
Committee Secretariat
Standing Committee on Health, Aged Care and Sport
PO Box 6021
Parliament House
Canberra
ACT 2600

22 December 2016

Dear Committee Secretariat

**Re: Inquiry into the Hearing Health and Wellbeing of Australia**

Thank you for the opportunity to offer a submission within the terms of reference set by the Standing Committee on Health, Aging and Sport inquiring into the hearing health and wellbeing of Australia.

This submission provides background information to explain current circumstances associated with the delivery of audiology services in Australia.

Terms of reference for the inquiry that have been selected for discussion in this submission (2, 3, 4 and 7) are not discrete entities, as explained in this submission which outlines current practices and scope for innovative change.

For clarity, a summary of the main points raised, and how they fit with the terms of reference for this inquiry, are presented in the table on the next page.



P.O. Box 164 Turramurra NSW 2074
T: 0424 720 915
E: exec@independentaudiologists.net.au

| **TERMS OF REFERENCE** | ***SUMMARY*** |
|---|---|
| 2 Community awareness, information, education and promotion about hearing loss and health care; | *Public and professional education of the realistic benefits and limitations of hearing devices, and the importance of a rehabilitative program is needed to counter public perception created by marketing that technologies (including wearable and implantable devices) solve listening and communication difficulties.*<br><br>*Public education about the role of the audiologist vs the role of the audiometrist is needed with clear and enforced referral pathways to ensure those with specialist needs are attended to by appropriately qualified professionals.* |
| 3 Access to, and cost of services, which include hearing assessments, treatment and support, Auslan language services, and new hearing aid technology;<br><br>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; | *All policies and associated legislation needs to be encompassing of all treatment options suited to all communities, taking into account the changing needs of all Australians at vulnerable stages across the lifespan. This requires a deviation from the preference given to hearing devices for specific age groups in private and public funding models.*<br><br>*Specifically, revision of Medicare item numbers to ensure equitable funding for services delivered (incorporating assessment and intervention), revision of OHS funding schemes to incorporate audiological intervention for associated auditory and vestibular conditions, and not focus primarily on hearing devices, as is currently the case.*<br><br>*Each individual's ability needs to be able to be taken into account based on an audiological diagnosis that involves understanding the individual's ability and the personal / social and financial resources they have available to maximise access using all available means, including, but not only, available technologies, language choices, environmental conditions and communication abilities of others.* |
| 7 Best practice and proposed innovative models of hearing health care to improve access, quality and affordability; | *Regulation of practitioners under AHPRA, as applies to most other healthcare practitioners, is a necessary and innovative step to ensure services are in keeping with standards applied internationally.*<br><br>*The separation of (but close relationship between) the profession of audiology and the hearing device industry is needed to ensure that the public is aware of the difference between professionals and industry when purchasing hearing devices and seeking rehabilitative services.*<br><br>*Transparency of billing and accountability of device limitations needs to be built into funding models. Commissions paid on device fitting and working to sales targets needs to be eliminated for the protection of the public. Self-regulation has not, to date, achieved this, so regulation needs to be external and set to standards and procedures that already apply to other healthcare professions.* |

**Audiologists** diagnose and treat the consequences of hearing and balance disorders in people of all ages (birth to the elderly). As knowledge of hearing, d/Deafness and cognition has expanded in recent years due to advances in research and innovation, the level of education required for clinical practice in audiology has increased to postgraduate (Masters) university qualifications and the role of audiologist expanded and adapted. This is exemplified in the hearing implant field, where audiologists are responsible for diagnosing deafness in newborns and preparing parents for complex intervention decisions that involve surgical options, recognising when implantable solutions may be appropriate at any age taking complex health and cognitive abilities into account, advising surgeons on intervention strategies, monitoring surgical outcomes, activating devices, monitoring progress and implementing supplementary training programmes to ensure age appropriate communication abilities and access. Perhaps less well exposed to the public, but equally important is the audiologist's role in healthcare fields such as balance disorders, medical audiology, diagnosing hearing loss in newborns and tailoring communication training in light of complex cognitive conditions in an increasingly aging population. Audiologists play a significant role in educational services for children who have hearing loss, are Deaf or have auditory processing disorders. Beginning with diagnosis for children with learning difficulties (which typically begins with an audiological assessment) and leading to provision of services to meet changing needs throughout the educational process (such as provision of FM systems, hearing devices, teacher support and training, auditory training or changed classroom environments for better auditory cues), audiologists play a central role in ensuring appropriate matches between children, the education system, available technologies and supportive services, assisting children to maximize learning opportunities which leads to gainful employment during adulthood. Audiologists play a role too in monitoring the progress of children affected by fluctuating hearing levels common during childhood, which can lead to significant language and learning delays if not treated appropriately. Thus, audiologists play a role in early identification to prevent costly debilitating consequences of undetected and untreated hearing disorders – in both children and adults.

Today's practicing audiologists form an essential element of medical teams [1-3] with responsibilities that span diagnosing hearing loss in newborn babies, working with young children developing speech and language, assisting school aged children in the classroom, enabling young adults to participate in the workforce, supporting middle aged adults and older adults, as well as those ensuring effective communication with those in palliative care. The role of rehabilitative audiologists is to interface available technologies with individuals who often face complex communication conditions; to support their adaptation to using technology (where applicable); and to train new communication skills to compensate for the limitations of technological benefit combined with the effects of neurological changes resulting from aging, hearing loss and other associated disorders.

As technologies such as implantable devices and future expectations of stem cell therapies emerge, public expectation is that those therapies will be successful for all, including those with conditions affecting hearing and balance. Yet, with aging populations and advanced healthcare, many Australians suffer co-morbidity of complex conditions, meaning that audiologists draw on increasingly extensive knowledge of neurology and cognition to establish realistic expectations from innovative technologies. Making appropriate clinical decisions between the growing range of available intervention options requires using all available diagnostic audiological information. Today's audiologists play an essential role in matching technology to ability and optimising function through supplementary training programmes that maximise each individual's neurological, cognitive, sensory and communicative resources. In summary, as research findings from around the world emerge in relation to brain processing of sound, in particular in complex conditions or complex listening situations, the application of clinical audiology becomes increasingly important to the hearing health and wellbeing of Australians living with any form of auditory (hearing / auditory perception) or vestibular (balance) condition.

The impact of auditory disorders on participation in society and on health must not be underestimated. For example, hearing loss may precede dementia [4]; can affect results of assessments for dementia and mild cognitive impairment [5]; is associated with reduced physical well- being and an increased incidence of falls in elderly people [6]; leads to social isolation which is directly associated with depression, anxiety and stress [7]; and in children, can impact on their ability to acquire their first language which may have consequences for learning [8]. Auditory and vestibular conditions are not uniform, and can range from the loss of ability to hear some sounds to an ability to hear but not recognise or understand sounds, to being intolerant of either sounds that occur in the environment or severely disturbed by internally generated sound (ie tinnitus). As hearing disorders affect communication, partners, families, colleagues and carers are typically the first to experience the effects of an unmanaged hearing loss, meaning that comprehensive rehabilitation of auditory disorders is, of necessity, family or community centred and extends well beyond the individual. The impact of a hearing loss on an individual's functioning is determined not by their hearing test results alone, but by the demands, supports, associated abilities and opportunities that apply in each individual circumstance. Dual sensory loss - the combination of vision and hearing loss, prevalent in older adults, is a group is growing in number, as the population ages and more people live longer, with consequent needs for specialist audiologist skills [9]. By providing the means to maintain communication including using telephones and maintaining social activity, audiologists can support older Australians with hearing loss to live in their own homes for as long as possible. Audiologists, ensuring communication skills such as telephone use is optimal, can help prevent unnecessary visits to emergency or expensive hospital stays. Communication is a significant determiner of quality of life for all older Australians. Audiologists can improve the quality of life of all who are either aged or who care for the aged [10].

As the **knowledge base** available to audiologists has expanded, the range of possibilities for rehabilitation has expanded beyond simple hearing device use. **Models of funding and service delivery** have not adapted to the changed clinical scenario, become increasingly commercialised and competitive. The selling of hearing aids is often reported as exploitative by the Australian public (see for example Radio National "Have I got a hearing aid for you" 2014 and ABC 7.30 report 2015).

**Independent Audiologists Australia Inc (IAA)** is a not-for-profit incorporated association whose members are all university qualified audiologists who hold a financial interest in audiology related businesses that are at least 50% owned by qualified audiologists. IAA members operate audiology clinics in 190 locations across Australia. Some employ other audiologists and/or audiometrists (who hold TAFE diplomas in audiometry or equivalent) to work in their practices.

***Independent audiologists*** are differentiated from their colleagues who are similarly qualified with university qualifications in audiology, but who are *employed* in clinics that may be owned or have ownership structures linked to hearing device manufacturers, Ear Nose and Throat specialists or business owners with no ties to the associated industry. Independent *audiologists* are also differentiated from independent ***audiometrists***, whose diploma level TAFE training equips them to conduct basic hearing tests for adults and to fit hearing aids and provide general advice about communication where a loss of hearing sensitivity is evident.

**Audiology training** was initially offered to graduates within the Commonwealth Acoustics Laboratories and evolved into the university programmes offered across Australian universities today, in parallel to the training of audiometrists through NSW TAFE. Audiology and audiometry continue to co-exist as separately trained groups in Australia. Government funding for audiology and audiometry is differentiated in that only Audiologists (not Audiometrists) are eligible for Medicare provider numbers. The Office of Hearing Services (OHS) that administers the government funded Voucher system for pensioners, which primarily funds hearing testing and hearing aid distribution, makes little distinction in their funding and regulatory model for their voucher scheme between audiologists and audiometrists, because arguably the voucher scheme mainly funds the part of audiology that audiometrists are also qualified to provide. As there is little regulation of the field outside of OHS, the unfortunate consequence is a general lack of awareness of the difference between audiology and audiometry by the public and referral sources.

**OHS** offers either **complete or partial subsidization of hearing devices** for pensioners. Hearing aid manufacturers produce varying levels of technical sophistication in hearing aids, with a wide variation in cost. Partial subsidization occurs when the pensioner pays a portion of the fee to purchase a more sophisticated top-up device. There is no restriction on the top-up fee charged,

presenting an attractive business opportunity for many hearing service providers. A much cited report by Access Economics “Listen Hear” published in 2006 suggested, somewhat simplistically, that a large untapped market existed for the sale of hearing devices to many Australians with hearing loss. The Listen Hear report increased the attraction of profit driven businesses to contract to OHS as service providers.

Profits driven by the hearing aid industry are evident in publicly available company annual reports, such as the Australian Hearing annual report of 2015 which announced a before tax profit of more than $25 million (see here). Not surprisingly, media attention has focused on the commercial elements and perceived exploitative aspect of hearing aid distribution in Australia. In the absence of external regulation or mandatory registration process (in contrast to most other healthcare fields in Australia who are regulated under AHPRA), sales targets and commissions paid to audiologists for device fitting are commonplace [11]. Similarly, in the absence of external regulation or any mandatory registration, a clear distinction of roles for audiologists, audiometrists and hearing aid manufacturers is not evident to the public. No protection of title for audiology or audiometry exists. Recent efforts commissioned by OHS to identify scope of practice for audiologists and audiometrists resulted in a self- assessment tool that is acknowledged by its authors to be unenforceable (see here). Establishing clear and mandatory scopes of practice has been shown to be difficult in the current model of self-regulation. Grandfathering existing audiometrists as audiologists with restricted scope and closing down the audiometry training programme could be considered. Postgraduate (Masters) university programmes for audiology are now established at six universities. IAA is not aware of any rationale for continuing to offer training in both audiometry and audiology in Australia, in the absence of clear, regulated boundaries around scope of practice.

Aggressive marketing of high end hearing devices is typically reported by those seeking help for hearing difficulties [12]. Many prospective hearing aid users may not require advanced features in their hearing aids or find them beneficial [13]. Prospective hearing aid users may not be able to afford the more costly hearing aids and should always be offered a choice of alternatives. OHS fully subsidised hearing aids are required to meet certain requirements. Bundling of fees with devices is common, so that services are hidden from the public as necessary to the rehabilitation process [14]. Public evidence exists of practices seeking to poach patients already attended to by other providers (see one example attached to this document). Where complaints and concerns are raised about such poaching programmes, responses from OHS and professional bodies alike is that commentary on business practices are beyond their jurisdiction and ought to be referred to Fair Trading. Fair Trading rules apply to retail models, rather than healthcare models of regulation, and to date have failed, apart from in a small number of cases, to prevent widespread poaching, aggressive competition, setting of sales targets and paying commissions to practitioners. The Australian Competition and Consumer Commission (ACCC) has sought reports

of the experiences of Australians purchasing hearing devices and have yet to announce the outcome of that enquiry. The public is increasingly enticed to purchase devices online and through third parties, on the grounds of saving money, in some cases even before an audiological assessment of their condition has been conducted. To explain to the public the difference between the hearing device industry and the profession of audiology, IAA, along with colleagues in New Zealand, developed the Wellington Declaration (attached) which provides an aspirational guide to future developments of the profession and its relationship to industry. The Wellington Declaration calls for ongoing efforts to establish a mandatory national registration system for audiology.

Currently, anyone employed or operating in the field (whether qualified in audiology, audiometry or neither) can choose to operate without belonging to any of the self-regulating professional bodies. No mandatory register of practitioners exists. National regulation of unregistered healthcare practitioners was approved by Council of Australian Governments (COAG) in April 2015, but has yet to be implemented (see here). The code of conduct adopted in NSW for the regulation of unregistered healthcare practitioners is expected to be very similar to a code that will be adopted nationally. The NSW code of conduct only loosely refers to avoiding financially exploiting patients, calling on practitioners not to receive gifts or inducements for referrals to suppliers of devices. Similarly, the code of conduct fails to address the situation common to audiology and audiometry, whereby practitioners may themselves be receiving commissions or inducements for providing devices to the public. The NSW code of conduct for unregistered healthcare practitioners has been largely replicated by the three major professional bodies that the Office of Hearing Services recognises as Practitioner Professional Bodies (Audiology Australia, the Australian College of Audiology and the Hearing Aid Audiometrists Association of Australia), as per a code of conduct adopted by all three bodies on 1 July 2016. As a result, members of IAA are the only group of audiologists who are signatories to a code of professional conduct (see here) that calls for full disclosure of any third party influences (real or potentially perceived) on the advice provided to the public. Further and importantly, regulatory systems (professional association membership and state/national regulation of unregistered healthcare practitioners) are reactive to complaints, without mandatory registration against which the public can check for qualifications or experience. Audiology Australia recently introduced a listing of accredited audiologists who are their members who hold a certificate of clinical practice who volunteer to have just their names and membership numbers listed. IAA members do have their contact details available from the IAA website, allowing the public to match membership of IAA to a practice they may be receiving services from or considering contacting for a consultation.

**Self-regulation by professional associations with voluntary membership** means that expulsion of individual members is the only disciplinary measure that can be applied. A member who fails to meet the criteria of a self-regulating professional association (as accredited or holding a clinical certificate) can still provide products and services to the fee-paying public. Membership status is not directly linked to service provision to the fee paying public. Self-regulation means fellow members of an association deciding matters of professional conduct may have an interest in the outcome of any complaint, a situation recognised by those calling for national regulation of those healthcare professions that remain unregistered in Australia (see here). Further explanations about the need for regulation in audiology can be found in discussions held here and internationally. See here for a presentation made recently on the topic in New Zealand.

The consequence of not having a compulsory register of audiologists in Australia is that any person can undertake audiology work regardless of their qualifications. Of note is that OHS contracts directly to service providers who are businesses and has no direct regulatory role in relation to practitioners, assigning that role to professional bodies to self-regulate.

The lack of mandatory registration requirements for audiologists and audiometrists in Australia contrasts with regulation around the world. The following regulatory requirements apply in countries with comparable healthcare systems:

**United Kingdom (UK):** Audiology in the UK is regulated by the Health Professionals Council (HPC). Registration as a Clinical Scientist (Audiology) 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 (USA):** 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.
**Israel:** Certificate of profession issued by the Ministry of Health entitles practicing the profession.

**South Africa:** Audiologists must register with the professional board for Speech Language and Hearing Professions, which falls under the Health Professions Council of South Africa.

**Brazil:** Audiologists must comply with federal regulatory (licensure) standards in order to practice the profession as set by the Brazilian Federal Speech Language Pathology and Audiology Council.

**Europe:** Hearing aid professions are regulated in Austria, Belgium, France, Germany, Ireland, Italy, Lichtenstein, Luxembourg, Norway, Poland, Portugal, Spain, Sweden, and Switzerland. As an example, in Sweden, the professional title audiologist is protected and may be used only by a professional who holds a license issued by the Board of Health and Welfare.

The lack of risk to the public associated with audiology is often cited as the reason for the lack of mandatory national registration for audiologists under AHPRA. Audiologists pose no less risk to the public than do their registered counterparts in optometry, occupational therapy, physiotherapy, psychology. The question of risk would not have arisen if audiology had been a profession that required state registration prior to the introduction of mandatory national registration. If state registration had been in place, audiology, like optometry, would now be a registered profession. Exclusion from the group of professions required to register when national boards were established under AHPRA in 2010 represents a disservice to the Australian public, who deserve service delivery at a standard that compares well to international standards.

As mentioned above, considerable **change to service delivery** has taken place in the past decades. The profession has evolved to meet the demands of increasingly invasive and medically oriented solutions to hearing loss, which are now part of mainstream audiology. For example, newborn hearing screening leads to diagnosis and intervention for increasingly young infants but there has been no consequent regulation implemented regarding the need for audiology qualifications to be involved in this highly risky work. In parallel, changes to the context in which audiologists operate, in part created and sanctioned by government, have created a highly commercialised and competitive environment. Australian Hearing, a Commonwealth Agency, used to be the only provider of services to eligible pensioners. Since the 1990s, the Australian government (through OHS) has signed contracts with businesses, including large multinational companies, to take on the provision of hearing related services to eligible pensioners. Australian Hearing is s a government agency with a profit motive that now competes with large and small businesses. Funding for services to children, previously only allocated to Australian Hearing, will shift from OHS to the NDIS by 2019 and moves are afoot to change legislation to allow for Australian Hearing to compete in a contestable environment (see here) .

Multinational companies with close links to hearing device manufacture and supply have established chains of clinics in Australia and OHS contracts to those multinationals to provide hearing aids to eligible pensioners. Audiology now faces influences from industry that are parallel to relationships between medicine and the pharmaceutical industry, but as explained above, to date has escaped external regulatory structures that serve to protect the public from the potential for exploitation.

**Media reports** of public reaction to coercion to purchase hearing aids can only be understood in relation to business structure ownership, targets for sales set by business owners and commissions paid to those advising on hearing devices (including audiologists and audiometrists), but which are often undisclosed. Repeatedly the media and consumer groups report on members of the public being advised that they need to replace hearing devices or that hearing devices with a very high price tag are the only ones that will benefit them. Consumer groups report regular complaints of dissatisfaction with hearing aid purchases, aggressive and misleading hearing aid sales, unregulated prices and unsubstantiated claims. Professionals and consumer groups agree that given the powerful and lucrative hearing device industry is so closely associated with audiology, external regulation is necessary to ensure conflicts of interest are not perceived to influence advice provided to the public.

Contrary to popular belief and clever marketing, hearing devices do not restore hearing ability. Hearing aids provide the required level of amplification to compensate for the loss of volume resulting from a hearing loss and modify the signal that reaches the ear through filtering. The inner ear damage from a significant sensorineural hearing loss will cause a significant loss of clarity. Hearing aids are not able to 'cure' this damage so they cannot overcome this – they will provide a clear undistorted sound to the damaged ears, but the sound is distorted as it passes through the ears. This distorted signal then travels to the brain where it is processed. The brain therefore receives speech much less clearly compared to people with normal hearing, and the hearing impaired person has to learn to decipher the speech sounds heard through the hearing aids to be able to communicate. Distorted hearing tends to be greater for those with a severe/profound hearing loss and hearing devices may have very limited benefit – even if they have many advanced features [13]. If a person with a hearing loss also has neurological impairment they can be additionally disadvantaged by difficulties processing sound in the brain.

A **clinical model of audiology** relies on a comprehensive assessment of hearing which is needed to identify the full range of rehabilitative measures needed for any individual. A comprehensive audiological assessment will indicate what device features will be likely to benefit an individual. For example, someone who has little residual hearing may need sounds amplified to a maximum possible at all times and may not require hearing aid features that filter out sounds that would be unwanted by other listeners. Learning new ways to communicate, brain retraining and adjustments to the environment may very effectively supplement the benefit from hearing aids, and are usually necessary to achieve outcomes that ensure effective and full participation in society.

Parents of children who are deaf and young D/deaf adults making decisions about what services and which service provider they ought to see, have little protection in the current system. Without prior knowledge of what they are looking for, and with no regulation to prevent exploitation, they

are left to seek out services on a trial and error basis. Under the current system, the Australian public has to navigate voluntary membership of professional associations, understand registered vs unregistered healthcare practitioner regulations and fall back on a complaints system in order for regulation to be enforced.

Self-regulation in ways that align closely to professional board systems has been promoted by some professional bodies as an alternative to mandatory registration. However, the view of IAA is that such **tightening up of self- regulation should serve as an interim measure until mandatory registration is approved by COAG**. Many audiologists and consumer groups representing the Australian public agree that self-regulation by professional associations and regulation by complaint is inadequate protection for the public in relation to the field of audiology. Clinic accreditation is cited by some professional bodies representing audiologists as a solution to the lack of regulation. Clinic accreditation is a form of regulation that needs to operate alongside, not instead of, professional registration. Ninety-seven percent of audiologists surveyed recently by IAA during a national conference attended by a broad spectrum of audiologists indicated that they support mandatory national registration. Representatives of consumer groups (Better Hearing Australia, Parents of Deaf Children, Aussie Deaf Kids, Self Help for the Hard of Hearing and Deafness Forum) have all expressed support for tighter regulation of audiology. COAG could react to public concern and decide to include audiology as a profession that requires mandatory national registration. As recently as 2015, COAG approved another profession (Paramedics) to be regulated under AHPRA.

Calls by Deafness Forum and their members to make hearing **Australia's 10th health priority** would not be made if existing systems were already serving the Australian public sufficiently. A general dissatisfaction with the outcomes for Deaf people – which relate not only to inadequate hearing services, but also to supports that provide access for Deaf people such as interpreters – is driving the call for hearing to be recognised as an urgent health need.

**IAA calls on government to recognise the needs of the patients we serve and to recognise the profession of audiology to ensure that professional services are available and funded fairly and equitably, with an external regulatory system under AHPRA that engenders public protection, as applies to other healthcare fields.**

# References

1. Khoza-Shangase, K., Ototoxicity in Tuberculosis Treatment in South Africa: Exploring the Current Status. *African Journal of Pharmacy and Pharmacology*, 2013. 7 (30):2141-2145.

2. Mccaslin, D.L., Falls in the Elderly and the Role of the Audiologist. *Journal of the American Academy of Audiology*, 2013. 24 (10):896-896.

3. Ortiz, C., The Tinnitus-Traumatic Brain Injury Link: What Is the Role of the Audiologist in Patient Care, Treatment and Coping Strategies? *The ASHA Leader*, 2016. 21 (8):16-17.

4. Gates, G.A., Feeney, M.P., and Mills, D., Cross-Sectional Age-Changes of Hearing in the Elderly. *Ear and Hearing*, 2008. 29 (6):865-874 10.1097/AUD.0b013e318181adb5.

5. Pichora-Fuller, K.M., Auditory and Cognitive Processing in Audiologic Rehabilitation., in *Adult Audiologic Rehabilitation*, J.J. Montano and J.B. Spitzer, Editors. 2013, Plural Publishing: San Diego, CA.

6. Viljanen, A., J. , Kaprio, I., Pyykkö, M., Sorri, M., Koskenvuo, M., and Rantanen, T., Hearing Acuity as a Predictor of Walking Difficulties in Older Women. *Journal of the American Geriatrics Society* 2009. 57 (12):2282–2286.

7. Danermark, B.D., Hearing Impairment, Emotions and Audiological Rehabilitation: A Sociological Perspective. *Scandinavian Audiology*, 1999. 27 (4) (Suppl 49):S125 - S131.

8. Fitzpatrick, E., Stevens, A., Garritty, C., and Moher, D., The Effects of Sign Language on Spoken Language Acquisition in Children with Hearing Loss: A Systematic Review Protocol. *Systematic Reviews*, 2013. 2 (1):108.

9. Heine, C., Dual Sensory Loss and Its Mental Health Impacts: Where to Now? *Frontiers in Aging Neuroscience*, 2014. 6:348.

10. Ciorba, A., Bianchini, C., Pelucchi, S., and Pastore, A., The Impact of Hearing Loss on the Quality of Life of Elderly Adults. *Clinical Interventions in Aging*, 2012. 7:159-163.

11. Audiology Australia, Thank You for Your Enthusiastic Response to Our Remuneration Survey. *Audiology Now*, 2016. Audiology Australia Ltd, 63:10.

12. Collingridge, L., *Patient-Professional Interaction in Clinical Settings in Audiology, in Department of Linguistics*. 2009, Macquarie University: Sydney, Australia.

13. Xu, J., Johnson, J.A., and Cox, R.M., Effect of Some Basic and Premium Hearing Aid Technologies on Non-Speech Sound Acceptability. *The Journal of the Acoustical Society of America*, 2015. 137 (4):2206-2206.

14. Sjoblad, S. and Warren, B.W., Can You Unbundle and Stay in Business? *Audiology Today*, 2011:37 - 45.

Signed by:

Myriam Westcott
IAA President

Mel Gray-Thompson
IAA Executive

Grant Collins
IAA Vice President

Sharyn Lim
IAA Executive

Deborah Pallett
IAA Treasurer

Philippa Long
IAA Executive

Tricia Sharples
IAA Secretary

Jane MacDonald
IAA Executive

Louise Collingridge
IAA Executive Officer

Elaine Melville
IAA Executive

Nolene Nielson
IAA Executive

*Encl:*
Wellington Declaration
Example of marketing materials sent to members of the public

# THE WELLINGTON DECLARATION

**17 MAY 2015**

www.independentaudiologistsnz.co.nz
Ms Jeanie Morrison-Low (Representative)
info@nziaud.co.nz

www.independentaudiologists.net.au
Dr Louise Collingridge (Executive Officer)
exec@independentaudiologists.net.au

**Relationships with industry** are an integral element of audiological practice, but as an emerging profession with few guidelines to follow, many of those relationships have not been transparent leaving the public unsure of the difference between the hearing device industry and the profession of audiology. The range of services that audiologists deliver has been obscured by the marketing of products via audiology clinics. The public is not well informed as to the differences between audiologists, audiometrists, hearing aid distributors or online or retail stores (such as pharmacists or direct to consumer businesses) that sell hearing devices direct to the public. Audiology currently falls outside of regulation by the Australian Health Practitioner Regulation Agency (AHPRA). Similarly, in New Zealand, audiology is currently an unregistered profession.

In response, Independent Audiologists Australia Inc and Independent Audiologists New Zealand engaged a panel of internationally recognised bioethicists comprising Prof Paul Komesaroff, Assoc Prof Ian Kerridge and Prof Grant Gillett to facilitate a three day seminar in Wellington, New Zealand from 15 – 17 May 2015. The facilitators drew attention to relationships that audiologists hold with industry that have emerged but which, to date have not been clearly defined, disclosed, constrained or regulated. These relationships are known to be of concern to patients, audiologists and other stakeholders, having been the topic of recent public scrutiny in the media. In order for the profession of audiology to achieve a position of trust within society, transparent and regulated relationships are needed between audiologists and all stakeholders (including other audiologists and industry).
Patient-centredness needs to be demonstrated in all aspects of audiological service delivery – including the prescribing and fitting of hearing devices.

**The Wellington Declaration** (next page) was accepted by all delegates on Sunday 17 May 2015 – including independent audiologists, audiologists employed in non-independent sectors, patients, consumer group representatives and regulators.

---

## The Wellington Declaration has been endorsed by

**Mojo Mathers**
*MP and Greens Political Party spokesperson for disability issues in the New Zealand parliament.*

**Richard Brading**
*President, Self Help for Hard of Hearing People Australia, Inc.*

**Sara Duncan**
*President, Better Hearing Australia.*

**Michele Barry**
*CEO Better Hearing Australia*

# The Wellington Declaration 2015

We, the participants at the seminar co- convened by Independent Audiologists Australia and Independent Audiologists New Zealand, in Wellington, New Zealand, are mindful of the responsibility that rests on us at this moment in the history of our profession, to declare our commitment to:

1. **Ensuring a patient-centred approach within audiological services including the prescribing / dispensing elements of our practice.**
2. **Building and strengthening relationships between stakeholders (including patients, colleagues, industry, funding bodies, regulators, training institutions, associations and health care practitioners) across the field of audiology in both Australia and New Zealand.**
3. **Promoting a single code of professional conduct for audiologists, that incorporates clinical, ethical and legal aspects of practicing audiology in Australia and New Zealand.**
4. **Reducing risk of harm (including risk of financial harm) to the public through seeking mandatory national registration in both New Zealand and Australia under the relevant regulatory structures.**
5. **Guaranteeing transparency of interests (financial and otherwise) that could be perceived to influence the clinical judgement and professional recommendations made by audiologists, including transparency in billing for products and services.**
6. **Encouraging professional bodies to uphold the code of conduct in the interests of all members regardless of their employment status including the offering of legal advice and mentoring within the profession.**

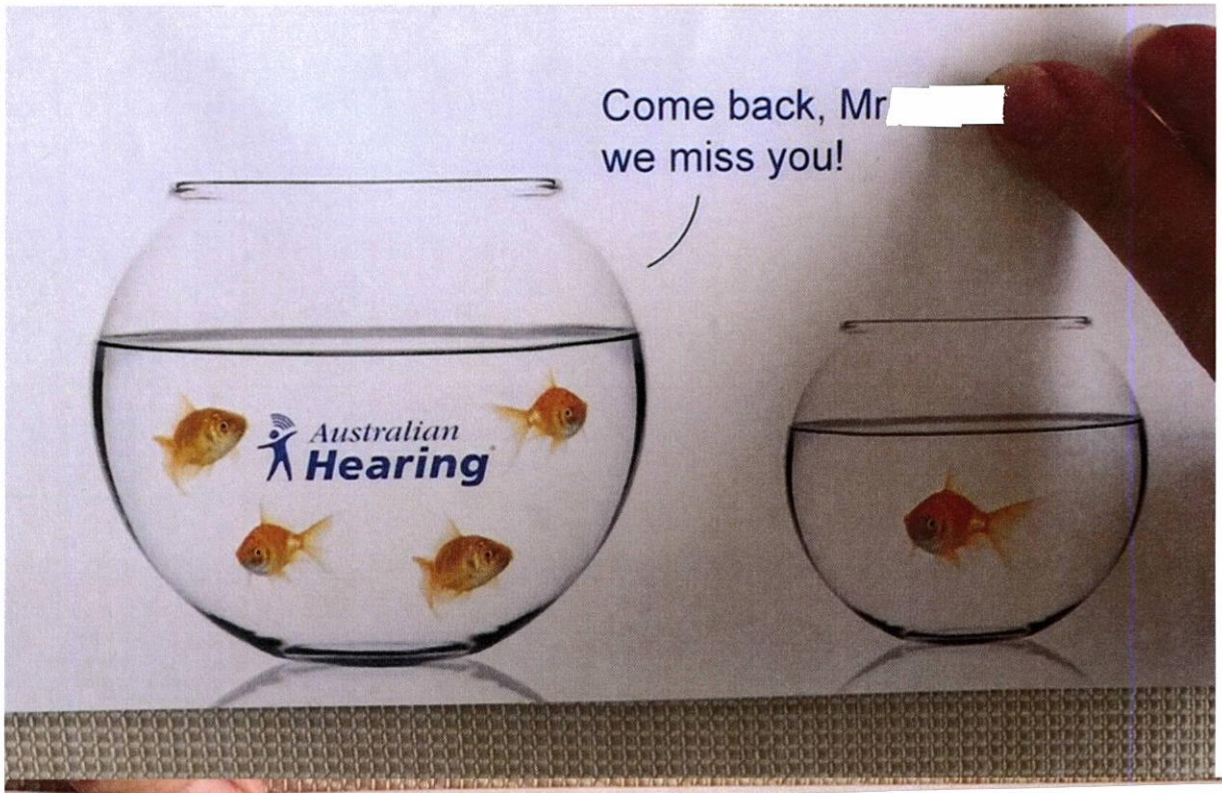
---

# Implementation of the Wellington Declaration

Independent Audiologists Australia Inc and Independent Audiologists New Zealand will set in motion the process of promoting this declaration and providing audiologists with practical skills to implement the declaration, including the following:

- **Drawing up and establishing a strategic plan including the ratification of this declaration.**
- **Formalising joint cooperation between at least their two organizations to implement this declaration.**
- **Seeking endorsement by stakeholders for this declaration.**
- **Preparing policy and position statements aimed at widespread implementation of this declaration.**
- **Applying and promoting this declaration when advocating for the profession of audiology.**
- **Providing guidance to professional bodies on the adjudication of complaints in light of this declaration including facilitating a culture of mentoring and sustaining the profession through regulation that promotes the practice of audiology in a collegial rather than a competitive fashion.**
- **Demonstrating patient-centredness in all aspects of audiology including the prescribing and dispensing of devices in policy documents and guidelines.**
- **Advising audiologists how to define and explain their relationships with industry and other stakeholders including guidelines about transparency, declaring interests, negotiating employment conditions, explaining billing practices, and disclosing commissions, sales targets and clinic ownership.**
- **Lobbying for mandatory national registration, thus demonstrating a commitment to the recognition of audiology as a profession distinct from industry.**

**One example of marketing materials sent by mail to voucher holders of the Office of Hearing Services Scheme**




Dear Mr

It has been a while since you left us so we thought we would check in to see how you and your hearing are going.

We understand you are currently with another hearing provider, however if you feel we are able to assist you in any way we invite you to come back in for a **Free* Hearing Review**.

At Australian Hearing our staff are highly trained in their technical ability and knowledge, and will create a hearing solution tailored to your lifestyle and budget.

Go into the draw for a chance to WIN# a $800 gift card

And as a thank you, if you attend a free* hearing review with us prior to the **27th November 2015**, you will go in the draw for a chance to **win# a $800 gift card** to treat yourself to something special (weekend away with a friend, sporting membership or to enjoy a series of concerts).

If you would like to book an appointment, call our customer priority line on **131 797.**
With centres conveniently located all across Victoria, we look forward to welcoming you back into the Australian Hearing Family.

*Conditions apply to clients under the Australian Government Hearing Services Program. Privacy and your personal information is handled in accordance with the Australian Hearing Privacy Policy.
#Please refer to terms and conditions of the draw located in your local centre. Our privacy policy is available at any Australian Hearing Centre or online at www.hearing.com.au. If you do not wish to receive future marketing communication from us, please contact us on 1300 963 832.

Australian Hearing