SUBMISSION OF AUDIOLOGY AUSTRALIA TO DEPARTMENT OF HEALTH HEARING SERVICES PROGRAM THEMATIC REVIEW

1. Do you consider any of the legislative instruments (or provisions within) are redundant or unnecessary or otherwise not fit-for-purpose?

Based on member feedback, Audiology Australia wishes to make the following overarching comments in regards to the Hearing Services Program (HSP):

- There are inconsistencies in eligibility for services across legislative instruments and programs, including the Community Service Obligations (CSO) program, Comcare and the National Disability Insurance Scheme (NDIS).
- The scope of services provided under the HSP is overly focused on hearing aids and not enough on a broader range of services such as community education, aural rehabilitation services, additional devices, tinnitus, vestibular, cochlear implants, Aboriginal and Torres Strait Islander peoples and family centred care as part of outcomes. There is also a lack of services for clients with auditory processing disorder or auditory neuropathy.
- Service fees are outdated and inconsistent.
- The HSP does not recognise the full range of diagnostic services that members of the profession of audiology can offer. This includes a broad range of rehabilitation services, specific diagnostic testing that is part of routine clinical assessments and wax management in accordance with Audiology Australia's Scope of Practice.
- Important models of service delivery are not included in the HSP such as services for the frail elderly. These include: home care services such as devices, home visits, residential aged care and facilities such as communication environments and group education. Sound field amplification in classrooms and implantable aid aftercare services are also not provided for under the HSP.
- The Deed of Standing Offer is outdated because device technology and manufacturer support services do not provide sufficient protection or value for practitioners and their clients. Client choice is limited due to the reduced range of products and devices, return services are insufficient and the technology/device standards have not been updated.

We also refer the Department of Health to Audiology Australia's comments made in our response to the recommendations of the PwC Review. This is in Appendix One.

Insufficient scope of services

Members have highlighted that the HSP does not recognise the broad range of assessment and rehabilitation options that audiologists should provide or have available.

For instance, members have expressed concerns about the provisions that set out the audiological testing requirements that clinicians have to meet in order to claim and fit clients

with hearing aids under the HSP. In particular, that these requirements present challenges for client's hearing health care needs.

Members have provided two case examples that illustrate these points. These are set out in detail in Appendix Two – Client Case Studies. In both these situations, HSP clients had been fitted with hearing aids when they did not need them and they had also been programmed to an incorrect hearing loss.

In the view of Audiology Australia, these case examples suggest that the testing requirements set by the HSP are not enough to reliably identify malingering clients and they do not enable clinicians to fully focus on the diagnostic or the whys of a client's hearing loss.

Malingering clients may occur for a variety of different reasons such as psychological or they do not understand the task they are asked to perform. It is the role of clinicians to be able to identify these clients using tests that cross-check each other.

However, as illustrated by the case studies, the minimum required testing under the HSP may not always identify these clients. Therefore, Audiology Australia recommends a broader range of service items be made available to audiologists and that these services be itemised and unbundled so that clients can be protected and better treated.

If this does not occur, there is an ongoing risk that HSP clients may be fitted with hearing aids that they do not need or obtain hearing aids, which may be overamplified. Both of these scenarios involve the risk of hearing loss for HSP clients. In turn, this also can lead to unnecessary financial and administrative costs for the Department of Health.

Consistency in client eligibility for HSP

As highlighted earlier, there are inconsistencies across the HSP's legislation and legislative instruments in terms of clients' eligibility for services. Consistent HSP legislation that encompasses hearing services for all agencies that include hearing – Comcare, Australian Hearing, the NDIS, the CSO program – would, in the view of Audiology Australia, improve the efficiency and operation of the HSP.

Some of these issues are highlighted in the *Declared Hearing Services Determination 1997:*

- Class 4 – referred Commonwealth employees – is probably now redundant as there are very few, if any, people in this category referred for a hearing test under the CSO program and there are also many private providers that can deliver hearing services to Commonwealth employees.
- Similarly, Comcare referrals do not need to be included in the CSO program eligibility criteria any more as we understand that they can access services from any provider under the HSP. The service was also never funded from the CSO program funding as Comcare was charged for the services provided.
- Schedule 2 lists postcodes from remote areas for eligible remote CSO clients. However, Audiology Australia believes that the remote postcode list should be reviewed as it does not always actually identify remote areas. For instance, one of the postcodes is 2800 – the town of Orange in NSW.

  While hearing service providers are now spread across the country, we note that this list can be useful for Voucher eligible clients living in or near some remote Aboriginal and Torres Strait Islander communities to access services from Australian Hearing when they are in the area delivering their outreach programs. This means that services can be delivered to the client as a one-off arrangement without the need to satisfy the site requirements of the Voucher component of the HSP.

2. **Do you consider the legislative instruments simple, clear and easy to read? If not, which elements of the legislation pose particular challenges, and what changes would you suggest?**

3. **Do you consider any of the legislative instruments generate unnecessary administrative burden (for service providers, hearing device manufacturers and suppliers, clients, government or others)? If so, what changes could be made to address this?**

Members report that the rules and management for the Voucher component of the HSP are overly complicated and recommend that they be simplified.

As highlighted in our comments on the PwC Review, Audiology Australia supports simplified claiming under the HSP because this idea benefits both clients and clinicians. This is because simplifying and unbundling the schedule of service items improves the transparency of the Voucher component of the HSP and enables clients to better understand where the expenses of the Voucher scheme lie – with the device.

Unbundling also gives improved recognition of audiology as a profession because it takes away the focus from the device and – by reducing the number of service items from 48 to 4 - gives clinicians greater professional autonomy to run their own appointment program.

4. **Do you consider any of the legislative instruments impose significant unnecessary compliance costs on business, community organisations and individuals? If so, how could compliance costs be reduced?**

As a general comment, Audiology Australia suggests reducing the number of legislative instruments that provide for the structure and operation of the HSP.

We believe that the current seven different legislative instruments create an unnecessary administrative and cost burden for the Department of Health and make it more difficult for clients and clinicians to locate and determine relevant HSP rules. For instance, in terms of client eligibility, it would be preferable to have one document rather than two.

Practitioner standards

Through our Code of Conduct and independent complaints procedure, Audiology Australia emphasises the importance of high quality, professional standards of hearing health care delivered by qualified and competent practitioners.

As these structures and standards protect and are in the interests of both clients and practitioners, we consider it important and necessary for the HSP to only include practitioners who are members of professional associations that are signatories to both the Code of Conduct and independent complaints procedure.

In that way, if HSP practitioners are already part of a robust scheme focused on the delivery of hearing health care by competent and qualified practitioners, then there is no need for a separate HSP Code of Conduct. In turn, this would help reduce HSP compliance costs.

Access to the HSP

Currently, clients wishing to obtain access to HSP funded services must ask their medical practitioner to complete and sign the “Hearing Services Program Medical Certificate” and take it with them to their chosen hearing service provider.

To improve the efficiency of the HSP, Audiology Australia recommends that the requirement for medical practitioners to sign this application form be removed, enabling audiologists to provide direct access to HSP funded services and devices to their eligible clients.

We note that hearing assessments for private clients (full/part time workers who are not receiving a government pension, self-funded retirees) do not require a GP referral.

Further, the HSP already provides for audiologists to provide HSP funded services to return clients as set out in Rules 5(3) and (4) of the *Hearing Services Voucher Rules 1997*. These state:

(3) The form must require an applicant who has not previously applied for a voucher to obtain a certificate from a medical practitioner stating whether there are any medical contraindications to the fitting of the applicant with a hearing device

(4) The form must require an applicant who has previously been fitted with a hearing device to obtain a certificate from a hearing services practitioner or a medical practitioner stating that the applicant needs the hearing service applied for.

There appears to be a discontinuity between Rule 5(3) and Rule 5(4). Noting that a person's medical status may change over time, Rule 5(4) suggests a hearing services practitioner or a medical practitioner can make the decision about who is a return client under the HSP.

Audiology Australia submits that the same approach should also apply to new clients under the HSP. By making this change, we consider that the HSP would benefit from reduced compliance costs, a lower administrative burden for both clients and providers and improved overall client access to the HSP. These decisions would also then be open to audit by the Department of Health in the usual way.

Australian Hearing Services Regulations 1992

Audiology Australia considers that it would beneficial if:

- these regulations were amended to allow for an annual increase in the maintenance fees for CSO clients in line with the fee paid by Voucher clients
- there was consistency about the amounts paid for different groups of adults. We also note that adults with complex hearing rehabilitation needs pay less than Voucher clients, which may be inconsistent given they are likely to be higher users of batteries and maintenance.
- the fee for children is reviewed. This fee has not increased since 1992 and, therefore, it is likely to cost more to collect the actual fee than the revenue it delivers.

Rule 4 sets out the calculation for the hearing aid service charge. This includes that the hearing aid service charge must not exceed $31.50 but if the person is under 26 years of age the hearing aid service charge must not exceed $26.25. As this calculation can result in awkward amounts being charged as the annual fee, we propose that these fees be rounded down to the nearest dollar amount to simplify their collection.

The Schedule sets out the hourly rate for the payment of audiometric testing:

Item	Description of services	Charges for services
1	Audiometric testing (other than for an audiological compensation package)	$119 for each hour or part of an hour

Feedback from members suggests that this calculation has led to the HSP paying too little for time and too much for devices fitted, which distorts service provision. For instance, a 25% increase in the hourly rate linked to a 25% decrease in the device payment could yield a service more focused on the rehabilitation needs of clients.

In this context, the unbundling of HSP services could also benefit clients and clinicians and ultimately the HSP. For instance, itemised services could improve client understanding of hearing health care services, improve the recognition of the value of audiology services and increase transparency of device costs.

5. Do you have suggestions for reducing regulatory burden or improving the operation of the legislation?

The following comments are based on member feedback received on different aspects of the HSP.

Eligibility of HSP clients

The operation of the HSP could be improved by addressing the following issues concerning the eligibility of HSP clients:

- There are many eligible HSP 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 clinicians and clients who may not even be aware that they are eligible and/or can access fully subsided devices.
- The category of "adult client" that arose after the NDIS is unclear and not well explained, leading to clinician confusion about who falls into this category.
- The current scenarios around "losing eligibility" and "regaining eligibility" under the HSP are unclear for both clients and clinicians.

Transition to the NDIS

The full roll out of the NDIS from 1 July 2019 is likely to have a major impact on those who are currently eligible for hearing services under the CSO program.

While Audiology Australia is aware that children fitted with hearing devices will transfer to the NDIS from 1 July 2019, we believe that the remaining CSO category groups need to have their eligibility and services covered by legislation in some form.

Children who are not fitted with a device currently have access to services under the HSP and it is important that this be retained.

Similarly, the specific eligibility arrangements for Aboriginal and Torres Strait Islanders aged under 26 years and over 50 years and Remote Jobs and Communities Programs also need to retain access to the HSP.

Audiology Australia considers it appropriate that these cohorts not be moved to the Voucher scheme but rather have access to a more culturally sensitive service delivery model as currently occurs under the CSO program. Adults with complex hearing rehabilitation needs also need to retain access to higher level services and technology.

With the impending full roll out of the NDIS, we also submit that it is very important that there be legislative clarification in the case of clients who are eligible for two schemes – the HSP and the NDIS – and what occurs in these situations.

Hearing Devices

Member feedback suggests that the operation of the HSP could be improved through addressing the following hearing device issues:

- There is a major gap in the instruments to cover cochlear implant users under the HSP, with ongoing use of speech processors and parts. For instance, there is no adequate choice for HSP clients who have single sided deafness.
- Currently, the HSP does not enable clinicians to fit wireless communication devices to clients who have minimal hearing losses but are having issues more with distance rather than close contact. For instance, if a Client Oriented Scale of Improvement goal is to hear a church sermon, a client has a mild hearing loss and cannot sit closer than 5 metres, a wireless communication device would be more suitable in these circumstances for the client than a hearing aid. However, as the HSP does not currently fund wireless communication devices, clients are more inclined to choose the hearing aids.

Dementia and HSP

As noted above, Audiology Australia considers that models of service delivery for the frail elderly are not included in the HSP. In particular, due to Australia's aging population, there are a growing number of people with dementia and/or cognitive issues and Audiology Australia members increasingly encounter and report that they are experiencing challenges with providing hearing services to this cohort.

For instance, to access services under the HSP, 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 HSP 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 HSP 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 Hearing Rehabilitation Outcomes (HROs) for Voucher Holders documents 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.
- checked for comfort.

In order to meet the requirements of this HRO, 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 behavioral 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 age care facilities.

To help address these issues, Audiology Australia would welcome the opportunity to work with the Department of Health to assist with the development of appropriate HSP guidelines in regards to providing hearing health care for people affected with dementia.

APPENDIX ONE – AUDIOLOGY AUSTRALIA'S RESPONSE TO THE RECOMMENDATIONS OF THE PWC REVIEW

Audiology Australia (AudA) welcomes the release of the Price Waterhouse Coopers (PwC) *Review of Services and Technology Supply in the Hearing Services Program* (the Review) commissioned by the Department of Health.

The Review identifies 13 major recommendations associated with the current service delivery model under the Voucher Scheme (VS) component of the Department of Health's Hearing Services Program (HSP). The Government has indicated that it will be responding to the Review by September 2018.

Recommendation 1 - Accelerate the transition towards an outcomes focused model. AudA supports this recommendation in principle. We consider that the meaning of 'outcomes' needs to be focused on all levels of services and non-hearing aid outcomes such as client wellbeing and teaching clients how to interact with their families.

AudA looks forward to working with Government to develop a comprehensive approach to achieving a standardised approach to measuring, collecting and reporting on clinical and lifestyle outcomes of all aspects of a client's diagnosis and treatment, including the impacts of any intervention on the client.

Recommendation 2 - Review the MHLT - 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, AudA is strongly opposed to the proposal of the World Health Organization's definition of disabling hearing loss (40dB) being the entry threshold for the VS. The WHO definition was created as a guide for developing countries and not the Australian context.

The evidence strongly supports early intervention rather than leaving hearing loss to reach a disabling level. This proposal also does not address the psychosocial aspects of hearing loss.

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.

Recommendation 3 - **Improve the information about hearing services and AHT, and dissemination of this information to clients in the VS**

AudA supports this recommendation. It will help improve clients' hearing/health literacy and knowledge about the VS.

Recommendation 4 - **Investigate the scope and cost of providing a range of additional services through the VS.**

AudA supports this recommendation in principle but considers that more detail is required. The range of additional services to consider providing through the VS should be expanded to include other items such as community work - education programs in regards to hearing loss.

Recommendation 5 - **Change the name of the VS**

AudA supports this recommendation.

Recommendation 6 - Adopt the simplified and unbundled model for the schedule of service items

AudA supports simplified claiming in principle because this idea benefits both clients and providers but, at the same time, more information is needed. In particular, the pricing structure underlying this model is currently unknown.

Simplifying and unbundling the schedule of service items improves the transparency of the VS and enables clients to better understand where the expenses of the VS lie – with the device.

Unbundling also gives improved recognition of audiology as a profession because it takes away the focus from the device and – by reducing the number of service items from 48 to 4 - gives clinicians greater professional autonomy to run their own appointment program.

AudA also seeks clarification about what 'bundling' and 'unbundling' means in the context of the HSP, and the associated implications for practitioners, clinics and clients. While AudA is keen to increase transparency of the value of audiology services and improve client understanding of costs, we consider that the Review does not provide enough detail about what is meant by bundling and unbundling in the context of hearing services, nor does it explore the impact of unbundling.

Recommendation 7 - **Adopt a new pricing structure for the simplified and unbundled model of service items**

AudA supports this recommendation in principle but considers further detail about how the model will work in practice is needed. In particular, further information is needed about PwC's modelling assumptions that underpin the proposed 'simplified model'.

Recommendation 8 – Remove the subsidy applicable to partially subsidised AHT (but retain the partially subsidised AHT schedule)

AudA supports this recommendation in principle but believes it needs to be carefully managed in such a way that does not undermine client choice.

More information is needed about the intent of this recommendation, how it would be linked with Recommendation 9 and how consumer choice would be affected.

If it is implemented, it will also be critical for the fully subsidised range of hearing devices to be constantly reviewed to ensure it is delivering the best devices for client's clinical needs.

Recommendation 9 – **Review the minimum specifications**

AudA supports this recommendation.

Recommendation 10 - Investigate the viability of including cost recovery levies

AudA has no comment on this recommendation.

Recommendation 11 – Implement additional AHT listing rules

AudA supports this recommendation and considers that it would need to be considered together with Recommendation 9.

Recommendation 12 - **Mandate the disclosure of the price and features of AHT**

AudA supports this recommendation in principle as it will help improve transparency of information about the VS and enable clients to make informed decisions.

Recommendation 13 – Rename the AHT schedules

AudA supports this recommendation.

APPENDIX TWO – CLIENT CASE STUDIES

Client One

Client One was a 20 year old female. She was referred by her GP for further audiological investigation due to progressive hearing loss of unknown cause. She was under the care of an audiology clinic in the community and had been fitted with binaural hearing aids after the clinic had performed the minimum requirements set by the HSP.

Client One's audiogram showed a moderate sensorineural hearing loss; air and bone conduction had been performed. Tympanometry had also been performed and was within normal limits. The hearing clinic reported that Client One's speech audiometry scores were consistent with the audiogram and that they had obtained a speech reception threshold.

When the clinician saw Client One, she obtained an audiogram that was worse than that provided from the audiology clinic. This showed flat moderately-severe sensorineural loss that was bilateral. However, the results for Client One's acoustic reflex testing showed normal results that were not consistent with the audiogram. Her speech results were also inconsistent.

Client One was subsequently booked for an auditory brainstem response and otoacoustic emissions to confirm her hearing. Her auditory brainstem response was normal, including stress test. Her transiently evoked otoacoustic emissions and distortion product otoacoustic emissions were also normal. Client One's overall results supported normal bilateral hearing and better hearing than shown in the original audiogram.

In this case, the clinician was of the view that testing Client One's acoustic reflexes would have quickly showed that she was malingering. That is, Client One did not require hearing aids and would not have met the HSP minimum threshold criteria. Unfortunately, Client One had been wearing binaural hearing aids programmed too loudly for some time and was at risk for permanently damaging her hearing.

Client Two

Client Two was a 43 year old male. His GP referred him to a surgeon for nasal issues. While there, he mentioned to the surgeon that he had trouble hearing and he was referred on to a clinician. Client Two was already under the care of a hearing aid clinic in the community and had been fitted with binaural hearing aids. He had mild sensorineural loss bilaterally in the high frequencies only. His speech and acoustic reflex results were consistent with this. Client Two stated that he did not wear his hearing aids as they were too loud.

The clinician was concerned that – even though Client Two had hearing aids – he did not meet the minimum HSP criteria based on the results received. The clinician therefore obtained his results from the first hearing provider. These showed severe to profound hearing loss – asymmetrical. When the clinician contacted the first hearing provider to enquire if they had performed any speech or acoustic reflex testing, they said they had not.

The end result was Client Two was severely over amplified and was at very high risk of permanent hearing loss if he continued to wear his aids.