



SUBMISSION:

# Hearing Services Program Review – Consultation Paper

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OTITIS MEDIA

## 1. What should be the objectives and scope of the Program?

Audiology Australia (AudA) considers it important that the objectives of the Hearing Services Program (Program) be clearly defined for the benefit of providers and clients considering there are currently no objectives set out in the legislation that underpins the Program.

Doing so would also enable the Hearing Rehabilitation Outcomes (HROs) for Voucher Holders, that document the hearing health care outcomes to be achieved by Contracted Service Providers (CSPs) for clients under the Voucher Scheme, to be explicitly connected to and based on these objectives.

In AudA's view, the Program should act as a safety net for those who are likely to be affected by hearing loss, such as older Australians, and would benefit from assistance with their hearing needs but are not in a position to afford these costs. The Program should also act as a safety net for vulnerable groups and those requiring specialised services and programs such as children with hearing loss, Aboriginal and Torres Strait Islander people and frail elderly people in residential aged care facilities.

Therefore, AudA recommends that the Program objectives should be to:

- provide high quality hearing services that are based on the latest research and delivered by appropriately qualified and skilled clinicians
- address the hearing needs of eligible clients and improve their quality of life, by improving the client's ability to participate socially, educationally and economically in the community
- provide advice and support to a client's family, carers and significant others
- deliver a hearing loss prevention program that:
  - addresses workplace and leisure noise
  - reduces the prevalence of hearing loss in Aboriginal and Torres Strait Islander communities that has been caused from otitis media

In terms of the scope of the Program, we believe that individuals should be able to access services that address the wide range of impacts that a person experiences on account of their hearing loss: including any associated tinnitus, the social impacts (communication and assertiveness training), the emotional impacts (self-esteem, isolation, rejection, loss, loneliness), the mental health impacts (anxiety and depression), access to education and work, and how to cope in the workplace (access to support devices and services).

For these reasons, we consider that the scope of the Program should extend to educational services – for example, providing information to clients about hearing loss, communication strategies, expectations management, developing communication plans for individuals and community groups and providing training for staff at residential aged care facilities.

We also consider that the Program's scope should expand to include a wider range of rehabilitation services for clients, including services for people with tinnitus, vestibular/balance disorders, auditory processing disorders, auditory neuropathy and cochlear implants.

Hearing loss affects a person's ability to communicate, and consequently can negatively impact a person's psychosocial well-being. Audiologists are well positioned to detect and provide front-line support for Australians who may be experiencing social and/or emotional distress on account of their hearing loss, including connecting clients to professional services in a timely manner. We consider that the Program's scope should expand its current focus on communication training to also include provision of psychosocial support to all Australians under the Program who require it.

## **2. Which consumers should be eligible for Program subsidies?**

We consider that all existing client groups should remain eligible for the Program. However, consideration should be given to helping more disadvantaged groups including:

### **(a) Self-funded retirees on low income and people who are unemployed or in low paid employment**

#### ***(i) Commonwealth Seniors Health Card holders***

While we recognise that some self-funded retirees may hold assets that exclude them from accessing the aged pension, they do not have high levels of superannuation to meet their health and medical expenses.

The Australian Government has provided this group with access to a Commonwealth Seniors Health Card to assist with the cost of health expenses but the Card does not include access to the Program.

When the Commonwealth Seniors Health Card was introduced in 1993, it included access to the Program but this access was withdrawn in 1997. The current economic situation is putting more financial pressure on many self-funded retirees as they are receiving less income from investments. This may mean they cannot afford the hearing services they need.

AudA recommends that access to the Program be restored for this client group as they are an important part of the unpaid workforce as carers of older parents, young grandchildren or as volunteer workers for not for profit organisations. Undiagnosed and untreated hearing problems may be restricting these people from participating in these important activities as well as limiting their social contact with others.

#### ***(ii) Health Care Card holders and Low-Income Health Care Card holders***

People who are unemployed or in low paid employment are not eligible for services under the Program. If they have mild to moderate hearing loss, they are also not eligible for the National Disability Insurance Scheme. This creates a significant gap for many Australians who are unlikely to be able to afford to address their hearing needs.

Providing access to the Program would improve the opportunities for this client group to gain employment, undertake further education, and/or improve their chances of promotion if their hearing needs were addressed. By contrast, unaddressed hearing loss can lead to premature retirement, increased sick days, a decreased capacity to work productively and/or psychological stress.

For these reasons, AudA recommends that the Program be extended to financially vulnerable Australians aged 26-64 years. It is expected that this Program extension would cost the Government \$25.3 million annually.

We highlight findings published in the Deloitte report (2020) called “The Value of Hearing Services for Vulnerable Australians.” The modelling undertaken by Deloitte found that providing hearing health care and devices to financially vulnerable Australians free of charge would likely assist 8,091 people into employment. This investment would deliver an estimated 10.6 to 1 return in Government benefits relative to Government costs and over \$268 million would be gained in employment and transfer benefits, relative to the cost of \$25 million for extending the Program (HCIA, 2020).

This importance of extending the Program in this way is reinforced by it being identified as a key short-term action in the Roadmap for Hearing Health: “*Provide additional support for people on low incomes to access hearing health services, for those not eligible for the HSP or the NDIS*” (HHSC, 2019).

### **(b) Residents of Aged Care Facilities**

People living in aged care facilities are more likely to have hearing loss than those people living in the general community. They are also more likely to have more complex health conditions combined with this hearing loss such as dementia, vision loss and physical impairments. This can mean that aged care residents require additional support to successfully use and manage devices and may often rely on home care staff to access hearing services and maintain device usage.

A recent Australian systematic review found that in many cases hearing loss in aged care facilities has been under-identified and unaddressed, and that the underestimation of hearing loss can be a major barrier to optimal hearing and communication for residents. The review also found a clear association between hearing loss and loneliness, reduced social engagement, and depression among residents (Punch et al, 2018).

However, the Program’s current model of service delivery does not sufficiently address the hearing health care needs of older people within aged care and especially those with complex hearing needs. The Program does not provide any funding for home visits, group training or training of aged care staff. It does not fund loop systems, acoustic modifications and has limited funding support for assistive listening devices.

By contrast, aged care providers can assist people to access specialised equipment to support assisted listening devices such as audio induction loops and provide assistance with maintaining hearing aids, which includes staff training. However, these services are offered at the discretion of the provider and may attract additional fees.

Under the CSO Program, people with hearing loss and severe communication impairment that prevents the person from communicating effectively in their daily environment or is caused or aggravated by significant physical, intellectual, mental, emotional or social disability are eligible to receive specialist hearing services. These specialist hearing services are available for Program clients who need additional assistance to manage their hearing loss and communication. Hearing Australia is the sole provider of these services, which may

include access to a broad range of fully subsidised hearing devices, communication training, ongoing services and support to assist clients with their hearing loss.

The CSO criteria suggests that many elderly people with complex health needs are eligible to receive specialist services because of their disabilities that impact communication. However, it is AudA members' experience that most service providers do not utilise this potential referral option when providing services to clients in nursing homes. As there is only one provider of specialist hearing services under the HSP, eligible clients who see audiologists in private practice cannot receive this funding.

The Royal Commission into Aged Care reinforced that the hearing needs of aged care residents are not being met. The evidence found that only 40% of residents had visitors which indicates how reliant the residents are on staff to help them with their needs. It also indicated that very few residents have anyone else to advocate for them on their behalf. Staff feel they do not have the knowledge or the time to help residents with their hearing needs, which leads to residents being isolated or unable to participate in social or community activities.

The Royal Commission also highlighted how vulnerable this client group is and research indicates that traditional service delivery models are ineffective. Frail elderly clients need to access appropriate support for their hearing needs and this very basic health need should not be related to a person's income level.

AudA members also regularly provide feedback about their concerns that the hearing health care needs of people who live in nursing homes, or who are unable to attend clinics and require a home visit, are neglected and not adequately addressed. A particular problem in aged care facilities is residents presenting with occluding wax which blocks the ear/s to the point where the person cannot hear and communicate with other people.

The difficulties of providing hearing health care services to this group is compounded by the current Program funding model. It is difficult to look after this cohort with their complex health issues and which requires providers to pack all their equipment, travel to their facility, locate the person and prepare the equipment without any extra funding. All these services and any extra services that are needed before hearing health care can commence are provided at the provider's own expense.

AudA recommends a service delivery model such as the one that is currently available through the CSO Program to eligible clients should be extended to all frail, elderly clients regardless of income level.

There is a precedent in the CSO Program for doing this as services to children and to Aboriginal and Torres Strait Islander people aged over 50 years, two groups that also require specialised services and programs, are not means tested.

The Counsel Assisting the Royal Commission presented a series of recommendations to the Royal Commissioners which included:

*Recommendation 18.1(b) - To ensure residential aged care includes a level of allied health care appropriate to each person's needs, the Australian Government and the*

*Australian Aged Care Commission should, by no later than 1 July 2024 – require providers to enter into arrangements with each of the following professional groups to provide services as required to care recipients: optometrists; audiologists.*

Currently, this would involve providers entering into arrangements to cover people requiring private audiology services and people who are eligible for the Voucher Scheme or the CSO Program. Extending eligibility to the Program for all frail, elderly clients would streamline those arrangements and provide a more cost-effective way of delivering the service with a model that will provide improved outcomes for clients.

### **3. How well does this Program interface with other schemes?**

Considerable work has been done to develop a streamlined pathway for children aged 0-6 years to access the CSO Program, the National Disability Insurance Scheme (NDIS) and early childhood education services. This pathway is working well and ensures that families are guided through what would otherwise be an overwhelming and complex process.

Children with later onset hearing loss may take some time to access the CSO Program as the referral pathway from diagnosis is not as clear cut. There is also confusion as to what services are provided through the CSO Program, the NDIS and State and Territory health and education services.

Adults are also confused as to where they can access different supports, particularly in relation to the Program if they are eligible, the NDIS and the Employment Assistance Fund.

There will not necessarily be equity between the different programs as they have different objectives and funding arrangements. The NDIS is aspirational and the range of supports is very broad. The only requirement is that the supports are assessed as being reasonable and necessary and the funding is provided based on an individual's needs. In this regard, two NDIS participants with similar conditions may receive very different levels of funding in their NDIS plan. The risk in this arrangement is that the level of funding and support is highly dependent on the NDIS planner that the person sees and their ability to advocate for their own needs. This model can work against more vulnerable groups such as people from culturally and linguistically diverse (CALD) backgrounds and people from low socio-economic backgrounds with low levels of health literacy.

The CSO Program provides evidence-based services and devices that address the needs of individual clients. However, there is a greater level of equity in the services and devices provided to clients due to the way the Program is structured and funded. Clients do not need high levels of health literacy or an ability to advocate for their hearing services in order to receive an appropriate level of care. The Program has standards, protocols and procedures covering services and devices that help guide the clinicians in the provision of evidence-based programs in consultation with their clients. There is also a quality framework in place to ensure that clients are receiving an appropriate standard of care.

By contrast, the Voucher Scheme is quite restrictive in the services that can be offered. Given it is directed towards people with non-complex hearing needs, the suite of services should be appropriate in the majority of cases. However, it is heavily weighted towards device fitting whereas better outcomes might be achieved if practitioners were appropriately

funded to spend more time on rehabilitation services. This is outlined further in our response to Question 5.

#### 4. Does the Program sufficiently support hearing loss prevention?

AudA considers that hearing loss prevention should have a much greater focus in the Program. Indeed, there appears to be limited awareness that hearing loss prevention is even part of the Program or that it aims to support hearing loss prevention initiatives. For instance, we note that ear plugs are not subsidised and education for younger adults of an age where hearing loss prevention is most vital is also not funded.

We recommend that a national strategy for hearing loss prevention be developed and that it should be part of the *National Preventive Health Strategy*. There is a need for leadership in this important area. The Program seems the obvious place to provide that leadership or to provide oversight for an alliance of interested parties that could be responsible for implementing a hearing loss prevention strategy.

The prevention activities need to be evidence based and cover different aspects of prevention such as

- maintaining immunisation rates
- implementing strategies to address workplace and leisure noise
- addressing the high levels of otitis media in Aboriginal and Torres Strait Islander children.

Delivering hearing loss prevention campaigns has been identified as a priority in the Roadmap for Hearing Health which received funding in the 2020-21 Federal Budget. A key action in the Roadmap is to “develop and implement a prevention focused campaign, using effective evidence-based strategies, that provide education on the importance of hearing health, including the potential impact of recreational and occupational noise, and knowledge of the potential impact of unaddressed ear infections, that is both broad-ranging and targeted at vulnerable populations using various formats”.

There is a lot of evidence already about the key drivers to support successful evidence-based strategies in the areas of hearing health. What is needed is leadership, commitment from interested agencies, agreement on a strategy and implementation plan, and adequate funding.

It could be useful for the Program to support hearing loss prevention through education. Years ago, research was conducted that looked at hearing loss prevention and a lot of this work has now been translated into practice.

Therefore, AudA considers that hearing loss prevention should be one of the main objectives of the Program. Any changes made to the Program have always focused on a direct cost reduction to government and the most substantial cost reduction would be to reduce the number of people in need of hearing amplification later in life.

Hearing loss prevention should cover maternal health through pregnancy, such as making sure that Rubella immunisations are up-to-date and awareness of cytomegalovirus through pregnancy to help preventable congenital cases of hearing loss.

Other preventable cases include noise exposure and hearing protection, ototoxic drugs, signs of hearing loss, and recognising sudden hearing loss which is often left undiagnosed and untreated past the critical 24-48 hour timeframe in which to provide the appropriate interventions to minimise the adverse impacts.

Prevention programs on TV, posters supplied for GP and audiology clinics and displayed on billboards will cost money but will ultimately increase awareness and reduce the incidence of truly preventable cases of hearing loss.

#### **5. Are the Program's assessment services and rehabilitation activities meeting consumer needs?**

AudA believes that the Program's assessment services and rehabilitation activities are not currently meeting clients' needs.

In particular, the range of services provided under the Program are overly focused on hearing aids rather than viewing a client's hearing health care needs from a more holistic perspective.

This point is illustrated through the requirements outlined in Section 2 of the current Schedule of Service Items, in which clients being fitted for the first time 'must be receiving fully subsidised devices, partially subsidised devices at no cost to client or an ALD'. This negates the evidence which indicates that appropriate hearing rehabilitation incorporates a management or care program, and not just solely the provision of a hearing aid. It is AudA's view that other services may need to be provided to meet the psycho/socio/emotional needs of a client with hearing loss at any stage of their hearing care journey.

AudA members have also highlighted that the Program does not recognise the broad range of assessment and rehabilitation options that audiologists can provide in accordance with the audiology profession's Scope of Practice.

Therefore, AudA recommends that a broader range of service items be made available to audiologists under the Program so that clients can be offered a wider range of services appropriate to their hearing health care needs and audiologists can be provided with greater autonomy in exercising their clinical judgement.

#### ***Voucher Scheme***

In AudA's view, the scope of rehabilitation services available under the Voucher Scheme need to be broadened.

We consider that wax removal should be covered as part of the rehabilitation services offered under the Voucher Scheme. It is common for clients to be booked in for a hearing aid fitting or service under the Program but present with ears full of wax. This requires the wax to be removed before hearing health care services can be provided and often takes a

substantial period of time (e.g. 40 minutes). This often leaves no time for the service the client was originally attending the provider for and means that they need to be rebooked. However, wax removal is not currently covered under the Program, meaning that the time of the practitioner is not recognised or covered for this service.

Another example of where we recommend that Program rehabilitation services be expanded is for Rehab Plus. The Rehab Plus item can only be provided to clients who have been fitted for the first time, it can only be claimed once per client, and the item is only available to clients fitted with a fully subsidised device. This item should be available to any client who would benefit from it regardless of the type of device fitted and the client should be able to access as many appointments as are required to meet their goals, provided those goals are realistic and achievable. We believe that a partially subsidised device that does incur a cost to the client also does not negate the need for Rehab Plus for some clients. Currently, providers are expected to absorb the cost for any clients who require these services but do not meet the criteria for claiming.

In addition, over the life course, adults with hearing loss will experience changes in their communication environments (such as a new work environment, or moving into an aged care facility) and these new environments can present new communication challenges and subsequently cause or exacerbate psychosocial distress relating to the hearing loss. We therefore recommend that Rehab Plus services be made available as a “when required” item, rather than a once only service item for adults with hearing loss. AudA believes that Rehab Plus is not only beneficial to all clients, it is also likely that some clients may need access to these services more than once as part of their hearing health care. Therefore, we consider that Rehab Plus should be offered at multiple time points in alignment with a client’s needs.

We also note that the current wording of the Rehab Plus code suggests that the training should relate specifically to communication and hearing aid use. However, people with hearing loss experience psychosocial distress on account of the communication breakdown caused by hearing loss, and audiologists are well placed to provide support and intervention. AudA believes that this code should be expanded to include support and training relating to more than just communication, and should also include emotional and psychosocial support and social skills training for people with and without hearing aids or assistive listening devices and at various stages of life.

These points are emphasised in a recent study, which found that time and funding are two key barriers preventing Australian audiologists from providing emotional support to clients, including referrals to mental health professionals (Bennett et al. 2020).

Furthermore, the recent Deloitte report titled “The Social and Economic Cost of Hearing Loss in Australia” (2017) suggested that almost 50% of the economic cost of hearing loss is due to its psychosocial impacts. This indicated that there is a significant cost saving to the Government if audiologists are empowered and enabled to provide psychosocial and mental health support to their clients.

In response to AudA’s advocacy, Rehabilitation Service items were recently expanded as part of the Program’s reaction to COVID-19 to “provide flexibility in their scope to be adapted to the participants(s) current needs”. This included managing communication during a time

of social distancing when clients could be physically isolated from their friends and family. AudA therefore recommends that the Department of Health consider revising the Rehab Plus service items to better reflect these considerations on an ongoing basis, and include support for the broader communication and psychosocial impacts of hearing loss.

AudA considers that the fee structure for the Voucher Scheme needs to be reviewed. Currently, revenue generated from the Voucher Scheme is based on providing claimable activities and the sale of partially subsidised devices. However, payments for some services do not cover the cost of providing the service and there is no payment associated with client outcomes. While it can be assumed that the specified clinical activities will support a positive client outcome, consideration also needs to be given as to how the level of reimbursement for the activities provided drives the behaviours of service providers. Businesses will focus on profitable activities and may try to restrict the non-claimable or less profitable activities. The clinician is in the difficult position of having to balance client needs and appropriate clinical practice with the business drivers. There can be pressure on clinicians to limit services that do not attract revenue or to provide devices (usually bilaterally) even when the client may be ambivalent about device fitting, or to sell partially subsidised devices, assistive devices or accessories.

The fees paid for some items do not meet the cost of delivering services. The 2017 review of services and technology supply in the Program by PWC (the PWC Review) identified that “the current level of funding for services is contributing to a higher prevalence of cross-subsidisation where cross-subsidisation refers to the situation where the sale of a device covers the losses accrued, or lack of profits derived, in the provision of hearing services”. This would explain the high fitting rate that has been identified in the Program.

The introduction of the Minimum Hearing Loss Threshold (MHLT) was potentially an attempt to ensure that devices were not provided where they were unlikely to provide benefit. However, the fitting of a device should not be linked to an arbitrary number, but rather a client’s rehabilitation needs.

AudA recommends that it would be more appropriate for this decision to be based on the functional impairment that the client reports and for the client to be presented with the options that may help remove the restrictions and limitations that they are experiencing. The options may include rehabilitation programs that do not involve a device or the provision of an assistive device as highlighted above.

We are concerned about and do not agree with the Consultation Paper’s reference to the Program’s eligibility being out of step with, for example, the NDIS and an “internationally accepted definition of disabling hearing loss” such as that of the World Health Organization.

Comparing eligibility for different hearing services programs should start with their relevant objectives. The NDIS is designed to support people with severe and profound hearing loss, and to provide “reasonable and necessary” hearing services based on an individual’s needs. By contrast, the Program’s eligibility is based on more moderate hearing loss for those who could not otherwise afford access to hearing care or hearing aids.

The Consultation Paper’s statement appears to reflect Recommendation 2 of the PWC Review – that the MHLT should be formally reviewed with the intention to investigate

aligning the MHLT with international practice definitions of hearing loss; mandating the measurement and reporting of hearing loss via international and industry practice (4 FAHL) and applying the outcomes of such a review to prospective clients.

While AudA supports mandatory 4FAHL as this is industry best practice, we are strongly opposed to the proposal of the WHO's definition of disabling hearing loss (40dB) being the entry threshold for the Voucher Scheme. The WHO definition was created as a guide for developing countries and not the Australian context – that it is an advanced country with a record of adopting emerging technologies early to enhance productivity and quality of life.

There is no evidence to show that individuals with mild hearing loss use their hearing aids less than those with greater degrees of hearing impairment. A recent study evaluating objective hearing aid use from over 8,000 hearing aid fittings showed the average hours of daily wearing time for individuals who have a 4FAHL between 25 and 40 dB HL was no different to individuals with a 4FAHL between 41 and 70 dB HL (Timmer et al 2017).

The research evidence also strongly supports early intervention rather than leaving hearing loss to reach a disabling level. What may appear to be “relatively low levels of hearing loss” misses the point that the Program should incorporate a management or care program to meet the communication and psycho-social needs of a person with hearing loss at any stage of their hearing care journey. Applying an arbitrary threshold to hearing loss will negate this.

This was also recognised recently with the National Institute for Health and Care Excellence (NICE) guidelines for the assessment and management of hearing loss in adults, released in 2018. NICE guidelines 1.6.1 states that evidence-based, best practice is to “offer hearing aids to adults whose hearing loss affects their ability to communicate and hear, including awareness of warning sounds and the environment, and appreciation of music”. These NICE guidelines reflect the available research showing that pure-tone audiometry is insufficiently sensitive in detecting the impact of hearing loss, and in particular mild hearing loss and that it does not predict the outcomes of interventions such as the provision of hearing aids.

Therefore, AudA considers that, while raising the MHLT may result in initial savings to government, the delay of early intervention is deleterious and risks significant and higher social and economic costs over the longer-term.

In line with the notion of a minimum hearing loss, we suggest that the Program also consider a maximum hearing loss indicator. Research shows that less than 5% of Australians who would benefit from a hearing implant (for example, a cochlear implant) actually receive one. One of the biggest barriers appears to be the lack of referral from hearing clinics that provide hearing aids as interventions to hearing implant clinics for candidacy assessment. One way in which the Program might consider supporting the transition of Australians with severe to profound hearing loss over to the Medicare funded hearing implant program, is by establishing a maximum hearing loss indicator that requires the audiologists to discuss hearing implant options with the client and provide referral should the client be interested in exploring implants as an option.

The Program needs to ensure that the suite of service items covers the range of activities that will lead to a positive client outcome and that the fees associated with the service items are fair and reasonable. A review of the way services are funded was one of the

recommendations of the PWC Review. The recommendation was “supported by benchmarking of the FY2016-17 schedule prices for services in the Voucher Scheme against the private market and other government programs, which indicates that the current fees are low for a range of key services”.

Fees should be similar across different programs. Comparing the NDIS fee schedule to the Voucher Scheme is difficult as it has various amounts payable for different activities. However, looking at the payment for an assessment by an audiologist as an example, under the NDIS the hourly rate is \$193.99 with higher rates payable for remote and very remote areas of \$271.59 and \$290.99 respectively. This rate is higher than the amount paid for an assessment in the Program which is \$143.90. Additionally, the NDIS recognises costs associated with travel for the provider, report writing and also pays the provider for short notice cancellations. The NDIS also covers the cost of interpreter services. In comparison, the Program does not fund any of these activities.

AudA also considers that the fee structure for the Voucher Scheme needs to be reviewed to ensure that it is not acting as a driver to clinical practice. We believe there needs to be recognition of the higher costs of delivering services in remote areas, for delivering services at the client’s home and the loss of revenue when a client cancels at short notice or does not attend and there is no opportunity to utilise the clinical time by arranging another client to fill the vacancy.

As highlighted in our response to Question 3, the Voucher Scheme does not adequately support the needs of frail elderly clients living in residential aged care facilities. It is too restrictive in the services it funds to allow providers to deliver an appropriate level of care to this high need group. It is also too reliant on device fitting which is often not appropriate for these clients and it does not guarantee that the provider has the competencies required to deliver services to these people with more complex hearing needs. Research has indicated a different model of service delivery is required for frail elderly residents in aged care facilities. Making changes to the environment, training staff, establishing a volunteer program for support residents with any technology, and using technology other than hearing aids has been shown to provide better outcomes for this client group.

These issues are widely recognised, noting Counsel Assisting the Royal Commission into Aged Care’s recent recommendation that aged care homes enter into arrangements with audiology providers to provide services as required to aged care recipients and that one of the Roadmap for Hearing Health’s key actions is to “develop and implement a screening and intervention program for aged care”.

On this basis, AudA believes that now is the appropriate time to implement a more appropriate model of service delivery and move away from the Voucher Scheme model that is so reliant on a hearing aid fitting which is often not appropriate for this client group. A new service delivery model would result in improved client outcomes and provide more cost-effective services.

### **CSO Program**

As the CSO Program is block funded, it is possible for Hearing Australia to be more flexible in the services and devices it provides. The funding levels drive efficiencies but it needs to

be recognised that there is a point where the funding levels are not supporting an appropriate level of care due to cost increases. It is important to ensure that the funding is adequate to allow appropriate levels of service and devices to be provided by reviewing the funding levels periodically. Vulnerable clients or those with high needs should not have technology levels or service time compromised by inadequate funding levels.

### ***Cochlear implants***

The Program is not meeting the needs of adults with a cochlear implant. Under the CSO Program, children can receive speech processor upgrades and replacements but that does not apply to adults. The Department of Veterans' Affairs will cover the cost for their clients but people on age or disability pensions have to pay for this high cost item themselves. There is also no adequate choice for Program clients who have single sided deafness.

This anomaly needs to be addressed and has been identified as an action item in the Roadmap for Hearing Health: "Extend coverage of the HSP to include cochlear implant speech processors, including addressing the gap in support for people over 26 and particularly those over 65" (HHSC, 2019).

### ***Dementia and hearing loss***

As noted above in Question 2, AudA considers that the needs of frail elderly clients are not being met under the current Program model.

Another aspect to this is dementia. The co-occurrence of hearing loss and dementia among people living in residential aged care facilities is very high, with prevalence rates reported to be around 90% (Bott et al. 2020). This group is increasingly growing in size due to Australia's aging population. AudA members increasingly encounter and report that they are experiencing challenges with providing hearing services to this cohort.

For instance, to access services under the Program, clients are required to complete a form detailing their eligibility. However, this presents difficulties for clinicians who visit clients who have dementia in nursing homes and, due to their condition, are unable to complete the form. These clients may often lack family assistance or have a power of attorney in place. We suggest that the Program would benefit from guidance as to how clinicians should provide for the hearing health care needs of people with dementia. It is important that there be provision for flexible service delivery in situations where a person has a likely need for hearing services but due to cognitive or memory loss, they are unable to complete practical details such as filling out the eligibility form.

Members also report that the Program does not provide for a practical assessment process for people with dementia who cannot follow a modified/simplified pure tone audiometry protocol. These clients appear to have a hearing loss but cannot be tested. This causes difficulties with families who want their family members' hearing health care needs addressed.

The HROs document the outcomes to be achieved by clinicians in delivering services to voucher holders. Under Outcome 4 (fitting of hearing devices), clinicians are required to show the device(s) fitted to the client has been appropriately programmed, with the aid(s)

response verified against a prescriptive target; optimised according to the client's needs and preferences and checked for comfort.

In order to meet these HRO requirements, clinicians need to complete an assessment and program the hearing aids to match the prescribed targets. However, it is common for clients with dementia to not be able to follow the hearing test protocol or any modified protocol.

The American Speech-Language Hearing Association suggests that traditional behavioural tests of hearing such as pure tone and speech audiometry are generally successful in the early stages of dementia. However, modifications such as simplifying directions, using pulse tones, slowing presentation of speech stimuli, providing reminders to respond, and responding with "yes" instead of raising a finger or pressing a button may be needed. However, during the later stages of dementia, more objective tests such as otoacoustic emissions or auditory steady state response may be necessary to obtain estimated thresholds as may be modifications of assessment procedures for those patients who cannot complete standard tasks.

In practice, clinicians perform the modified protocols with those who can accommodate it but for people who are more severely affected by dementia and/or have limited response ability, there are practical difficulties testing their hearing. This may be because clinicians do not have these tests available in their clinics and cannot also readily conduct these tests when visiting clients in aged care facilities.

We refer you to AudA's October 2020 position statement ["Hearing Health and Dementia"](#) for more information about this important issue.

## 6. Is the Program supportive of consumer choice and control?

AudA considers that there are ways that the Program could be more supportive of consumer choice and control. This is consistent with the *Roadmap for Hearing Health* that has as one of its guiding principles the importance of hearing services being delivered in a person and family centric (rather than device-centric) way, ensuring that individuals and their families can effectively exercise choice and control.

### **Voucher Scheme**

To help achieve this, Program clients need comprehensive, balanced information and price transparency to help them make informed choices about their hearing health care.

One way to achieve this is to support and update the conditions of device supply, including devices standards, the Deed of Standing Offer and modernising the range of fully subsidised hearing aids that can be offered to Program clients.

Another initiative to support consumer choice and control is the introduction of a simplified, unbundled model of claiming under the Program whereby the cost of devices and audiology services are itemised and separated out. We consider that this idea would benefit both clients and providers to help improve the transparency of the Voucher Scheme and enable clients to better understand where the expenses of the Voucher Scheme lie – with the device. Unbundling also gives improved recognition to audiology as a profession because

the client's focus will shift away from the device to having a better understanding of the full range of services an audiologist can offer.

Recommendation 6 of the PWC Review called for a simplified, unbundled model of claiming under the Program. However, the Review provided very little information about what was meant by 'unbundling' in the context of the Program and the associated implications for clients and providers. Therefore, while AudA supports increasing transparency of the value of audiology services and improving clients' understanding of costs, if the Program were considering introducing such a model, it is critical that there be a detailed, publicly available analysis of what kind of impacts an 'unbundled' model would have on clients and providers.

Another area for improvement is the lack of consumer awareness of what their hearing aids can do. With the influx of hearing devices that offer features and more complex self-adjustment through an app, AudA members report that Program clients, being older, are often also likely to need additional assistance in understanding the features of their devices and training in and in using them correctly in order to be able to benefit from those features. Providers are not reimbursed for this time.

To assist the Program with improving the quality of fittings and service delivery, it is recommended that this client need should be taken into account as part of any Program changes.

### **CSO Program**

AudA recommends that the Department of Health reconsider the eligibility criteria for Specialist Services (Complex) Clients whereby clients must have a '3 Frequency Average Hearing Loss (FAHL) greater than or equal to 80dB in the better ear measured at 0.5, 1 and 2 kHz'. We note that evidence repeatedly shows that pure tone thresholds are not well correlated with hearing disability.

This was recognised in the 2018 NICE Guideline, which removed pure tone thresholds as a criteria and instead recommended that hearing aids are offered "to adults whose hearing loss affects their ability to communicate and hear, including awareness of warning sounds and the environment, and appreciation of music" (NICE, 2018). This decision was underpinned by findings from the high-quality Cochrane systematic review into hearing aids for mild and moderate hearing loss which revealed a significant beneficial effect of hearing aids on hearing-specific, health-related quality of life associated with participation in daily life (Ferguson et al, 2017).

AudA therefore recommends that the Department consider removing the use of pure tone average in the eligibility criteria for these clients. Alternatively, we suggest that if pure tone average is to be included in the eligibility criteria, that consideration be given to the use of an average of at least two octave frequencies up to and including 4000 Hz. We believe this better captures the sloping high-frequency hearing loss that many Program clients with acquired hearing loss first present with to an audiologist. We also note that hearing aid technology has evolved and that the use of old averaging criteria does not reflect these improvements in hearing aid technology.

Section 50 of the Voucher Instrument outlines what CSPs must do if they believe a voucher client is eligible for specialist hearing services, including advising that client the services that may be available to them. Section 50(1)(b) also indicates that a fact sheet on Specialist Hearing Services can be viewed on the Program website.

AudA members advise that there is a lack of information available to clinicians and clients about what actually is available to these clients in practice under “Specialist Hearing Services”. It would be beneficial for there to be information about what level of hearing aid technology and assistive listening technology is available to clients through the CSO Program, what counselling services are offered and what other services – not related to technology – are provided to these clients.

### **7. Are the Program’s service delivery models making best use of technological developments and services?**

In AudA’s view, the Program service delivery models could make better use of technological developments and services.

One important feature of modern devices is rechargeable batteries. These offer benefits to clients through the convenience of not having to regularly change batteries and also help improve safety for children and other vulnerable groups who may be at risk of swallowing them. However, devices with rechargeable batteries are not currently listed on the fully subsidised schedule of devices under the Program.

In particular, the Program could better leverage and expand service delivery via teleaudiology. We define “teleaudiology” – sometimes referred to as telepractice or telehealth - as the use of telecommunications and digital technology to provide access to audiological services for clients who are not in the same location as the clinician. This could be via email or a phone or video consultation.

AudA considers telehealth to be an appropriate alternative method of service delivery for the audiology profession that can encompass diagnostics, intervention services, counselling and education for clients and their families/carers.

The majority of health services provided in Australia are delivered as face-to-face services in clinical environments. For Australians living in rural and remote areas, specialist medical practitioners visit infrequently resulting in long waiting times if people are to be seen in their local environment. Alternatively, people can travel long distances to be seen in a large metropolitan centre. Health outcomes of Australians who experience these barriers to accessing health care are reduced relative to their peers in metropolitan Australia.

Technology provides a tool to obtain better care, better access, and ultimately a lower cost for care and, as a result, teleaudiology has the potential to change existing service delivery methods and the opportunity to provide audiology services to those who would otherwise not have benefited from them (Ruskbrooke & Houston 2016). From a clinical perspective, teleaudiology is a potential means to enable each service to structure a scalable and less costly service to attract more clients and achieve greater impact on the hearing health of the population (Saunders 2019). In their research into the sustainability of teleaudiology, Wade Elliott and Hiller (2014) also reported that teleaudiology is beneficial in reducing adverse

events, improving health outcomes, offering increased client choice of service delivery and improving access to services in rural areas and home care.

However, teleaudiology also presents some barriers. Psarros (2014) identified the following barriers that emerged after three years of clinical use of teleaudiology as a model of service delivery: organisational attitudes, consumer choice, reimbursement issues, equipment costs and access to remote sites to deliver services.

However, Psarros reported that organisational attitudes and consumer choice have been strongly impacted by positive experiences through teleaudiology along with increased access to a range of sites. In addition, the Ida Institute publishes a range of tools that will assist audiologists in successfully implementing teleaudiology, including the selection of the teleaudiology service.

The Victorian Department of Health and Human Services Audiology Workforce Report (2018) reported that only fifteen per cent of audiology respondents use teleaudiology or other forms of technology for remote or virtual service delivery. However, in their survey of the attitudes of practitioners toward teleaudiology, Singh et al. (2014) concluded that practitioners were most receptive to teleaudiology for tasks related to the exchange of information (i.e., answering questions or providing counselling and aural rehabilitation), programming of hearing aids for counselling and aural rehabilitation, programming adjustments to a hearing aid, and screening activities, and for patients who are technologically-savvy, living in remote locations, or who experience mobility or transportation limitations. However, the lack of recognition of and reimbursement for teleaudiology in government schemes has presented a major barrier for the widespread use of teleaudiology in recent years.

The CSO Program has been using teleaudiology to deliver services in remote locations for some time. These practices could be utilised under the Voucher Scheme but there needs to be client choice in using the technology versus face to face appointments as well as standards relating to the skill of the clinician and the software and hardware capabilities required to conduct an appointment successfully using teleaudiology.

While the Program service items do not specifically refer to teleaudiology, the Australian Government's response to *Still Waiting to be Heard* stated that the Program does not prohibit the use of teleaudiology as long as the services are delivered in accordance with its technical and clinical standards. However, it was not clear how technical and clinical standards were assessed for teleaudiology services and the Program did not offer extra reimbursement for services delivered via teleaudiology.

However, there has been major changes recently introduced to the Program as a result of the COVID-19 pandemic. The traditional hearing health care service delivery model was severely disrupted due to the need to limit face to face service delivery wherever possible but it has also created important opportunities for audiologists who wish to provide services via teleaudiology under the Program.

From 16 March 2020 until 30 June 2021, the Program has amended its service items to enable providers to continue to see vulnerable clients but encouraging them to use teleaudiology services wherever clinically appropriate and to strictly enforce social distancing

and disinfecting procedures within their clinics when services must be completed face to face to minimise clinical risk.

The sudden and rapid expansion of teleaudiology services as a result of the COVID-19 pandemic has the potential to transform audiology in the longer term. While the capability for teleaudiology has existed for a long time, there has been no previous example of it being available on such a widespread scale for the audiology profession through government schemes. These changes create an important precedent for the ability of audiologists to provide clinically appropriate services without compromising clinical outcomes. At the same time, it also creates a new experience for clients who may have never considered telehealth as a way to receive ongoing hearing health care.

While teleaudiology is currently being used as a replacement for face to face services under the Program, the example of audiologists across Australia successfully providing these services strongly supports the idea of teleaudiology being utilised in tandem with face to face hearing health care on an ongoing basis to provide the best outcomes for clients and for the changes to the Program introduced as a result of COVID-19 to be made permanent.

#### **8. Does the Program sufficiently support consumers in thin markets?**

AudA considers that the Program does not sufficiently support consumers in thin markets due to a lack of services in rural/remote areas as well as insufficient support for those with specialised or complex needs.

As highlighted above in our responses to Questions 2 and 5, there are a number of services that are not accessible to clients with complex or specialised needs and clients with low incomes. There is also no support for individuals from rural or regional areas or for those who have difficulty travelling to access hearing services as noted in our response to Questions 2 and 7.

At the same time, due to the nature of the Voucher Scheme, it is difficult for providers to address thin markets as it is unlikely to be profitable to take on more costly work such as travelling to regional areas or providing interpreters.

To help address these matters, we consider the new teleaudiology/alternative model of service delivery introduced in response to COVID-19 should be permanently adopted and promoted for people in rural and remote communities as outlined in Question 7, but also for older adults who struggle with mobility in aged care, home care or who are bedridden.

The CSO Program has been created to support thin markets and delivers services in rural and remote areas and covers the cost of interpreters for CALD clients. It also provides a safety net for clients requiring specialised programs such as a culturally appropriate program for Aboriginal and Torres Strait Islander people and groups where the numbers are low such as children with hearing loss. It would be hard to deliver cost effective programs and for clinicians to maintain their skill levels if these client groups were spread across multiple providers.

## 9. Are there opportunities to improve the administration of the Program?

AudA and its members welcomed and strongly supported the flexibility that the HSP offered providers in terms of administration and service delivery during the COVID-19 pandemic. We also appreciate the removal of the requirement for a client to obtain a medical referral to enter the Voucher Scheme. This makes the Program more accessible for clients and reduces the administrative burden on providers.

AudA believes that there are several opportunities to improve the Program's administration as outlined below.

### ***Determining Program eligibility***

A key problem is knowing who is and who is not eligible for the Program. It seems that the only way to be sure about Program client eligibility is to check in the Program Portal and clients often do not know how to do this and should not have to. We recommend that more information should be available on the Program website about client eligibility.

For instance, there are many eligible Program clients who do not fit the primary criteria of "full pensioner". The only way to find out a person's eligibility for certain is to put their pension card number into the portal. We suggest this is inefficient for both providers and clients who may not even be aware that they are eligible and/or can access fully subsidised devices.

### ***Schedule of Service Items recommendations***

In September 2020, the Department commenced a review of the Schedule of Service Items. In response, AudA made a submission, making a number of recommendations to help improve the Program's administration. Key recommendations are repeated below.

In principle, AudA supported the Program's intention to consolidate the Program standards, service items, claiming and evidence requirements into one reference document. This will help ensure greater clarity of Program requirements for service delivery.

However, AudA notes that in the Department of Health's previous consultations on the revised Program legislation and Service Provider Contract, it was indicated that clinical decision making was the responsibility of Contracted Service Providers (CSP) as aligned with the CSP's Practitioner Professional Body's (PPB) Scope of Practice and documented in individual CSP Policies and Procedures Manual. It was also noted that the Program would not be prescriptive when discussing clinical practice or in defining how clinical outcomes would be met. Rather, this responsibility would lie with individual CSPs based on their clinical judgment as well as guidance of their PPBs.

AudA believes that the current draft Schedule does not reflect the key considerations noted in the previous consultations and appears to be even more prescriptive and focused on devices than the previous Schedule. Furthermore, we note that during the Department of Health's previous consultation, it was highlighted that the 'Evidence for Compliance Monitoring' document was a highly prescriptive document which would be revised to align

with the underlying philosophy of the new Service Provider Contract. In addition, CSPs were advised that their focus should be on the HROs which were updated and revised in 2019.

AudA acknowledges that numerous documents have been merged in the draft Schedule. However, we note that the primary document being referenced to in the draft Schedule is the overly prescriptive and outdated 'Evidence for Compliance Monitoring' document and not the updated and more appropriate HROs document.

AudA recommends that the Department of Health consider using the HROs as the primary document by which to inform both the service and evidence requirements in the Schedule. Further specific recommendations in relation to the HROs are outlined below.

### ***Hearing Rehabilitation Outcomes***

We note that in the recent Program consultation on the Schedule of Service Items, the HROs were incorporated into the proposed Schedule of Service Items.

Whilst AudA supports the incorporation of the HROs into the proposed Schedule, we believe that further consideration is needed by the Department of Health. AudA considers that the Schedule's service and evidence requirements should be revised to align with the HROs. AudA believes that by aligning the Schedule with the HROs, Qualified Practitioners (QP) will be better positioned to use their clinical judgement and knowledge of the current best practices in client-centred care when providing hearing services to clients.

We have provided specific recommendations on how the proposed Schedule can be further revised in line with the HROs as set out in our submission to the [Program's consultation on the Schedule of Service Items, which can be found here](#).

## **10. Does the Program effectively make use of data and information to inform decision-making?**

AudA considers that the Program does not have sufficient data on the outcomes of the Program to inform decision-making.

While practitioners measure individual client outcomes, the Program does not report broader hearing services outcomes and most of the data collected under the Voucher Scheme does not indicate how the intervention provided has impacted on the client. The data that is published is mostly related to outputs such as vouchers issued or devices fitted. Modern hearing aid technology also provides for objective data to be collected to indicate outcomes. One example of this is hearing aid usage which can be collected by the hearing devices themselves in the form of data-logging.

From a research perspective, it would be beneficial if the Program collected and stored data that helped inform future Program improvements. This could include data relating to:

- quality of service
- client quality of life
- expected client clinical outcomes including whether communication goals were attained

- outcome measures for people who receive devices
- outcome measures for people who do not get fitted with a hearing aid
- whether groups targeted for assistance are accessing services
- client satisfaction with the services provided.

We consider that there also needs to be more information on client demographics and the profile of the clients who are using the Program to see if there are client groups, for instance, clients from CALD backgrounds or clients from particular areas who are not accessing services. Making de-identified data available to other research programs could be useful for research into issues such as hearing loss and dementia.

Hearing Australia publishes an annual demographic report on children fitted with devices. This is a vital piece of information and is used by newborn hearing screening programs, early childhood early intervention agencies and other educational programs.

A key enhancement to the data collection for children would be the development and implementation of a national database for newborn hearing screening to help monitor the effectiveness of programs and to ensure that no children fall through the gaps between screening, diagnosis, hearing rehabilitation and early childhood early intervention programs. This would be important data for not only the agencies involved but also for the Australian Institute of Health and Welfare to report on the timeliness and effectiveness of the pathway and also for other research projects such as Generation Victoria.

This initiative would also be consistent with the *Roadmap for Hearing Health*, which recommended as a key action: “Enhance national data collection from the UNHS program and departments of education for longitudinal tracking and analysis” (HHSC, 2019).

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