



audiology australia ltd

Submission to the Medicare Benefits Schedule Review Taskforce Consultation Paper

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Executive Summary

Audiology Australia thanks the Medicare Benefits Schedule Review Taskforce (the Taskforce) for the opportunity to provide a submission in response to the *Consultation Paper, Public Submissions (September 2015)*.

Audiology Australia is the peak body representing 2300 audiologists in Australia. As hearing is one of the most common health disorders to affect Australians, Audiology Australia welcomes the opportunity to have input into improvements of the MBS, particularly in regard to improvements in the delivery of audiological services.

Audiology Australia believes that there are parts of the MBS that are out-of-date and that a review of the MBS is required. In this response to the consultation paper and survey for a broad audience, Audiology Australia submits that:

- A representative from Audiology Australia and/or a professional audiologist are included in the membership of the Ear, Nose and Throat (ENT) Surgery Clinical Committee (including audiology) and the Allied Health Clinical Committee (including currently funded chronic disease management services).
- The restriction on the number of allied health services that a patient can access must be removed. Decisions as to the number and nature of the services required should be based on a multi-disciplinary evaluation of the patient's needs.
- Bundled payments for audiological services should be introduced to represent the patients' audiological care needs over a discrete period of time.
- An integrated system must be developed which allows patients to seek the services of an audiologist without requirement for a medical referral and which allows audiologists to refer directly to specialists such as Ear Nose and Throat surgeons when necessary.
- The MBS needs to be reviewed and brought up-to-date with current telepractice models of service delivery.
- The MBS should be reviewed to allow for audiological consultations of different lengths, depending on the client's needs.
- That audiologists should be remunerated for an initial assessment of the client's needs before the care plan is developed.
- The MBS items for patients with a chronic condition and complex care needs should be revised to allow audiologists to be remunerated for contributing to the planning and review of care plans for patients with a chronic condition and complex care needs.
- An information sheet specific for audiologists outlining the items of relevance to their profession specifically would assist clinicians and consumers to understand and apply the rules and regulations correctly.

Introduction

Audiology Australia thanks the Medicare Benefits Schedule Review Taskforce (the Taskforce) for the opportunity to provide a submission in response to the *Consultation Paper, Public Submissions (September 2015)*.

Audiology Australia is the peak body representing 2300 audiologists in Australia. Audiology Australia requires members to operate under a Code of Ethics and a Code of Conduct, and supports audiologists to offer the optimum care to their clients by awarding the Certificate of Clinical Practice.

Audiologists are University trained health professionals (entry level is a Masters Degree) who specialise in the identification, diagnosis and rehabilitation of hearing loss, tinnitus, balance disorders, auditory processing disorders, hyperacusis and acoustic shock. Audiologists provide services through hospitals, community health clinics, government funded agencies, hearing aid clinics, cochlear implant clinics, private practice, university clinics, medical practices, ear nose and throat (ENT) specialist and otology clinics, occupational hearing conservation programs, programs for compensation of occupational noise injury, community awareness and consumer advocacy. Scientific research and the employment of evidence-based practice are fundamental to high quality and successful outcomes in Australian audiology practices.

In 2006 it was estimated that one in four Australians suffer from hearing loss with this figure expected to rise to one in six Australians by 2050. Amongst elderly Australians the prevalence of hearing loss increases to as much as one in two (1). With an ageing population there will be a continuing and increasing need for the services of audiologists.

As hearing is one of the most common health disorders to affect Australians, Audiology Australia welcomes the opportunity to have input into improvements of the MBS, particularly in regard to improvements in the delivery of audiological services.

Audiology Australia agrees with the conclusion of the Australian Minister for Health, the Hon Sussan Ley MP, following consultations that *“Medicare’s structure no longer efficiently supported patients and practitioners to manage chronic conditions [...]”* (p.1, (2)). Audiology Australia addresses this issue in this submission by identifying multiple issues with the current MBS structure that are hindering the efficient support of patients and practitioners to manage the chronic condition of hearing loss.

Audiology Australia supports the submissions made by The Shepherd Centre and Allied Health Professions Australia to the Medicare Benefits Schedule Review Taskforce.

Audiology Australia's responses to the Survey for a broad audience

Do you think that there are parts of the MBS that are out-of-date and that a review of the MBS is required?

Audiology Australia believes that there are parts of the MBS that are out-of-date and that a review of the MBS is required. In this submission which responds to the questions posed by the Taskforce, Audiology Australia highlights the following areas of pertinence to the audiology profession and its patients which need to be addressed:

- The restriction on the number of allied health services that a patient can access should be removed.
 - Bundled payments for audiological services should be introduced to represent the patients' audiological care needs over a discrete period of time.
 - An integrated system must be developed which allows patients to seek the services of an audiologist without requirement for a medical referral and allows audiologists to refer directly to specialists such as Ear Nose and Throat surgeons when necessary.
 - The MBS needs to be brought up-to-date with current telepractice models of audiological service delivery.
 - The MBS should be reviewed to allow for audiological consultations of different lengths, depending on the client's needs.
 - Audiologists should also be remunerated for an initial assessment of the client's needs before the care plan for patients with a chronic condition is developed.
 - The MBS items for patients with a chronic condition and complex care needs should be revised to allow audiologists to be remunerated for contributing to the planning and review of care plans for patients with a chronic condition and complex care needs.
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Do you have any comments on the proposed MBS Review process?

Audiology Australia is pleased to note that the Taskforce has identified that the Ear, Nose and Throat (ENT) Surgery Clinical Committee (including audiology) has been identified as one of the six initial Clinical Committees to conduct reviews of specified priority services (3).

Audiology Australia submits that a representative from Audiology Australia and/or a professional audiologist are included in the membership of the Ear, Nose and Throat (ENT) Surgery Clinical Committee (including audiology) and the Allied Health Clinical Committee (including currently funded chronic disease management services).

Audiology Australia has nominated a Board member, Professor Robert Cowan, and The Shepherd Centre's Principle Audiologist, Yetta Abrahams, to be a representative on both of these committees.

How can the impact of the MBS Review be measured?

What metrics and measurement approaches should be used?

Audiology Australia believes that there should be a focus on patient outcomes and patient satisfaction. Simple questionnaires to a random sample of patients who utilise audiological services could provide such information.

In addition, there should be clear and easily accessible pathways that allow clinicians to provide ongoing feedback regarding the application of the MBS items. This would provide a valuable metric and may provide insight over time into why some items are underutilised or problematic.

How should we seek to improve this measurement and monitoring capability over time?

The metrics and measurement approaches used should be continually updated and adapted over time in order to best utilise new information sources (e.g. through utilising information in eHealth records).

Which services funded through the MBS represent low value patient care (including for safety or clinical efficacy concerns) and should be looked at as part [of] the Review as a priority?

The MBS services provided by audiologists represent high-value patient care. Audiology Australia welcomed the addition of audiological services for patients with chronic conditions and complex care needs in 2004 as well as the additions of nine new Medicare items for diagnostic audiology services provided by an audiologist (Group M15- Diagnostic Audiology Services) in 2012.

However, Audiology Australia believes that the current restrictions on patient access to audiological services are reducing the potential value of these diagnostic services and other audiological services to patients. As detailed in the responses to the following questions, these restrictions include: limits on the number, nature and length of services audiologists can provide; restrictions relating to referrals to and by audiologists, and; the requirement that audiological services must be provided in person. For example, as stated by Foster et al. (2008):

"[...] although the contribution of AHPs to primary care management of chronic conditions is being recognised, their role is being significantly prescribed. AHPs are being encouraged to contribute to care management and to participate in multidisciplinary team care, but under conditions that do not take maximum advantage of their clinical expertise in tailoring care plans for individuals and facilitating the self-management and behaviour change required." (p.30, (4)).

Which services funded through the MBS represent high value patient care and appear to be under-utilised?

According to the Bettering the Evaluation and Care of Health (BEACH) data for 2013-14, 34.2% of all referrals from general practitioners were for allied health services. Audiologists were in the top 10 allied health referrals, with 123 referrals to audiologists by general practitioners (2.6% of all allied health service referrals) (Table 11.2, p.95, (5)). This reflects the fact that audiological services are in high demand and represent high value patient care. Nonetheless, Audiology Australia believes that these services are under-utilised because of the current restrictions on the total number of allied health services that a patient can access are restricting patients' access to these effective services and the ability for audiologists to meet these patients' needs by applying evidence-based best practice. If these barriers were removed, the number of referrals to audiologists may increase.

The following restrictions currently exist regarding patients' access to audiological services:

- Five allied health services (in total) per calendar year for
 - Patients who have a chronic medical condition and complex care needs, and
 - Aboriginal and Torres Strait Islander peoples
- Four allied health services for assessment (in total per child) and up to 20 early intervention treatment services (in total per child) for
 - Children with autism, pervasive developmental disorder (PDD) or an eligible disability

Audiology Australia submits that the restriction on the number of allied health services that a patient can access must be removed. Decisions as to the number and nature of the services required should be based on a multi-disciplinary evaluation of the patient's needs.

The bundling of payments for audiological services identified as required by the multidisciplinary care team, referring general practitioner and/or audiologist would simplify the system for audiologists and referring practitioners and provide certainty to the patient that they will receive the care they need. For example, a bundled payment could include fitting of a hearing device, post-fitting care and device maintenance, aural rehabilitation and consultations.

Audiology Australia submits that bundled payments for audiological services should be introduced to represent the patients' audiological care needs over a discrete period of time.

Are there rules or regulations which apply to the whole of the MBS which should be reviewed or amended?

If yes, which rules and why? Please outline how these rules adversely affect patient access to high quality care.

RULES AND REGULATIONS REGARDING REFERRALS TO/FROM AUDIOLOGISTS

The current requirements regarding referrals that apply to the MBS items for audiologists place unnecessary barriers to the smooth transition of patients along their pathways of care.

Requirement that a patient can only see an audiologist with a referral from a medical practitioner or ENT specialist

Under the current system, a patient must be referred to an audiologist by a medical practitioner or ENT specialist. Common examples of disruptions to the care of patients resulting from these requirements are:

1. An adult who has their hearing assessed by an audiologist working in a hospital and who is identified as requiring hearing aids will need to obtain a referral from a medical practitioner in order to access the Office of Hearing Services Voucher scheme and will then require a second hearing assessment prior to being fitted with hearing aids.
2. An infant who is identified as having a sensorineural hearing loss cannot be fitted with hearing aids without clearance from an ENT specialist. Long waiting times for ENT services in public hospitals can delay the hearing aid fitting with potential adverse consequences for the infant's speech and language development.

Restriction that an audiologist cannot write a referral to another allied health practitioner or ENT specialist

Audiologists are currently unable to refer patients directly to an ENT specialist or other allied health practitioner (such as a speech pathologist). Examples of how this process negatively affects patients are:

1. A patient identified by an audiologist as having a disorder that is most appropriately treated by surgery must return to their general practitioner just to obtain the required referral to an ENT surgeon.
2. An audiologist visiting a remote community and recognises that a child has otitis media with accompanying hearing loss and would benefit from use of hearing aids. The audiologist must request the local nurse to organise for the child to be seen by the next visiting medical officer so that the medical officer can make a referral to the ENT to obtain clearance to fit the hearing aids. It is not inconceivable that there will be a six to twelve month delay before the hearing aids are actually fitted.

Audiology Australia submits that an integrated system must be developed which allows patients to seek the services of an audiologist without requirement for a medical referral and which allows audiologists to refer directly to specialists such as Ear Nose and Throat surgeons when necessary.

These changes would streamline patient care and reduce the cost and time imposts of unnecessary appointments with other medical practitioners.

RULES AND REGULATIONS REQUIRING THAT AUDIOLOGICAL SERVICES MUST BE PROVIDED IN PERSON

The advances in technology over the past decades provide new and exciting opportunities for the delivery of services (6), especially in remote areas where access to health care is limited and significant inequalities exist (7). In Australia, the prevalence of ear disease and hearing loss in Indigenous communities is often significantly higher than in the overall Australian population, particularly in remote areas. Teleaudiology¹ and teleotology, therefore, is likely to shape future audiological practice by changing the way services are delivered to these populations. **Audiology Australia's position is that telepractice is an appropriate model of service delivery for the audiology profession.**

Teleaudiology is already used in Australia by, for example: Australian Hearing for fitting hearing aids; The Shepherd Centre in assisting children develop their listening, spoken language and social skills (9); and SCIC (Sydney Cochlear Implant Centre, a Royal Institute for Deaf and Blind Children service) in the programming of cochlear implants (10). Indeed, the majority of services related to cochlear implants can be delivered using telepractice, from otoscopy to cochlear implant programming (11).

Audiology Australia submits that the MBS needs to be reviewed and brought up-to-date with current telepractice models of service delivery.

Expected outcomes of revision of the MBS to allow for teleaudiology services:

- Increased and more timely access to audiological services for populations who are unable to access face-to-face services due to geographical reasons
- Increased and more timely access to audiological services for populations who are unable to access face-to-face services due to socioeconomic or physical disadvantage
- Increased professional support to personnel involved in delivering services
- Competent performance of services and mitigation of risk for patient and clinic (8)

¹ Teleaudiology is defined as the use of telecommunications technology such as the internet, computer networks, videoconferencing or telephone to provide access to audiological services for patients who are not in the same location as the clinician (8).

Are there rules and which apply to individual MBS items which should be reviewed or amended?

If yes, which rules and why? Please outline how these rules adversely affect patient access to high quality care

RULES RELATED TO THE LENGTH OF CONSULTATIONS WITH AUDIOLOGISTS

The MBS item for audiologists providing care for patients with a chronic condition and complex care needs (Item 10952), Aboriginal and Torres Strait Islander Peoples (Item 81310), and children with autism, pervasive developmental disorder (PDD) or an eligible disability (Items 82030 and 82035) not only place a limit on the total number of allied health services per calendar year (as discussed on page 7 of this submission), but also do not allow for longer consultations with patients which may be required in some cases. Thus, audiologists may have to set fees for longer consultations which are higher than the Medicare benefit, resulting in significant out-of-pocket costs for the patient and possibly creating disparities in the accessibility of care.

Audiology Australia submits that the MBS should be reviewed to allow for audiological consultations of different lengths, depending on the client's needs.

RESTRICTIONS REGARDING AUDIOLOGISTS INVOLVEMENT IN MULTIDISCIPLINARY CARE PLANS FOR PATIENTS WITH CHRONIC CONDITIONS

Although Team Care Arrangements and multidisciplinary care plans required in Item 10952 appear to acknowledge the need for interdisciplinary collaboration, the current funding arrangements do not remunerate audiologists for case conferences for planning/review purposes, assessment consultations with patients, or communication with GPs (4). Audiology Australia agrees with the statement made by Foster et al. (2008):

“Essentially, this policy forces AHPs to engage in pro-bono work, which is at odds with operating a financially viable small business. The policy reinforces the notion of allied health services being “optional” rather than central to multidisciplinary team care. This may discourage AHPs from participating in more than a minimalist way in multidisciplinary activities, and is likely to reduce the quality and effectiveness of chronic care.” (p.30, (4))

Audiology Australia submits that audiologists should also be remunerated for an initial assessment of the client's needs before the care plan is developed.

Furthermore, the MBS items for patients with a chronic condition and complex care needs should be revised to allow audiologists to be remunerated for contributing to the planning and review of care plans for patients with a chronic condition and complex care needs.

What would make it easier for clinicians and consumers to understand or apply the rules or regulations correctly?

Audiology Australia submits that an information sheet specific for audiologists outlining the items of relevance to their profession specifically would assist clinicians and consumers to understand and apply the rules and regulations correctly.

What kind of information do consumers need to better participate in decisions about their health care?

Consumers would benefit from the following information so that they can better participate in decisions about their hearing health care:

- The nature of services provided by different health professionals involved in hearing healthcare.
- The chronic nature of hearing difficulties and evidence about the optimum management of these difficulties across the lifespan.
- The options for effective hearing health care across the lifespan and how these can be accessed.

References

1. Access Economics. Listen Hear! The economic impact and cost of hearing loss in Australia. 2006.
2. Medicare Benefits Schedule Review Taskforce. Public Submissions Consultation Paper. 2015 Sep.
3. Department of Health. The MBS Review Taskforce Process [Internet]. Australian Government; 2015 Sep. Available from: <http://www.mbsonline.gov.au/internet/main/publishing.nsf/Content/MBSRTprocess>
4. Foster MM, Mitchell G, Haines T, Tweedy S, Cornwell P, Fleming J. Does Enhanced Primary Care enhance primary care? Policy-induced dilemmas for allied health professionals. *Med J Aust*. 2008;188(1):29–32.
5. Britt H, Miller GC, Henderson J, Bayram C, Harrison C, Valenti L, et al. General practice activity in Australia 2013-14. BEACH Bettering the Evaluation and Care of Health. Family Medicine Research Centre, The University of Sydney; 2014 Nov.
6. Psarros C, McMahon CM. Evaluating the Benefits of a Telepractice Model. In preparation.
7. Williams T, May C, Mair F, Mort M, Gask L. Normative models of health technology assessment and the social production of evidence about telehealth care. *Health Policy*. 2003;64:39–54.
8. Audiology Australia. Audiology Australia Professional Practice Standards- Part B Clinical Standards. 2013 Jul.
9. The Shepherd Centre. Submission to the Senate Select Committee on Health (Submission 154). 2015 Jul.
10. Sydney Cochlear Implant Centre (SCIC). Are you struggling to hear with your hearing aids on? A cochlear implant could help you restore your hearing [Internet]. 2015 Oct. Available from: <http://www.scic.org.au/are-you-struggling-to-hear-with-your-hearing-aids-on/>
11. Psarros C, van Wanrooy E. Remote programming of cochlear implants. In preparation.