

Senate Submission

Out-of-pocket costs in Australian hearing health care June 2014

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Introduction

Audiology Australia is the professional body that represents over 98% of audiologists in Australia. Members of Audiology Australia aim to promote hearing health care in the community through quality professional assessment, rehabilitation, education and research.

This submission provides detail about the out-of-pocket costs to consumers in Australian hearing health care within the scope of the terms of reference. Several recommendations put forward for consideration are included at the conclusion of this submission.

We welcome the opportunity to contribute to this Senate Inquiry and would be willing to elaborate further on the content of this submission in person.

The socioeconomic impact of hearing loss has been well documented [Access Economics, Listen Hear (2006) <http://www.audiology.asn.au/pdf/listenhearfinal.pdf>]. Approximately one in six Australians has some degree of hearing loss, and this is expected to increase to one in every four Australians by 2050. Compared to those with no hearing loss, people with hearing loss are more likely to earn less, require access to the health system more, have lower quality of life and experience additional health problems. As the primary impact of hearing loss is a reduced capacity to communicate, there may be additional impact on those living with and caring for people with hearing loss. Thus, people with hearing loss are more likely to experience greater disadvantage when faced with out-of-pocket expenditure in hearing health care.

The cost of service delivery is impacted significantly by International Price Discrimination (IPD) employed by the manufacturers and distributors of hearing aids and audiological equipment supplied to Australia. The wholesale cost of hearing devices in comparable countries is estimated to be approximately 40% of those imposed upon Australian hearing health care providers. Hearing health care practices that are charged higher wholesale prices for hearing devices and audiological equipment will incur greater out-of-pocket expense, relative to comparable countries, and these business costs may be passed onto the consumer as higher retail prices. In addition to the device cost, professional services associated with the provision of devices may contribute to the out-of-pocket expense.

Hearing health care in Australia is supported through public programs as well as private arrangements. The range of activities undertaken in relation to hearing health care include: hearing screening, diagnostic assessment services, medical services, hearing rehabilitation services including device fitting, hearing loss prevention programs and research.

Publicly funded programs include:

- The Australian Government Hearing Services Program is administered by the **Office of Hearing Services**, and funds hearing rehabilitation services, for eligible people (<http://www.hearingservices.gov.au>). Eligible people include (but are not limited to) pension concession cardholders, DVA gold card holders, children up to 26 years of age and research through the National Acoustics Laboratories.
- National Disability Insurance Scheme participants.

- Some funding support for audiology services are available through **Medicare**, such as diagnostic assessment of hearing and balance; chronic disease management; Better Start for Children with Disability (delivered by Australian Hearing). Diagnostic assessment by audiologists and with Medicare subsidy is only accessed via the ENT or neurologist.
- Commonwealth and State-based **Workcover** programs cover hearing services and devices for approved clients.
- State-based programs provide **universal neonatal hearing screening** across all states and territories (although coverage is not universal in WA).
- State-based funding for **cochlear implant programs** is available.
- **Private health insurance** offers variable levels of reimbursement to policyholders and is focused on partial funding for devices, but not for consultation or rehabilitation services

Current and future trends

Current out-of-pocket expenditure

Ongoing **maintenance of hearing aids** is an annual out of pocket expense for all hearing aid users in Australia. Eligible clients of the Office of Hearing Services Program have maintenance costs subsidized and may pay a small annual fee for batteries, repairs and associated support.

For Deaf and hearing impaired people who do not meet eligibility requirements for Government hearing programs, the out-of-pocket expenditure relates to:

- Audiological services including device fitting
- Replacement devices
- Repairs and maintenance of the device
- Replacement earmoulds, domes and tubing
- Batteries – the cost can be considerable if the person is severely to profoundly deaf and uses 2 hearing aids and needs to change batteries every 1-2 days
- Supplementary devices to improve communication

There is limited access to Government-funded hearing assessment services for **children** whose parents/caregivers are concerned about their child's hearing. State-based services (e.g community health centres, hospitals) are dwindling which makes it difficult for parents/caregivers to obtain hearing assessment for children who require specialized testing facilities. Services often need to be accessed privately. Only a medical specialist can claim a rebate provided at a significantly higher cost than if testing were done in the community by an audiologist. There is currently no specific Medicare Claim Item Number that describes Sound Field Assessment for infants. The associated physician consultation fee can result in significant out-of-pocket expense for clients in this situation.

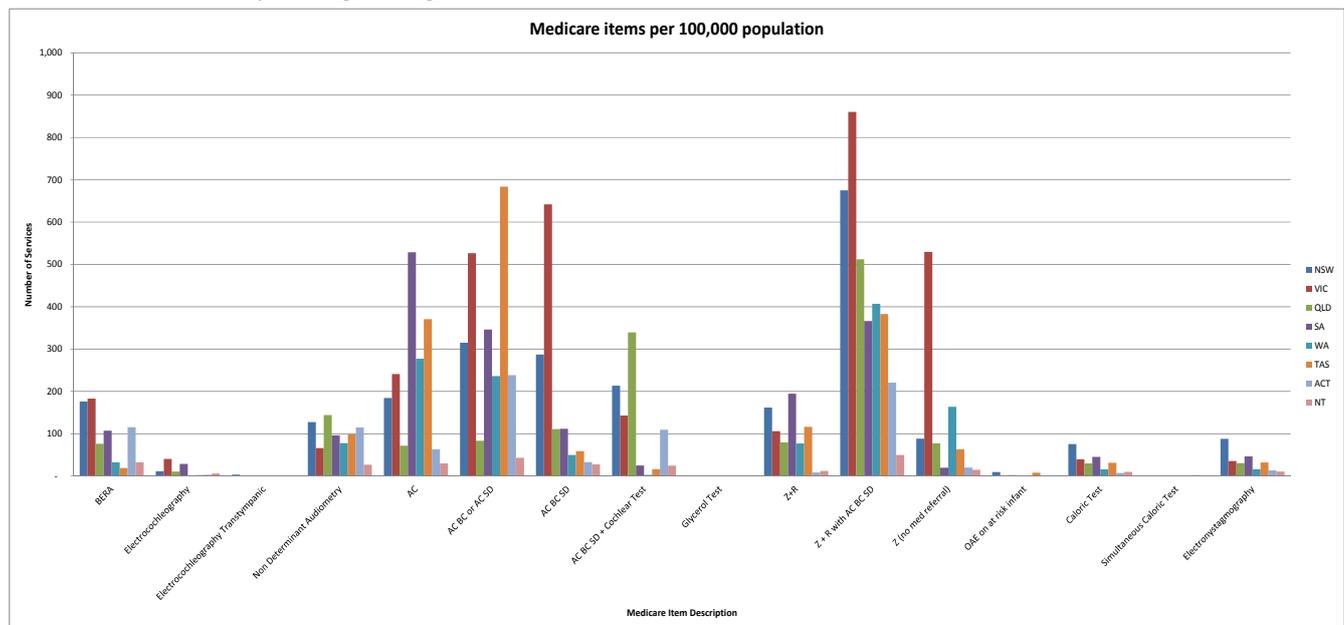
Services in rural and remote areas are not extensive, particularly for children. Some charitable organisations and hearing service providers offer hearing screening services in Aboriginal and Torres Strait Islander communities, which provide some limited access to services.

Clients of the Australian Government Hearing Services Program are able to access free hearing devices if these are suitable for the client’s specific requirements. Co-payment for ‘top-up’ hearing aids is an available option. **Co-payment for top-up hearing aids** in the OHS program drives costs for clients if (i) clients believe that quality of free-to-client device technology does not meet their specific requirements, and/or (ii) if incentives/working conditions promote the fitting of top-up hearing aids. Pressures on the cost of service delivery via **International Price Discrimination** may impact upon the range of services offered by Contracted Office of Hearing Service providers, and upon the range of affordable device options for the program. This may then affect the quality of services and devices available to clients, under the current funding model of this program.

Tinnitus management is not included in the Government funded hearing programs. People with tinnitus need to privately fund cost of tinnitus management therapies, devices and counseling services, or claim these services through Workers Compensation.

The **cost of travel** to and from audiology appointments is not covered under state-funded patient assistance travel schemes. This provides a significant barrier to accessing hearing services for people in rural and remote areas of Australia.

Hearing services provided under **Medicare** may incur gap fees for audiology consultations. In addition, the cost of Diagnostic Audiology Medicare payments per 100,000 population suggests patterns of expenditure that are disproportionate on a State by State basis: the more populous states appear to receive a higher proportion of Medicare funded services per population, which suggests inequitable access to services depending on region.



Implantable hearing devices such as cochlear implants and bone-anchored devices may be funded by state or federal government for the initial device, or by private health insurance policies that cover surgically implantable prostheses. Clinical services for cochlear implantees are covered by Medicare. If a client does not receive private health insurance or government funding then the client would pay for the implantable device privately, if the choice of implantation were made. Ongoing maintenance, repairs and technology upgrades of implanted devices is an ongoing out-of-pocket expense.

Future out-of-pocket expenditure

For Deaf and hearing impaired people, the cost of **hearing device technology** is likely to increase. The release of new generation hearing aids and cochlear implants occurs more frequently than in the past. These devices generally provide improved features that are designed to result in a better outcome for the client. However, the increased cost may preclude the client from readily accessing this technology.

Implantable hearing devices (eg cochlear implants and bone-anchored devices) will reach an age where the manufacturer is no longer able to support older, obsolete devices. If the device no longer functions, and the client is unable to afford a replacement, then the client may be left with nothing as hearing aid use may no longer be possible. This will become more of a problem with the more frequent release of new products.

There will be increasing use of **telehealth** to deliver hearing services in the future. This has potential to be particularly helpful for Indigenous communities and clients in rural and remote areas. However, there is no current funding for telehealth in audiology. Reimbursement for telehealth services in audiology is likely to provide flexible access options to those in regional, rural and remote settings, and increase uptake of this method of service delivery.

The prevalence of hearing loss increases with age, with 60% of people over the age of 60 experiencing hearing loss. Therefore, **increases to the age at which people can access the aged pension** may impact on employment capacity and workforce productivity with increased numbers of older workers. If an older person is no longer able to work due to hearing loss and qualifies for unemployment benefits, hearing service expenses remain out-of-pocket because unemployed people are ineligible for the Australian Government Hearing Services Program.

The steady decline in availability of **state government-funded hearing assessment services** is likely to continue with the issues arising over hospital funding. State-funded hospitals may or may not offer audiology services, and few (if any) offer hearing devices. If that is the case, more people, particularly children requiring hearing assessments, will need to be seeking services privately.

There is likely to be an increased prevalence of **online hearing aid sales**. This model of service is privately funded and may present a risk to clients if they are not provided within an accepted model of clinical service (for example, self-assessment of hearing loss).

Demand for **Medicare**-funded hearing services is increasing and this is likely to continue with the ageing of the Australian population, yet the available funding is not commensurate with demand.

The impact of co-payments on Consumer Access, Outcomes and Costs

People with hearing loss who are not eligible for the Australian Government Hearing Services program may not access hearing services because they are cost prohibitive. This means that their health outcomes may be poorer and negative socioeconomic impact of hearing loss is greater for those people.

The effects of co-payments on Other Parts of the Health System

The GP remains the gatekeeper for entry into the Australian Government Hearing Services Program, and also for audiology services under Medicare. Reduced access to audiology services under Medicare may occur if copayments for visits to the GP are introduced. Health outcomes for these people may therefore be adversely impacted. The cost (and perceived cost) of hearing services may be seen by GPs as a potential barrier for referral to hearing services (Gilliver and Hickson, 2011).

The physical and mental health of hearing impaired people may be adversely affected if they are unable to access hearing services due to the effect of copayments.

The Implications for the Ongoing Sustainability of the Health System

The ageing population is accompanied by an increased prevalence of hearing loss. The Australian Government Hearing Services Program has experienced sustained growth since its inception in 1997 and is likely to continue to increase. Costs such as funding audiological services and ongoing hearing aid maintenance for participants of the Program may have implications for its sustainability. National Disability Insurance Scheme participants referred to the Program may increase Program demand.

Key Areas of Expenditure, Including Pharmaceuticals, Primary Care Visits, Medical Devices or Supplies, and Dental Care

Aside from the cost of professional services, implantable devices, hearing aids, and specialized equipment used for the provision of these devices, are the key areas of expenditure in hearing health care. International Price Discrimination impacts on the purchase of diagnostic equipment and devices for the provision of hearing health care.

Audiology Australia's position statement on primary ear health care, which details key areas of expenditure, is found at the following url:

<http://www.audiology.asn.au/public/1/files/HearingtheNeedAudiologyandPrimaryEarHealthCareReformv1November2010.pdf>

The Role of Private Health Insurance

Private health insurers usually (but not always) provide full cover for implantable devices such as cochlear implants and bone-anchored hearing aids. However, whereas the majority of private health insurers offer some rebate for hearing aids, the type of coverage and extent of rebate varies from insurer to insurer and usually provides insufficient coverage for hearing services and devices. The out-of-pocket expense remains high and ancillary cover is often unaffordable. The various rebates available from different health insurers, collated by: (i) Independent Audiologists Australia and (ii) HCIA can be found at the following url:

(i) <http://www.aaapp.org.au/wp-content/uploads/2014/02/AAAPP-Private-Health-Funds-February-2014-pdf.pdf>

(ii) <http://www.audiology.asn.au/public/1/files/Members%20only/Hearing-Health-Insurance-Benefits-Comparison.pdf>

Private Health Fund Rebate Discrimination for Hearing Aid Subsidy

Some health insurers deny hearing aid rebates to clients seeking top-up hearing aids in conjunction with their government subsidy, whereas other do not. This practice could be viewed as inequitable. Funders often relegate hearing loss to the category of a pre-existing condition, which affects ability to access rebate support, timeliness and frequency.

Private Health Fund Splitting Benefits across Membership Anniversaries

Some front end staff of private health funds advise members to claim one hearing aid in one membership year then claim for a hearing aid in the other ear in the subsequent membership year, to receive higher total rebates. Apart from the fact this is an inappropriate interference in the hearing health care management of their members it drives up the cost of premiums to their existing and prospective members, when a simple linearity approach would be more prudent.

The Appropriateness and Effectiveness of Safety Nets and Other Offsets

The Australian Government Hearing Services program offers a safety net for eligible people. The program, administered by the Office of Hearing Services is effective for the vast majority of people who access its services. Services for hearing impaired people under the age of 26, rural and remote clients and adult clients with complex hearing rehabilitation needs are largely effective at reducing the consequences of hearing loss for these people.

There is a national approach to neonatal hearing screening which is detailed in the National Framework for Neonatal Hearing Screening, found at the following url:

<http://www.health.gov.au/internet/main/publishing.nsf/Content/neonatal-hearing-screening>

Services are largely effective for the majority of people with implantable devices. There may be eligibility restrictions for some children (e.g. devices for single-sided deafness) which means full support for an implanted device may not be available.

Hearing impairment is often a chronic condition. However, the Medicare safety net is unlikely to apply in the case of diagnostic audiology items, which are generally used for acute conditions.

Market Drivers for Costs in The Australian Healthcare System

The Australian Government Hearing Services Program, which places hearing aids as central to the rehabilitation of eligible people, may drive increased hearing aid sales. For example, people who do not want or need hearing aids may be fitted with hearing aids. This increases program expense via increased numbers of service claims submitted.

Increasing competition among service providers can drive recruitment of participants to the program, for people who may not want or need services (e.g., telemarketing).

Any Other Related Matter

The Australian Government Hearing Services Program currently requires clients to obtain approval from their GP prior to entry to the Program. Removing the need for the GP to act as 'gatekeeper' would reduce costs to the client, particularly if the GP co-payment is introduced. However, it would also remove a level of protection afforded to audiologists that is provided by the medical advice received by the client at entry.

Out-of-pocket expenses for hearing loss relate to the range of services provided to clients including assessment, rehabilitation and ongoing support, not just the cost of devices supplied to the person.

Access to hearing services may be improved by enabling easier referral pathways between GPs, ENTs and audiologists.

Several reforms to audiology service items under Medicare may improve equity and accessibility of services for people with hearing impairment. For example, a GP currently cannot refer a patient for audiological investigation under Medicare other than via the Chronic Disease Management program, which is ill-suited to management of hearing loss. As the system currently exists, in order for the client to receive a Medicare rebate or have no out-of-pocket expense, the GP must refer to a medical specialist or a hospital outpatients department. If an alternative existed for the GP to refer to an audiologist for hearing-related concerns, then the high cost of a medical specialist in both out of pocket expense and Medicare costs would be diminished, some competition in fees charged would ensure, specialists' time would be set to more productive purpose, hospitals would be more efficiently used and better access would prevail. In addition, the inclusion of allied health in Medicare via Chronic Disease Management has resulted in very few referrals and claims, because the methodology of this program is not adequately suited to management of hearing loss. The Chronic Disease Management may not be well understood, and very few GPs see hearing loss as a chronic disease.

RECOMMENDATIONS

Recommendation One – Consideration is given to expanding Medicare rebates for Diagnostic Audiology at GP discretion

The necessity for medical involvement in the provision of diagnostic hearing services may be a cost driver that displaces valuable medical resources away from higher skilled endeavors. Hearing health care often does not require a medical specialist, a medical specialist consultation fee and audiological service fees.

Recommendation Two – Greater consistency and clarity of reimbursement of audiology services to be offered by Private Health Funds

The differing coverage of audiology services from private health insurers is cost-prohibitive for consumers, can be confusing for policyholders, and does not provide adequate reimbursement for costs.

Recommendation Three – Preserve and enhance the Australian Government Hearing Services Program

The Office of Hearing Services successfully administrates a world-class hearing services program for eligible people. Enhancements to the Program could further improve access and reduce out-of-pocket expenses. For example, changes to the service funding model that place emphasis on client rehabilitation and outcome, rather than the provision of hearing aids, may reduce the perceived need for copayment of top-up hearing aids.

Recommendation Four – Enable funded delivery of audiology telehealth services

Telehealth in audiology can improve access to hearing services in rural and remote areas.

Appendix 1: Diagnostic Audiology Medicare Expenditure

