hearing is a Commonwealth entity and the Minister for Human Services has responsibility for administering the *Australian Hearing Services Act*. Australian Hearing added, however, that the website had 'only one direct link to Australian Hearing in regards to the provision of hearing services.'<sup>21</sup>

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<sup>17</sup> HBA, *Submission 61.1*, pp 5-6.

<sup>18</sup> Australian Hearing, *Submission 58.3*, p. 2.

<sup>19</sup> Mr Tony Khairy, President, Hearing Aid Audiometrist Society of Australia (HAASA), *Official Committee Hansard*, Sydney, 6 April 2017, p. 23.

<sup>20</sup> Mr Michael Smith, Managing Director, National Hearing Care (NHC), *Official Committee Hansard*, Adelaide, 3 May 2017, p. 28.

<sup>21</sup> Australian Hearing, *Submission 58.2*, p. 5. The link is on a webpage providing information on sources of financial assistance for older Australian and states that 'Australian Hearing has information to help people manage their hearing impairment so they have a better quality of

5.19 Australian Hearing also added that its commercial arm undertakes ‘a few screenings in Centrelink offices’ but that this is a commercial arrangement and it pays Centrelink for the use of its facilities.<sup>22</sup>

### **Cost of Hearing Aids and Available Subsidies**

5.20 In 2015-16, the Office of Hearing Services Voucher Scheme provided services to nearly 700 000 clients, 85.7 per cent of whom were Pensioner Concession Card holders.<sup>23</sup> Voucher Scheme recipients have access to fully or partially subsidised hearing devices as well as maintenance and support.<sup>24</sup>

5.21 Voucher Scheme recipients are eligible for fully subsidised base level, or standard, hearing aids. Australian Hearing stated that the Office of Hearing Services pays providers approximately \$2000 on average to fit a person with hearing aids in both ears (comprising \$400 to \$500 per device and \$1000 or more in fitting fees).<sup>25</sup>

5.22 Voucher holders may choose to purchase a more expensive model of hearing aid, in which case the voucher will partially subsidise the device with the consumer contributing the remainder of the cost.<sup>26</sup> This type of purchase is known as a ‘top-up’. The IAA commented that ‘top-up hearing device sales can be lucrative and the market for voucher holders has become highly competitive.’<sup>27</sup>

5.23 The HCIA stated that the sale of top-up devices cross-subsidised the provision of ‘free to client’ (fully voucher subsidised) devices suggesting that the:

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life’, <https://www.humanservices.gov.au/individuals/subjects/payments-older-australians>. Accessed 4 September 2017.

<sup>22</sup> Ms Gina Mavrias, Chief Operating Officer, Australian Hearing, *Official Committee Hansard*, Canberra, 16 June 2017, p. 17.

<sup>23</sup> Department of Health, *Submission 16*, p. 13.

<sup>24</sup> Department of Health, *Submission 16*, p. 12.

<sup>25</sup> Professor Harvey Dillon, Australian Hearing, *Official Committee Hansard*, Canberra, 3 March 2017, p. 18.

<sup>26</sup> HCIA, *Submission 30*, p. 9.

<sup>27</sup> IAA, *Submission 20.1*, p. 1.

... industry can only sustain the best level of 'free to client' products in Australia if the balance between 'free to client' and 'top up' is maintained ... without this cross subsidy, client access and choice would be diminished.<sup>28</sup>

- 5.24 The HBA stated that there are generally five levels of hearing aids (and different styles within each level).<sup>29</sup> The HBA described the base level hearing aids, available free to eligible clients through the Voucher Scheme, as 'very good hearing aids'.<sup>30</sup> The HBA also stated that 'there are benefits' from more expensive devices and so the question for the client becomes 'do you want to spend more money for a more sophisticated device?'<sup>31</sup>
- 5.25 The HBA explained that in a quiet environment where people are speaking on a one-to-one basis there was 'very little difference between a basic hearing aid and a very sophisticated one.' In an environment with more background noise, the more sophisticated devices can 'narrow down the directionality' of sounds and 'smooth out unwanted sounds'.<sup>32</sup>
- 5.26 Australian Hearing stated the most expensive hearing aids in its standard range cost approximately \$7800 for two hearing aids.<sup>33</sup> William Demant Holding (William Demant) stated that the most expensive aids it sells were 'up to \$6000 or \$8000' (per device) but that these were 'not a high percentage of what we sell'.<sup>34</sup>
- 5.27 National Seniors Australia advised a recent survey had revealed that 75 per cent of its members had been deterred from buying hearing aids due to their cost.<sup>35</sup> National Seniors added that it was 'disappointed with the lack of competition [and] price transparency in the retail market for hearing aids.'<sup>36</sup>

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<sup>28</sup> HCIA, *Submission 30*, p. 14.

<sup>29</sup> Mr Stephen Logan, Company Secretary, HBA, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 15.

<sup>30</sup> Mr Donald MacDonald, Chair, HBA, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 15.

<sup>31</sup> Mr Donald MacDonald, HBA, *Official Committee Hansard*, Brisbane, 21 April 2017, pp 15, 16.

<sup>32</sup> Mr Donald MacDonald, HBA, *Official Committee Hansard*, Brisbane, 21 April 2017, pp 15-16.

<sup>33</sup> Ms Emma Scanlan, Principal Audiologist, Adults, Australian Hearing, *Official Committee Hansard*, Canberra, 3 March 2017, p. 19.

<sup>34</sup> Ms Janet Muir, Managing Director, Retail, William Demant Holding, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 38.

<sup>35</sup> National Seniors Australia, *Submission 79*, p. 4.

<sup>36</sup> National Seniors Australia, *Submission 79*, p. 2.

## *Hearing Aid Banks*

- 5.28 Hearing Aid Banks, which receive donated hearing aids and repurpose them for resale at a low cost, are available in each state and territory except Western Australia and the Australian Capital Territory.<sup>37</sup> National Seniors Australia advised that 'hearing aid banks offer cost-effective hearing services to people ineligible for free or subsidised services offered through the Australian Government Hearing Services Program.'<sup>38</sup>
- 5.29 Self-Help for Hard of Hearing People Australia (SHHH Australia) outlined the services provided by the Hearing Aid Bank it runs in conjunction with Macquarie University. SHHH Australia stated:
- Under this program hearing aids donated by the public are reconditioned at Macquarie University, fitted and resold at low cost to clients who hold a Commonwealth Health Care card, a doctor's referral and a current audiogram. In the last 12 months around 20 applications for this service, mostly asylum seekers, have proceeded through to final fittings.<sup>39</sup>
- 5.30 National Seniors Australia advised that the services which hearing aid banks can provide are 'limited', mainly due to 'a lack of supply of second hand hearing aids that can be reconditioned'.<sup>40</sup> In order to boost the supply of second hand hearing aids, National Seniors recommended that:
- a national hearing aid register be established to enable hearing aid users to register to donate their hearing aids when no longer needed;
  - hearing aid providers be required to give information to their hearing aid clients about registering to donate their hearing aids to a hearing bank; and
  - the Australian Government consider offering a financial incentive to encourage people to donate hearing aids.<sup>41</sup>
- 5.31 National Seniors Australia further recommended that eligibility for hearing aid banks 'be extended to Commonwealth Seniors Health Card holders and Health Care Card holders aged under 65 [years].'<sup>42</sup>

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<sup>37</sup> National Seniors Australia, *Submission 79.1*, p. 1.

<sup>38</sup> National Seniors Australia, *Submission 79*, p. 7.

<sup>39</sup> Self Help for Hard of Hearing People Australia (SHHH Australia), *Submission 42*, p. 21.

<sup>40</sup> National Seniors Australia, *Submission 79*, p. 7.

<sup>41</sup> National Seniors Australia, *Submission 79*, pp 6-7.

<sup>42</sup> National Seniors Australia, *Submission 79*, p. 7.

### *Subsidies for Working Age Australians*

- 5.32 The HBA stated that ‘eligible Pensioners, Veterans, and young people up to the age of 26 years’ are eligible for government subsidised hearing assessments and hearing devices but that this ‘leaves a large gap for those people who fall between these safety nets’. The HBA suggested that, unless they can afford private fees, working age people may ‘go without hearing assessments and possible early intervention for their hearing health issues’.<sup>43</sup>
- 5.33 William Demant suggested that for Australians between 26 and 64 years who cannot afford private health cover experiencing a hearing loss would make it difficult to ‘fully participate in our community’.<sup>44</sup> William Demant recommended that the Government provide support to those ‘with a hearing loss aged between 26 and 64 years of age from a low socio-economic background’.<sup>45</sup>
- 5.34 Goulburn Valley Hearing Clinic supported the extension of subsidies for hearing devices to people of working age and stated:
- ... extension of the [HSP] program would ensure that anybody with a hearing disability would be able to access hearing services and devices and would solve the problems currently faced by those with low incomes who face significant obstacles to their participation in the workplace and participation socially but cannot afford to buy hearing aids.<sup>46</sup>
- 5.35 Goulburn Valley Hearing Clinic added that the cost of extending subsidies would be relatively low as the incidence of people with hearing loss under the age of 65 years is much less than among those over 65 years and highlighted that it would make ‘a huge difference’ to the lives of low-income people with hearing loss.<sup>47</sup>
- 5.36 Deloitte Access Economics recently undertook a cost-benefit analysis of providing hearing aids free of charge to unemployed hearing impaired Australians. Deloitte Access Economics estimated that providing unemployed hearing impaired Australians with hearing aids would increase

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<sup>43</sup> HBA, *Submission 61*, p. 3.

<sup>44</sup> William Demant Holding, *Submission 52*, p. 6.

<sup>45</sup> William Demant Holding, *Submission 52*, p. 6.

<sup>46</sup> Ms Dierdre Robertson, Practice Manager, Goulburn Valley Hearing Clinic (GVHC), *Official Committee Hansard*, Shepparton, 2 May 2017, p. 10.

<sup>47</sup> Ms Dierdre Robertson and Mr Lindsay Symons, GVHC, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 14.

employment by almost 50 000 people.<sup>48</sup> This intervention was estimated to result in a \$1.7 billion productivity gain at a cost of \$326.4 million, a benefit to cost ratio of 5.2 to 1.<sup>49</sup>

- 5.37 Deloitte Access Economics also observed that ‘it would only require one person in every fifteen given new aids to move [from unemployment benefits] to the equivalent of a full time minimum wage position’ to have a positive impact on the Government budget.<sup>50</sup>
- 5.38 Another option to assist working age Australians with the cost of hearing devices would be to make them tax deductible. This option was recommended by the Deafness Forum of Australia (Deafness Forum) which compared hearing devices to mobile phones and laptops used in the workplace. The Deafness Forum stated:

Like [mobile phones and laptops], hearing devices are communication and productivity aids in the workplace, yet they are not afforded the same tax deductibility arrangement. By making hearing devices and their batteries more affordable for working Australians via tax deductibility or similar means, the national economy will benefit from better workforce participation and keeping people in the workforce longer.<sup>51</sup>

- 5.39 SHHH Australia supported this recommendation, but suggested that rather than being analogous to mobile phones and laptops, hearing devices were comparable to ‘academic qualifications or industry experience, in that without them people with hearing loss are unlikely to be able to perform the duties of the job’.<sup>52</sup>

### *Cochlear Implants*

- 5.40 The Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) stated that ‘it is estimated that only ten per cent of the population who would benefit from a cochlear implant have received one.’<sup>53</sup> The ASOHNS added that this could be due to low community awareness of

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<sup>48</sup> Deloitte Access Economics, *Exhibit 18: An Update on the Social and Economic Cost of Hearing Loss and Hearing Health Conditions in Australia*, p. 66.

<sup>49</sup> Deloitte Access Economics, *Exhibit 18*, p. 74.

<sup>50</sup> Deloitte Access Economics, *Exhibit 18*, p. 74.

<sup>51</sup> Deafness Forum of Australia, *Submission 17*, p. 18.

<sup>52</sup> SHHH Australia, *Submission 42*, p. 17.

<sup>53</sup> Australian Society of Otolaryngology Head and Neck Surgery, *Submission 24*, p. 3.

hearing loss treatments and a lack of access to publicly funded services in some states and territories.<sup>54</sup> Australian Hearing raised a similar issue, stating that ‘cochlear implantation has been shown to improve outcomes for adults with a severe to profound hearing loss, yet this technology is still under-utilised within Australia.’<sup>55</sup>

- 5.41 Australian Hearing advised that ‘the majority of Australians who are suitable for a cochlear implant can access this technology through private health insurance or public funding.’<sup>56</sup> The ASOHNS stated that ‘in some states you can be on the waiting list [for a cochlear implant] for a very long time, and this is an issue, particularly for young children.’<sup>57</sup>
- 5.42 Following an implantation, the CSO program covers repairs, batteries and replacement speech processors for Australians aged under 26 years.<sup>58</sup> The National Disability Insurance Scheme (NDIS) does not fund implantation surgery but may provide funding for speech processor upgrades.<sup>59</sup>
- 5.43 Those who do not qualify for Government assistance<sup>60</sup> ‘must fund repairs, replacement parts and batteries themselves’.<sup>61</sup> Australian Hearing advised that private health insurance does not usually cover maintenance of cochlear implants, but may be available for replacement processors or upgrades.<sup>62</sup>
- 5.44 Cochlear recommended speech processors be upgraded every four to six years to obtain design and hearing performance benefits. If processors are not upgraded by about the eight year mark they become obsolete and cannot be viably repaired. The cost of upgrading speech processors is approximately \$8000.<sup>63</sup>

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<sup>54</sup> Australian Society of Otolaryngology Head and Neck Surgery, *Submission 24*, pp 3, 5.

<sup>55</sup> Australian Hearing, *Submission 58*, p. 5.

<sup>56</sup> Australian Hearing, *Submission 58*, p. 11.

<sup>57</sup> Professor Stephen O’Leary, Member, Australian Society of Otolaryngology Head and Neck Surgery, *Official Committee Hansard*, Sydney, 6 April 2017, p. 44.

<sup>58</sup> Australian Hearing, *Submission 58*, p. 11.

<sup>59</sup> Mr Peter De Natris, Expert Advisor, Early Childhood and Early Intervention, National Disability Insurance Agency, *Official Committee Hansard*, Canberra, 3 March 2017, p. 25.

<sup>60</sup> Government assistance for maintenance costs may be included under the CSO program, the NDIS or the Department of Veterans’ Affairs. Australian Hearing, *Submission 58*, p. 11.

<sup>61</sup> Australian Hearing, *Submission 58*, p. 11.

<sup>62</sup> Australian Hearing, *Submission 58*, pp 11, 12.

<sup>63</sup> Cochlear, *Submission 91*, p. 16.

## Box 5.1 Cost of Hearing Devices

Many individuals were concerned about the cost of hearing devices:

- 'I have spent well over \$120 000 over the years on hearing aids [and] hearing tests and have had limited success claiming the costs of these on my tax ... the access to and cost of hearing services and the inability to afford the best hearing aids means I have to settle for less and fight constantly just to maintain a standard existence.'<sup>64</sup>
- 'Without aids I can't hear. We aren't looking forward to the day my cochlear processor breaks. We don't live at all and struggle to pay even everyday bills.'<sup>65</sup>
- '... due to my age I do not qualify for any government rebates, my private health fund extras level does not cover any rebates, and due to the costs of raising a family on only my husband's income, we cannot afford hearing aids ... I am in a Catch-22 situation — I find it hard to work in a workplace with my level of hearing loss, but without working I cannot afford to fund the purchase of hearing aids.'<sup>66</sup>
- 'To stay at the level of employment in my career or to consider moving to the next level, it was important, like a mobile phone, that ideally I secure an updated hearing aid every two to three years. However in reality it is, for me, between four to six years, after saving up the funds to afford it.'<sup>67</sup>
- 'As a parent of a child with hearing loss I am concerned about what happens once my son turns 26. I look around my workplace and realise that open plan offices, most meeting rooms and auditoriums are not hearing loss friendly. I hope that as an adult my son chooses to pay for his hearing expenses rather than a holiday or a night out.'<sup>68</sup>
- 'I was appalled when I discovered that my hearing impaired children were making-do in difficult working situations with old, inadequate hearing aids because as parents they felt that they could not justify the \$8500 to \$10 000 cost of adequate hearing aids and supplementary devices.'<sup>69</sup>

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<sup>64</sup> Mr Andrew Swindell, *Submission 101*, p. 2.

<sup>65</sup> Name Withheld, *Submission 31*, p. 3.

<sup>66</sup> Name Withheld, *Submission 40*, p. 1.

<sup>67</sup> Mr David Brady, *Submission 65*, p. 5.

<sup>68</sup> Ms Gemma Jackson, *Submission 43*, p. 3.

<sup>69</sup> Mr Basil Turner, *Submission 33*, p. 4.

## Hearing Aid Clinic Sales Targets and Commissions

- 5.45 On 3 March 2017 the Australian Competition and Consumer Commission (ACCC) released its report *Issues around the Sale of Hearing Aids: Consumer and Clinician Perspectives*. This ACCC investigation was instigated after ‘potential consumer protection issues’ were identified in an ABC Radio National program, and included a survey of consumers and clinicians and discussions with major hearing clinic operators.<sup>70</sup>
- 5.46 The ACCC report investigated the use of commissions and other sales incentives and found that they are ‘commonly used to motivate clinicians to sell hearing aids, particularly in clinics run by major operators’.<sup>71</sup> The ACCC stated that ‘commissions can be as much as 15 per cent’ and that ‘more expensive hearing aids generally attract higher commissions’.<sup>72</sup>
- 5.47 In addition to commissions, other sales indicators were used to measure clinicians’ performance. These included the number of hearing aids sold, their average price, and the number of high-end and ‘top-up’ devices sold.<sup>73</sup>
- 5.48 Some clinicians surveyed by the ACCC stated they believed their employers were more focused on sales than providing independent advice or serving the consumer’s best interests.<sup>74</sup> Clinicians also stated that ‘devices may be recommended based on commissions rather than consumers’ needs’.<sup>75</sup>
- 5.49 The ACCC was critical of the use of commissions in a ‘healthcare setting’ where consumers would expect clinicians to ‘provide independent and impartial advice and have as their primary consideration the wellbeing and best interest of the consumers they are consulting’.<sup>76</sup> The ACCC expressed concern that these sales practices could jeopardise the impartiality of clinicians, and stated:

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<sup>70</sup> Australian Competition and Consumer Commission (ACCC), *Issues around the Sale of Hearing Aids: Consumer and Clinician Perspectives*, 3 March 2017, p. 1.

<sup>71</sup> ACCC, *Issues around the Sale of Hearing Aids: Consumer and Clinician Perspectives*, 3 March 2017, p. 1.

<sup>72</sup> ACCC, *Issues around the Sale of Hearing Aids: Consumer and Clinician Perspectives*, 3 March 2017, p. 1.

<sup>73</sup> ACCC, *Issues around the Sale of Hearing Aids: Consumer and Clinician Perspectives*, 3 March 2017, p. 2.

<sup>74</sup> ACCC, *Issues around the Sale of Hearing Aids: Consumer and Clinician Perspectives*, 3 March 2017, p. 2.

<sup>75</sup> ACCC, *Issues around the Sale of Hearing Aids: Consumer and Clinician Perspectives*, 3 March 2017, p. 2.

<sup>76</sup> ACCC, *Issues around the Sale of Hearing Aids: Consumer and Clinician Perspectives*, 3 March 2017, p. 4.

... commissions, incentives and other mechanisms designed to drive sales can create a conflict with clinical independence, professional integrity and the primary obligation to consumers. This conflict is particularly troubling in the sale of hearing aids, given that consumers who require hearing devices are often disadvantaged or vulnerable due to their hearing loss, age, other medical conditions, disability, income, or a combination of these things.<sup>77</sup>

- 5.50 The ACCC commented that the information it had received was often anecdotal and it was therefore 'difficult to find instances that we were able to pursue from an enforcement perspective'.<sup>78</sup>
- 5.51 National Seniors Australia criticised the up-selling of hearing aids, stating 'our members often feel pressured into purchasing more expensive hearing aids without any real understanding of the comparative cost benefit of the product being sold'.<sup>79</sup>
- 5.52 The Deafness Forum was critical of the lack of transparency around the use of commissions stating that the 'practitioner is not obliged to declare whether they receive a commission for fitting a particular device.'<sup>80</sup> The Deafness Forum further stated that 'the payment of commissions should be discontinued or at the very least be made transparent so the client knows that the practitioner is obtaining a benefit from recommending a particular device.'<sup>81</sup>
- 5.53 The Department of Health advised that service providers contracted under the Voucher Scheme were required to 'disclose preferred provider arrangements for hearing devices, including payments of commissions or incentives.'<sup>82</sup> The Department of Health also advised that 'service providers must not encourage a client to purchase a partially subsidised device where an approved free-to-client device would reasonably meet their needs.'<sup>83</sup>
- 5.54 Inquiry participants from smaller or independent clinics, and the peak bodies representing these clinics, tended to be critical of the use of

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<sup>77</sup> ACCC, *Issues around the Sale of Hearing Aids: Consumer and Clinician Perspectives*, 3 March 2017, p. 4.

<sup>78</sup> Mr Scott Gregson, Executive General Manager, Consumer Enforcement, ACCC, *Official Committee Hansard*, Canberra, 23 March 2017, p. 2.

<sup>79</sup> National Seniors Australia, *Submission 79*, p. 2.

<sup>80</sup> Deafness Forum of Australia, *Submission 17*, p. 17.

<sup>81</sup> Deafness Forum of Australia, *Submission 17*, p. 17.

<sup>82</sup> Department of Health, *Submission 16.1*, p. 6.

<sup>83</sup> Department of Health, *Submission 16.1*, p. 7.

commissions. Arafura Audiology described commissions as ‘relatively reprehensible’, stating ‘they do influence the way clinicians behave’.<sup>84</sup> The IAA stated that commissions are ‘unacceptable in any healthcare setting’.<sup>85</sup>

- 5.55 Goulburn Valley Hearing Clinic contended there was a difference between hearing providers that operate as clinical practices and focus ‘on the needs of clients’; and those that operate as retail practices and focus on ‘profit in hearing aid sales’.<sup>86</sup> Goulburn Valley added that retail practices ‘pay commissions to and set sales targets for their clinicians, with pressures on clinicians to upsell hearing devices’.<sup>87</sup>
- 5.56 National Hearing Care, which uses commissions as part of its remuneration packages for clinicians, explained that the purpose of commissions and incentives:
- ... is not to encourage upselling and the prescribing of devices that are not required ... It is a remuneration structure that National Hearing Care and our clinicians have been very happy with in the past. I think the most important point here is that it is not a remuneration structure that has led to any material complaints from our customers.<sup>88</sup>
- 5.57 The HCIA commented on the difficulty of defining what would be considered a commission or incentive, for example questioning whether profit-sharing would be included. The HCIA also stated that the motivations for an independent operator may be the same as an audiologist working for a commission, stating ‘with an independent operator who owns their own business, the more people they see, the more work they do and the more devices they prescribe the [better the] commercial performance of their business’.<sup>89</sup>
- 5.58 The Can:Do Group recounted that it had originally paid commissions to its clinicians, due to believing it was an industry norm and a concern that as a not-for-profit business it would not be able to ‘match base [salary] rates with

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<sup>84</sup> Dr Matthew Callaway, Director, Senior Audiologist, Arafura Audiology, *Official Committee Hansard*, Darwin, 7 June 2017, p. 23.

<sup>85</sup> Dr Louise Collingridge, IAA, *Official Committee Hansard*, Sydney, 6 April 2017, p. 49.

<sup>86</sup> Ms Dierdre Robertson, GVHC, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 11.

<sup>87</sup> Ms Dierdre Robertson, GVHC, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 11.

<sup>88</sup> Mr Michael Smith, NHC, *Official Committee Hansard*, Adelaide, 3 May 2017, p. 27.

<sup>89</sup> Mr Ashley Wilson AM, HCIA, *Official Committee Hansard*, Adelaide, 3 May 2017, p. 17.

government or corporate owned clinics.<sup>90</sup> In 2015-16 Can:Do made the decision to 'cease paying any commissions, a decision reached in consultation with [its] clinicians.'<sup>91</sup> Can:Do stated that its staff were 'happier with this arrangement' and that 'client satisfaction numbers remain high'. Can:Do stated that the abolition of commissions had not changed the number of top-up hearing aids sold.<sup>92</sup>

- 5.59 The HBA commented that its members were aware of other providers who set sales targets and used 'league tables' of clinicians to highlight who is 'letting the side down' in meeting these sales targets. The HBA believed that these employment conditions 'must influence the clinical judgement of clinicians when providing hearing advice'.<sup>93</sup>
- 5.60 On 21 June 2017, the Australian College of Audiology (ACAud) released a position paper stating that 'the use of sales commissions and sales based incentives may lead clinicians and businesses to make decisions that are questionable and may, in fact, be unethical.'<sup>94</sup> The ACAud recommended that 'sales commissions and sales based incentives should cease to be a part of the salary packages of ACAud members as soon as it is feasible to make changes in the workplace'.<sup>95</sup>

## Sales Practices

- 5.61 Audiology Australia and the IAA<sup>96</sup> were both opposed to the practice of selling hearing aids as bundled packages. Audiology Australia explained the practice and the reason for its opposition to it and stated:

... the term "bundled" refers to the bundling of the audiologist's service fee and the device into one package – a practice that Audiology Australia is

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<sup>90</sup> Can:Do Group, *Submission 50.1*, p. 1.

<sup>91</sup> Can:Do Group, *Submission 50.1*, p. 1.

<sup>92</sup> Can:Do Group, *Submission 50.1*, p. 2.

<sup>93</sup> HBA, *Submission 61.1*, p. 8.

<sup>94</sup> Australian College of Audiology (ACAud), *ACAud Position on Sales Commissions and Sales Based Incentives*, <https://www.acaud.com.au/documents/item/257>, Accessed 4 August 2017.

<sup>95</sup> ACAud, *ACAud Position on Sales Commissions and Sales Based Incentives*, <https://www.acaud.com.au/documents/item/257>, Accessed 4 August 2017.

<sup>96</sup> Dr Louise Collingridge and Mr Grant Collins, Vice President, IAA, *Official Committee Hansard*, Sydney, 6 April 2017, pp 51-52.

opposed to as it simultaneously minimises the value of the audiological service and obscures the true cost of the device.<sup>97</sup>

- 5.62 National Seniors Australia supported the unbundling of clinical services from the sale of devices stating that 'ideally, hearing assessments should occur separately from sales so that an individual can receive a hearing assessment and then take the audiogram result and shop around to find the best product and service.'<sup>98</sup>
- 5.63 The HAASA suggested that the hearing clinic industry was moving towards a system of unbundling the cost of devices and service provision. The HAASA raised concerns about this trend and stated:

In the past, our hearing aid fittings were part of the service. You walk into a clinician's office, you discuss the issue with them and they will give you an option that would fit your hearing loss. And that option would include the cost of the hearing aid, the hearing fitting, the rehab ... There is a mixed feeling about [the move towards unbundling] within the industry. Do we really want to go that way? ... We have prided ourselves on having probably one of the best hearing systems in the world. And it has worked because we have taken a holistic approach [to] it.<sup>99</sup>

- 5.64 William Demant commented on a current review into services and technology supply in the HSP being undertaken by Pricewaterhouse Coopers on behalf of the Department of Health.<sup>100</sup> William Demant was critical of proposals within the review which considered:

... uncoupling the funding of a device acquisition from the clinician who prescribes, supports and provides rehabilitation throughout the lifetime of that device. If uncoupled, this could lead to clients acquiring devices not clinically suited to their needs, resulting in poor clinical outcomes and wastage of Government dollars.<sup>101</sup>

- 5.65 National Seniors Australia suggested that free hearing tests are being used as a means of generating sales for hearing clinics. National Seniors relayed the story of a member who had a free test and then was immediately pressured to buy a hearing aid and asked how much they were able to

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<sup>97</sup> Audiology Australia, *Submission 49*, p. 6.

<sup>98</sup> National Seniors Australia, *Submission 79*, p. 5.

<sup>99</sup> Mr Tony Khairy, HAASA, *Official Committee Hansard*, Sydney, 6 April 2017, p. 23.

<sup>100</sup> William Demant Holding, *Submission 52*, p. 25.

<sup>101</sup> William Demant Holding, *Submission 52*, p. 7.

spend.<sup>102</sup> The IAA stated that ‘there is no such thing as a free hearing test ... it is just bundled into the price of the hearing aid’.<sup>103</sup>

### *Agreements between Hearing Clinics and GP Clinics*

5.66 The HBA raised concerns about Memorandums of Understanding (MoUs) between hearing clinics and GP clinics. The HBA stated that MoUs enable GPs to undertake and bulk bill hearing screenings which result in a referral to the specific hearing clinic in the MoU agreement. The HBA stated that these:

MoUs tend to advantage the large hearing chains and the result is that the hearing chains and large GP chains/super clinics have formed alliances which have the effect of excluding the local small to medium hearing service providers from their market place.<sup>104</sup>

5.67 Australian Hearing confirmed that it does offer GPs ‘an opportunity to enter into a memorandum of understanding so they [can] offer hearing checks within their own practice’, but there was no clause in these MoUs preventing the GPs also engaging with other hearing service providers.<sup>105</sup> Australian Hearing added that the ACCC had investigated these arrangements and found that there was ‘no anticompetitive behaviour’<sup>106</sup> and that they did not involve a financial arrangement between Australian Hearing and GPs.<sup>107</sup>

5.68 National Hearing Care suggested that hearing clinics would regularly set up temporary clinic sites and that these could be in GP clinics and stated:

... you have your part-time shops or your visiting sites. They will often be where you rent out a room in a GP’s site for a day per week or a day per month ... often it will be in a GP clinic or a pharmacy or anywhere that is deemed appropriate.<sup>108</sup>

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<sup>102</sup> Mr Ian Henschke, Chief Advocate, National Seniors Australia, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 30.

<sup>103</sup> Mr Grant Collins, IAA, *Official Committee Hansard*, Sydney, 6 April 2017, p. 52.

<sup>104</sup> HBA, *Submission 61*, p. 2.

<sup>105</sup> Ms Gina Mavrias, Australian Hearing, *Official Committee Hansard*, Canberra, 16 June 2017, p. 17.

<sup>106</sup> Mr Mike Thomas, Manager, Stakeholder Relationships, Australian Hearing, *Official Committee Hansard*, Canberra, 16 June 2017, p. 18.

<sup>107</sup> Australian Hearing, *Submission 58.3*, p. 1.

<sup>108</sup> Mr Michael Smith, NHC, *Official Committee Hansard*, Adelaide, 3 May 2017, p. 28.

## Methods of Regulating Sales in Hearing Aid Clinics

- 5.69 Goulburn Valley Hearing Clinic suggested that HSP contracts with providers should be used to remove top-ups and regulate the provider 'rather than practitioner behaviour'.<sup>109</sup> Goulburn Valley highlighted that '80 per cent of hearing aids in this country are paid for by the government ... Because the [HSP] is ruled by a contract, provisions could be written into the contract to say that these behaviours are unacceptable under the terms of the contract.'<sup>110</sup>
- 5.70 The ACCC suggested that a potential regulatory model for hearing aid clinics could involve the 'separation of the provision of health services from the delivery of retail supply of products'.<sup>111</sup> The ACCC added that changes such as the banning of commissions could be made through the use of the administrative requirements of government programs.<sup>112</sup>
- 5.71 The Department of Health advised that the 'prohibiting of commissions within the Hearing Services Program would require a decision of Government to amend the program legislation, [the] *Hearing Services Administrative Act 1997*' (Cwlth).<sup>113</sup>
- 5.72 EARtrak, a company which provides measurement of hearing clinic client outcomes, stated that the HSP program currently 'rewards providers simply for fitting hearing aids to clients rather than for achieving outcomes which reduce the burden of disease'.<sup>114</sup>
- 5.73 EARtrak recommended the development of a system where clients of hearing clinics would be surveyed six months after they have been fitted with a hearing aid in order to assess whether the fitting had resulted in an improved clinical outcome.<sup>115</sup> Individual results would be compiled and used to assess the quality of care being provided by clinics. Clinics would then be rated based on the clinical outcomes of their clients and this

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<sup>109</sup> Mr Lindsay Symons, GVHC, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 12.

<sup>110</sup> Mr Lindsay Symons, GVHC, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 13.

<sup>111</sup> Mr Scott Gregson, ACCC, *Official Committee Hansard*, Canberra, 23 March 2017, p. 5.

<sup>112</sup> Mr Scott Gregson, ACCC, *Official Committee Hansard*, Canberra, 23 March 2017, p. 5.

<sup>113</sup> Department of Health, *Submission 16.1*, p. 6.

<sup>114</sup> EARtrak, *Submission 22*, p. 3.

<sup>115</sup> Metrics used to measure outcomes could include usage rates for hearing devices, and the proportion of listening situations where the clinic has delivered satisfactory results for its customers. EARtrak, *Submission 22*, pp 5 and 8-9.

information would be publically available to assist consumers to choose a clinic providing a high quality of care.<sup>116</sup>

- 5.74 Arafura Audiology questioned the need for a medical review (for example by a GP) prior to seeing an audiologist and stated:

Studies from other parts of the world show that 80 to 90 per cent of these people do not actually need a medical review before they have audiology. Audiologists are well versed, with over five to six or more years of training, as to where patients should go once they are seen. If there is a disorder that is not manageable by an audiologist, we are to refer onwards.<sup>117</sup>

- 5.75 The Department of Health advised it is currently reviewing the 'Hearing Service Program Schedule of service items and fees' and as part of this review consideration would be given to the 'Voucher Program model of service delivery' and 'other reimbursement models which might better support client outcomes, business processes, and simplify administration'.<sup>118</sup>

## Post-Sales Support

- 5.76 Australian Hearing commented that the provision of hearing devices is only one aspect of addressing hearing issues:

While technology is beneficial for people with hearing impairment it is not the answer on its own. Support, training, counselling, auditory rehabilitation and connection with other family members are all critical to successful outcomes for clients.<sup>119</sup>

- 5.77 The Bionics Institute further explained:

It is not just a matter of sticking a hearing aid on somebody; you need to advise people not only about what they need to do or how they can improve their communication skills but also how they can improve their use of the hearing device.<sup>120</sup>

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<sup>116</sup> EARtrak, *Submission 22*, p. 5.

<sup>117</sup> Dr Matthew Callaway, Arafura Audiology, *Official Committee Hansard*, Darwin, 7 June 2017, p. 21.

<sup>118</sup> Department of Health, *Submission 16.2*, p. 4.

<sup>119</sup> Australian Hearing, *Submission 58*, p. 8.

<sup>120</sup> Professor Colette McKay, Leader in Translational Hearing Research, Bionics Institute, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 8.

5.78 Speech Pathology Australia advised that speech pathologists 'are usually part of a multidisciplinary hearing team, but not always.'<sup>121</sup> Speech Pathology Australia outlined the role of speech pathologists in assisting people with hearing impairments:

Typically, speech pathologists would be involved at the onset and, after assessment, with device intervention and the provision of aural rehabilitation services, which in speech pathology is management designed to assist the person with maximising their hearing, speech, language and communication given their hearing impairment.<sup>122</sup>

5.79 Speech Pathology Australia further advised that 'aged care pension recipients fitted with hearing aids as part of an Office of Hearing Services funding package, are eligible for five aural rehabilitation sessions'.<sup>123</sup>

5.80 The Australian Society of Rehabilitation Counsellors (ASORC) advised that for hearing services, 'best practice service models are not offered to the Australian community.'<sup>124</sup> Features of best practice models included 'client education, effective communication training [and] psychological support for individuals and their families', in addition to the provision of hearing devices.<sup>125</sup>

5.81 SHHH Australia observed that 'hearing health professionals generally have limited knowledge of the rehabilitation aspects of managing hearing loss.'<sup>126</sup> As such, SHHH Australia advocated for greater recognition of the value of rehabilitation in treating hearing impairment.<sup>127</sup> The ASORC also stated that while the Office of Hearing Services provides funding for rehabilitation services, 'barely five per cent of clients were offered this service by existing eligible service providers.'<sup>128</sup>

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<sup>121</sup> Dr Chyrisse Heine, Board Director, Speech Pathology Australia (SPA), *Official Committee Hansard*, Melbourne, 1 May 2017, p. 27.

<sup>122</sup> Dr Chyrisse Heine, SPA, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 27.

<sup>123</sup> SPA, *Submission 51*, p. 10.

<sup>124</sup> Ms Cristina Schwenke, Chief Executive Officer, Australian Society of Rehabilitation Counsellors (ASORC), *Official Committee Hansard*, Sydney, 6 April 2017, p. 27.

<sup>125</sup> Ms Cristina Schwenke, ASORC, *Official Committee Hansard*, Sydney, 6 April 2017, p. 27.

<sup>126</sup> SHHH Australia, *Submission 42.1*, p. 3.

<sup>127</sup> SHHH Australia, *Submission 42*, p. 5

<sup>128</sup> Ms Cristina Schwenke, ASORC, *Official Committee Hansard*, Sydney, 6 April 2017, p. 27.

- 5.82 Better Hearing Australia Canberra suggested that the payment model for audiologists needed to move to an ‘outcome-based funding model’ where audiologists are paid for ‘solving the problem of the person with the hearing loss, not just selling them a hearing aid.’<sup>129</sup> SHHH Australia recommended the Government increase regulation of the hearing industry to ‘ensure that the focus is on professional diagnosis and support.’<sup>130</sup>
- 5.83 SHHH Australia also stated that there is a need to develop a management plan to assist new hearing aid users, as this is ‘the time that a new user will experience frustration and just give up.’<sup>131</sup> SHHH Australia advised that a management plan could outline communication strategies for a range of scenarios, such as in the house, the car and in public venues.<sup>132</sup>
- 5.84 A number of submissions supported greater funding for rehabilitation services. Better Hearing Australia recommended that ‘organisations be funded to provide aural rehabilitation using properly trained staff (e.g. social and welfare workers, psychologists and counsellors).’<sup>133</sup> SHHH Australia drew attention to the role of consumer advocacy groups in providing practical advice and support from people who have had ‘lived experience’ of hearing loss,<sup>134</sup> and recommended funding be provided to these organisations to deliver services.<sup>135</sup> The ASORC recommended the Government accredit and fund Rehabilitation Counsellors to provide psychosocial support programs for people receiving hearing services.<sup>136</sup>
- 5.85 In order to increase access to speech pathology services, Speech Pathology Australia recommended the Government:
- Increase the number of speech pathology consultations that can be rebated per year through the MBS Chronic Disease Management Items (currently less than five per year).

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<sup>129</sup> Better Hearing Australia Canberra, *Submission 12*, p. 6.

<sup>130</sup> SHHH Australia, *Submission 42*, p. 12.

<sup>131</sup> SHHH Australia, *Submission 42.2*, p. 2.

<sup>132</sup> SHHH Australia, *Submission 42.2*, p. 2.

<sup>133</sup> Better Hearing Australia, *Submission 83*, p. 18.

<sup>134</sup> SHHH Australia, *Submission 42.1*, p. 3.

<sup>135</sup> SHHH Australia, *Submission 42.1*, p. 4.

<sup>136</sup> ASORC, *Submission 23*, p. 15.

- Provide MBS rebates for speech pathology service provided through telepractice format for Australians with hearing loss.<sup>137</sup>

## Alternatives to Using Hearing Aids

- 5.86 The ASORC estimated that the Government is spending hundreds of millions of dollars on providing hearing aids to people who rarely or never end up using them.<sup>138</sup> The ASORC further stated that many people who do use their hearing aids experience difficulty doing so.<sup>139</sup>
- 5.87 The ASORC advised that Rehabilitation Counsellors can provide assistance to people who have not yet received a hearing aid, to assess their readiness for such a device. The ASORC explained that rehabilitation programs:
- ... introduce people to alternate communication strategies and have been shown to reduce stress associated with hearing impairment ... only one third of people undertaking these programs immediately proceed to purchasing a hearing aid, with others choosing instead to use other communication strategies or assistive hearing devices that aid with hearing the TV etc.<sup>140</sup>

## Communication Strategies

- 5.88 Speech pathologists can develop communication strategies for people who choose not to use, or are not eligible for, hearing devices.<sup>141</sup> Speech Pathology Australia advocated for the 'development of information materials' outlining 'alternative communication strategies' for hearing impaired Australians who do not want to use a hearing device.<sup>142</sup>
- 5.89 Speech Pathology Australia further recommended funding mechanisms be used to 'encourage more interdisciplinary [work] between audiologists and speech pathologists', which would result in more comprehensive care and an enhancement of communication strategies for hearing impaired people not using hearing devices.<sup>143</sup>

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<sup>137</sup> SPA, *Submission 51*, p. 22.

<sup>138</sup> ASORC, *Submission 23*, p. 11.

<sup>139</sup> ASORC, *Submission 23*, p. 11.

<sup>140</sup> ASORC, *Submission 23*, p. 12.

<sup>141</sup> SPA, *Submission 51*, p. 10.

<sup>142</sup> SPA, *Submission 51*, p. 22.

<sup>143</sup> SPA, *Submission 51*, p. 16.

## *Assistive Technologies*

- 5.90 SHHH Australia considered that, in some cases, assistive technologies ‘are all that is needed’ to address a hearing impairment and can ‘negate the need for more expensive technology’, such as hearing aids.<sup>144</sup>
- 5.91 Assistive technologies can also be used in conjunction with hearing devices.<sup>145</sup> SHHH Australia listed assistive devices as including ‘Captel phones, shake awake alarms, earphones and head phones for TV, induction loops and door chimes.’<sup>146</sup>

## **Training, Registration, and Skills Shortages in Audiology and Audiometry**

### **Regulatory Settings in Hearing Health Professions**

- 5.92 The audiology and audiometry industries are currently self-regulated.<sup>147</sup> The ACCC described the regulatory settings in the hearing health sector by stating:
- ... there are some associations for audiologists and audiometrists, and they provide some level of oversight and standards. Of course, participation in the government schemes is a further check and balance that provides some regulation. Beyond that, my understanding is that there is not that level of regulation that you see in other health sectors.<sup>148</sup>
- 5.93 There are three Practitioner Professional Bodies that represent audiologists and/or audiometrists:
- Audiology Australia, the peak professional body for audiologists,<sup>149</sup>
  - The ACAud, which represents both audiometrists and audiologists<sup>150</sup>; and

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<sup>144</sup> SHHH Australia, *Submission 42*, p. 23.

<sup>145</sup> SHHH Australia, *Submission 42*, p. 23.

<sup>146</sup> SHHH Australia, *Submission 42*, p. 23.

<sup>147</sup> Mr Tony Khairy, HAASA, *Official Committee Hansard*, Sydney, 6 April 2017, p. 22.

<sup>148</sup> Mr Scott Gregson, ACCC, *Official Committee Hansard*, Canberra, 23 March 2017, p. 4.

<sup>149</sup> Audiology Australia, *Submission 49*, p. 2.

<sup>150</sup> ACAud, *Submission 94*, p. 1.

- The HAASA, which represents audiometrists.<sup>151</sup>
- 5.94 These three Practitioner Professional Bodies developed a joint Code of Conduct for their members, based on the National Code of Conduct for healthcare workers.<sup>152</sup>
- 5.95 In order to provide hearing services under the Australian Government's HSP, an audiologist or audiometrist must be a member of one of the Practitioner Professional Bodies, as well as meeting other qualification requirements.<sup>153</sup> Audiology Australia further advised that 'private healthcare funds also require that the audiologist is a member of Audiology Australia for hearing service fees to be reimbursed.'<sup>154</sup>
- 5.96 Audiology Australia stated that it provided a 'high standard of self-regulation'<sup>155</sup> for the audiology profession, and that '95 per cent of audiologists in Australia are members of Audiology Australia.'<sup>156</sup> Similarly, the HAASA advised that for the audiometry industry, self-regulation 'has worked really well for ... many decades.'<sup>157</sup>
- 5.97 William Demant expressed concern that there is 'no formal centralised registration of audiologists and audiometrists as a registered profession', and that although practitioners providing government services must be registered with a Practitioner Professional Body, 'this information is not accessible to consumers.'<sup>158</sup> The IAA stated that 'the consequence of not having a compulsory register of audiologists in Australia is that any person can undertake audiology work regardless of their qualifications.'<sup>159</sup>
- 5.98 Audiology Australia recommended the Government:

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<sup>151</sup> HAASA, *Submission 66*, p. 1.

<sup>152</sup> Dr Jason Ridgway, President and Chair of Board, Audiology Australia, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 25.

<sup>153</sup> Department of Health, 'How do I become a registered hearing practitioner?', [http://www.hearingservices.gov.au/wps/wcm/connect/b4386181-1c04-4769-bc74-ee4d0578714d/How+do+I+become+a+registered+hearing+practitioner.pdf?MOD=AJPERES&COVERT\\_TO=url&CACHEID=b4386181-1c04-4769-bc74-ee4d0578714d](http://www.hearingservices.gov.au/wps/wcm/connect/b4386181-1c04-4769-bc74-ee4d0578714d/How+do+I+become+a+registered+hearing+practitioner.pdf?MOD=AJPERES&COVERT_TO=url&CACHEID=b4386181-1c04-4769-bc74-ee4d0578714d), Accessed 31 August 2017.

<sup>154</sup> Audiology Australia, *Submission 49*, p. 10.

<sup>155</sup> Audiology Australia, *Submission 49*, p. 10.

<sup>156</sup> Dr Jason Ridgway, Audiology Australia, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 24.

<sup>157</sup> Mr Tony Khairy, HAASA, *Official Committee Hansard*, Sydney, 6 April 2017, p. 23.

<sup>158</sup> William Demant Holding, *Submission 52*, p. 17.

<sup>159</sup> IAA, *Submission 20*, p. 8.

... formally recognise the role of self-regulation by officially endorsing the [National Alliance of Self-Regulating Health Professions (NASRHP)] model and recommending members of the public to see only those clinicians who have been certified by a NASRHP professional body.<sup>160</sup>

5.99 The IAA stated that self-regulation has not prevented ‘corrupt practices’ from taking place.<sup>161</sup> The Goulburn Valley Hearing Clinic expressed similar sentiments, stating that in the current self-regulatory environment ‘there is no mechanism for controlling the more avaricious and exploitative behaviours of the large providers, who between them control over 80 per cent of the market.’<sup>162</sup> Country Hearing Care also stated that self-regulation in the industry is ‘failing miserably.’<sup>163</sup>

5.100 As such, the IAA considered that:

... mandatory registration for audiologists and audiometrists, each with their own and separately defined scope of practice, and with a professional board under the Australian Health Practitioner Regulation Agency – AHPRA – that regulates influences from industry as well as clinical practices is essential to enforcing professional standards acceptable in health care within the audiology field.<sup>164</sup>

5.101 The Goulburn Valley Hearing Clinic agreed and stated that ‘we need to bring audiology under AHPRA.’<sup>165</sup> Audiology Australia also stated it ‘would welcome any consideration by the COAG Health Council to include audiology as a registered profession’.<sup>166</sup>

5.102 The IAA further stated that Australia’s hearing services regulatory system ‘contrasts with regulation around the world.’<sup>167</sup> The IAA cited examples of regulation from comparable countries, including:

- United Kingdom (UK): Audiology in the UK is regulated by the Health Professionals Council (HPC). Registration as a Clinical Scientist (Audiology)

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<sup>160</sup> Audiology Australia, *Submission 49*, p. 11.

<sup>161</sup> Dr Louise Collingridge, IAA, *Official Committee Hansard*, Sydney, 6 April 2017, p. 49.

<sup>162</sup> Ms Dierdre Robertson, GVHC, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 11.

<sup>163</sup> Mrs Jane MacDonald, Country Hearing Care, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 4.

<sup>164</sup> Dr Louise Collingridge, IAA, *Official Committee Hansard*, Sydney, 6 April 2017, p. 49.

<sup>165</sup> Mr Lindsay Symons, GVHC, *Official Committee Hansard*, Shepparton, 2 May 2017, p. 12.

<sup>166</sup> Audiology Australia, *Submission 49*, p. 11.

<sup>167</sup> IAA, *Submission 20*, p. 8.

with the HPC is required. The title of 'Clinical Scientist' is protected, meaning it is illegal to work under this title in the UK unless registered with the HPC.

- United States of America: Licensing (by state) is required to practice the profession of audiology. The minimum educational level is a doctorate.
- Canada: Provinces regulate the profession of audiology. Registration with the regulatory body (known as colleges) in a regulated province or territory is required.<sup>168</sup>

5.103 William Demant commented that the Office of Hearing Services established a steering group in 2016, with representatives of the hearing industry, to 'review and recommend the most appropriate regulatory model for hearing services in Australia, including governance arrangements.'<sup>169</sup> William Demant recommended the Government introduce a regulatory model for hearing services that:

- Ensures a nationally consistent approach to quality hearing services to clients that is cost effective and will not impose unnecessary burden on service providers and practitioners; and
- Establishes central regulatory oversight of qualifications and professional training in the hearing health industry, which is made accessible to the public.<sup>170</sup>

## Skills Shortages – Audiology and Audiometry

5.104 William Demant stated that:

There is a shortage of clinically trained audiologists and audiometrists in Australia, which is limiting the industry's capacity to support an increasing number of Australians who need hearing healthcare.<sup>171</sup>

5.105 William Demant further advised that as Australia's population ages, and hearing needs and treatment becomes more complex, demand for hearing services will increase.<sup>172</sup>

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<sup>168</sup> IAA, *Submission 20*, p. 8.

<sup>169</sup> William Demant Holding, *Submission 52*, p. 17.

<sup>170</sup> William Demant Holding, *Submission 52*, p. 17.

<sup>171</sup> William Demant Holding, *Submission 52*, p. 5.

<sup>172</sup> Ms Janet Muir, William Demant Holding, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 36.

- 5.106 Regional areas in particular may experience shortages of hearing health professionals.<sup>173</sup> According to National Hearing Care, this is largely due to difficulties in attracting hearing health professionals to regional locations, but may also be due to the 'clear shortage' of audiologists and audiometrists in Australia.<sup>174</sup>
- 5.107 William Demant recommended the Government address the current enrolment shortages in audiology and audiometry courses to increase the number of hearing health workers.<sup>175</sup> The HCIA made a similar point, urging the Government to ensure the Diploma of Audiology continues to attract government financial assistance.<sup>176</sup>
- 5.108 William Demant also recommended the Government address barriers to recruiting audiologists and audiometrists from overseas through the skilled migration program.<sup>177</sup> The HCIA similarly stated that 'the industry needs to utilise the 457 Visa program to meet workforce need.'<sup>178</sup>
- 5.109 The HBA put forward a different view, stating that it has 'concerns about the use of 457 [Visas] in the hearing industry'.<sup>179</sup> In fact, the HBA questioned whether there was a workforce shortage in the hearing services market:

It was brought to our attention by some of our members who have started seeing competition in regional areas where there was really no need for another clinic, but the chains were trying to get market share. So they believed they advertised however many times ... and, when you cannot fill the position, you say, 'I have a shortage' and bring in a foreign audiologist.<sup>180</sup>

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<sup>173</sup> Mr Michael Smith, NHC, *Official Committee Hansard*, Adelaide, 3 May 2017, p. 29.

<sup>174</sup> Mr Michael Smith, NHC, *Official Committee Hansard*, Adelaide, 3 May 2017, p. 29.

<sup>175</sup> William Demant Holding, *Submission 52*, p. 5.

<sup>176</sup> HCIA, *Submission 30*, p. 12.

<sup>177</sup> William Demant Holding, *Submission 52*, p. 16.

<sup>178</sup> HCIA, *Submission 30*, p. 12.

<sup>179</sup> Mr Donald MacDonald, HBA, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 13.

<sup>180</sup> Mr Stephen Logan, HBA, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 13.

## Concluding Comment

### *Australian Hearing*

- 5.110 A number of organisations<sup>181</sup> representing small audiology and audiometry businesses and their professional staff were concerned about Australian Hearing's commercial practices in the Hearing Services Program Voucher Scheme market. The Committee understands that Australian Hearing acts as a commercial provider in this market and as such has a need to promote and advertise its services. Nevertheless, there is a perception among some businesses that Australian Hearing's practices may be undermining competition in the Voucher Scheme market and so limiting the ability of clients to receive services from a provider of their choice.
- 5.111 On the basis of the evidence received it is not possible to determine whether Australian Hearing's commercial approach in the Voucher Scheme market is having a detrimental impact on competition. As such the Committee believes that this is an issue that requires more detailed investigation.

### *Subsidies for Working Age Australians*

- 5.112 The Committee notes that many hearing impaired Australians of working age are not eligible for government assistance in purchasing hearing devices or accessing hearing health services. For many hearing impaired Australians in the workforce their hearing devices are an essential support enabling them to continue in employment. Hearing devices are expensive items and for some hearing impaired Australians purchasing or updating a hearing device may not always be possible.
- 5.113 Deloitte Access Economics research suggests that providing unemployed hearing impaired Australians with free hearing aids would have a benefit-to-cost ratio of 5.2 to 1. If only one in every fifteen of the people provided with free hearing aids moved into full time employment there would be an overall positive impact on the Government budget. There is also a risk that if access to subsidised hearing aids was only available to the unemployed this may create perverse incentives for hearing impaired Australians on low incomes to leave employment. Therefore, financial support for the purchase of hearing aids should be extended to unemployed and low income earning hearing impaired Australians.

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<sup>181</sup> For example Independent Audiologists Australia, the Hearing Business Alliance, and the Hearing Aid Audiometrist Society of Australia.

### *Commissions and Sales Practices in Hearing Aid Clinics*

- 5.114 The Committee is concerned by the findings of the Australian Competition and Consumer Commission's (ACCC) investigation into the use of commissions and other sales practices in the hearing clinic industry. Although the ACCC advised that it was unable to undertake any enforcement actions against individual clinics, the practices that it described were confirmed by a number of organisations and individuals who participated in this inquiry.
- 5.115 The Committee believes that the use of these sales practices is not appropriate in a healthcare setting. The clinical decisions of audiologists and audiometrists need to be based on the best interests of their client's health, not potential financial gain. The Committee considers the use of these practices as unethical as they undermine the clinical judgement and impartiality of audiologists and audiometrists and also place a vulnerable group of consumers at risk of financial exploitation.
- 5.116 The Committee calls on Australian Hearing to cease the use of commissions and similar sales practices as soon as is feasible. The Committee also calls on the Department of Health to begin making the necessary arrangements to prohibit the use of commissions by private providers operating in the Hearing Services Program. The Committee encourages private providers to voluntarily phase out the use of commissions and similar practices as soon as is practicable.

### *Support and Rehabilitation*

- 5.117 Unfortunately some hearing impaired Australians do not get the benefit from hearing aids that they expected. In many cases training and support can help people properly benefit from hearing aids. Volunteer organisations such as Better Hearing Australia and Self Help for Hard of Hearing People Australia help hearing impaired Australians benefit from their hearing aids and learn additional techniques to improve their communication skills. The Committee commends these groups for their activities.

### *Regulation of Audiologists and Audiometrists*

- 5.118 The Committee considers that the majority of audiologists and audiometrists are appropriately qualified and acknowledges that there are currently three professional bodies representing audiologists and audiometrists. Nevertheless, several representatives of hearing clinic businesses (representing both small independent clinics and large chains) are calling for

the registration of audiology and audiometry under the Australian Health Practitioner Regulation Agency (AHPRA). This would bring audiology and audiometry into line with the regulatory procedures used by other, broadly equivalent, healthcare professions. The Committee believes that AHPRA registration would strengthen the professional standards regulating the professions of audiology and audiometry.

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### **Recommendation 10**

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**5.119 The Committee recommends a review be undertaken of Australian Hearing's commercial operations to ensure it is undertaking a competitively neutral approach to its participation in the Hearing Services Program Voucher Scheme.**

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### **Recommendation 11**

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**5.120 The Committee recommends that the Community Service Obligations program be extended to provide hearing services to hearing impaired Australians aged 26 to 65 years on low incomes or who are unemployed and qualify for lower income support or the Low Income Superannuation Tax Offset.**

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### **Recommendation 12**

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**5.121 The Committee recommends the Australian Government's Hearing Services Program prohibit the use of commissions or any other similar sales practices likely to undermine the ability of audiologists and audiometrists to provide independent and impartial clinical advice. The Committee also recommends that:**

- **Australian Hearing cease the use of commissions and similar sales practices as soon as is feasible.**
- **The Department of Health amends contracts with service providers operating under the Hearing Services Program Voucher Scheme to prohibit the use of commissions and similar sales practices as soon as is feasible.**
- **If necessary, changes be made to the *Hearing Services Administrative Act 1997* (Cwlth), and any other relevant legislation or regulation, to enable the prohibition of commissions and similar sales practices as described above.**

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**Recommendation 13**

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**5.122 The Committee recommends that the Australian Government pursue the registration of the audiology and audiometry professions under the Australian Health Practitioner Regulation Agency framework with the Council of Australian Governments.**



# 6. Future of Hearing Services in Australia

## Overview

- 6.1 The introduction of the National Disability Insurance Scheme (NDIS) will result in changes to how hearing services are funded and delivered in Australia. This chapter will discuss how the NDIS will interact with the system currently in place to identify and treat young children with hearing impairment.
- 6.2 In addition, this chapter discusses possible improvements to universal newborn hearing screening programs and the potential for implementing additional screenings for young children and more mature adults. The availability of Auslan interpreters and the ownership of Australian Hearing will also be highlighted. Finally, whether hearing health should become a National Health Priority Area will also be discussed.

## National Disability Insurance Scheme

- 6.3 The NDIS is in the process of being implemented across Australia and is expected, at full implementation, to provide cover for about 460 000 Australians.<sup>1</sup>
- 6.4 Hearing impaired Australians who currently receive services from the Hearing Services Program (HSP) will be transitioned to the NDIS if they:
  - are aged under 65 years of age;

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<sup>1</sup> National Disability Insurance Agency (NDIA), *Submission 45*, p. 1.

- meet residence requirements;
- have a permanent hearing loss; and
- have a significant loss in functional capacity to communicate and/or socially interact without support (such as hearing devices) or assistance.<sup>2</sup>

6.5 The majority of younger children accessing Community Service Obligations services,<sup>3</sup> as well as adults with ‘substantially reduced functional impairment’<sup>4</sup> are expected to transition to the NDIS by 2019-20.<sup>5</sup>

6.6 The National Disability Insurance Agency (NDIA) indicated that it expects approximately 16 000 to 20 000 hearing impaired Australians to enter the NDIS.<sup>6</sup> The NDIA cautioned that the NDIS has a legislated scope that cannot be exceeded and that mainstream health services will remain responsible for providing support for most people with hearing impairment, particularly those with mild hearing loss.<sup>7</sup>

6.7 In March 2017, the NDIA stated that it was ‘currently working with the Office of Hearing Services and Australian Hearing to identify clients for transition from the [HSP] to the [NDIS]’.<sup>8</sup>

### *Services Funded by the National Disability Insurance Scheme*

6.8 The NDIA advised that it may fund ‘hearing services and supports not available under the HSP’. The NDIA also stated that if a HSP client chooses a more expensive, top-up, hearing device that requires the client to pay a co-contribution than the NDIS may cover some, or all, of these out-of-pocket expenses.<sup>9</sup>

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<sup>2</sup> NDIA, *Submission 45*, p. 1.

<sup>3</sup> NDIA, *Submission 45*, p. 1.

<sup>4</sup> NDIA, *Submission 45.1*, p. 3.

<sup>5</sup> Department of Health, *Submission 16*, p. 17.

<sup>6</sup> This figure does not include people entering the NDIS due to a different primary disability who may also be hearing impaired. NDIA, *Submission 45*, p. 3.

<sup>7</sup> Ms Vicki Rundle, Acting Deputy Chief Executive Officer, NDIA, *Official Committee Hansard*, Canberra, 16 June 2017, p. 15; and Ms Louise Glanville, Deputy Chief Executive Officer, Governance and Stakeholder Relations, NDIA, *Official Committee Hansard*, Canberra, 3 March 2017, p. 25.

<sup>8</sup> NDIA, *Submission 45.1*, p. 3.

<sup>9</sup> NDIA, *Submission 45*, p. 4.

6.9 The NDIA stated that the typical NDIS plan for a hearing impaired client would include:

- Capacity building supports – this may include therapy identified by therapists working with the child, e.g. one on one or group based activities to promote social skills
- Auslan interpreters
- Assistive technology – for hearing aids that are not covered by the HSP, e.g. waterproof hearing aids, waterproof covers for cochlear implants, or other cochlear accessories. Occasionally an Augmentative and Alternative Communication service.
- Core supports – for example for older children there could be support to sustain informal care or support coordination. This is not as common for younger children.<sup>10</sup>

### **Contestability in the Community Service Obligations Market**

6.10 The HSP's Community Service Obligations (CSO) scheme is currently delivered solely by Australian Hearing with funding provided by the Department of Health's Office of Hearing Services.<sup>11</sup>

6.11 The NDIA acknowledged Australian Hearing's 'high level of expertise' in the delivery of services to children and adults with complex needs. The NDIA stated that Australian Hearing's functions would need to be 'carefully analysed and understood' to ensure these functions are preserved within the NDIS.<sup>12</sup>

6.12 The implementation of the NDIS may introduce a contestable market, allowing private hearing service providers to compete with Australian Hearing to deliver services to CSO clients. The Department of Health stated:

The NDIS will introduce major change to the way government funded disability services will be delivered by mid-2019, with the introduction of full contestability for services, and NDIS participant control to choose any service provider.<sup>13</sup>

6.13 In March 2017, the NDIA indicated that a final decision had not been taken on whether a contestable market for the provision of CSO services would be

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<sup>10</sup> NDIA, *Submission 45*, p. 5.

<sup>11</sup> Department of Health, *Submission 16*, p. 14.

<sup>12</sup> NDIA, *Submission 45.1*, p. 6.

<sup>13</sup> Department of Health, *Submission 16*, p. 17.

created, stating ‘the question of moving from a sole specialist provider for children and young Australians to contestability of services is under consideration.’<sup>14</sup>

- 6.14 The Australasian Newborn Hearing Screening Committee (ANHSC) stated that one of the difficulties regarding the introduction of the NDIS is that the provision of hearing services is ‘such a well-developed, mature service system that a lot of the ills that the [NDIS is] seeking to rectify do not exist in our system’.<sup>15</sup>
- 6.15 The ANHSC referred to the example of the United Kingdom of Great Britain which, following the introduction of contestability into the child hearing services market, experienced ‘market failure and a gap in the system’ when a major provider reduced its services in many areas.<sup>16</sup>
- 6.16 The ANHSC also contended that in a contestable market providers are not obligated to provide services in all locations and this could lead to reduced services in rural and remote areas.<sup>17</sup> The ANHSC stated:

In the absence of that obligation on a service provider, we will see failure, and that failure will be in rural and remote locations ... where it is less possible to provide a service in a commercially and economically viable way for someone who is in the market for what are, essentially, commercial reasons.<sup>18</sup>

### ***Expertise in Paediatric Audiology***

- 6.17 Aussie Deaf Kids and Parents of Deaf Children also referred to the risk that the introduction of a contestable market could impact on the quality of care provided to deaf children, stating that under a contestable system there are few safeguards:

... in place to ensure that children and young people receive services from appropriately trained audiologists with paediatric experience. Poor quality service delivery for children can have lifelong consequences but there is no

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<sup>14</sup> NDIA, *Submission 45.1*, p. 6.

<sup>15</sup> Professor Greg Leigh, Chair, Australasian Newborn Hearing Screening Committee (ANHSC), *Official Committee Hansard*, Sydney, 6 April 2017, p. 10.

<sup>16</sup> Professor Greg Leigh, ANHSC *Official Committee Hansard*, Sydney, 6 April 2017, p. 6.

<sup>17</sup> Professor Greg Leigh, ANHSC, *Official Committee Hansard*, Sydney, 6 April 2017, p. 7.

<sup>18</sup> Professor Greg Leigh, ANHSC, *Official Committee Hansard*, Sydney, 6 April 2017, p. 7.

system in place that will penalise providers who do not comply with proposed standards and guidelines.<sup>19</sup>

6.18 The Royal Institute for Deaf and Blind Children (RIDBC) raised concerns regarding whether new providers in a contestable environment will have the necessary experience in children's hearing services. The RIDBC stated:

... the private market is untested in the delivery of services to children with hearing loss, with no mechanisms currently in place to assess competency for services or individuals delivering services to children, whose families on diagnosis are in a state of crisis and highly vulnerable.<sup>20</sup>

6.19 Aussie Deaf Kids stated it had recently surveyed its members and found that a 'very low' number of them 'supported being able to choose a hearing service provider'. Aussie Deaf Kids explained that overall its members had a positive impression of the quality of care provided by Australian Hearing. Aussie Deaf Kids stated that 'there is a really strong recognition amongst families that this is an amazing service ... and they are really grateful to have that facility where they get the best aids and FM systems.'<sup>21</sup>

6.20 The Hearing Care Industry Association stated, in relation to children's hearing services, it was logical to 'develop and concentrate expertise in one area, namely Australian Hearing.'<sup>22</sup>

6.21 The NDIA commented that it is:

... absolutely committed to ensuring that the approaches in early childhood are, as much as possible, based on the evidence of best practice. We absolutely recognise that in Australia the effort through Australian Hearing meets some of the best international standards so we are very keen to understand what are the core elements of that and how to integrate that into our early childhood approach.<sup>23</sup>

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<sup>19</sup> Aussie Deaf Kids and Parents of Deaf Children, *Submission 72*, p. 8.

<sup>20</sup> RIDBC, *Submission 48*, p. 6.

<sup>21</sup> Mrs Ann Porter, Chief Executive Officer, Aussie Deaf Kids, *Official Committee Hansard*, Sydney, 6 April 2017, p. 19.

<sup>22</sup> Hearing Care Industry Association, *Submission 30*, p. 13.

<sup>23</sup> Ms Anne Skordia, Expert Advisor, Mainstream Interface and Government Relations, NDIA, *Official Committee Hansard*, Canberra, 16 June 2017, p. 8.

## Early Intervention Services in the NDIS

### *Accessing Early Intervention Services*

- 6.22 Currently, Australian children are screened at birth as part of the universal newborn hearing screening programs. If a potential hearing loss is detected, they undergo further diagnostic testing at the hospital. If a permanent hearing impairment is detected the child is referred to Australian Hearing, which aims to see the child within two weeks to begin the process of fitting a hearing device.<sup>24</sup>
- 6.23 First Voice stated that previously Australian Hearing had regularly referred children to early intervention providers but that ‘it has stepped back from that over the course of the rollout’ of the NDIS.<sup>25</sup> In addition, First Voice stated prior to the introduction of the NDIS that almost all families of hearing impaired children in South Australia had visited the Cora Barclay Centre (as well as the other early intervention providers) before choosing a service. Since the introduction of the NDIS less than 40 per cent of the families of newly diagnosed hearing impaired children had visited the Cora Barclay Centre.<sup>26</sup>
- 6.24 Aussie Deaf Kids advised that since the introduction of the NDIS, state and territory governments have been reducing their provision of early intervention services.<sup>27</sup>
- 6.25 The NDIA stated that it ‘recognised the importance of early diagnosis and very streamlined, timely clinical pathways so that children get the right sort of supports early.’<sup>28</sup> The NDIA further advised that it has established an Early Intervention Hearing Expert Reference Group which includes representatives of ‘hearing loss experts, peak bodies, service providers and organisations’ and has responsibility to:

... consider evidence relating to a range of issues including; the NDIS access criteria, potential for delays in referral from newborn hearing screening

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<sup>24</sup> Ms Alison King, Principal Audiologist, Paediatric Services, Australian Hearing, *Official Committee Hansard*, Canberra, 3 March 2017, p. 13.

<sup>25</sup> Dr Jim Hungerford, Chief Executive Officer, The Shepherd Centre and Board Member, First Voice, *Official Committee Hansard*, Canberra, 16 June 2017, p. 4.

<sup>26</sup> Mr Michael Forwood, Chair, First Voice, and Chief Executive Officer, Cora Barclay Centre, *Official Committee Hansard*, Canberra, 16 June 2017, p. 6.

<sup>27</sup> Mrs Ann Porter, Aussie Deaf Kids, *Official Committee Hansard*, Sydney, 6 April 2017, p. 20.

<sup>28</sup> Ms Vicki Rundle, NDIA, *Official Committee Hansard*, Canberra, 16 June 2017, p. 4.

programs and the clinical standards, governance, and expertise required to deliver specialist hearing services for infants and young children.<sup>29</sup>

### *Choice of Service Providers*

- 6.26 The introduction of a contestable market will allow parents to choose between different service providers. The Shepherd Centre questioned whether, without guidance, the parents of newborns recently diagnosed with hearing impairment had the 'knowledge to make the informed choices for their child that would make possible the outcomes they wish.'<sup>30</sup> Aussie Deaf Kids added that for most of these parents 'the first deaf child that they have ever met is their very own child ... so besides the stress of it and going through the grieving process and everything, you do not have a clue what you are supposed to be doing.'<sup>31</sup>
- 6.27 First Voice contended that the 'choice-and-control' principle in the NDIS Act giving clients the opportunity to choose the services they require is not always appropriate for highly specialised health care services.<sup>32</sup> To highlight the point that, in some cases, the guidance of expert medical practitioners is crucial, First Voice drew a comparison with someone suffering a serious injury. First Voice commented:
- If you break your neck, you go into a multidisciplinary rehab unit and people manage your rehabilitation ... and it is individualised. They do not give you \$150 000 and say 'go and put your own team together.'<sup>33</sup>
- 6.28 The RIDBC commented that parents at this point are 'highly vulnerable' and are 'in incredible levels of grief at the diagnosis of hearing loss. They are looking for a light, and any light will do.'<sup>34</sup>
- 6.29 The RIDBC contended that not all providers would be able to deliver a high quality outcome for a hearing impaired child, stating that 'there is a very

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<sup>29</sup> NDIA, *Submission 45*, p. 2.

<sup>30</sup> The Shepherd Centre, *Submission 19*, p. 12.

<sup>31</sup> Mrs Ann Porter, Aussie Deaf Kids, *Official Committee Hansard*, Sydney, 6 April 2017, p. 17.

<sup>32</sup> Mr Michael Forwood, First Voice and Cora Barclay Centre, *Official Committee Hansard*, Adelaide, 3 May 2017, p. 3.

<sup>33</sup> Mr Michael Forwood, First Voice, *Official Committee Hansard*, Adelaide, 3 May 2017, p. 5.

<sup>34</sup> Mr Bart Cavalletto, Director, Services, RIDBC, *Official Committee Hansard*, Sydney, 6 April 2017, p. 37.

significant difference and evidence around outcomes for multidisciplinary ... and transdisciplinary teams as opposed to sole providers',<sup>35</sup> and that:

... specialisation is really important, too. Not everybody can work with a paediatric caseload ... we are a highly specialised organisation ... small-based providers are somewhat challenged to be experts across all fronts.<sup>36</sup>

- 6.30 Aussie Deaf Kids suggested that 'if we are going to a contested environment, parents are going to need significant help in understanding the process'.<sup>37</sup> Aussie Deaf Kids also commented some families are more likely to be disadvantaged by the changes than other families, stating:

... those of low socioeconomic status, migrant families and regional and remote families ... are going to be the people who are most disadvantaged by this. People in metropolitan areas – well-educated families – will manage. But we want every child to have the same opportunities. It should not be dependent on the capacity of your parents to understand the system.<sup>38</sup>

### *Delays Accessing Early Intervention Services*

- 6.31 The ANHSC stated that with the introduction of new service providers parents will need a 'period of shopping around' to understand the different types of services available.<sup>39</sup> This could result in the child's engagement with an intervention service being delayed and 'even small delays, measured in months – weeks even – can be represented in long-term delays to language and communication development that go on into childhood and potentially into adulthood.'<sup>40</sup>
- 6.32 Since the introduction of the NDIS in South Australia, early intervention services advised that children's entry into their services had been delayed. The Cora Barclay Centre, an early intervention service based in Adelaide, has seen the average age of children commencing treatment rise from six months to over 12 months since the introduction of the NDIS.<sup>41</sup>

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<sup>35</sup> Mr Bart Cavalletto, RIDBC, *Official Committee Hansard*, Sydney, 6 April 2017, p. 37.

<sup>36</sup> Mr Chris Rehn, Chief Executive Officer, RIDBC, *Official Committee Hansard*, Sydney, 6 April 2017, p. 37.

<sup>37</sup> Mrs Ann Porter, Aussie Deaf Kids, *Official Committee Hansard*, Sydney, 6 April 2017, p. 18.

<sup>38</sup> Mrs Ann Porter, Aussie Deaf Kids, *Official Committee Hansard*, Sydney, 6 April 2017, p. 18.

<sup>39</sup> Professor Greg Leigh, ANHSC, *Official Committee Hansard*, Sydney, 6 April 2017, p. 8.

<sup>40</sup> Professor Greg Leigh, ANHSC, *Official Committee Hansard*, Sydney, 6 April 2017, p. 5.

<sup>41</sup> Mr Michael Forwood, First Voice, *Official Committee Hansard*, Adelaide, 3 May 2017, p. 3.

- 6.33 First Voice illustrated the negative impacts of delayed entry into early intervention services by relaying that the Cora Barclay Centre had recently received:

... a number of really quite late referrals ... of children who were diagnosed at birth who had been receiving services from, say, a speech pathologist in their local area. [Cora Barclay] had a three-year-old who came to us a week ago with half a dozen single-syllable words, so they have got a three-year language delay because they have been to a person who is an accredited and registered NDIS provider but they have not been to an NDIS provider who has got the relevant skills and experience.<sup>42</sup>

- 6.34 First Voice and the RIDBC summarised their concerns about the impact the NDIS was having on children's hearing health.

The introduction of the NDIS is resulting in a huge backward step for children with hearing loss in Australia. Immediate action must be taken to prevent a generation of children growing up without the language they require.<sup>43</sup>

### *Funding for Early Intervention Services*

- 6.35 The RIDBC was critical of the NDIA's use of planners without clinical expertise to make funding decisions on cases of individual clients. The RIDBC stated:

Currently, decisions on service types and funding levels that are available ... [for] early intervention are being taken by NDIA planners who in most cases have little or no knowledge of a deaf or hard of hearing child's requirements and do not typically have relevant clinical expertise ... This has resulted in widely discrepant levels of funding availability for children with similar needs and stands to compromise the quality and adequacy of available services.<sup>44</sup>

- 6.36 First Voice expanded on the issue of variability in the plans provided to NDIS clients, stating that 'children with apparently identical levels of hearing loss and need and family circumstances [are getting] widely varying packages. So what you get depends on who you see in the NDIA and how articulate and persistent you are.'<sup>45</sup>

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<sup>42</sup> Mr Michael Forwood, First Voice, *Official Committee Hansard*, Canberra, 16 June 2017, p. 6.

<sup>43</sup> First Voice and the RIDBC, *Submission 111*, p. 1.

<sup>44</sup> RIDBC, *Submission 48*, p. 11.

<sup>45</sup> Mr Michael Forwood, First Voice, *Official Committee Hansard*, Adelaide, 3 May 2017, p. 5.

- 6.37 Early intervention service providers were also concerned that the funding they received from the NDIA was insufficient to cover the costs of the services they were providing.<sup>46</sup> A joint submission by First Voice and the RIDBC explained that currently funding under the NDIS is based on the expectation that therapy will be provided by a sole provider (such as a speech pathologist). The quantity of funding is based on the number of hours the client is directly served by the practitioner.<sup>47</sup>
- 6.38 First Voice and the RIDBC contended that, compared to single discipline services, multidisciplinary services produced superior language outcomes but were more expensive to deliver. First Voice and the RIDBC stated that 'evidence clearly demonstrates that a specialised holistic multidisciplinary / transdisciplinary service is required to produce [positive language] outcomes; however this service comes with 30 to 50 per cent increased cost.'<sup>48</sup>
- 6.39 First Voice advised that, following the introduction of the NDIS, the Cora Barclay Centre's state government funding was reduced and Cora Barclay was now 'sustaining a monthly loss of \$120 000'. First Voice added that the gap between the funding provided by the NDIS and the actual cost of providing services was between \$6000 and \$8000 per child. First Voice suggested that once the NDIS was fully operational in New South Wales the Shepherd Centre could expect a shortfall in government revenue of between \$1.5 million and \$2 million per year.<sup>49</sup>
- 6.40 The NDIA advised that the NDIS aims to use transdisciplinary services for the delivery of early childhood support.<sup>50</sup> The NDIA also stated that 'the NDIS provides individualised funding to participants, giving them choice and control over the services and supports they receive'. The NDIA further added that it:

... continues to work with providers to encourage development of alternative business models that align with the individualised approach to funding and

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<sup>46</sup> RIDBC, *Submission 48*, p. 11.

<sup>47</sup> First Voice and the RIDBC, *Submission 111*, p. 2.

<sup>48</sup> First Voice and the RIDBC, *Submission 111*, p. 2.

<sup>49</sup> Mr Michael Forwood, First Voice, *Official Committee Hansard*, Adelaide, 3 May 2017, p. 4.

<sup>50</sup> NDIA, *Submission 45.2*, p. 2.

the NDIS terms of business. Existing quality and safeguards arrangements continue to apply.<sup>51</sup>

## Policy Options for Young Children

6.41 A number of organisations suggested that the creation of a ‘guided pathway’ to assist parents choose a service provider could help ameliorate the potential risks associated with a contestable market for children’s hearing services. The Shepherd Centre stated that a number of the states and territories have a:

... dedicated service that guides the referral of these diagnosed children into the specialised early intervention service of the family’s choice. However this service is absent in NSW, the ACT, Tasmania and the Northern Territory. With the introduction of the NDIS, the continuation of this service may be at risk in the other states.<sup>52</sup>

6.42 The Shepherd Centre suggested that the establishment of a nationally coordinated guided referral service would have an annual cost of approximately \$3 million.<sup>53</sup>

6.43 First Voice and the RIDBC suggested that Australian Hearing is ‘ideally placed’ to provide a guided referral service due to its ‘national footprint, expertise, and independence’.<sup>54</sup>

6.44 The RIDBC advocated for the continued provision of an obligated provider to provide CSO hearing services under the NDIS, and stated:

... it is the fundamental position of RIDBC that there should continue to be a Single Obligated Provider under the Hearing Services Program or the NDIS for all Australians currently covered under the CSO obligations component of current policies. The Single Obligated Provider would be required to continue to deliver services to all current CSO clients, regardless of complexity, geography, or cost of service delivery.<sup>55</sup>

6.45 The RIDBC also questioned whether the advent of a contestable market would make it difficult for the government to invest in expanding the

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<sup>51</sup> NDIA, *Submission 45.2*, p. 2.

<sup>52</sup> The Shepherd Centre, *Submission 19*, p. 12.

<sup>53</sup> The Shepherd Centre, *Submission 19*, p. 12.

<sup>54</sup> First Voice and the RIDBC, *Submission 111*, p. 1.

<sup>55</sup> RIDBC, *Submission 48*, p. 6.

services provided by Australian Hearing. The RIDBC stated that, although Australian Hearing was a 'world leading organisation', there were:

... opportunities for improvement and expansion of services. The challenge that we see specifically in investing is that it is slightly at odds with the philosophical approach with the NDIS. Having full contestability of a space and the government seeking to be and remain to be a big player in it is an oddity to us.<sup>56</sup>

## Hearing Screening Programs

### Improvements to Universal Newborn Hearing Screening Programs

6.46 Australian Hearing put forward two potential improvements to newborn hearing screening:

- Implementation of a national data collection system to monitor children's progress along the clinical and intervention pathway, and their outcomes; and
- National monitoring of the quality of newborn screening programs.<sup>57</sup>

6.47 Australian Hearing added that 'the true magnitude of the impact of newborn hearing screening' can only be measured if the progress of children with hearing impairment is tracked over time.<sup>58</sup>

6.48 The ANHSC also called for national data collection and management to provide:

- information on the prevalence of hearing impairment across Australia;
- a basis for ensuring newborns identified with hearing impairment are not lost to follow up;
- a database that can be used for research purposes; and
- a basis for tracking outcomes and cost-effectiveness of newborn screening.<sup>59</sup>

6.49 In order to monitor the quality of newborn screening programs, Australian Hearing and the ANHSC recommended state and territory newborn screening programs be required to report against the 'National Performance

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<sup>56</sup> Mr Chris Rehn, RIDBC, *Official Committee Hansard*, Sydney, 6 April 2017, p. 36.

<sup>57</sup> Australian Hearing, *Submission 58.2*, p. 3.

<sup>58</sup> Australian Hearing, *Submission 58.2*, p. 3.

<sup>59</sup> ANHSC, *Submission 68*, p. 2.

Indicators to Support Neonatal Hearing Screening in Australia.<sup>60</sup> These indicators were published by the Australian Institute of Health and Welfare in 2013, but newborn screening programs are not required to report against them.<sup>61</sup> The ANHSC recommended that national reporting and monitoring come under the responsibility of the Australian Health Ministers Advisory Council's Standing Committee on Screening.<sup>62</sup>

## Additional Hearing Screening for Children

6.50 Two thirds of children who have a hearing loss at school age developed the loss after birth.<sup>63</sup> As such, newborn hearing screening programs cannot identify a hearing impairment in these children. The Australian Hearing Hub stated because of this:

... many children go undiagnosed and untreated, with communication problems misunderstood for lengthy periods during which development and learning delays manifest, and impact more negatively, than would have been the case if there had been early intervention.<sup>64</sup>

6.51 Hear and Say added that many children who were born overseas but are now living in Australia may not have had access to newborn hearing screening programs.<sup>65</sup>

6.52 A number of organisations advocated for the implementation of hearing screening programs for children either before<sup>66</sup> or on entry to school.<sup>67</sup> The Australian Society of Otolaryngology Head and Neck Surgery stated 'hearing screening at age four to five would ensure each child has optimal hearing when starting school.'<sup>68</sup> The Shepherd Centre advocated for

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<sup>60</sup> Australian Hearing, *Submission 58.2*, p. 4, the ANHSC, *Submission 68*, p. 2.

<sup>61</sup> Australian Hearing, *Submission 58.2*, p. 4.

<sup>62</sup> ANHSC, *Submission 68*, p. 2.

<sup>63</sup> The Shepherd Centre, *Submission 19*, p. 13.

<sup>64</sup> Australian Hearing Hub, *Submission 60*, p. 3.

<sup>65</sup> Hear and Say, *Submission 67*, p. 5.

<sup>66</sup> These included the Audiometry Nurses Association of Australia, *Submission 15*, p. 6; the Shepherd Centre, *Submission 19*, p. 13; Speech Pathology Australia, *Submission 51*, p. 21; and the ANHSC, *Submission 68*, p. 2.

<sup>67</sup> These included Sound Scouts Australia, *Submission 41*, p. 13; Can:Do Group, *Submission 50*, p. 5; the HEARing CRC, *Submission 59*, p. 11; and Mr Dig Howitt, Chief Operating Officer, Cochlear Limited, *Official Committee Hansard*, Sydney, 15 November 2016, p. 9.

<sup>68</sup> Australian Society of Otolaryngology Head and Neck Surgery, *Submission 24*, p. 5.

screening at age three to four, to ensure a child's hearing impairment is picked up and treated before they enter the school system.<sup>69</sup>

6.53 The ANHSC further explained why preschool or at the start of schooling were the recommended ages for screening:

... by that age a number of children will have developed a permanent hearing loss, so that is a good time to try and catch them. So, it is a clinical reason. The other one is really because of being able to catch a large group of children in fewer places rather than having to visit them in many places ... So, it is for convenience and efficacy.<sup>70</sup>

6.54 The HEARing Cooperative Research Centre proposed that hearing screening should include screening for auditory processing disorders, which 'affect the ability of the child to hear in noisy environments.'<sup>71</sup>

6.55 Sound Scouts Australia stated that the World Health Organisation has recommended hearing tests for children around the time they start school.<sup>72</sup> Sound Scouts Australia also cited other international examples, stating that the 'UK government has a goal of all children having their hearing tested within 60 days of starting school' and the 'New Zealand Government includes a hearing test as part of the comprehensive B4 School health check.'<sup>73</sup>

6.56 Screening at other ages in childhood was also suggested. The Royal Australasian College of Surgeons (RACS) considered that school entry testing was too late, and that 'the one-to-three-year-old age group is crucial in picking up conductive hearing loss.'<sup>74</sup> Sound Scouts Australia recommended school entry screening and then 'a follow-up test in year 5, in line with NAPLAN, or upon high school entry.'<sup>75</sup> The RIDBC,<sup>76</sup> the

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<sup>69</sup> Ms Aleisha Davis, General Manager, Listening and Spoken Language Therapy, the Shepherd Centre, *Official Committee Hansard*, Sydney, 15 November 2016, p. 4.

<sup>70</sup> Dr Zeffie Poulakis, Secretary, ANHSC, *Official Committee Hansard*, Sydney, 6 April 2017, p. 9.

<sup>71</sup> The HEARing CRC, *Submission 59*, p. 11.

<sup>72</sup> Sound Scouts Australia, *Submission 41*, p. 6.

<sup>73</sup> Sound Scouts Australia, *Submission 41*, p. 7.

<sup>74</sup> Associate Professor Kelvin Kong, Indigenous Health Committee, Royal Australasian College of Surgeons (RACS), *Official Committee Hansard*, Sydney, 6 April 2017, p. 69.

<sup>75</sup> Ms Carolyn Mee, Director, Sound Scouts Australia, *Official Committee Hansard*, Sydney, 6 April 2017, p. 12.

<sup>76</sup> RIDBC, *Submission 48*, p. 18.

Australian Hearing Hub,<sup>77</sup> and Speech Pathology Australia<sup>78</sup> also recommended screening before starting high school in addition to early childhood screening.

- 6.57 The South Australian Department for Education and Child Development stated that ‘the cost-benefit if you were doing population screening is unknown.’<sup>79</sup> The department explained the prior research done in the South Australian setting suggested:

... the possibility of a screening process prior to school or upon school entry would be admirable, but the research that was done here with the health services at the time was just not cost productive. They were diagnosing one or two per cent out of every hundred children they were screening. It just was not worth it.<sup>80</sup>

- 6.58 The South Australian Department for Education and Child Development added that many children with hearing impairments are picked up through the school system already, when teachers notice they are struggling to hear in a noisy classroom.<sup>81</sup> The RACS also commented that screening programs ‘are quite expensive and time consuming.’<sup>82</sup>

- 6.59 Hear and Say stated that in 2016 it launched a screening program in some schools in Queensland,<sup>83</sup> aimed at children entering primary school.<sup>84</sup> Hear and Say has screened approximately 15 000 children, and found that ‘20 to 25 per cent of those children have had some sort of hearing issue on the day of screening’, and that of these, approximately 11 per cent will need to be referred to an audiologist or general practitioner (GP) for further testing.<sup>85</sup>

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<sup>77</sup> Australian Hearing Hub, *Submission 60*, p. 3.

<sup>78</sup> Speech Pathology Australia, *Submission 51*, p. 21.

<sup>79</sup> Mr Quenten Iskov, Senior Adviser, Disability Policy and Programs, South Australian Department for Education and Child Development, *Official Committee Hansard*, Adelaide, 3 May 2017, p. 24.

<sup>80</sup> Mr Quenten Iskov, Senior Adviser, Disability Policy and Programs, South Australian Department for Education and Child Development, *Official Committee Hansard*, Adelaide, 3 May 2017, p. 24.

<sup>81</sup> Mr Quenten Iskov, South Australian Department for Education and Child Development, *Official Committee Hansard*, Adelaide, 3 May 2017, p. 24.

<sup>82</sup> Associate Professor Kelvin Kong, RACS, *Official Committee Hansard*, Sydney, 6 April 2017, p. 69.

<sup>83</sup> Hear and Say, *Submission 67*, p. 5.

<sup>84</sup> Mr Chris McCarthy, Chief Executive Officer, Hear and Say, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 2.

<sup>85</sup> Mr Chris McCarthy, Hear and Say, *Official Committee Hansard*, Brisbane, 21 April 2017, p. 2.

- 6.60 Sound Scouts Australia provided details of an app, Sound Scouts, designed by cmee4 Productions and the National Acoustic Laboratories. Sound Scouts is a tablet based application that uses an interactive game to test children for conductive and sensorineural hearing loss, and central auditory processing disorder.<sup>86</sup>
- 6.61 Sound Scouts is suitable for children from the age of four years and nine months to twelve years of age.<sup>87</sup> To take the hearing test the child requires a quiet environment, a digital tablet device, a set of headphones and supervision by a responsible adult such as a parent or teacher.<sup>88</sup> The results of the test are emailed to the responsible adult along with, if necessary, suggested options for treatment for any hearing issues discovered.<sup>89</sup> Sound Scouts Australia stated that they were seeing a lot of use of the app in remote areas where there is a lack of access to hearing services.<sup>90</sup>
- 6.62 The Shepherd Centre estimated that screening all children aged four in Australia using an app such as Sound Scouts could cost approximately \$8 million per year.<sup>91</sup>
- 6.63 Following a diagnosis of a hearing impairment at a screening, the Shepherd Centre recommended that children aged up to seven should be able to see a paediatric audiologist with bulk billing to Medicare and without a doctor's referral (at a limit of one test per year).<sup>92</sup> The Shepherd Centre stated that currently 'there are no self-referral possibilities for parents to take their child to an audiologist and have that diagnostic done under Medicare.'<sup>93</sup>

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<sup>86</sup> Sound Scouts Australia, *Submission 41*, p. 1.

<sup>87</sup> Sound Scouts Australia, *Submission 41*, p. 1.

<sup>88</sup> Ms Carolyn Mee, Sound Scouts Australia, *Official Committee Hansard*, Sydney, 6 April 2017, p. 14.

<sup>89</sup> Sound Scouts Australia, *Submission 41*, p. 12.

<sup>90</sup> Ms Carolyn Mee, Sound Scouts Australia, *Official Committee Hansard*, Sydney, 6 April 2017, p. 14.

<sup>91</sup> The Shepherd Centre, *Submission 19*, p. 13.

<sup>92</sup> The Shepherd Centre, *Submission 19*, p. 13.

<sup>93</sup> Dr Jim Hungerford, The Shepherd Centre, *Official Committee Hansard*, Sydney, 15 November 2016, p. 2.

## Hearing Screening for Adults

6.64 Hearing screening of adults may enable them to stay productive and in the workforce for longer.<sup>94</sup> The RIDBC recommended adults have their hearing screened at age 50 and periodically after that, as this would:

... improve the timely diagnosis and treatment of hearing loss in working age Australians, improving health outcomes for this demographic while reducing the negative impact hearing loss has on the nation's productivity.<sup>95</sup>

6.65 The Australian Hearing Hub also suggested screening at ages 50 and 60, as this is when 'other primary-health screening is prioritised.'<sup>96</sup> Cochlear put forward a similar point, stating that:

There are a number of programs in place for Australian's in the over 55 category to be reminded and supported to have health tests. It would not be complex to move towards this in Australia in the case of hearing tests.<sup>97</sup>

6.66 The RIDBC outlined the benefits of screening for elderly Australians and stated:

Improved screening rates for hearing loss for the elderly will improve the uptake of hearing health services for seniors, with benefits in terms of better productivity and reducing the prevalence of hearing loss as a factor for cognitive decline and the onset of dementia.<sup>98</sup>

6.67 Audiology Australia also recommended aged care recipients receive a hearing screening upon entering an aged care facility.<sup>99</sup>

6.68 Cochlear advised that research in the UK has found an eight to one benefit-cost ratio for 'providing national hearing screening at ages 55 and 65.'<sup>100</sup> A Deloitte Access Economics report found that the cost of

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<sup>94</sup> Australian Hearing Hub, *Submission 60*, p. 3.

<sup>95</sup> RIDBC, *Submission 48*, p. 18.

<sup>96</sup> Australian Hearing Hub, *Submission 60*, p. 3.

<sup>97</sup> Cochlear, *Submission 91*, p. 25.

<sup>98</sup> RIDBC, *Submission 48*, p. 18.

<sup>99</sup> Audiology Australia, *Submission 49*, p. 9.

<sup>100</sup> Cochlear, *Submission 91*, p. 18.

implementing hearing assessments for all Australians over the age of 50 years was estimated to be \$134.3 million.<sup>101</sup>

- 6.69 A study into the perspectives of GP's on hearing screening for adults found some potential barriers. In particular, the study found that:

In the context of a typical consultation, routine screening for hearing impairment was generally not considered [by the GPs] to be an issue of high priority. Consequently, the prevailing view was that a proactive screening approach was inappropriate and not economically viable.<sup>102</sup>

## Availability of Auslan Interpreters

- 6.70 According to Deaf Australia, there are currently 961 Auslan interpreters accredited under the National Accreditation Authority for Translators and Interpreters, and that of these, there are 300 interpreters 'actively working in Australia.'<sup>103</sup> There are varying numbers of interpreters across the country:

Victoria does have the largest number of Auslan interpreters—I think the number is about 260. In New South Wales there are fewer, Queensland has fewer again and South Australia even fewer. In the Northern Territory I know that there are four.<sup>104</sup>

- 6.71 The Can:Do Group in South Australia also identified a shortage of qualified Auslan interpreters in Australia. The Can:Do Group advised that this was related to 'problems around funding and incentives for Auslan courses'<sup>105</sup>, stating that:

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<sup>101</sup> This amount was 'based on the assumption that in 2017 all people aged 50, 55, 60, 65, 70, 75 and 80 were to be invited for hearing assessment. At 50, 55 and 65, 55 per cent of people are assumed to participate in screening. At 65, 70, 75 and 80, 65 per cent of people are assumed to participate in screening...the cost of a hearing assessment as reported by the OHS Fee Schedule for 2016-17 was \$136.25 per person.' Deloitte Access Economics, *Exhibit 18: An Update on the Social and Economic Cost of Hearing Loss and Hearing Health Conditions in Australia (June 2017)*, p. 65.

<sup>102</sup> Dr Anthony Hogan, *Exhibit 3: Barriers against the implementation of hearing impairment screening programmes for adults – a scoping study into the General Practitioners' perspective*, pp 13-14.

<sup>103</sup> Mr Kyle Miers, Chief Executive, Deaf Australia, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 34.

<sup>104</sup> Mr Kyle Miers, Deaf Australia, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 34.

<sup>105</sup> Ms Heidi Limareff, Acting Chief Executive, Can:Do Group, *Official Committee Hansard*, Adelaide, 3 May 2017, p. 8.

The current size of the cohort in South Australia is only 15 students a year, and it only runs a course every two years, so demand far outweighs supply for these courses and for the profession in general. In regard to time frames to complete these courses, in South Australia it is up to six years, although we do know that interstate it is almost half this time.<sup>106</sup>

6.72 TAFE SA stated that the demand for Auslan courses exceeds the number of places they were able to offer, due in part to ‘the lack of appropriately qualified and experienced teachers of Auslan.’<sup>107</sup>

6.73 Deaf Australia considered that the rollout of the NDIS will see demand for Auslan interpreters ‘dramatically increase’, and that:

Deaf people's access to interpreters in the workplace will be compromised, because many of the interpreters there will not be working in employment settings; they will be working in NDIS related areas. That is a major risk that deaf people who are employed face in their workplaces.<sup>108</sup>

6.74 To address current and projected shortages of qualified Auslan interpreters, the Australian Sign Language Interpreters Association recommended the Australian Government ‘work with industry to devise and implement a National Strategy to significantly increase the pool of qualified professional interpreters across Australia.’<sup>109</sup> Deaf Australia also recommended this course of action and further stated that ‘given the urgency, an interpreter training initiative must be established immediately to help alleviate the concerns created by the [NDIS].’<sup>110</sup>

## Ownership of Australian Hearing

6.75 In February 2014, the National Commission of Audit recommended that Australian Hearing should be ‘reviewed with a view to privatisation’.<sup>111</sup> The Commission of Audit suggested that Australian Hearing should be

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<sup>106</sup> Ms Heidi Limareff, Can:Do Group, *Official Committee Hansard*, Adelaide, 3 May 2017, p. 8.

<sup>107</sup> Mrs Jenice Wheeler, Education Manager, Foundation Skills, TAFE SA, *Official Committee Hansard*, Adelaide, 3 May 2017, p. 12.

<sup>108</sup> Mr Kyle Miers, Deaf Australia, *Official Committee Hansard*, Melbourne, 1 May 2017, p. 31.

<sup>109</sup> Australian Sign Language Interpreters Association, *Submission 85*, p. 4.

<sup>110</sup> Deaf Australia, *Submission 82*, p. 32.

<sup>111</sup> National Commission of Audit, *Towards Responsible Government: The Report of the National Commission of Audit Phase One*, February 2014, p. 215.

considered for privatisation in the 'short term (2014 to 2016)', stating 'the Government could examine the potential to increase contestability in markets where Australian Hearing has a monopoly and allow, through privatisation, it to compete in markets where it is currently precluded.'<sup>112</sup>

- 6.76 In September 2015 the Senate Select Committee on Health released its third interim report *Australian Hearing: Too Important to Privatised*. As the report's title makes clear, the Senate Select Committee recommended against the privatisation of Australian Hearing.<sup>113</sup>
- 6.77 In February 2016 the Australian Government received a 'proposal from a consortium of consisting of the RIDBC, Macquarie University and Cochlear Ltd to transfer Australian Hearing to non-government ownership.'<sup>114</sup>
- 6.78 The RIDBC stated that following the Commission of Audit's recommendation, the RIDBC formed a consortium with Cochlear and Macquarie University:
- ... not because we have wanted to entice government to privatise Australian Hearing but because, more importantly, we were concerned with the types of ownership that could happen should it go through a normal commercial sale process from the government into private ownership.<sup>115</sup>
- 6.79 The Australian Society of Otolaryngology Head and Neck Surgery recommended 'against any structural change, privatisation among them, which would jeopardise [Australian Hearing]'.<sup>116</sup> The Deafness Forum stated that 'whatever the future ownership arrangement might be, it should not compromise Australian Hearing's capacity to provide independent advice.'<sup>117</sup>
- 6.80 In the 2017-18 Budget the Australian Government announced that 'following consideration of the future ownership of Australian Hearing Services, the

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<sup>112</sup> National Commission of Audit, *Towards Responsible Government: The Report of the National Commission of Audit Phase One*, February 2014, p. 221.

<sup>113</sup> Senate Select Committee on Health, *Third Interim Report: Australian Hearing: Too Important to Privatised*, Canberra, September 2015, p. xi.

<sup>114</sup> Deafness Forum of Australia, *Submission 17*, p. 38.

<sup>115</sup> Mr Chris Rehn, RIDBC, *Official Committee Hansard*, Sydney, 6 April 2017, p. 34.

<sup>116</sup> Australian Society of Otolaryngology Head and Neck Surgery, *Submission 24*, p. 3.

<sup>117</sup> Deafness Forum of Australia, *Submission 17*, p. 38.

Government [had] decided to retain full ownership and control of the entity.<sup>118</sup>

## National Health Priorities

6.81 The National Health Priority Areas (NHPAs) were established in 1996, in order to:

... focus public attention and health policy on areas contributing most to the burden of illness in the community, particularly where that burden had the potential to be significantly reduced through improvements in prevention and treatment.<sup>119</sup>

6.82 There are nine NHPAs:

- arthritis and musculoskeletal conditions;
- asthma;
- cancer control;
- cardiovascular health;
- dementia;
- diabetes;
- injury prevention and control;
- mental health; and
- obesity.<sup>120</sup>

6.83 The potential addition of hearing health and wellbeing as the tenth NHPA was widely supported by organisations and individuals during the inquiry. Organisations who supported making hearing health and wellbeing a NHPA included: consumer advocate organisations,<sup>121</sup> peak professional bodies,<sup>122</sup> research institutions,<sup>123</sup> and hearing service providers.<sup>124</sup>

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<sup>118</sup> Australian Government, *Budget 2017-18: Budget Measures, Budget Paper No.2*, p. 98.

<sup>119</sup> Department of Health, *Submission 16.2*, p. 2.

<sup>120</sup> Department of Health, *Submission 16.2*, p. 2.

<sup>121</sup> For example: Better Hearing Australia, *Submission 83*, p. 16; The Deafness Forum of Australia, *Submission 17*, pp 33-35; Self-Help for Hard of Hearing People Australia, *Submission 42*, p. 24.

<sup>122</sup> For example: Audiometry Nurses Association of Australia, *Submission 15*, p. 6; Audiology Australia, *Submission 49*, p. 13; Speech Pathology Australia, *Submission 51*, p. 19.

<sup>123</sup> For example: Australian Hearing Hub, *Submission 60* p. 2; The Bionics Institute of Australia, *Submission 27*, p. 4; The HEARing Cooperative Research Centre, *Submission 59*, p. 16.

<sup>124</sup> For example: Cochlear Ltd, *Submission 91*, p. 26; Hearing Care Industry Association, *Submission 30*, p. 1; RIDBC, *Submission 48*, p. 20.

- 6.84 The Deafness Forum of Australia suggested that ‘without hearing health and wellbeing becoming a National Health Priority the deep seated need for improvements in this area will continue to be inadequately addressed’.<sup>125</sup> The Deafness Forum added that hearing health represents a ‘greater health burden than existing [NHPAs] such as asthma, diabetes, and musculoskeletal conditions’.<sup>126</sup>
- 6.85 Deaf Australia provided an alternative viewpoint suggesting there is a risk in including hearing health as a NHPA
- ... as it would couch deafness as “negative” and under a “deficit” model, which is out of step with current human rights based approaches and ... would undo a lot of work that Deaf Australia has engaged in to “destigmatised” hearing loss and deafness.<sup>127</sup>
- 6.86 The Department of Health advised that ‘contrary to stakeholder expectation, not all NHPAs are supported by individual funding allocations or dedicated programs.’<sup>128</sup> The Department of Health added ‘the government’s response to some of the calls for hearing to be considered [a NHPA] is that hearing is part of the national disability strategy and continues to be a focus under that.’<sup>129</sup>

## Concluding Comment

### *The National Disability Insurance Scheme*

- 6.87 The introduction of the National Disability Insurance Scheme (NDIS) is a major reform to the provision of disability services in Australia. Once fully rolled out, the NDIS is expected to provide support for approximately 460 000 Australians.
- 6.88 The Committee is pleased that Australia is considered to be a world leader in the provision of hearing services to children. The Australian system begins with universal screening of newborn children’s hearing, allowing children with hearing impairment to be identified, and treated, from a very

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<sup>125</sup> Deafness Forum of Australia, *Submission 17*, p. 33.

<sup>126</sup> Deafness Forum of Australia, *Submission 17*, p. 33.

<sup>127</sup> Deaf Australia, *Submission 82*, p. 3.

<sup>128</sup> Department of Health, *Submission 16.2*, p. 2.

<sup>129</sup> Ms Trisha Garrett, Assistant Secretary, Office of Hearing Services, Department of Health, *Official Committee Hansard*, Canberra, Friday 16 June 2017, p. 39.

early age. The Community Service Obligations (CSO) program, and Australian Hearing's role as the sole provider of paediatric audiology services, was widely commended by inquiry participants. Further, not-for-profit early intervention services are providing therapy which is yielding remarkable communication outcomes for deaf and hearing impaired children.

- 6.89 There is some concern among hearing service providers and advocacy groups that these positive outcomes could be at risk due to the introduction of the NDIS. In particular, there is concern around the creation of a contestable (competitive) market for the provision of children's hearing services. The Committee believes that it is vital that the strengths of Australia's system of providing children's hearing services are protected.
- 6.90 The Committee believes that the introduction of competition into the market for services for very young children carries too great a risk. The evidence shows that children who receive specialist treatment from a very young age can expect very positive outcomes but that any delays can have significant negative developmental impacts.
- 6.91 Australian Hearing has a wealth of paediatric audiology experience and the Committee sees little benefit in diluting this expertise. In addition, parents of children newly diagnosed with hearing impairment will need to make decisions quickly. On initial diagnosis parents may still be in shock and are unlikely to have the necessary experience or knowledge to navigate the different offerings of service providers. In this situation the introduction of new service providers may make it more difficult for parents to make a choice that guarantees a positive outcome for their children. Of paramount importance is that hearing impaired children continue to receive timely provision of evidence-based specialist treatment. The Committee believes the safest way to ensure this, is for Australian Hearing to remain the sole provider of audiological services for very young children.
- 6.92 In addition, the Committee acknowledges the positive impact on developmental outcomes gained from engagement with multidisciplinary early intervention programs. The Committee is recommending the creation of 'guided referral pathways' from Australian Hearing into these early intervention programs. This would involve 'case managers' advising parents and guiding them to expert providers who are able to provide their children with the best possible hearing health outcomes. These systems already exist in some jurisdictions but the creation of a national scheme based at

Australian Hearing would provide significant benefits for a modest investment.

- 6.93 The Committee received evidence suggesting multidisciplinary early intervention services have encountered significantly increased funding pressure since the introduction of the NDIS. The Committee urges the National Disability Insurance Agency to work with these organisations to ensure they are able to continue to provide their services to all deaf and hearing impaired children.

### *Additional Hearing Screenings*

- 6.94 The Committee was concerned that only a third of childhood hearing loss is identified at birth, leaving two thirds of hearing impaired children without a defined pathway for diagnosis and treatment. Having undiagnosed hearing loss when entering the school system is likely to negatively impact a child's ability to learn in the classroom and establish social connections with classmates.
- 6.95 The Committee considers that, given the potentially lifelong impact of untreated childhood hearing loss, there is a clear need for hearing screening in preschool or the first year of school. Using a clinically validated mobile app, such as Sound Scouts, to deliver the screening test could significantly reduce the costs associated with delivering these screenings. The Committee is also of the view that changes to allow for bulk billing and a self-referral to an audiologist following the screening would streamline the process and ensure timely treatment.
- 6.96 The Committee received evidence that screening could also be used for adults aged 50 years and over. The Committee considers the most effective way to reach this cohort is through public health campaigns to raise awareness of hearing issues and the importance of seeking treatment early. This campaign should include a focus on ensuring general practitioners are aware of the importance of hearing tests and treatment options.
- 6.97 The Committee received evidence that, although universal newborn hearing screening is considered extremely successful in Australia, there is no data collection or monitoring of program outcomes at the national level. As such, we cannot be certain that all children are being captured by the screening programs and that no child is being lost to follow up. The Committee considers that national data collection and monitoring of newborn screening programs should be implemented to ensure children are not falling through

the gaps. This approach should also be considered in the context of school age screening.

### *Auslan Interpreter Shortages*

- 6.98 The Committee acknowledges the vital role that Auslan interpreters have in enabling Deaf and Hearing Impaired Australians to fully participate in society. The Committee witnessed the work of interpreters first hand, as they supported the Committee's public hearings throughout this Inquiry, and thanks them for their contribution and expertise.
- 6.99 The Committee received evidence that there is a shortage of Auslan interpreters across Australia. In particular, there is a critical shortage in the Northern Territory, with only four interpreters working within this jurisdiction. The rollout of the NDIS is only going to increase demand for Auslan interpreters, and the Committee is uncertain as to whether there will be enough interpreters to meet this demand.
- 6.100 The Committee also acknowledges the important role of interpreters in enabling people to participate in the workforce. The Committee is concerned that the shortage of Auslan interpreters, combined with increased demand for interpreting from the NDIS, will mean people needing interpreters for employment purposes may have difficulty finding a service.
- 6.101 The Committee commented in Chapter 3 on the importance of the National Auslan Interpreter Booking and Payment Service (NABS), which provides interpreters for medical appointments. The NABS should continue to be accessible for all Auslan users, regardless of whether or not they qualify for the NDIS.
- 6.102 The Committee is concerned that the introduction of the NDIS may see a reduction in the support provided by state and territory governments, potentially creating gaps in the provision of hearing services. Services such as Auslan interpreters at hospitals should continue to be provided, as they are essential for the wellbeing of hearing impaired and deaf Australians.

### *Ownership of Australian Hearing*

- 6.103 The Committee welcomes and supports the decision not to privatise Australian Hearing and believes that Australian Hearing should be retained in government ownership.

### *National Health Priorities*

- 6.104 The possibility of hearing health becoming the next National Health Priority Area (NHPA) was the issue most commonly raised by inquiry participants. There was near universal support for hearing health to become the tenth NHPA. With 3.6 million Australians currently experiencing hearing impairment, and this number being expected to double by 2060, hearing health is clearly an issue that needs to be prioritised.
- 6.105 The Committee was surprised to hear from the Department of Health that the NHPAs have no policy significance, that is, that there is no funding attached to NHPAs, they do not result in specific plans or programs, and they do not require additional reporting.
- 6.106 Despite this, the Committee believes that *hearing health is a priority health issue for Australia* and does see value in it attaining the status of a NHPA.
- 6.107 The Committee notes that the NHPAs are a Council of Australian Governments policy but suggests that the Department of Health work to clarify what role NHPAs have in determining the health policy and funding priorities of the Commonwealth, state and territory jurisdictions.

### **Recommendation 14**

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- 6.108 The Committee recommends that audiological services for children aged zero to five years remain under the Department of Health's Community Service Obligations program, with Australian Hearing retaining its role as the sole provider of these services.**

### **Recommendation 15**

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- 6.109 The Committee recommends that the Office of Hearing Services fund the creation of a national 'guided pathway' system, based in Australian Hearing, to assist parents in choosing expert early intervention services for their children.**

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**Recommendation 16**

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**6.110 The Committee recommends the Council of Australian Governments:**

- establish a universal hearing screening program for children in their first year of school, with the aim of having all children tested within the first 60 days of the school year; and
- investigate the use of an evidence based online screening program, to deliver a cost effective screening process.

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**Recommendation 17**

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**6.111 The Committee recommends the Department of Health establish a system of automatic referral to a paediatric audiologist, which can be bulk billed, following identification of a hearing impairment at a school screening program.**

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**Recommendation 18**

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**6.112 The Committee recommends that states and territories be required to report against the 'National Performance Indicators to Support Neonatal Hearing Screening in Australia', and that the Standing Committee on Screening coordinates the monitoring and reporting in this area.**

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**Recommendation 19**

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**6.113 The Committee recommends that the National Disability Insurance Agency undertake modelling to determine the likely demand for Auslan interpretation services following the introduction of the National Disability Insurance Scheme, and the capacity of existing services to meet this demand.**

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**Recommendation 20**

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**6.114 The Committee recommends the Government work with states and territories to ensure that Auslan interpretation services are available for interactions with medical, law and other essential services.**

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**Recommendation 21**

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**6.115 The Committee supports the decision not to privatise Australian Hearing and recommends that Australian Hearing be retained in government ownership.**

**Recommendation 22**

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**6.116 The Committee recommends that hearing health is made a National Health Priority Area.**

**Mr Trent Zimmerman MP**

**Chair**

**7 September 2017**

# A. Submissions

- 1 *Name Withheld*
  - 1.1 Supplementary to submission 1
- 2 *Name Withheld*
- 3 Australian Medical Association
- 4 Council of Presidents of Medical Colleges
- 5 Mr Warner Dakin
- 6 Ms Mardi O'Leary
- 7 Mr Michael North
- 8 Ms Barbara Alcock
- 9 Mr Anthony Ferguson
- 10 Mr Richard Hancock
- 11 *Name Withheld*
- 12 Better Hearing Australia Canberra Inc
- 13 National Rural Health Alliance
- 14 Mr Tommy Ravlic
- 15 Audiometry Nurses Association of Australia
- 16 Department of Health
  - 16.1 Supplementary to submission 16
  - 16.2 Supplementary to submission 16
  - 16.3 Supplementary to submission 16
  - 16.4 Supplementary to submission 16

- 16.5 Supplementary to submission 16
- 17 Deafness Forum of Australia
  - 17.1 Supplementary to submission 17
  - 17.2 Supplementary to submission 17
  - 17.3 Supplementary to submission 17
- 18 Ms Julie Hill
- 19 The Shepherd Centre - for deaf children
  - 19.1 Supplementary to submission 19
- 20 Independent Audiologists Australia Inc
  - 20.1 Supplementary to submission 20
- 21 Conexu Foundation
  - 21.1 Supplementary to submission 21
- 22 EARtrak
- 23 Australian Society of Rehabilitation Counsellors
  - 23.1 Supplementary to submission 23
- 24 The Australian Society of Otolaryngology Head & Neck Surgery
- 25 Ms Shelley Straw
- 26 Ms Erica Smith
- 27 The Bionics Institute of Australia
- 28 First Voice
- 29 WA Foundation for Deaf Children
- 30 Hearing Care Industry Association
  - 30.1 Supplementary to submission 30
- 31 *Name Withheld*
- 32 HEARsmart and The HEARing CRC
- 33 Mr Basil Turner
- 34 Ms Rosalind Brady
- 35 Safe Work Australia
  - 35.1 Supplementary to submission 35
- 36 Deaf Sports Australia

- 36.1 Supplementary to submission 36
- 37 Children and Young People with Disability Australia
- 38 Royal Flying Doctors Service
- 39 Ms Ada Yip
- 40 *Name Withheld*
- 41 cmee4 Productions
- 42 SHHH Australia Inc (Self Help for Hard of Hearing People)
  - 42.1 Supplementary to submission 42
  - 42.2 Supplementary to submission 42
- 43 Mrs Gemma Jackson
- 44 Telethon Kids Institute
- 45 National Disability Insurance Agency
  - 45.1 Supplementary to submission 45
  - 45.2 Supplementary to submission 45
- 46 Royal Australasian College of Surgeons
- 47 Deafness Council of NSW Inc
- 48 Royal Institute for Deaf and Blind Children
- 49 Audiology Australia
- 50 Can Do Group
  - 50.1 Supplementary to submission 50
- 51 Speech Pathology Australia
- 52 William Demant Holding A/S
- 53 Dr Elaine Saunders
- 54 Australian Institute of Occupational Hygienists Inc
  - 54.1 Supplementary to submission 54
- 55 W.A. Council of State School Organisations Inc.
- 56 *Name Withheld*
- 57 Queensland Aboriginal and Islander Health Council
- 58 Australian Hearing
  - 58.1 Supplementary to submission 58

- 58.2 Supplementary to submission 58
- 58.3 Supplementary to submission 58
- 59 The HEARing CRC Ltd
  - 59.1 Supplementary to submission 59
- 60 Australian Hearing Hub
- 61 Hearing Business Alliance Ltd
  - 61.1 Supplementary to submission 61
- 62 Deadly Ears Program
- 63 Neurosensory
- 64 Hear For You Limited
  - 64.1 Supplementary to submission 64
- 65 Mr David Brady
- 66 The Hearing Aid Audiometrist Society of Australia (HAASA)
- 67 Hear and Say
- 68 Australasian Newborn Hearing Screening Committee
  - 68.1 Supplementary to submission 68
- 69 Deafblind Australia
- 70 Ms Jessica Lissaman
- 71 Pat Fulton
- 72 Aussie Deaf Kids (ADK) and Parents of Deaf Children (PODC)
- 73 CICADA AUSTRALIA INC.
- 74 Country Hearing Care
  - 74.1 Confidential
- 75 *Confidential*
- 76 *Confidential*
- 77 Whirled Foundation
- 78 *Name Withheld*
- 79 National Seniors Australia
  - 79.1 Supplementary to submission 79

- 80 *Name Withheld*
- 81 Ms Margaret M. Robinson
- 82 Deaf Australia Inc.
- 83 Better Hearing Australia (National) Inc.
- 83.1 Supplementary to submission 83
  - 83.2 Supplementary to submission 83
  - 83.3 Supplementary to submission 83
- 84 *Confidential*
- 85 Australian Sign Language Interpreters Association (ASLIA)
- 86 Vicdeaf
- 87 Mr Christian James
- 88 Ms Jordanna Smith
- 89 Ms Sharon Xabergas
- 90 Department of Veterans Affairs
- 90.1 Supplementary to submission 90
- 91 Cochlear Limited
- 92 Mrs Carolyn Eccleston
- 93 Northern Territory Government
- 94 Australian College of Audiology
- 95 Ms Bronwyn Fletcher
- 96 Dr Matthew Hunter
- 97 NT Council of Government School Organisations Inc
- 97.1 Supplementary to submission 97
  - 97.2 Supplementary to submission 97
- 98 Dr Damien Howard and Jody Barney
- 99 Ms Rhonda Gallagher
- 100 Dr Daniel Brown, The University of Sydney
- 101 Mr Andrew Swindell
- 102 Australian Competition and Consumer Commission
- 103 Mr Stephen Spring

- 104** Goulburn Valley Hearing Clinic Pty Ltd
- 105** Mr Glenn Butcher
- 106** Mr Lynnden Beaumont
- 107** Mrs Shirley Burke
- 108** Professor Amanda Leach and Professor Peter Morris, Child Health Division,  
Menzies School of Health Research
- 109** *Confidential*
- 110** *Confidential*
- 111** First Voice and the Royal Institute for Deaf and Blind Children
- 112** Arafura Audiology
- 113** Deaf Services Queensland

## B. Exhibits

- 1 Dr Jim Hungerford, CEO, The Shepherd Centre  
Appearance at the House Standing Committee on Health, Aged Care and Sport Inquiry into the Hearing Health and Wellbeing of Australia, 15 November 2017.
- 2 The Australian Society of Rehabilitation Counsellors Inc  
The Australian Society of Rehabilitation Counsellors Inc, *Hearing Services Capacity and Expertise – A Report on a National Survey of ASORC members*, May 2016.
  - a) Anthony Hogan, *Hearing Aid Use and Benefit: A Nationally Representative Study of Australians Aged Over 50*, 2017.
  - b) Australian Society of Rehabilitation Counsellors Inc, *Brochure*.
- 3 Dr Anthony Hogan  
Research project: *Barriers against the implementation of hearing impairment screening programmes for adults – a scoping study into the General Practitioners’ perspective*, 2010.
- 4 First Voice  
Extract from *Report on Education, Employment & Social Outcomes of First Voice Member Centre Graduates (18-28 years)*, March 2017.

- 5 Better Hearing Australia  
*Beyond Blue, Anxiety and Depression in People who are Deaf or Hard of Hearing*, 2014.  
 a) Queensland Government, *Deafness and Mental Health*, 2017
- 6 HEARing CRC  
 HEARing CRC, Brochure pack including brochures on the HEARing CRC (2); HEARworks; HEARnet Learning; HEARsmart; Know Your Noise.
- 7 Whirled Foundation  
 Whirled Foundation, Change.Org petition relating to Meniere's Disease addressed to the Hon Greg Hunt MP, the Hon Ken Wyatt AM MP, the Hon Dr David Gillespie MP, Professor Andrew Wilson, Professor Rosalie Viney, Professor Geoff McColl, Cynthia Tan, Elizabeth Remedios, Denis Bastas, Hon Jane Prentice MP.
- 8 Eartrak  
 Eartrak, Graphs titled: '*Basic vs High-end technology: OHS clients*'; '*Basic vs High-end technology: Satisfaction, Private clients*', '*Listening situations – satisfaction with hearing aid performance OHS Basic technology – 2010 & current.*'
- 9 Associate Professor Susan Brumby  
 Professor Susan Brumby, *Shhh hearing in a farming environment: Parliamentary Inquiry Hearing Health and Wellbeing*, May 2017.
- 10 Watto Purrinna Aboriginal Health Service  
 Australian Government Department of Health, *Recommendations for Clinical Care Guidelines on the Management of Otitis Media in Aboriginal and Torres Strait Islander Populations (April 2010)*, 2015.  
 a) Government of South Australia SA Health, *An Aboriginal Ear Health Framework for South Australia*, 2017.  
 b) Associate Professor Nicola Spurrier and Dr Annapurna Nori, '*Aboriginal ear and hearing health – a priority issue for closing the gap*', in *medicSA: Magazine of the Australian Medical Association (South Australia) Inc.*, Volume 30, Number 1, March 2017.

- 11 Better Hearing Australia  
*A Fairer Hearing (enhancing the social inclusion of people with hearing loss)*
  - a) Reference to association of hearing impairment and chronic diseases with psychosocial health status in older age.
- 12 Conexu Foundation  
*National User Needs: Report of Findings, Conexu Foundation, 7 October 2017.*
- 13 Can:Do Group  
Bhatt, I. S., & Guthrie, O. N. (2017). Analysis of audiometric notch as a noise-induced hearing loss phenotype in US youth: data from the National Health And Nutrition Examination Survey, 2005–2010. *International Journal of Audiology*, 1-8.
- 14 First Voice  
*First Voice, Report on education, employment & social outcomes of first voice member centre graduates (18-28 years).*
  - a) Deloitte Access Economics, *Cost-benefit analysis of First Voice's early intervention program*, 9 January 2017.
  - b) First Voice, *Response to the 2017 Price Controls Review Consultation on NDIS pricing arrangements*, 13 April 2017.
- 15 Northern Territory Government - Department of Health and Department of Education  
*Australian Institute of Health and Welfare, Northern Territory Remote Aboriginal Investment: Ear and Hearing Health Program, July 2012 - June 2016.*
- 16 Deafness Forum of Australia  
*Deafness Forum of Australia, Submission to the Inquiry into the Provision of Hearing Services under the National Disability Insurance Scheme (NDIS): Joint Standing Committee on the NDIS – Hearing Services, January 2017.*
  - a) Deafness Forum of Australia, *Productivity Commission Issues Paper – NDIS Cost: Submission from the Deafness Forum of Australia*, March 2017.
  - b) Deafness Forum of Australia, *100 Stories: Personal Accounts of Life with Hearing Loss*, 2017.
- 17 Confidential

- 18 Hearing Care Industry Association  
*Deloitte Access Economics - An update on the social and economic cost of hearing loss and hearing health conditions in Australia, June 2017.*
- 19 First Voice  
First Voice, Royal Institute for Deaf and Blind Children, *The Sector Model: An Evidence-Based Approach to Early Intervention for Children who are Deaf or Hard of Hearing*, 30 June 2017.  
a) First Voice, Royal Institute for Deaf and Blind Children, *NDIS Cost Modelling*, 16 June 2017.
- 20 Australian Society of Rehabilitation Counsellors Ltd  
Williams, W, Kyaw-Myint, SM, Crea, J, Hogan, A, *Occupational Noise Management: What's Happening in the Industry, Journal Occupational Health Safety*, 2008.

# C. Hearings and Witnesses

## Tuesday, 15 November 2016 - Sydney

### *The Shepherd Centre*

- Dr Jim Hungerford, Chief Executive Officer
- Ms Aleisha Davis, General Manager
- Ms Sharon Baldacchino, Director, Listening and Spoken Language Therapy

### *Cochlear*

- Mr Dig Howitt, Chief Operating Officer
- Ms Georgina Sanderson, Director Policy and Market Access
- Ms Lisa Shannon, Operations Manager Australia and New Zealand

## Tuesday, 14 February 2017 - Canberra

### *Canberra ENT*

- Dr Tim Makeham, Ear Nose and Throat Surgeon

### *Human Genetics Society of Australasia*

- Dr Matthew Hunter, Head of Unit, Genetics, Monash Health

## Friday, 3 March 2017 - Canberra

### *Department of Health*

- Dr Wendy Southern, Deputy Secretary
- Mr Andrew Stuart, Deputy Secretary
- Ms Bobbi Campbell, First Assistant Secretary
- Ms Trisha Garrett, Assistant Secretary
- Ms Lynelle Moon, Head, Health Group, Australian Institute of Health and Welfare

### *Department of Human Services*

- Mr Jonathan Hutson, Deputy Secretary, Enabling Services Group
- Ms Alison Fitzgerald, National Manager, Governance Branch

### *Australian Hearing*

- Ms Samantha Harkus, Principal Audiologist - Aboriginal and Torres Strait Islander Services
- Ms Alison King, Principal Audiologist - Paediatric Services
- Ms Emma Scanlan, Principal Audiologist - Adults
- Adjunct Professor Harvey Dillon, Director, National Acoustic Laboratories

### *National Disability Insurance Agency*

- Ms Louise Glanville, Deputy Chief Executive Officer, Stakeholder Relations and Organisational Capability
- Mrs Vicki Rundle, Acting Deputy Chief Executive Officer, Markets and Supports Group
- Mr Peter de Natris, Expert Advisor, Early Childhood and Early Intervention

### *Department of the Prime Minister and Cabinet*

- Mr Brendan Gibson, Assistant Secretary, Health Group, Indigenous Affairs Group

*Department of Veterans' Affairs*

- Ms Sue Campion, First Assistant Secretary
- Mr Paolo Kraushaar, Acting Assistant Secretary, Programme Management Branch

**Thursday, 23 March 2017 - Canberra***Australian Competition and Consumer Commission*

- Mr Scott Gregson, Executive General Manager Consumer Enforcement
- Mr Richard Fleming, General Manager Enforcement ACT

**Thursday, 6 April 2017 - Sydney***The University of Sydney*

- Dr Daniel Brown, Senior Research Fellow

*Australasian Newborn Hearing Screening Committee*

- Professor Gregory Leigh AO, Chair
- Dr Zeffie Poulakis, Secretary

*Sound Scouts (cmee4 Productions)*

- Ms Carolyn Mee, Director

*Parents of Deaf Children*

- Ms Fleur Henderson, Executive Officer

*Aussie Deaf Kids*

- Mrs Ann Porter, Chief Executive Officer

*The Hearing Aid Audiometrist Society of Australia*

- Mr Tony Khairy, National President

*Australian Society of Rehabilitation Counsellors*

- Ms Cristina Schwenke, Chief Executive Officer
- Professor Anthony Hogan, Member

*Royal Institute for Deaf and Blind Children*

- Mr Chris Rehn, Chief Executive Officer
- Mr Bart Cavalletto, Director, Services

*Audiometry Nurses Association of Australia*

- Mrs Tracy Hawes, President
- Mrs Julia Cunningham, Treasurer

*The Australian Society of Otolaryngology Head and Neck Surgery*

- Professor Stephen O'Leary, Member

*Independent Audiologists Australia*

- Mr Grant Collins, Vice President
- Dr Louise Collingridge, Executive Officer

*Mr Stephen Spring, Private capacity**Hear For You*

- Mrs Kim Jones, Chairperson
- Mrs Olivia Andersen, Founder and Director
- Mr David Brady, Chief Executive Officer
- Mr John Lui, Mentor (Hear for You Mentorship Program)
- Miss Olivia Barnes, Mentee (Hear for You Mentorship Program)

*Royal Australasian College of Surgeons*

- Dr Philip Truskett, President
- Associate Professor Kelvin Kong, Founding Chair of the Indigenous Health Committee

**Friday, 21 April 2017 - Brisbane***Hear and Say*

- Ms Emma Rushbrooke, Clinical Director
- Mr Chris McCarthy, Chief Executive Officer

*Neurosensory*

- Ms Shaunine Quinn, Chief Executive Officer
- Ms Anthea Arkcoll, Manager, Professional Standards
- Mr Benjamin Hoddinott, Manager, Clinics

*Hearing Business Alliance*

- Mr Donald MacDonald, Board Chair
- Mr Stephen Logan, Company Secretary

*Deadly Ears Program, Children's Health Queensland Hospital and Health Service*

- Mr Matthew Brown, Director
- Mr Jonathon Wood, Program Manager
- Ms Anette Smith, Nurse Unit Manager – ENT Outreach
- Ms Maggie Allen, Audiologist, Acting Allied Health Team Leader

*Queensland Aboriginal and Islander Health Council*

- Ms Neil Willmet, Chief Executive Officer
- Mr Alistair MacDonald, Manager, Policy and Programs
- Mr Mark Mitchell, Hearing Health Project Officer

*National Seniors Australia*

- Mr Brendon Radford, Senior Policy Advisor
- Mr Ian Henschke, Chief Advocate

*William Demant Holding A/S*

- Ms Janet Muir, Managing Director, Retail

*Conexu Foundation*

- Dr Philip Harper, Community Liaison Manager

**Monday, 1 May 2017 - Melbourne***Better Hearing Australia*

- Ms Michele Barry, President
- Mr Andrew D'Arcy Edgell Bush, National Secretary
- Mr Thomas McCaul, Member
- Mrs Joan Belle, President, Geelong Branch

*The Bionics Institute of Australia*

- Professor Colette McKay, Leader in Translational Hearing Research
- Dr Hamish Innes-Brown, Research Fellow

*The HEARing CRC and HEARsmart*

- Professor Robert Cowan, Chief Executive Officer

*Deaf Sports Australia*

- Ms Kathryn O'Brien, Chairperson
- Ms Irena Farinacci, Sports Development Manager
- Mrs Tamara Trinder-Scacco
- Miss Kayla Trinder-Scacco

*Audiology Australia*

- Dr Jason Ridgway, President and Chair of Board
- Dr Tony Coles, Chief Executive Officer
- Dr Sandra South, Research and Policy Manager

*Speech Pathology Australia*

- Dr Chyrisse Heine, Board Director
- Ms Catherine Olsson, National Advisor Disability

*Deaf Australia Inc.*

- Mr Kyle Miers, Chief Executive

*Whirled Foundation*

- Ms Desley Ward, President
- Ms Beatrice Tarnawski, Vice President
- Mr John Cook, Immediate Past President

*Australian Institute of Occupational Hygienists*

- Mr Jeremy Trotman, Councillor and Executive Officer

*EARtrak*

- Mrs Tracey Matthies, Chief Executive Officer
- Mr Neil Clutterbuck, President
- Mrs Susan Clutterbuck, Vice President, Research and Clinical Studies

*Dr Elaine Saunders, Private capacity**Australian Sign Language Interpreters Association*

- Ms Julie Ann Judd, Interim Chairperson

**Tuesday, 2 May 2017 - Shepparton***Country Hearing Care*

- Mrs Jane MacDonald, Senior Audiologist / Director
- Mr Donald MacDonald, Audiometrist / Director

*Vicdeaf*

- Mr Andrew Lyall, Chief Operations Officer

*Goulburn Valley Hearing Clinic*

- Ms Dierdre Robertson, Director and Practice Manager
- Mr Lindsay Symons, Senior Audiologist

*National Centre for Farmer Health*

- Associate Professor Susan Brumby, Director

**Wednesday, 3 May 2017 - Adelaide***First Voice / Cora Barclay Centre*

- Mr Michael Forwood, Chair

*Can:Do Group (Deaf Can:Do)*

- Ms Heidi Limareff, Acting Chief Executive, General Manager Group Operations and Client Services
- Ms Jena Mayne, General Manager Group Service Development

*TAFE SA*

- Mrs Jenice Wheeler, Education Manager, Foundation Skills
- Ms Ann Beacham, Director Foundation Skills, Primary Industries, Animal and Laboratory Sciences
- Ms Debbie Kennewell, Manager Client Services, Deaf Can:Do

*Hearing Care Industry Association*

- Mr Ashley Wilson AM, Chairman
- Ms Donna Staunton, Chief Executive Officer

*SA Department for Education and Child Development and Brighton Primary School*

- Mr Ian May, Director, Disability Policy and Programs
- Mr Quenten Iskov, Senior Advisor, Sensory
- Ms Melissa Phillips, Coordinator, Centre for Deaf Education

*National Hearing Care*

- Mr Michael Smith, Managing Director

*Watto Purrinna Aboriginal Health Service*

- Ms Vendula Corston, Clinical Services Coordinator
- Dr Penny Silwood, Medical Head of Unit, Senior Consultant
- Mrs Leanne Quirino, Under 8 Ear Health Coordinator

## **Wednesday, 7 June 2017 - Darwin**

*Centre of Research Excellence in Ear and Hearing Health of Aboriginal and Torres Strait Islander Children*

- Professor Amanda Leach, Director
- Professor Peter Morris, Chief Investigator

*Deaf NT*

- Ms Elizabeth Franklin, Advocacy Coordinator
- Mrs Vanessa Adzaip, Auslan Coordinator/Tutor

*Dr Damien Howard, Private capacity*

*NT Council of Government School Organisations Inc*

- Ms Tabitha (Tabby) Fudge, President
- Ms Michelle Parker, Executive Officer
- Mr Jeff Cook, Arnhem Regional Representative
- Mr Chris Blackham-Davison, Teacher, Malati School

*Arafura Audiology*

- Ms Kathryn Burnes, Business Manager
- Dr Matthew Callaway, Senior Audiologist

*Northern Territory Government - Department of Health and Department of Education*

- Ms Kathy Currie, Hearing Health Program Leader, Department of Health
- Ms Denyse Bainbridge, Senior Education Advisor – Hearing, Department of Education

**Friday, 16 June 2017 - Canberra***National Disability Insurance Agency*

- Ms Vicki Rundle, A/g Deputy Chief Executive Officer
- Ms Anne Skordis, Expert Advisor, Mainstream Interface and Government Relations

*Deafness Forum of Australia*

- Mr David Brady, Chairperson
- Ms Margaret Dewberry, Advisor

*First Voice*

- Mr Michael Forwood, Chairman
- Mr Jim Hungerford, CEO, The Shepherd Centre

*Royal Institute for Deaf and Blind Children*

- Mr Bart Cavalletto, Director, Services

*Australian Hearing*

- Ms Gina Mavris, Chief Operating Officer
- Mr Mike Thomas, Manager, Stakeholder Relationships

*Coalition of Concerned Deaf Elders and Friends*

- Ms Lorraine Mulley, Member
- Ms Laurel Payne, Member

*Self Help for Hard of Hearing People*

- Mrs Christine Hunter, President

*Safe Work Australia*

- Ms Amanda Grey, Deputy Chief Executive Officer
- Ms Amanda Johnston, Branch Manager, Hazards
- Mr Kristopher Garred, Director, Evidence
- Mr Paul Taylor, Director, Chemicals Policy

*Department of Health*

- Mr Andrew Stuart, Deputy Secretary
- Ms Trisha Garrett, Assistant Secretary, Office of Hearing Services