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# REPORT OF THE INDEPENDENT REVIEW

## OF THE HEARING SERVICES PROGRAM



Professor Michael Woods  
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August 2021

# Foreword – letter of transmittal

The Hon Dr David Gillespie MP

Minister for Regional Health  
Minister Assisting the Minister for Trade and Investment  
Deputy Leader of the House

Cc: The Hon Greg Hunt MP  
Minister for Health and Aged Care

Dear Minister

As the Hearing Services Program Review Expert Panel (Expert Panel) appointed in August 2020 by the Hon Mark Coulton MP, the then Minister for Regional Health, Regional Communications and Local Government, it is our pleasure to present to you our Report of the Independent Review of the Hearing Services Program. We would, at your request, be happy to meet with you and Minister Hunt to discuss the report and our recommendations.

We have undertaken the review in accordance with the terms of reference and have focused on:

- optimising outcomes for the program's clients
- improving the equity, effectiveness, efficiency and sustainability of service delivery
- ensuring good governance
- modernising key components of the program in the context of changes in policy, markets and technological developments.

In conducting the review we undertook extensive consultations, including responses to the draft report which we issued in May 2021. We met with and received submissions from consumer advocacy groups, clients, industry, professional associations and academics. With the assistance of a Department of Health secretariat, we conducted our own analyses and drew on previous reports and research.

It is evident to us that the Hearing Services Program is highly valued by those with hearing loss and others who support them in their personal and work lives. However, over half of those people with hearing loss who are currently eligible under the program are not actively taking advantage of its services. In our report we have identified various barriers that eligible people face in accessing the program and have recommended reforms. Current barriers of note include:

- a lack of early access to information and resources to help them make informed choices about how to manage their hearing health (including selecting a service provider), understanding the services that are available to meet their needs and having control over how those services are delivered
- that, despite hearing health care being complex and multifactorial, a number of providers under the program are focused on the supply and fitting of hearing devices, with minimal use of additional communication support and education or other rehabilitation services being made available to clients to help them understand and manage their needs
- a delayed use of hearing devices as a result of an actual or perceived stigma of wearing a device, together with poor client readiness
- difficulties for Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse backgrounds to access culturally appropriate hearing services
- the limited availability of services for those who live in rural and remote areas and those living in aged care homes.

We have also determined that there would be significant public and private benefits from certain additional groups of people receiving subsidised hearing services, including by enabling them to participate more fully in the community and in the labor force. In particular, we recommend that eligibility to the program be extended to the following people:

- Low Income Health Care Card holders from 26 years of age until Age Pension eligibility age
- Aboriginal and Torres Strait Islander people aged from 26 to 50, supplementing the current service provided to those aged under 26 and over 50
- permanent residents of aged care homes.

Overall, we have made 22 recommendations which aim to give clients greater choice and control over the management of their hearing loss; improve the equity, effectiveness, efficiency and sustainability of service delivery; ensure good governance; and modernise the program to reflect changes in policy, markets and technological developments.

We recognise that some of the recommendations from the review would be relatively simple to implement. However, we also acknowledge that other recommendations are more complex and, in some cases, would involve changes to existing legislation and/or collaboration with other jurisdictions – or require more detailed analysis of their budgetary impacts. Many recommendations are likely to have a significant impact on consumers, the professional workforce and industry; and there would be benefit in consultation to ensure successful implementation.

We look forward to meeting with you in the coming weeks to discuss our report.

Yours sincerely



Professor Michael Woods



Dr Zena Burgess

Hearing Services Program Review Expert Panel

16 August 2021

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# Acknowledgement of Country

We acknowledge the traditional owners and custodians of Country throughout Australia and acknowledge their continuing connection to land, waters and community. We pay our respects to the people, the cultures and the elders past, present and emerging. This report was drafted on Ngunnawal country.

## Acknowledgement of contributions to the review

We are grateful for the considerable contributions of time, data and insights provided by a wide range of stakeholders during the course of this review. Inputs from consumer advocates, program clients, industry (including service providers and hearing device manufacturers), professional associations and academics have been generously offered and openly received.

We also express our deep gratitude to the secretariat, which greatly assisted us in all aspects of this review and worked tirelessly to meet our various deadlines.

### A note on the use of data in this report

Modelling and forecasting of demand and public expenditure for subsidised hearing services through the program are based on a variety of source datasets and should be treated as estimates only. This information is included to illustrate potential expected client numbers and public costs and does not include associated administrative costs for the Department of Health or for industry. The information should not be used as a definitive costing for any change in government policy.

Most of the Hearing Services Program data extracted for this report come from the Hearing Services online administrative database. Although every effort has been made to ensure that the data are accurate at the time of data extraction, there is no time limit on claims – and record changes due to recoveries of any provider funding – so there may be slight differences between the data included in this report and previously published statistics.



# Recommendations



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The Hearing Services Program Review Expert Panel (Expert Panel) makes the following recommendations to reform the Hearing Services Program. The focus is on optimising outcomes for the program's clients; improving the equity, effectiveness, efficiency and sustainability of service delivery; ensuring good governance; and modernising key components of the program.

# Chapter 2

## Objectives of the Hearing Services Program

### Recommendation 1: Defining new objectives for the Hearing Services Program

- 1(a) The Australian Government should define the objectives of the Hearing Services Program to guide the expectations of those with hearing loss; the Department of Health's administration of the program; the delivery of services by contracted service providers; the participation of other stakeholders in the program; and the measurement and assessment of client outcomes. The Australian Government should also establish a regular assessment of program outcomes to ensure the accountability of all participants.
- 1(b) The Australian Government should undertake consumer and broader stakeholder consultation on the following draft objectives before committing to a final set of program objectives and subsequently enshrining them in legislation:
  - A. The program's objectives for eligible people with hearing loss are that they:
    - A.1 have equitable access to prescribed services which comprise hearing assessment and hearing rehabilitation, hearing devices and other support - specifically, that eligible people:
      - i. have equitable access to support, irrespective of their location or personal attributes and circumstances
      - ii. be provided with support which is culturally safe and appropriate to them
    - A.2 are able to exercise informed choice about and control how to live with and manage their hearing loss, including:
      - i. how to address their communication needs and maximise social inclusion through social activity and economic participation and in physical and cultural pursuits to the fullest extent possible
      - ii. how they can be engaged in the planning, assessment, selection and delivery of the services offered to them
    - A.3 are able to exercise informed choice about, and control the selection of, their service provider and have clear and independent processes for resolving any complaints.
  - B. The program's objectives for contracted service providers under the Hearing Services Program are that they:
    - B.1 always act in the best interests of the eligible clients who have chosen them
    - B.2 demonstrate that they meet program contract requirements such as key performance indicators
    - B.3 provide culturally safe and appropriate services that respond to the needs of people with hearing loss in their local area.
  - C. The objectives for qualified practitioners/hearing professionals are that they:
    - C.1 deliver safe services

- C.2 abide by all current Practitioner Professional Bodies' codes of conduct and meet all professional standards and/or competencies.
- D. The program's objectives for the government and its Hearing Services Program administrators are that:
  - D.1 when defining the subsidised set of prescribed services, categories of eligibility, hearing loss thresholds and criteria for contracted service provider accreditation, they have regard to:
    - i. supporting the communication needs of people with hearing loss and their social inclusion through social activity, economic participation, and physical and cultural pursuits
    - ii. the benefits to families and other persons with whom people with hearing loss communicate
    - iii. the broader benefits of employability, participation in society, social cohesion and economic growth
    - iv. the quantum and sustainability of costs to, and opportunities forgone by, current and future taxpayers
  - D.2 they ensure that the services, hearing devices and other technologies made available to people with hearing loss through the Hearing Services Program are regularly reviewed against agreed outcomes to reflect best practice and ensure that people with hearing loss do not experience harm arising from poor quality services or supports
  - D.3 they raise community awareness of the issues that affect the social and economic participation of people with hearing loss and facilitate their greater community inclusion
  - D.4 they support the measurement and collection of data associated with hearing loss in Australia and the outcomes achieved by hearing services programs, and invest in research, to:
    - i. facilitate innovation, continuous improvement and contemporary best practice in improving hearing health, preventing hearing loss and supporting people with hearing loss
    - ii. inform the future direction of hearing services programs.

# Chapter 3

## Eligibility requirements for support under the Hearing Services Program

### **Recommendation 2: Modernising the voucher stream terminology**

The Australian Government should replace the term ‘voucher stream’ with a term such as ‘Hearing Benefits Scheme’ to modernise the program terminology and better reflect the purpose of the stream (noting that the current term ‘voucher stream’ has been retained throughout this report).

### **Recommendation 3: Clearer delineation of Community Service Obligations stream clients**

The Australian Government should retain the eligibility for all young Australians and young adults under 26 years of age to access hearing services through the Community Service Obligations stream as currently provided for in the Australian Hearing Services (Declared Hearing Services) Determination 2019.

### **Recommendation 4: Greater choice of provider for young adults and for adults with complex hearing needs**

The Australian Government should enable adults from 21 years of age to have greater choice of provider on the following basis:

- 4(a) Subject to Recommendation 4(c), all young adults from 21 to 25 years of age with hearing loss should be able to access hearing services from any Hearing Services Program provider of their choice.
- 4(b) Subject to Recommendation 4(c), all voucher-eligible adults from 26 years of age who have complex hearing or communication needs and/or cochlear/bone anchored implants should be able to access appropriate specialist services from any Hearing Services Program provider of their choice.
- 4(c) The Australian Government should require all contracted service providers who intend to provide specialist services to people from 21 years of age who have complex hearing or communication needs and/or cochlear/bone anchored implants to demonstrate that they can support these clients with the capacity, skills and cultural awareness capabilities that accord with the standards and guidelines developed by the Practitioner Professional Bodies. The Australian Government should implement a system of audits to ensure that providers are claiming appropriately for specialist services delivered in accordance with this recommendation.

### **Recommendation 5: Extension of eligibility to additional priority populations**

The Australian Government should expand the categories of eligible people under the voucher stream to include:

- 5(a) people who are Low Income Health Care Card holders from 26 years until Age Pension eligibility age
- 5(b) Aboriginal and Torres Strait Islander people from 26 years of age
- 5(c) permanent residents of aged care homes.

## Recommendation 6: Making better use of Medicare

The Australian Government, through its management of Medicare, should encourage general practitioners (GPs) to undertake awareness raising of hearing health and, where considered warranted by the patient and GP, provide a referral for a full diagnostic hearing assessment for the following Medicare claimable items:

- a health assessment for people aged 75 years and older
- a health assessment for people aged 45–49 years who are at risk of developing chronic disease
- a comprehensive medical assessment for permanent residents of aged care homes
- a health assessment for people with an intellectual disability
- a health assessment for refugees and other humanitarian entrants
- a health assessment for Aboriginal and Torres Strait Islander peoples (children and adults).

## Chapter 4

### Clinical need and client experience within the Hearing Services Program

#### Recommendation 7: Engagement with consumer groups

The Australian Government should establish a hearing services consumer consultation forum with consumers and carers, consumer/carer organisations representative of consumer diversity and cultures. The forum would facilitate information exchange; seek advice on improving the equitable, effective, efficient and sustainable functioning of the Hearing Services Program and associated hearing activities; and explore ways to increase the opportunities for consumer organisations to support their members and assist people with hearing loss.

#### Recommendation 8: Client decision-making support

8(a) The Australian Government should co-design a range of illustrative service pathways on the Hearing Services Program website that clearly show the options for clients who are eligible for hearing services in the voucher stream (including Community Service Obligations (CSO) specialist services) and the CSO stream. Pathways should identify links with related programs. These pathways should be reviewed, at an appropriate time period following implementation to assess their usefulness.

Specific pathways, using appropriate language and communication modes, should be developed for clients who might benefit from targeted wayfinding information, including:

- children and young people aged under 26 receiving services through Hearing Australia
- clients with complex hearing or specialist needs
- adults with cochlear/bone anchored implants
- Aboriginal and Torres Strait Islander clients seeking hearing services
- clients from culturally and linguistically diverse backgrounds
- clients living in rural and remote areas
- permanent residents of aged care homes.

- 8(b) The Australian Government, following consultation with stakeholders, should incorporate a set of privacy-protected decision aid tools into the Hearing Services Program's website to assist prospective clients to make more informed choices about managing their hearing loss and to be informed of the services available through the program. This initiative should be reviewed within 2 years of implementation to assess its effectiveness and advise on improvements.
- 8(c) Subject to the outcome of the review recommended in Recommendation 8(b), the Australian Government should consider trialling a set of decision aid tools in the hearing assessment process, with the data to be stored in a client's clinical file and made available to them.

### **Recommendation 9: Availability of translation, interpreting and Auslan services**

The Australian Government should ensure that audiologists and audiometrists are made aware of the Auslan services available under the National Disability Insurance Scheme and the National Auslan Interpreter Booking and Payment Service (NABS) programs and how to access these services. Audiologists and audiometrists should be included as 'approved groups and individuals' who are able to freely access the national Translating and Interpreting Service.

### **Recommendation 10: Delivering rehabilitation and other holistic support services**

- 10(a) The Australian Government should amend the scope of the Hearing Services Program to require contracted service providers to offer a more holistic assessment of clients' communication and hearing needs and a broader range of services to better address those needs. This should include:
- a holistic assessment of client needs which supplements an assessment of hearing loss with an understanding of an individual's communication requirements, lifestyle and life circumstances, and psychosocial needs
  - a broad scope of communication support and education alternative services prior to offering the option of being supplied and fitted with a hearing device
  - rehabilitation services as part of providing a fully or partially subsidised hearing device or as a standalone intervention
  - communication, education and psychosocial support alongside hearing assistance
  - assessment and management plans better suited to clients from diverse backgrounds.
- 10(b) The Australian Government should require qualified practitioners who deliver these services to ensure that they can be safely and appropriately provided, in line with Practitioner Professional Bodies' scope of practice and codes of conduct.

### **Recommendation 11: Access to teleaudiology**

The Australian Government should continue its current support and funding for teleaudiology as a service delivery option for Hearing Services Program clients. Providers of teleaudiology should ensure that the service meets the needs of their client, is provided with appropriate comfort and sound quality, and is delivered in accordance with Practitioner Professional Bodies' scope of practice and codes of conduct. The Expert Panel notes that:

- this may be an appropriate mode of service delivery for many rehabilitation and communication/education services
- in some instances and for some cohorts, contemporaneous face-to-face support from another person may be required to make the most of the teleaudiology service (for example, from a family member, Aboriginal Health Worker, aged care worker or translation service).

### **Recommendation 12: Streamlining the Schedule of Service Items and Fees**

The Australian Government should undertake a review of the current Schedule of Service Items and Fees (Services Schedule) to:

- clearly define and describe communication support and education, and rehabilitation services, as they relate to the Hearing Services Program
- simplify the services defined in the current Services Schedule, including by removing any current restrictions around the use of communication support and education, and rehabilitation services, in the current service delivery model
- review the current fees payable under the Services Schedule to ensure that service items which have a strong focus on communication support and education, and rehabilitation, are appropriately remunerated; and undertake any necessary rebalancing of the fees.

### **Recommendation 13: Improving access for Aboriginal and Torres Strait Islander peoples**

13(a) The Australian Government should co-develop an Aboriginal and Torres Strait Islander framework for hearing health, with Aboriginal and Torres Strait Islander leadership, aligned with the National Agreement on Closing the Gap. This should include alternative models of hearing service delivery that are culturally safe and accessible to increase the proportion of eligible Aboriginal and Torres Strait Islander people with hearing loss taking part in the Hearing Services Program.

13(b) The Expert Panel endorses the proposed actions in the *Roadmap for Hearing Health* to improve access for Aboriginal and Torres Strait Islander peoples and recommends that the Australian Government implement and evaluate the following short-term action regarding enhancing this sector's workforce:

*Strengthen the Aboriginal and Torres Strait Islander workforce to deliver hearing health services. This would include support for Aboriginal Health Workers to develop skills in hearing health.*

## **Recommendation 14: Improving access for people from culturally and linguistically diverse backgrounds**

The Australian Government should identify and analyse shortfalls in engagement with, and outcomes from, the Hearing Services Program for culturally and linguistically diverse populations, including issues related to availability of information and advice in community languages (see Recommendation 9). The Australian Government should undertake a co-design approach to working with peak bodies representing these groups to address any identified issues impacting on access for eligible clients to the Hearing Services Program.

## **Recommendation 15: Improve access for regional, rural and remote communities**

- 15(a) The Expert Panel recognises the ongoing challenges for regional, rural and remote communities in accessing hearing health services and references its previous advice to the Australian Government regarding the changes to Hearing Services Program voucher stream. The preference of the Expert Panel remains for Option 1 – Provide a loading on service items delivered in rural and remote regions (MM 3–7), irrespective of the size of the provider – as one of the ways to ameliorate the transition impacts of the changes to the program. The Expert Panel also continues to support Option 3 – Expand teleaudiology services available through the program.
- 15(b) The Expert Panel endorses the proposed actions in the *Roadmap for Hearing Health* to improve access for people experiencing hearing loss in regional, rural and remote communities; and recommends that the Australian Government implement and monitor the outcomes of the following action regarding enhancing the sector's workforce capacity to support these people:

*Telehealth is made more accessible for hearing healthcare practitioners to provide services to consumers, particularly those living in rural and remote communities.*

## **Recommendation 16: Improve access for residents of aged care homes**

- 16(a) The Expert Panel endorses the proposed actions in the *Roadmap for Hearing Health* to improve access for older Australians living in aged care homes and/or receiving aged care services; and recommends that the Australian Government implement and monitor the outcomes of the following actions:

*Enhancing awareness and inclusion: Lift the quality of hearing health and care in aged care across the country, with a focus on identification, management and workforce training.*

*Identify hearing loss: Ensure aged care assessment processes, including on entry to residential care, appropriately identify hearing loss and balance disorders.*

In line with the Australian Government's response to the final report of the Royal Commission into Aged Care Quality and Safety, the Expert Panel encourages further action to ensure that aged care providers include routine opportunities for their residents to have access to hearing services. Models of care should match both residents' specific needs (for example, their cognitive impairment) and the environment in which they live.



# Chapter 5

## Service delivery of the Hearing Services Program

### Recommendation 17: Supply and client choice

The Australian Government should enable improved consumer choice by amending the contract with providers to require them to publish (as a minimum, on their website in an easily accessible manner):

- the range of services they provide and the features (including quality and limitations) of all devices (fully and partially subsidised) that they supply under the program
- prices of the partially subsidised devices that they provide under the program
- qualifications and relevant accreditation status of the provider
- information on the mechanism through which clients can provide feedback on service experience and outcomes.

### Recommendation 18: Broadening the scope of technology to facilitate client choice

18(a) The Australian Government should evaluate the benefits and costs of including developing technologies, such as rechargeable devices and batteries, directional microphones, alerting devices, mobile applications and remote controls, in the Schedule of Service Items and Fees.

18(b) The Australian Government should commission the following reviews and convene one or more broad sector working groups of stakeholders, including consumer representatives, to participate in them:

- a review of hearing technologies which should be listed under the Hearing Services Program
- a review of the minimum specifications for fully subsidised hearing devices under the Hearing Services Program, as outlined in the manufacturers' Deeds of Standing Offer, and the criteria which guide the inclusion of those devices in the Deeds of Standing Offer.

# Chapter 6

## Design of the Hearing Services Program

### Recommendation 19: A national data service

The Australian, state and territory governments should implement a national digital database of hearing screening of infants and children, recognising that the responsibility for universal newborn hearing screening and screening at any other age, such as prior to starting school, lies with state and territory governments. This initiative could act as a precursor to the development of a broader national hearing health data service.

### Recommendation 20: Program monitoring and evaluation

- 20(a) The Australian Government should develop and invest in a Hearing Services Program monitoring and evaluation framework that supports the monitoring of the program's achievement of its objectives, in terms of both client outcomes and program-level outcomes.
- 20(b) The Australian Government should report on the performance of the program in 2 years, drawing on improved data availability and measurement tools, and commission an independent evaluation within a further 5 years.

# Chapter 7

## Hearing health and hearing loss research

### Recommendation 21: Research strategy

- 21(a) The Australian Government should develop a research strategy in consultation with hearing services stakeholders and publish it on the Hearing Services Program website. Guiding principles should be that research is co-designed with relevant population cohorts and that those groups are involved in the conduct of the research, its analysis and the dissemination of the research findings.
- 21(b) Research funded directly through the Hearing Services Program should be aligned with this broader research strategy. Research priorities should be advised through consultation but should include the removal of barriers to accessing the program's services and facilitating the cultural appropriateness of service delivery.

### Recommendation 22: Longitudinal studies

The Australian Government should support meaningful longitudinal studies that align with the research strategy, noting the rich data that such studies provide about the life course of hearing loss.

In this respect, the Australian Government should continue to fund the National Acoustic Laboratories to extend the conduct of the Longitudinal Outcomes of Children with Hearing Impairment (LOCHI) Study.

# Executive summary

## The Independent Review of the Hearing Services Program

The independent Hearing Services Review Expert Panel (Expert Panel) was commissioned by the Australian Government to review its Hearing Services Program and recommend opportunities to improve all aspects of the program's scope and operation. The Expert Panel, comprising Professor Michael Woods and Dr Zena Burgess, examined:

- whether the Hearing Services Program delivers services aligned with clinical need and contemporary service delivery
- how the voucher and hearing device maintenance payment system compares with advances in the manufacturing sector and in product offerings
- how technology is changing the provision of services through the program
- how program services are currently delivered and whether access can be enhanced for vulnerable Australians and in thin markets such as in regional, rural and remote areas.

The deliberations of the Expert Panel were informed by policy papers, previous reviews and audits of the Hearing Services Program, national and international research, and its own analyses of the issues. In December 2020 the Expert Panel sought submissions from, and consulted with, stakeholder groups comprising consumer advocates, program clients, industry (including service providers and hearing device manufacturers), professional associations and academics. Further stakeholder feedback was sought on the Expert Panel's draft report in May-June 2021 and responses were considered when preparing this final report.

## Previous reviews

There have been several previous reviews of all or part of the Hearing Services Program, including the relatively recent *Review of Services and Technology Supply in the Hearing Services Program* undertaken by PricewaterhouseCoopers (PwC) in 2017. However, the current arrangements for delivery of hearing services through the program have remained largely unchanged since its establishment in 1997.

The Expert Panel has conducted an independent review of the Hearing Services Program and provides detailed recommendations to government in this report. The Expert Panel notes that some of its recommendations align with those contained in the PwC report.

## Hearing Services Program objectives

The enabling legislation for the Hearing Services Program provides no statement of purpose for the Hearing Services Program and does not set out specific objectives. While high-level statements about the program are contained in other documentation, they provide only a generalised framework for the program and its funding streams. This lack of clarity of objectives contrasts with the legislation establishing the aged care system and the National Disability Insurance Scheme (NDIS).

The Expert Panel considers that there is a need to explicitly define the objectives of the Hearing Services Program to emphasise the centrality of client outcomes, choice and control; provide clarity and direction for its administration; ensure alignment with contemporary service delivery; enable accountability through the measurement of outcomes; and guide its future reform.

The Expert Panel has proposed a set of draft objectives which are directed to eligible people with hearing loss, contracted service providers, qualified practitioners and program administrators. The Expert Panel recommends that these draft objectives be the subject of further consultation with all relevant stakeholders.

## Eligibility for the Hearing Services Program

To access publicly subsidised services through the Hearing Services Program, a person needs to be in one of the categories of eligible people specified under the *Hearing Services Administration Act 1997*.

Australians who are currently eligible under the broadly based voucher stream of the Hearing Services Program include those holding a Pensioner Concession Card; Department of Veterans' Affairs Veteran Gold Card holders and some Veteran White Card holders and their dependents; current permanent and full-time reservist members of the Australian Defence Force; and those referred by Disability Employment Services under its Disability Management Services program.

Eligible clients under the voucher stream can receive one full hearing assessment (usually inclusive of questions about how their hearing loss is affecting their lives and what their goals might be) and can be offered a hearing device per ear if their hearing loss is above the Minimum Hearing Loss Threshold (MHLT) of 23 decibels. The voucher also covers an annual review of their hearing loss, maintenance and repair services for their hearing device and any adjustment of their device. Clients are also fully or partially covered for a hearing device replacement if the device is lost or damaged beyond repair.

Voucher clients whose level of hearing impairment is assessed as being below the MHLT are not eligible for a subsidised device. However, following their hearing assessment they can receive up to 2 rehabilitation sessions until their next voucher in 5 years.

Those eligible for the Community Service Obligations (CSO) stream include people who are eligible for the voucher stream of the Hearing Services Program but who have complex hearing or communications needs or live in a remote area; Aboriginal and Torres Strait Islander people over the age of 50 years or participants in the Community Development Program; and anyone under the age of 26 years, including NDIS participants.

After considering the perceived confusions about eligibility for some age groups, the Expert Panel recommends that the eligibility definitions for the 2 age cohorts of 21–25 years and over 26 years be clarified. As described above, the CSO stream currently includes infants, children, adolescents and those aged up to 25 (including 'young Australians' aged up to 21 years of age and 'young adults' aged 21–25 years as defined in the *Australian Hearing Services (Declared*

*Hearing Services) Determination 2019)* and voucher-eligible adults with complex needs. The Expert Panel recommends that those aged up to 25 years remain with CSO and be eligible to access services through Hearing Australia.

However, the Expert Panel recommends that adults from 21 years of age should have greater choice of service provider on the following basis:

- adults from 21 to 25 years of age with hearing loss should be able to access hearing services from any Hearing Services Program provider of their choice
- voucher-eligible people from 26 years of age who have complex hearing or communication needs and/or cochlear/bone anchored implants should be able to access appropriate specialist services from any Hearing Services Program provider of their choice.

For all contracted service providers who intend to deliver specialist services to people from 21 years of age who have complex hearing or communication needs and/or cochlear/bone anchored implants, there will be specific requirements. The providers will be asked to demonstrate that their practitioners can support these clients with the capacity, skills and cultural awareness capabilities that meet the clients' needs; and that their service delivery accords with the standards and guidelines developed by the Practitioner Professional Bodies. Hearing Australia would continue to be a provider of these services (it is currently the sole provider of services under the CSO stream).

## Extending the eligibility criteria

The Expert Panel examined the various public benefits, private benefits and costs of extending the categories of eligibility for the Hearing Services Program to additional groups of people with hearing loss. Following analysis, the 3 groups identified as having high-priority net benefits are Low Income Health Care Card holders from 26 years of age until Age Pension eligibility age, all Aboriginal and Torres Strait Islander peoples, and permanent residents of aged care homes.

The Expert Panel also noted the opportunity provided by Medicare billing arrangements to encourage general practitioners (GPs) to undertake awareness raising of hearing health. The Expert Panel recommends that, where considered warranted by the patient and GP, there be a referral for a full diagnostic hearing assessment for claimable assessments. This would apply to those aged 75 years and older, 45–49 year-olds who are at risk of developing chronic disease, permanent residents of aged care homes, people with an intellectual disability, refugees and other humanitarian entrants, and Aboriginal and Torres Strait Islander people (children and adults).

## The client experience and need for support

The Expert Panel notes the importance of client choice and control as an underpinning principle of all health care. It advises that, to the extent possible, people with hearing loss should be able to make choices about the hearing health services they receive and the contracted service providers they choose to use, and they should have control over how those services are provided. This has been a recurring theme in earlier reviews and parliamentary inquiries.

For client choice to have meaning, people must have knowledge and understanding of the available options and the consequences of choosing them. This requires that people have timely and reliable information in an easily understood and accessible format before they make those decisions.

The client journey often begins at the Hearing Services Program website. The Expert Panel recommends that there be a range of illustrative client service pathways on the website which clearly show the options for clients who may be eligible for hearing services now or in the future. This should be further developed to direct clients to various service options through the relevant entry points for registration under the program.

The options should particularly address the needs of children and young people, Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, people living in rural and remote locations, and adults with complex hearing needs, as well as the broader community of people with hearing loss. The service pathways should also assist people who are not eligible for the publicly funded subsidies under the program but are seeking help with managing their hearing loss. The Expert Panel considers that further stakeholder engagement, through public consultation, on the recommendations of this report will help develop optimum pathways.

Stakeholder submissions and research evidence demonstrate that when people use decision aids they improve their knowledge of the options and feel better informed and clearer about what matters most to them. On this basis, the Expert Panel recommends the development and application of decision aids on the program website. Additionally, the website could continue to be upgraded to make it easier to navigate and also include more information to support consumer decision-making.

A particular priority for the Expert Panel has been to seek input from consumers and organisations that represent clients' interests. Consumer organisations are very supportive of the Hearing Services Program and believe it makes a significant difference to people's lives. Similarly, families generally do not want to see changes to existing arrangements, where Hearing Australia is the sole CSO provider for children's services. The Expert Panel recommends that the Department of Health establish a permanent hearing services consumer consultation forum with relevant consumers and their representative organisations. Such a forum would facilitate information exchange; enable the provision of advice on improving the equitable, effective, efficient and sustainable functioning of the Hearing Services Program and associated hearing activities; and explore ways to increase the opportunities for consumer advocacy groups and organisations to assist people with hearing loss. This would not preclude opportunities for the broader range of stakeholders to provide input into improving the operation of the program.

The Expert Panel found that hearing impairment, hearing care help-seeking and hearing health care provision are complex and multifactorial. Current interventions by a number of program contracted service providers are focused on the supply and fitting of hearing devices, recognising that devices are often integral to helping with hearing loss. A related issue is that the assessment of the hearing loss of voucher clients relies primarily on the use of pure tone audiometry. Recent evidence, including from the World Health Organization, indicates that this should not be the sole method of understanding the holistic needs of people with hearing loss or as the indicator of appropriate interventions. Even where a hearing device is warranted, evidence suggests that positive outcomes from their use depend on client readiness, motivation and support and not solely on the level of hearing loss. The Expert Panel also noted that it is difficult to obtain a full picture of the uptake of rehabilitation options within the Hearing Services Program, as this component of care is often billed as part of other services, such as fittings and maintenance items.

A concern that consumer groups commonly express is that there is minimal use of additional support services – separate from any fitting of a hearing device – as part of the overall package of hearing health care made available to clients. This is despite stakeholder support for this approach. Having examined the evidence, the Expert Panel recommends that the scope of the program be more clearly defined to include a holistic assessment of client needs and their communication requirements, lifestyle and life circumstances, as well as any psychosocial needs. There should be a specific requirement under the program for the delivery of rehabilitation, communication and education services during several stages within the overall support available to all clients, irrespective of whether, or by whom, a hearing device has been fitted.

A review of the current Schedule of Service Items and Fees (Services Schedule) was outside the scope of this review but is strongly recommended by the Expert Panel. This review is needed to ensure that the Services Schedule includes items with a strong focus on communication and education support, and rehabilitation, and that those items are appropriately remunerated. The Services Schedule review should also assess whether there is a need to rebalance the fees—for example, if there is an unintended bias in profit margins which favours hearing devices ahead of providing rehabilitation services.

The Expert Panel noted that the COVID-19 pandemic has had an impact on the face-to-face delivery of services through the Hearing Services Program. Changes to the program have included the use of teleaudiology for some clinical appointments, a relaxation of the rules to allow verbal client consent for services, and the provision of hearing services at temporary business sites and home visits. The Expert Panel heard that the ongoing provision of flexible modalities for service delivery, such as teleaudiology and settings-based service delivery models, will be welcomed by some clients (including those in residential aged care) but that the alternative modalities are not well suited to all services and they do not meet the needs of all clients. The Expert Panel considers that these more flexible options for service delivery should continue to be available where they are clinically appropriate and suitable for client preferences, circumstances and capability. This view was supported by feedback received on the Expert Panel's draft report.

The positive client experience of the program described above is tempered by evidence that over 60% of people who are currently eligible for its services are not engaged with the program. In particular, there is significant under-representation of some eligible populations that face specific barriers to accessing those services.

Given the increased risk and incidence of ear health problems among Aboriginal and Torres Strait Islander peoples, it is a concern that they are under-represented in the CSO stream and that they find it difficult to access culturally appropriate hearing services across the entire Hearing Services Program. The Expert Panel has recommended a co-design approach to developing culturally safe and accessible hearing health services – in a way that maximises opportunities for collaboration with the Aboriginal Community Controlled Health Sector. The National Aboriginal Community Controlled Health Organisation (NACCHO) highlighted its support for this approach, noting that it must align with the broader Closing the Gap initiatives.

The Expert Panel found that there are other high-priority populations that experience additional challenges in accessing hearing health services. These barriers should be addressed with a view to improving their access to the program. The high-priority populations include people from culturally and linguistically diverse backgrounds; people living in regional, rural and remote communities; residents of aged care homes; and older people in general.

The Expert Panel acknowledges the Australian Government's response to the final report of the Royal Commission into Aged Care Quality and Safety, which contained recommendations for access to allied health services that had implications for the hearing health support for residents of aged care homes; and the work currently being undertaken through the 2019 *Roadmap for Hearing Health* to address access for these groups. The Expert Panel has endorsed those initiatives, including the enhancement of sector workforce capacity. Again, a co-design approach is recommended, especially for culturally and linguistically diverse communities.

## Contemporary service delivery

Client choice of a contracted service provider can affect what services they are offered (such as education and counselling and/or a hearing device), how services are offered and the quality of services they receive. It probably even determines the range and brands of hearing devices recommended to them. However, provider decisions on these matters can be shaped by corporate concerns such as vertical integration with hearing device manufacturers rather than by the comprehensive communication and education needs of clients based on the principle of informed choice and control over their management of hearing loss.

A related issue is that, under the voucher stream, a client may either choose a fully subsidised hearing device or use their voucher to contribute to the cost of a partially subsidised hearing device and pay the additional amount themselves. This may be creating a perverse incentive for contracted service providers to market the more expensive, partially subsidised hearing devices. The Expert Panel considers there is a need for increased transparency and accessibility of information to consumers across all aspects of the program, including by contracted service providers publishing additional information on the range and function of available hearing devices; pricing of partially subsidised hearing devices; qualifications and accreditation details of contracted service providers and/or practitioners; and how clients can provide feedback on service experience and outcomes.

The Expert Panel has noted that continual technological advances in hearing health care are shaping consumer demand and contracted service provider offerings to clients but considers that the program Services Schedule may not be keeping pace with these advances. In addition to the review of the Services Schedule proposed earlier, there is an opportunity to review and update the minimum specifications of fully subsidised devices and review all program technologies, with input and advice from the broad range of stakeholders. These reviews are interlinked and could be conducted under a single governance structure.

## Hearing Services Program administration

There is a complex legislative, contractual and policy framework underpinning the delivery of services through the Hearing Services Program. While positive steps have been taken to simplify the regulatory framework for the program, there is agreement that further work is needed.

Most stakeholders who responded to the *Hearing Services Program Review consultation paper* suggested amendments to the current service delivery model rather than broader reform. Nevertheless, the Expert Panel considers that there are opportunities to implement changes to the current administration of the program to ensure that its objectives are being met; the contracted service providers, workforce and suppliers are appropriately regulated; the program demonstrates value for money; and the program has the flexibility to adapt to emerging trends.



As mentioned above, there are no legislated Hearing Services Program objectives. In addition, there are no clearly described client clinical outcomes or standardised client outcome measures for contracted service providers or any defined program-level outcomes or associated measures or processes in place to monitor and evaluate these. A more strategic and comprehensive collection, analysis and reporting of client-centred data within the program is a necessary part of continual improvement of the program into the future. The data collections that are currently available are inadequate for this task.

The Expert Panel recommends that the Australian Government develop and invest in a Hearing Services Program monitoring and evaluation framework that supports the monitoring of the program's achievement of its objectives. This framework should address improvement to client clinical outcome measurement (hearing and non-hearing); qualitative and quantitative program outcome measurement, including client reported experience measures; measurement of the impact on administration of regulatory and program changes; better use of the Hearing Service Online (HSO) portal to capture and analyse data; and ensuring clients can access their audiological records and assessment reports.

The Expert Panel also notes the value of establishing a national hearing health database and has recommended, as a minimum, that the Australian, state and territory governments implement a national digital database of hearing screening of infants and children.

## Research

The Expert Panel acknowledges that the 2019 *Roadmap for Hearing Health* and various parliamentary inquiries have provided suggestions for future research and that the Australian Government is supporting the Roadmap's research recommendations through its \$7.3 million investment in research, which will improve evidence to support better hearing outcomes.

The Expert Panel has identified further research opportunities - for example, research on service delivery models, clinical and program outcomes and their measurement tools; and program evaluation research. Importantly, though, what is missing is a strategic approach to considering and planning for research. The Expert Panel considers it critical that a research strategy for hearing health and hearing loss is developed in consultation with stakeholders and then published on the Hearing Services Program website. A guiding principle should be that research is co-designed with relevant population cohorts and that those groups of people be involved in the conduct of the research, in its analysis and in the dissemination of research findings. Research funded through the Hearing Services Program also needs to have a more strategic approach, aligning with this broader research strategy.

Furthermore, noting the rich data that longitudinal studies provide about the life course of hearing impairment, the Expert Panel recommends that the Australian Government support meaningful longitudinal studies that align with the research strategy - in particular, funding the extension of the Longitudinal Outcomes of Children with Hearing Impairment (LOCHI) Study conducted by the National Acoustic Laboratories.

# Chapter 1

## Introduction

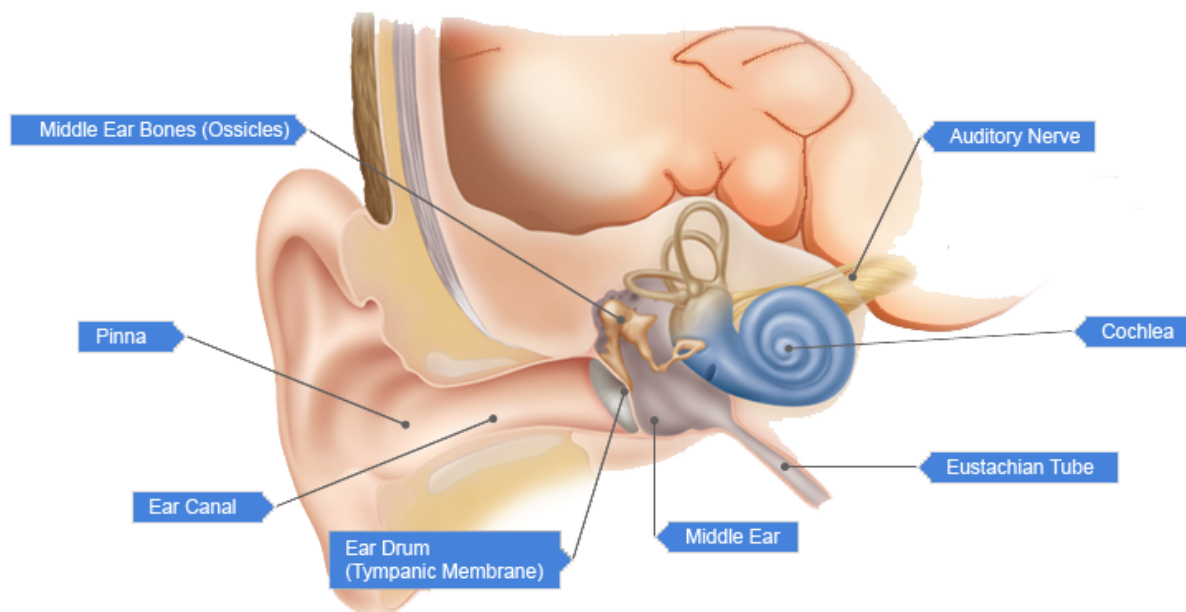
### Hearing loss prevalence in Australia

Hearing loss can have a significant impact on a person's ability to communicate, be aware of and enjoy their environment, and function fully across most parts of their life. Hearing loss is a chronic health condition experienced by approximately 1 in 6 Australian adults, and this number is expected to increase to 1 in 4 Australian adults by 2050 as a consequence of demographic ageing.(1) In Australia, hearing loss is more prevalent for those over 60 years of age and more than half of this population group experiences some form of hearing impairment (and this is likely to be an under-representation of the actual incidence).(2)

## How hearing works

The ear is divided into 3 parts and each plays a role in how hearing works (see Figure 1).

**Figure 1:** How hearing works



The 3 parts are as follows:

- The outer ear captures and concentrates the sounds we hear and channels them into the middle ear. It is made up of 2 parts:
  - the pinna - a soft and flexible tissue that makes up most of the visible ear. It plays an important role in shaping the sound to help the brain work out the direction from which sounds are coming
  - the ear canal - the physical pathway that directs sound into the middle ear.
- The **middle ear** is made up of the tympanic membrane (or eardrum), which vibrates due to differences in pressure caused by soundwaves, and 3 small, interconnected bones called the ossicles, which vibrate with the eardrum.
- The **inner ear** includes the cochlea, which converts mechanical sound vibrations into nerve signals that are then transmitted to the auditory nerve. The auditory nerve passes through several parts of the brainstem and on to the auditory cortex in the brain, where the information contained in the sound can be interpreted and understood.(3)

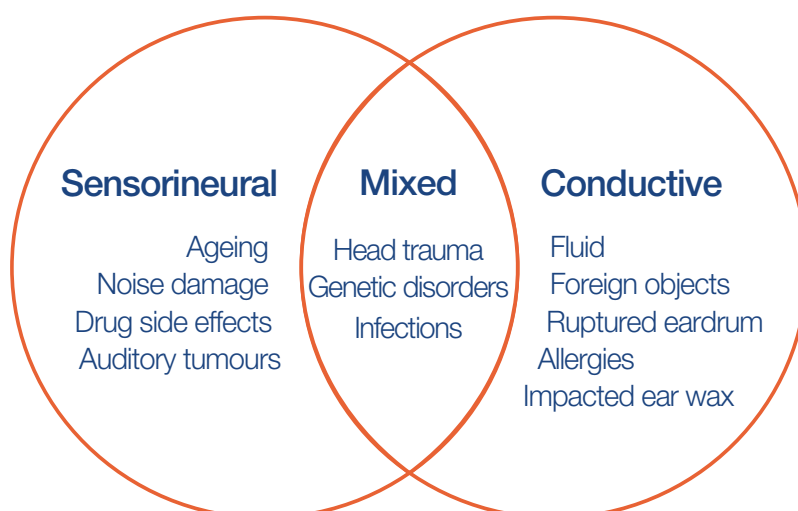
## Types of hearing loss

Hearing loss can be portrayed on a spectrum. At one end of the spectrum, mild hearing loss usually means that there are some minor hearing difficulties in some situations. At the other end of the spectrum, profound hearing loss means that the person cannot hear any sounds without an amplification device such as a hearing device or cochlear implant.

Hearing loss can be categorised as either 'acquired', meaning it occurs due to age, a disease process or injury; or 'congenital', meaning it occurred or was identified at birth. As Figure 2 describes, under each of these categories hearing loss can occur when there is:

- a problem in the inner ear or with the auditory nerve (sensorineural) which disturbs the sound signals being sent to the brain for understanding. It is most often associated with ageing or noise-induced damage
- a problem in the outer or middle ear (conductive) which stops the sounds reaching the hearing nerve, mostly affecting the loudness of the sound. Conductive hearing loss is usually caused by a blockage in the outer ear or poor functioning of the middle ear bones (often seen with ear infections)
- a problem with sound travelling through both the middle ear and the inner ear (mixed hearing loss).

**Figure 2:** Causes of hearing loss  
(Adapted from: <https://www.healthyhearing.com/help/hearing-loss/types>)



Hearing loss can also occur as a consequence of a number of medical conditions, including otitis media (an inflammation of the middle ear); Menière's disease (an inner ear disorder that can affect both hearing and balance); central auditory processing disorder (a central nervous system disorder that disrupts the processing of sound); and tinnitus (where a person experiences a ringing or similar sound in the ears).

## Preventing hearing loss

Hearing loss is an irreversible health condition. Prevention is the most effective way to reduce the future incidence of hearing loss and tinnitus. Exposure to excessive noise is a cause of approximately one-third of adult onset hearing loss.

Early identification of hearing loss, when followed by timely and appropriate management, can effectively reduce the impact that hearing loss has on a person's ability to live their life and fully

engage with their family, friends and community (secondary prevention). Neonatal and infant hearing screening programs are an effective strategy for early intervention in cases of congenital and early onset hearing loss.(4) Hearing rehabilitation services and interventions (such as providing communication strategies and/or hearing devices) may be necessary where hearing loss has progressed.

## The impacts of hearing loss

Hearing loss is an immensely personal experience that can have a significant impact on a person's life. It also affects partners, family, friends, co-workers and others with whom the person communicates. The effects can differ between children and adults but can also overlap.

A child with hearing loss will have difficulty developing speech and language and may also have other issues. These can have a detrimental effect on the child's education (poor performance and attendance), which may then lead to poorer long-term quality of life outcomes.

An adult with hearing loss may have difficulties with communication, lifelong learning and being able to fully function in home, social and work settings. Their ability to earn an income may be reduced and they may experience or perceive stigmatisation. Hearing loss can affect a person's mental wellbeing and overall quality of life. There is some emerging evidence indicating a higher risk of cognitive decline or dementia in people with hearing loss.(5,6)

The Hearing Care Industry Association, with assistance from Deloitte Access Economics, estimated that the costs of hearing loss in the 2019–20 financial year in Australia were as high as \$20.0 billion. The paper stated that this comprised:

- health system costs of approximately \$1.0 billion
- productivity losses of \$16.2 billion
- informal care costs of \$174.7 million
- deadweight losses of \$1.9 billion
- other financial costs of \$683.4 million.(7)

## Introduction to the Hearing Services Program

### Context of the Hearing Services Program within the health sector

The aim of the Australian Government's Hearing Services Program is to assist people with hearing loss to maximise their potential for independent communication and improve their quality of life by facilitating access to high-quality hearing services and devices; and reduce the consequences of hearing loss in the Australian community. There is a particular focus on improving accessibility for the most vulnerable Australians. In establishing the current program, the Australian Government stated:

*[The Hearing Services Program] provides for assessment of hearing impairment and rehabilitation programs for non-medical problems. Rehabilitation usually consists of fitting a hearing aid or aids and assisting clients to fully utilise the aids and develop other techniques to improve their capacity for communication. Treatment for medical conditions that impair hearing are outside the scope of the program and training for signing and speech reading are not provided ... (8)*

For the community as a whole, there is a range of ways to access hearing health care, including through private providers and government programs as detailed below:

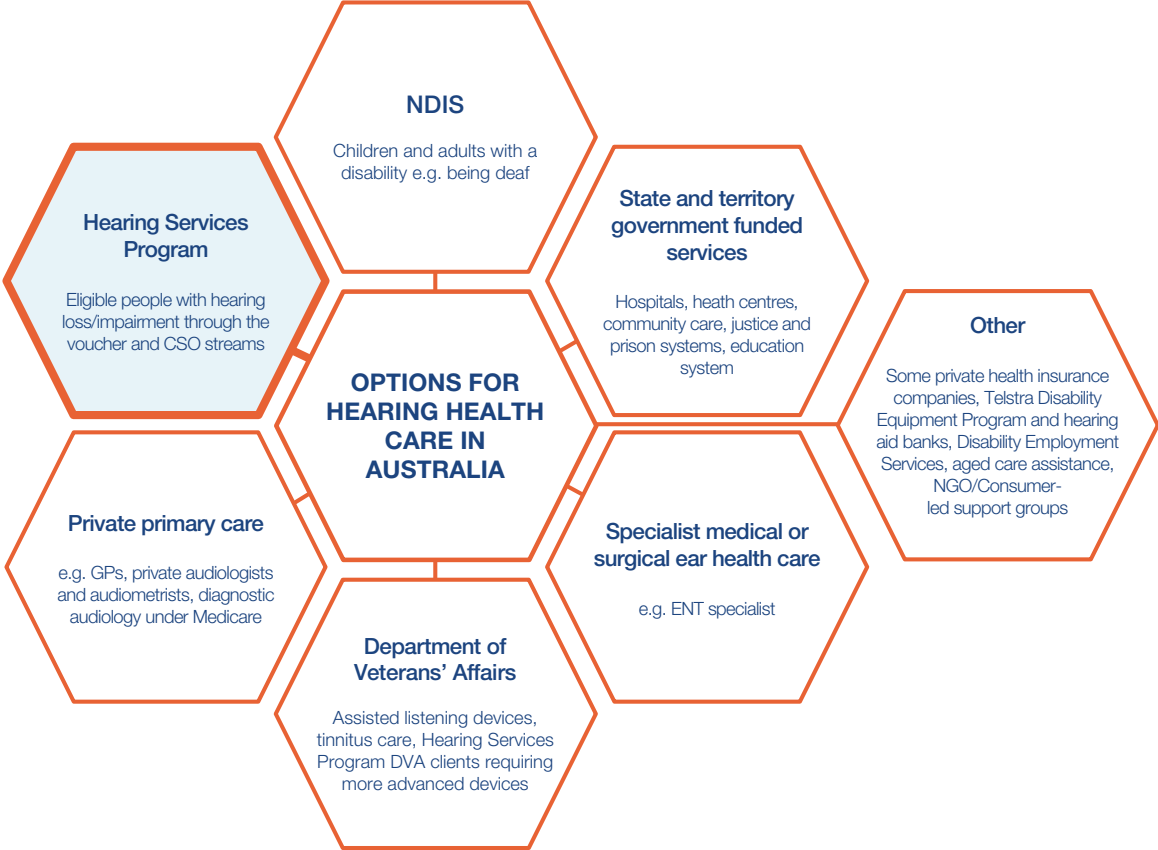
- State and territory governments are significant providers of primary, secondary and tertiary hearing health care. They are responsible for hearing health across the domains of health, justice, education, workplace noise and the hearing health workforce. Examples of where services are provided are hospitals, health centres, community care, schools and prisons. Clinicians include audiologists, audiometrists and Ear Nose and Throat (ENT) specialists.
- Private primary care services include clinical audiology and audiometry and ear health care (for example, wax removal). Where the client is referred by a general practitioner (GP) or ENT, some of these are supported by Medicare.<sup>(9)</sup> Other general health assessment checks funded through Medicare – such as those that focus on chronic disease, eye health and oral health – do not include ear and hearing checks.
- ENT services are provided through private health services (Medicare supported) and state and territory health services (that is, public hospitals).
- Some private health insurers offer audiology services and hearing devices under their ‘extras’ products.
- The National Disability Insurance Scheme (NDIS) supports people with disability in Australia, including those with profound hearing loss. It is available to:
  - children under 7 years of age, for whom it funds additional supports such as early childhood intervention or other assistive technology that is not funded under the Hearing Services Program
  - those over 7 years of age, for whom it funds reasonable and necessary hearing supports that are not available through the Hearing Services Program.<sup>(10)</sup>

People with hearing loss can access the NDIS and the Hearing Services Program at the same time. However, they cannot get the same supports from both programs at the same time.

- The Department of Veterans’ Affairs (DVA) provides additional hearing supports for eligible DVA clients with a Veteran Gold Card or a Veteran White Card (for those with accepted conditions of hearing loss and/or tinnitus). The additional supports include access to Assistive Listening Devices (ALDs) and ALD repairs, parts and replacements, all at no cost to DVA clients. Also at no cost to eligible veterans, the DVA Tinnitus Program funds support, equipment and treatment for eligible DVA Veteran Gold Card or Veteran White Card holders who have tinnitus as an accepted condition. Specialised hearing devices with tinnitus settings, sleeping aids, tinnitus counselling and scientifically validated audiologist treatment can be provided under the DVA Tinnitus Program.
- Hearing aid banks (run by volunteers) are available for people who are ineligible for the Hearing Services Program and are unable to afford hearing care. They may be able to have a hearing aid device fitted at a reduced cost. Hearing aid banks, which are available in most states and territories, recondition donated hearing devices and distribute them according to their eligibility criteria.
- The Telstra Disability Equipment Program offers assistance to people whose hearing loss affects their ability to use a standard telephone handset.<sup>(11)</sup>

**Figure 3** depicts the different ways that Australians can seek hearing health care. It shows that the Hearing Services Program is a small but critical element of the hearing health system.

**Figure 3:** Avenues for accessing hearing health care in Australia



CSO: Community Service Obligations; ENT: ear, nose and throat; GP: general practitioner; NDIS: National Disability Insurance Scheme; DEP: Disability Employment Program; NGO: non-government organisation.

### The two streams of the Hearing Services Program

The Hearing Services Program was established by the *Hearing Services Administration Act 1997* to provide access to high-quality hearing services and devices.<sup>(12)</sup> The program also funds research on strategies to prevent hearing loss or lessen its impact.

Program services are delivered through 2 streams:

- The **voucher stream** delivers subsidised hearing services to holders of an Australian Government concession card, specifically:
  - Pensioner Concession Card holders, including Age Pension, Carer Payment, JobSeeker Payment recipients (if partially able to work, or single with a dependent child), Disability Support Pension, Parenting Payment (if single), and Youth Allowance (if single, looking for work and caring for dependents). It excludes Commonwealth Seniors Health Card holders
  - members of the Australian Defence Force
  - people referred by the Disability Employment Services Program
  - DVA Veteran Gold Card holders and Veteran White Card holders (where the card is issued for hearing loss).

The voucher stream services are delivered by approximately 300 contracted private service providers as well as Hearing Australia (a statutory authority established under the *Australian Hearing Services Act 1991*).

- The **Community Service Obligations (CSO)** stream delivers subsidised hearing services to population cohorts with specific needs, including all children and young adults up to the age of 26 years; adults with specialist hearing needs; and Aboriginal and Torres Strait Islander people over the age of 50 or who live in a remote location or have participated in a particular work scheme such as the Community Development Program.(13)

Hearing Australia is the exclusive provider of hearing services to CSO clients.

Following a full diagnostic hearing assessment, eligible people who have a hearing loss over a set threshold are offered hearing services without cost or charge (up to a preset limit), including hearing rehabilitation, hearing devices, annual hearing check-ups and advice on hearing loss prevention.

## Total Hearing Services Program expenditure

The Hearing Services Program is demand-driven within the eligibility criteria (meaning that there is no monetary cap on how much government funding is contributed to the program as long as eligibility is met by each client). In the 2019–20 financial year, the program provided 1,607,286 services to 821,726 clients with mild or greater level of hearing loss (primarily through the voucher stream) at a cost of \$531.655 million. Table 1 provides a summary of costs.(14) A more detailed breakdown of services and costs for eligible voucher and CSO categories is set out in **Chapter 3**. Research activity under the program is examined in **Chapter 7**.

**TABLE 1:** Breakdown of Hearing Services Program costs for the 2019–20 financial year

Active clients by eligibility	Number	Expenditure \$
Voucher stream	751,052	451,791,000
CSO stream (15)	70,674	79,864,000
<b>Total</b>	<b>821,726</b>	<b>531,655,000</b>

Source: Department of Health annual report 2019–20 (14), Hearing Australia CSO quarterly report 2019–20 (15).

## Implementation of some Australian Government Roadmap for Hearing Health initiatives

As well as the Hearing Services Program – and the hearing health service delivery models outlined above – there are several initiatives that the Australian Government is funding which aim to minimise the impact of hearing loss and prevent hearing loss.

From October 2020 the Government is investing \$21.2 million over 5 years to implement key initiatives from the *Roadmap for Hearing Health* (the Roadmap).(4) This investment aims to increase public awareness of hearing health, generate scientific evidence through research, and support vulnerable Australians who are most likely to need hearing loss support.



The Roadmap package comprises:

- \$5 million for a national hearing health awareness and prevention campaign
- \$7.3 million for a program of research to develop a sound evidence base for effective treatment, service delivery and prevention of hearing loss
- \$5 million for early identification of, and improvements in overcoming, hearing and speech difficulties for Aboriginal and Torres Strait Islander children
- \$2 million for initiatives in the aged care sector to improve the capability of the aged care workforce to support people with hearing loss
- \$350,000 for development and adoption of new teleaudiology standards for hearing services
- \$190,000 to support rural service delivery through a workforce audit and a rural hearing workforce summit
- \$1.4 million for the government to implement this package.

## The impact of disasters on the delivery of health care programs

Australia has always experienced natural disasters such as floods, bushfires and (at times) earthquakes – usually at a local or regional level. In the past we have also experienced pandemics, such as the Spanish influenza, Avian influenza and H1N1. The last 2 years have seen a ‘perfect storm’ of natural disasters and the COVID-19 pandemic, with impacts on service delivery across a range of services. Some impacts have been region-specific, while others have been felt at state or national level. The extended time frame and range for the COVID-19 pandemic has changed the rules in terms of how health care providers provide services, including increased opportunities for remote models of practice (16) but also the potential for service disruption with very little notice due to public health responses to local outbreaks.

More severe and prolonged weather events and further pandemics have been predicted to occur in the future.(17) This may well be the ‘new normal’ and raises important questions about how to build adaptation and flexibility into program planning – to enable a ‘business as usual’ approach to disaster preparation, response and recovery rather than responding to each individual adverse event.

## Context and conduct of the review of the Hearing Services Program

In the 2 decades since the establishment of the Hearing Services Program in 1997, the hearing health sector has grown in scope and scale. Developments in hearing technology and changes to retail service delivery mean that people accessing hearing health care services (herein referred to as clients) have more choice than ever in both service delivery options and hearing devices. A greater focus on early detection and intervention, particularly among vulnerable client groups, as well as the ageing of Australia’s population, is expected to continue to increase the demand for hearing services.

In addition to these developments there have been several reviews of aspects of the Hearing Services Program, including those conducted by Access Economics (2006), the Australian Competition and Consumer Commission (2017) and PricewaterhouseCoopers Australia (2017). These and other reviews are described in **Appendix A**.

Notwithstanding these developments and reviews, the current arrangements for delivery of hearing services through the Hearing Services Program have remained largely unchanged since its establishment in 1997. The Expert Panel has conducted the Independent Review of the Hearing Services Program and has developed detailed recommendations to government in this report.

## Terms of reference of the review of the Hearing Services Program

The Australian Government has stated that it is committed to improving and refining the support it offers Australians who suffer from hearing loss to enable them to reach their potential and live life to the fullest. As part of that commitment, on 14 August 2020 the Hon Mark Coulton, the then Minister for Regional Health, Regional Communications and Local Government, announced the review of the Hearing Services Program.

In accordance with the Minister's request, this review has examined:

- whether the Hearing Services Program delivers services aligned with clinical need and contemporary service delivery
- how the voucher and hearing device maintenance payment system compares with advances in the manufacturing sector and product offering
- how technology is changing the provision of services through the Hearing Services Program
- how program services are currently delivered and whether access can be enhanced for vulnerable Australians and in thin markets, such as those in regional, rural and remote areas.

The review has included consideration of but was not limited to:

- the needs and experiences of clients
- professional standards developed by the hearing sector
- interactions between the Hearing Services Program and other government programs
- the sensitivity of changes to the Hearing Services Program to established business models in the sector
- impacts of the COVID-19 pandemic on service provision
- outcomes from any previous inquiries and consultations.

The review identifies opportunities to:

- improve access to hearing services for low income earners; vulnerable Australians; those over 65 years of age; and those living in regional, rural and remote areas
- refine the current voucher and maintenance payment system
- improve program design, including compliance and oversight
- implement new targeted initiatives that encourage the provision of services in thin markets and the development of alternative service delivery channels.

## The Hearing Services Program Review Expert Panel

The Expert Panel was established in July 2020 and has met regularly since then. Its members are:

- **Professor Michael Woods**—a Professor of Health Economics at the Centre for Health Economics Research and Evaluation (CHERE) at the University of Technology Sydney. Professor Woods was previously Deputy Chair of the Productivity Commission and presiding commissioner on over 20 national inquiries in the fields of health, aged care and other sectors of the economy. He has conducted reviews for the Council of Australian Governments (COAG) Health Council, the Department of Health and peak bodies.
- **Dr Zena Burgess**—a doctor of psychology and a registered clinical and organisational psychologist. Dr Burgess has a Masters of Business Administration and Education and has delivered frontline services to urban and regional communities for over 2 decades. For over a decade she was the CEO of the Royal Australian College of General Practitioners and is currently CEO of the Australian Psychological Society.

The Department of Health has provided secretariat services to the Expert Panel, including providing support for extensive stakeholder consultations, undertaking in-depth research and carrying out detailed data analysis.

## Conduct of the review of the Hearing Services Program

In accordance with the terms of reference, the Expert Panel has undertaken a review of the Hearing Services Program and has investigated and identified potential reforms. The Expert Panel has focused on optimising outcomes for the program's clients; improving the equity, effectiveness, efficiency and sustainability of service delivery; ensuring good governance; and modernising key components of the program in the context of changes in policy, markets and technological developments.

During the review the Expert Panel considered a series of policy papers and previous reviews, inquiries and audits of the program (see **Appendix A**), as well as national and international research. It sought submissions from, and consulted with, stakeholder groups, including industry (for example, service providers and hearing device manufacturers), consumer advocate groups and clients, professional associations and academics. A list of stakeholders who contributed views or submissions on the Hearing Services Program for this review is provided at **Appendix E**.

## Hearing Services Program Review consultation paper

The Hearing Services Program Review consultation paper (18) was released on 30 October 2020, to prompt discussion on key areas that could inform the program's modernisation. Submissions were sought from interested stakeholders up until 4 December 2020. These submissions were considered by the Expert Panel. Where requested by either the stakeholder or the Expert Panel, virtual one-on-one discussions took place with the stakeholder. The Hearing Services Program Review consultation paper asked 10 questions of stakeholders:

1. What should be the objectives and scope of the Hearing Services Program?
2. Who should be eligible for Program subsidies?
3. How well does this Program Interface with other schemes?
4. Does the Hearing Services Program sufficiently support hearing loss prevention?

5. Are the Hearing Services Program's assessment services and rehabilitation activities meeting client needs?
6. Is the Hearing Services Program supportive of client choice and control?
7. Are the Hearing Services Program's service delivery models making best use of technological developments and services?
8. Does the Hearing Services Program sufficiently support clients in thin markets?
9. Are there opportunities to improve the administration of the Hearing Services Program?
10. Does the Hearing Services Program effectively make use of data and information to inform decision-making?

## Interim Advice to the Australian Government on changes to the Hearing Services Program

On 6 October 2020, as part of the federal Budget, the Australian Government announced changes to the Hearing Services Program voucher stream. The changes related to the voucher period, the 12-month warranty period maintenance payment, and the timing of the maintenance payments.

The Minister requested that the Expert Panel provide interim advice to the government on the impact of the implementation of these changes to the Hearing Services Program.

On 4 December 2020 the Expert Panel released their Hearing Services Program Review *Interim Advice to government – Implementation of Hearing Services Program changes* (Interim Advice), seeking any feedback from stakeholders by 18 January 2021. Following consideration of the stakeholder responses, the Expert Panel provided their final Interim Advice to the Minister on 25 February 2021.(19)

## Consultation on the review of the Hearing Services Program draft report

On 21 May 2021 the draft report of the Independent Review of the Hearing Services Program was released for public consultation. The draft report set out the Expert Panel's proposed advice to the Australian Government on future Hearing Services Program settings to support hearing-impaired Australians and to ensure appropriate access to program services.

As part of the consultation process, interested parties were invited to attend one of 4 virtual information sessions, during which the Expert Panel presented an overview of the draft report and recommendations and gave an opportunity for stakeholders to ask questions. Interested stakeholders were also invited to submit a written submission in response to the draft report and its recommendations by 24 June 2021.

About 60 individuals attended the virtual information sessions and 31 written submissions were received from stakeholder groups and individuals.

## Next steps – implementation of the outcomes of this review

Now that this report has been presented to the Hon Dr David Gillespie MP, Minister for Regional Health, the Expert Panel understands that the government will consider the recommendations of the review and respond accordingly.

The Expert Panel recognises that some of the recommendations from this review would be relatively simple to implement. However, the Expert Panel also acknowledges that other recommendations, as has been the case with prior reviews, are more complex and in some cases involve changes to existing legislation and/or collaboration with other jurisdictions. For some, the government will need to give thorough consideration to fiscal impacts (particularly the estimated annual cost increases of the program arising from the recommendations surrounding expansion of eligibility). Many recommendations which are likely to have a significant impact on consumers, the professional workforce and industry would require further stakeholder consultation to ensure successful implementation.

Nevertheless, it is the view of the Expert Panel that these challenges are part of the opportunity for change and can be addressed through a well-constructed reform implementation plan. The Expert Panel encourages stakeholders to engage in future consultation with the Government around the implementation of the recommendations of this review.

## Structure of this report

The remaining chapters of this report are as follows:

**Chapter 2** - Defining the objectives of the Hearing Services Program

**Chapter 3** - Eligibility requirements for support under the Hearing Services Program

**Chapter 4** - Improving the client experience and assessing need for support

**Chapter 5** - Contemporary service delivery

**Chapter 6** - Program design and administration

**Chapter 7** - Hearing health and hearing loss research

**Appendix A** - History of reviews related to the Hearing Services Program and broader hearing health

**Appendix B** - Hearing devices available through the Hearing Services Program

**Appendix C** - Better practice regulation – legislative and regulatory changes since 2019

**Appendix D** - Program administration – details

**Appendix E** - Stakeholders who contributed to the review of the Hearing Services Program

**Appendix F** - Abbreviations used in this report

**Appendix G** - Glossary of terms used in this report

# Chapter 2

## Defining the objectives of the Hearing Services Program

### KEY POINTS

- The enabling legislation for the Hearing Services Program provides no statement of purpose for the program or specific objectives. This lack of clarity contrasts with the legislation establishing aged care and the National Disability Insurance Scheme.
- The high-level statements of objectives of the program which are contained in other documentation provide only a generalised framework for the program and its funding streams.
- There is a need to explicitly define the objectives of the Hearing Services Program to emphasise the centrality of client outcomes, choice and control; provide clarity and direction for its administration; ensure alignment with contemporary service delivery; facilitate accountability through the measurement and reporting of outcomes; and guide its future reform.
- A set of more defined program objectives is presented in this chapter for further consultation.

# Current objectives of the Hearing Services Program

The enabling legislation for the Hearing Services Program does not currently provide any guidance on its objectives. The *Hearing Services Administration Act 1997* sets out the categories of eligible persons under the voucher stream and associated prescribed services but does not identify the objectives of that stream of public funding. Similarly, the *Australian Hearing Services Act 1991* provides for the delivery of declared services to Community Service Obligations (CSO) clients by Hearing Australia, as well as the conduct of research, but it does not define the objectives.

Some statements relating to the objectives of the current program can be found in several key documents. The Department of Health website summarises the main objective of the Hearing Services Program as being 'to work towards reducing the incidence and consequences of avoidable hearing loss in the Australian community by providing access to high quality hearing services and devices'.<sup>(12)</sup>

The Portfolio Budget Statements for the Department of Health refer to the management of hearing loss and also to the conduct of research in its reporting of the Hearing Services Program objective:

*Provide hearing services and a range of fully and partially subsidised hearing devices to eligible Australians to help manage their hearing loss and improve engagement with the community. Continue support for hearing research, with a focus on ways to reduce the impact of hearing loss and the incidence and consequence of avoidable hearing loss.*<sup>(20)</sup>

In essence, the Hearing Services Program currently has 3 broad activities which aim to:

- mitigate the impact of hearing loss in the community by providing equitable access to hearing services (voucher stream)
- mitigate the impact of hearing loss for those needing specialist support, such as all children and young people; specific groups of Aboriginal and Torres Strait Islander peoples; and adults with complex needs (currently provided through the CSO stream)
- support research which contributes to evidence-based approaches to improving hearing health for Australians.

Although the website and the Portfolio Budget Statements guide the Australian Government's funding and administration of the Hearing Services Program, they do not provide guidance on the intended client and service level outcomes. This lack of definition has led to a program which measures transaction-level inputs and outputs but not client-focused outcomes or any measurement of those outcomes. In parallel, intended or otherwise, the program has become focused on the provision of hearing devices rather than on assistance with communication and social engagement.

Effective and measurable program objectives are the foundation of any program management and evaluation. The Australian National Audit Office reports that good performance management is underpinned by clear objectives and states that:

*Performance information is clearly linked to the objectives and intended results of programs and activities, and enables a ready assessment of program performance in terms of effectiveness, efficiency, and service quality.*<sup>(21)</sup>

The Hearing Services Program has seen several different reviews focused on specific issues (for example, technology supply). Notwithstanding these developments and reviews, the current arrangements for delivery of hearing services through the Hearing Services Program have remained largely unchanged since its establishment in 1997. This review has identified that the program objectives are poorly defined and do not support contemporary service delivery or performance monitoring. A 2018 Department of Health program assurance review identified a need for improved program governance documentation, including a program logic, governance structures, roles and responsibilities, and overall program risk management.(22) This was supported by the 2020 internal report, which also identified that a lack of clear program objectives was hampering the achievement of program outcomes.(23)

This review provides an opportunity to improve how the Hearing Services Program objectives are defined, described and used in the future for program administration and evaluation.

## Improving the objectives of the Hearing Services Program

The Expert Panel received submissions advocating for the Hearing Services Program's objectives to be more explicit and set out how the program aims to reduce the impact of hearing loss. Submissions included some insights into what the improved objectives should encompass. For example, Deafness Forum of Australia identified that:

*Consumers need more information about the options available within a rehabilitation program so they understand there are more choices than a device fitting ... The Program should aim to ... provide quality information, advice and support to clients, their family and significant others of Program participants ... (24)*

Audiology Australia noted that:

*Hearing loss affects a person's ability to communicate, and consequently can negatively impact a person's psychological well-being ... 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. (25)*

Many stakeholders raised the need for improved public awareness about the issue of preventing hearing loss. Reducing hearing loss was seen as important for individuals, because it enables them to have better lifelong hearing; and for the community, because it reduces the social and economic costs of hearing loss. Hearing Health Sector Alliance highlighted in their submission that:

*The Program Objectives should include: ... hearing loss prevention strategies that: address workplace and leisure noise ... (26)*

The Hearing Health Sector Committee developed a set of principles to guide the development of its 2019 *Roadmap for Hearing Health*, several of which have a direct bearing on objectives for the Hearing Services Program:



*That services are delivered in a person- and family-centric way — and ensure that individuals and their families can effectively exercise choice and control.*

...

*That there is a priority focus on vulnerable individuals and communities, to ensure that people do not ‘slip through the cracks’.*

...

*self-determination is the foundation for designing and implementing culturally-appropriate services to close the gap between Aboriginal and Torres Strait Islander people and non-Aboriginal people.(4)*

A comparison with more recently developed social service programs, such as aged care and the National Disability Insurance Scheme (NDIS), illustrates the need to define the purpose of the Hearing Services Program in the enabling legislation to ensure that the objectives are presented in a clear, consistent and concise manner that allows for the equitable, effective, efficient and sustainable administration of the program and the measurement of outcomes. In doing so it would be adopting the better practice approaches contained in other social services legislation. For instance, section 2.1 of the Aged Care Act 1997 includes objectives that cover such matters as:

- promoting a high quality of care and accommodation for the recipients of aged care services
- encouraging diverse, flexible and responsive aged care services that meet recipients' needs
- protecting the health and wellbeing of the recipients of aged care services
- ensuring that aged care services are targeted towards, and accessible by, the people with the greatest needs.(27)

*The National Disability Insurance Scheme Act 2013 (Part 2, section 3) takes the development of scheme objectives one step further by being clear on the purposes of the program and the intended outcomes for people with disability as being to:*

- C. support the independence and social and economic participation of people with disability; and*
- D. provide reasonable and necessary supports, including early intervention supports, for participants in the National Disability Insurance Scheme launch; and*
- E. enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports; and*
- F. facilitate the development of a nationally consistent approach to the access to, and the planning and funding of, supports for people with disability; and*
- G. promote the provision of high quality and innovative supports that enable people with disability to maximise independent lifestyles and full inclusion in the mainstream community; and*
- H. raise community awareness of the issues that affect the social and economic participation of people with disability, and facilitate greater community inclusion of people with disability ... (28)*

The Expert Panel considers that the disability objectives encapsulate many of the suggestions put forward by stakeholders in relation to hearing loss and form a sound basis for its own proposals. When program objectives are defined at this level, they provide greater clarity and direction for the people receiving the services as well as for contracted service providers,

government and other stakeholders who deliver and administer the services to ensure they are more client-centric.

Some submissions on the Expert Panel's draft report did not agree with having such a comprehensive list of objectives, and some proposed the development of an overarching or guiding principle.(29–31) However, most stakeholders gave full support to the clarity and definition that the Expert Panel's proposed objectives offer. They would welcomed an invitation to participate in the next stage of consultation on the proposed objectives and offered to join any committee that is established to advise on that process.

## Recommendations

### Recommendation 1: Defining new objectives for the Hearing Services Program

- 1(a) The Australian Government should define the objectives of the Hearing Services Program, to guide the expectations of those with hearing loss; the Department of Health's administration of the program; the delivery of services by contracted service providers; the participation of other stakeholders in the program; and the measurement and assessment of client outcomes. The Australian Government should also establish a regular assessment of program outcomes to ensure the accountability of all participants.
- 1(b) The Australian Government should undertake consumer and broader stakeholder consultation on the following draft objectives before committing to a final set of program objectives and subsequently enshrining them in legislation.
  - A. The program's objectives for eligible people with hearing loss are that they:
    - A.1 have equitable access to prescribed services which comprise hearing assessment and hearing rehabilitation, hearing devices and other support - specifically, that eligible people:
      - i. have equitable access to support, irrespective of their location or personal attributes and circumstances
      - ii. be provided with support which is culturally safe and appropriate to them
    - A.2 are able to exercise informed choice about, and control how to live with and manage their hearing loss, including:
      - i. how to address their communication needs and maximise social inclusion through social activity and economic participation and in physical, and cultural pursuits to the fullest extent possible
      - ii. how they can be engaged in the planning, assessment, selection and delivery of the services offered to them
    - A.3 are able to exercise informed choice about, and control the selection of, their service provider and have clear and independent processes for resolving any complaints.
  - B. The program's objectives for contracted service providers under the Hearing Services Program are that they:
    - B.1 always act in the best interests of the eligible clients who have chosen them

- B.2 demonstrate that they meet program contract requirements such as key performance indicators
- B.3 provide culturally safe and appropriate services that respond to the needs of people with hearing loss in their local area.
- C. The objectives for qualified practitioners/hearing professionals are that they:
  - C.1 deliver safe services
  - C.2 abide by all current Practitioner Professional Bodies (PPBs) codes of conduct and meet all professional standards and/or competencies.
- D. The program's objectives for the government and its Hearing Services Program administrators are that:
  - D.1 when defining the subsidised set of prescribed services, categories of eligibility, hearing loss thresholds and criteria for contracted service provider accreditation, they have regard to:
    - i. supporting the communication needs of people with hearing loss and their social inclusion through social activity, economic participation, and physical and cultural pursuits
    - ii. the benefits to families and other persons with whom people with hearing loss communicate
    - iii. the broader benefits of employability, participation in society, social cohesion and economic growth
    - iv. the quantum and sustainability of costs to, and opportunities forgone by, current and future taxpayers
  - D.2 they ensure that the services, hearing devices and other technologies made available to people with hearing loss through the Hearing Services Program are regularly reviewed against agreed outcomes to reflect best practice and ensure that people with hearing loss do not experience harm arising from poor quality services or supports
  - D.3 they raise community awareness of the issues that affect the social and economic participation of people with hearing loss, and facilitate their greater community inclusion
  - D.4 they support the measurement and collection of data associated with hearing loss in Australia and the outcomes achieved by hearing services programs, and invest in research, to:
    - i. facilitate innovation, continuous improvement and contemporary best practice in improving hearing health, preventing hearing loss and supporting people with hearing loss
    - ii. inform the future direction of hearing services programs.

# Chapter 3

## Eligibility requirements for support under the Hearing Services Program

### KEY POINTS

- In the 2019–20 financial year, it was estimated that 3.9 million Australians lived with hearing loss. In that year an estimated 2.1 million of these people also fulfilled the eligibility criteria for the Hearing Services Program. However, only approximately 39% of eligible people participated in the program.
- Adults from 21 years of age should be able to have greater choice of provider through the Hearing Services Program:
  - Young adults aged from 21 to 26 should be able to continue to access hearing services, including specialist services where needed, but they should be able to access those services from any Hearing Services Program Provider of their choice.
- In addition, all voucher-eligible adults from 26 years of age who have complex hearing or communication needs and/or cochlear/bone anchored implants should be able to access appropriate specialist services from any Hearing Services Program provider of their choice. All contracted service providers and qualified practitioners who intend to provide voucher services to adults with complex hearing needs will have to demonstrate that they have the appropriate capacity, skills and cultural awareness capabilities to meet the clients' needs and to comply with the standards and guidelines developed by Practitioner Professional Bodies.
- There are several groups of currently non-eligible people who experience a higher prevalence of hearing loss or require financial support, who would benefit from access to publicly subsidised hearing services through the Hearing Services Program. The Expert Panel examined the various public and private benefits and costs of extending eligibility to each of those groups of people.
- People with hearing loss who are at most need of priority inclusion in the Hearing Service Program are:
  - adults from 26 years until Age Pension eligibility age who hold a Low Income Health Care Card
  - Aboriginal and Torres Strait Islander people from 26 to 49 years, supplementing services already provided to those up to age 25 and over 50
  - all permanent residents of aged care homes.
- There is an opportunity to expand the availability of full diagnostic hearing assessments under the Hearing Service Program, through utilising the several Medicare Items specifically related to health assessments in general practice.

The Expert Panel was requested by the former Minister for Regional Health, Regional Communications and Local Government, the Hon Mark Coulton MP, to investigate how the Hearing Services Program services are currently delivered and to advise on how to improve access to hearing services for low income earners; vulnerable Australians, including Aboriginal and Torres Strait Islander peoples; those over 65 years of age; and those living in regional, rural and remote areas.

To address these terms of reference, the Expert Panel has had to examine 2 separate but related issues:

1. Should the scope of eligibility be broadened to include some groups of people with hearing loss who are currently not eligible?
2. What are the barriers that inhibit or prevent eligible people from accessing the Hearing Services Program?

The issue of eligibility has at its core the question of which groups of people with hearing loss should receive publicly subsidised services, hearing devices and other technologies that are otherwise available in the private market. The rationale for taxpayer funding of these subsidies rests in the assessment of the balance of public and private benefits, equity of access, social cohesion and the sustainability of public and private funding.

On the other hand, overcoming the barriers to access which are experienced by those who are already eligible is largely a matter of improving program design, funding, service delivery and administration, as well as overcoming market failures. As such, these issues provide rationales for funding either clients or providers to overcome these barriers as well as for regulation and direct intervention by government (such as by delivering services through Hearing Australia, undertaking information campaigns and the like).

This chapter addresses the issue of the scope of eligibility. The second issue – overcoming barriers to access by those who are eligible under the Hearing Services Program – is addressed in **Chapter 4** and **Chapter 5**.

## Distinguishing between eligibility and participation in the Hearing Services Program

As noted in Table 2, hearing loss is estimated to be experienced by 3.9 million Australians in the 2019–20 financial year, according to Deloitte Access Economics (2020).<sup>(7)</sup> Prevalence modelling using United Kingdom (UK) data (which are based on single year age data and have been applied to eligible program cohorts such as aged pensioners and veterans for this review) indicates that during that year a total of approximately 2.1 million people with hearing loss were eligible for subsidised hearing services under the Hearing Services Program. However, as Table 2 shows, only around 822,000 were active across the voucher and Community Service Obligations (CSO) streams, representing an estimated participation rate of only approximately 39% of eligible persons with hearing loss.

**TABLE 2:** Distinguishing between eligibility and participation in the Hearing Services Program

Category	Population
Total Australian population with mild or greater hearing loss <sup>1</sup>	3,952,000
Total Australian population with mild or greater hearing loss who are also eligible for the Hearing Services Program <sup>2</sup>	2,121,580
Total number of clients registered for the voucher stream <sup>3</sup>	1,070,598
Total number of active clients under the voucher stream <sup>4</sup>	751,052
Total number of active clients under the Community Service Obligations stream <sup>5</sup>	70,674
<b>Total estimated private clients<sup>6</sup></b>	<b>205,432</b>

## Notes:

- 1 Source: HCIA and Deloitte Access Economics, Hearing for life: The value of hearing services for vulnerable Australians, March 2020, [https://www.hcia.com.au/hcia-wp/wp-content/uploads/2020/02/Hearing\\_for\\_Life.pdf](https://www.hcia.com.au/hcia-wp/wp-content/uploads/2020/02/Hearing_for_Life.pdf)
- 2 Estimated prevalence of persons with mild hearing loss or greater based on Davis UK study (32), noting that its results, which are single year age data, have been applied to age profiles of the Hearing Services Program eligible populations such as age pensioners and veterans
- 3 Voucher clients who were eligible and had a current voucher and were classified as eligible in the Hearing Service Online (HSO) portal system.
- 4 Voucher clients who had at least one service in the financial year.
- 5 Community Service Obligations clients who had at least one service in the financial year.
- 6 Estimated private hearing aid clients based on statement by Professor Harvey Dillon, Director, National Acoustic Laboratories, Australian Hearing, Official Committee Hansard, Canberra, 3 March 2017, pp 19–20.

Source: HCIA and Deloitte Access Economics, Hearing for life: The value of hearing services for vulnerable Australians, March 2020, [https://www.hcia.com.au/hcia-wp/wp-content/uploads/2020/02/Hearing\\_for\\_Life.pdf](https://www.hcia.com.au/hcia-wp/wp-content/uploads/2020/02/Hearing_for_Life.pdf)

## Current eligibility requirements of the Hearing Services Program

As noted in the introduction to this report, the Hearing Services Program is split into 2 streams - the voucher stream and the CSO stream - each with its own eligibility requirements as set out below. The eligibility criteria for the voucher stream of the program are set out in the *Hearing Services Administration Act 1997*,(33) while the CSO stream eligibility criteria are set out in the *Australian Hearing Services Act 1991*.(34)

### Voucher stream

Eligibility for the voucher stream of the program includes Australian citizens and permanent residents aged 21 years or older who are:

- Pensioner Concession Card holders (this does not include Seniors Health Card holders), including those receiving:
  - an Age Pension (age requirement of 66 years and 6 months as of 1 July 2021)
  - a Carer Payment (an income support payment if an individual gives constant care to someone who has a severe disability or illness or to an adult who is frail aged)
  - a Disability Support Pension
  - a JobSeeker Payment (if partially able to work or single with a dependent child) or Youth Allowance (and are single, caring for a dependent child and looking for work). This does not include those who receive a Jobseeker Payment who are single or a couple with/without dependent children
  - a Parenting Payment (single) (35)

- Department of Veterans' Affairs (DVA) Veteran Gold Card holders
- DVA Veteran White Card holders (with hearing specific conditions)
- dependents of people in one of the above categories
- members of the Australian Defence Force, including a current member of the:
  - permanent Navy, the regular Army or permanent Air Force
  - Reserves and who is rendering continuous full-time service
- referred by the Disability Employment Services (Disability Management Services) Program.

Voucher services are provided by accredited contracted service providers (including Hearing Australia and other private providers) throughout Australia.

Clients of the voucher stream are entitled to receive a range of services, including one full hearing assessment, rehabilitation and client reviews. Voucher stream clients will also be able to receive one hearing device per ear if the client's hearing loss is above the Minimum Hearing Loss Threshold (MHLT) of 23 decibels or they meet one of the MHLT exemption criteria. Vouchered clients are also covered for an unrestricted number of hearing device replacements if their devices are lost or damaged beyond repair and a remote control if they are unable to manage their device. Each voucher is valid for a period of 5 years.

If fitted with a hearing device, voucher stream clients can also elect to enter into an annual maintenance agreement with their service provider to receive ongoing maintenance, repairs and consumables for their device as required. The program gives the contracted service provider an annual amount per client on a maintenance agreement, except for the first year after fitting, and the client can be asked to pay an annual maintenance co-payment. For fully subsidised devices, the client co-payment is capped and indexed by inflation each year. For clients who have a partially subsidised device, the annual maintenance co-payment is set by their hearing service provider. The average client maintenance co-payment for fully and partially subsidised devices is \$33.48 (see Table 14 in **Chapter 5**).

While considering eligibility issues throughout the course of this review, the Expert Panel noted that the term 'voucher' was established at a time when there was a physical voucher provided to Hearing Services Program clients. As of 2021, the voucher is no longer a physical entity, with the support provided online. As such, the term has become obsolete. Several stakeholder submissions to the Hearing Program Services Review consultation paper made the same observation. In the draft report, the Expert Panel suggested a change in name to modernise this stream of the program. Submissions were overall supportive of this move. In considering the various ideas submitted by stakeholders, the Expert Panel suggests using the term 'Hearing Benefits Scheme' (while also maintaining the 'Community Service Obligations' title).

## Community Service Obligations stream

The CSO stream of the Hearing Services Program offers specialist hearing services targeted at Australian citizens or permanent residents who:

- are eligible for the voucher stream of the Hearing Services Program but who have complex hearing or communications needs or live in a remote area
- identify as an Aboriginal and Torres Strait Islander person and are:

- over 50 years of age
  - a participant in the Community Development Program (formerly known as the Remote Jobs and Communities Program and the Community Development Employment Projects (CDEP) program), or
  - a person who was a CDEP program participant on or after 30 June 2013, has since ceased participating in the Hearing Services Program, and was receiving hearing services from Hearing Australia prior to ceasing participation
- are under 26 years of age (including those who are National Disability Insurance Scheme (NDIS) participants).

Hearing Australia is the sole provider of CSO services.

## Crossover in eligibility across the voucher and Community Service Obligations streams

There is some crossover in eligibility within the 2 streams of the Hearing Services Program. This has been known to cause confusion and administrative burden, particularly for service providers. These circumstances are outlined below.

### Adults with complex hearing needs

The glossary on the Hearing Services Program website states:

*A complex client is a client who has severe to profound bilateral hearing loss or whose communication is limited due to significant physical, intellectual, mental, emotional or social disability. Complex clients are entitled to receive specialist hearing services through Community Service Obligations.(36)*

Adults over 26 years of age with complex hearing needs have the choice to receive support through Hearing Australia by using either the voucher stream or the CSO supports (or both if that is what they require). They currently represent 40% of the CSO client base.(37) However, confusion lies in the fact that all adults with complex hearing needs must be eligible for (but not necessarily hold) a voucher before they can access CSO supports.

### Referral of voucher clients to Community Service Obligations

Contracted service providers are required to notify their voucher clients that they can receive additional supports through the CSO stream of the Hearing Services Program if and when their hearing needs become complex. The client can choose to move across to the CSO stream or remain with their current provider. Section 50 of the *Hearing Services Program (Voucher) Instrument 2019 (Cth)* states that:

*If a contracted service provider knows or reasonably believes that a person who asks it for hearing services is a voucher-holder and is eligible for specialist hearing services ... the contracted service provider must:*

- A. *notify the Department that a voucher-holder who is eligible for specialist hearing services is requesting hearing services; and*
- B. *explain to the voucher-holder the specialist hearing services that may be available to him or her from AHS; and*



- C. *allow at least 10 business days from the time at which the explanation under (1)(b) was provided before contacting the voucher-holder to ask whether he or she has decided whether to receive specialist services from AHS; and*
- D. *not provide further hearing services to the voucher-holder until the person advises the contracted service provider that he or she has made an informed decision not to receive specialist services from AHS; and*
- E. *retain evidence on the voucher-holder's record of the advice given to the voucher-holder and the voucher-holder's decision.(38)*

The Expert Panel highlights that there is a contradiction in the communication around how clients with complex hearing needs should be supported through the Hearing Services Program.

As described earlier, under CSO legislation, children and young adults up to the age of 26 who have a need for hearing services – including those with complex needs and cochlear/bone anchored implants – can access services through Hearing Australia. In addition to standard hearing assessments and interventions, all clients up to age 26, depending on the level of need, can access CSO ‘specialist’ services that may include a broader range of fully subsidised hearing devices, communication training and ongoing services or support to assist them with their hearing loss. The Expert Panel does not recommend any changes to this arrangement given positive feedback from many stakeholders about these services to this age group.

However, the Expert Panel considers that young adults from 21 to 26 years of age with a need for hearing services (including those with complex needs and cochlear/bone anchored implants) should be allowed to have a wider choice of providers. The services could be offered by contracted service providers registered as qualified practitioners under the voucher stream as well as by Hearing Australia. The type and quality of service provision to those young adults would not be affected by this move – they would all remain eligible for voucher services and, depending on their need, specialist services.

Currently, once an adult has reached 26 years of age, they can start or continue to receive hearing services through the voucher stream if they meet its eligibility requirements. Under the Expert Panel’s proposal, adults eligible under the voucher stream who are assessed as having complex needs – at whatever age they acquire that need – would be eligible for the voucher stream services and the specialist services according to their needs, irrespective of their choice of Hearing Australia or a contracted service provider. This would be subject to the provider and/or qualified practitioner being able to demonstrate that they can support these complex needs clients with the capacity, skills and cultural awareness capabilities that accord with the standards and guidelines developed by Practitioner Professional Bodies. This might require additional skills development and qualifications. (This matter is discussed further in **Chapter 4**). Clients could remain with Hearing Australia if they choose, as it would continue to be a provider of these services (for which it was the sole provider under the CSO stream) as a contracted service provider under the voucher stream.

The Expert Panel notes that some contracted service providers advised in their responses to the draft report that they are already providing services to adults with complex hearing needs. The Expert Panel also acknowledges that there will be some current providers under the voucher stream who may decide not to offer services to these client groups and therefore would not be required to demonstrate additional qualifications.

Several stakeholders noted that this change to eligibility would require the voucher stream to include service items and funding currently available through the CSO to address the special needs of these groups, such as length of consultations or the types of services and hearing

devices available. Deafness Forum of Australia was particularly concerned that any change should not disadvantage the most vulnerable clients by increasing bureaucracy and reducing the level of service funded.(39,40)

Audiology Australia, echoing the concerns of several stakeholders, noted there would need to be 'set standards and competencies for voucher hearing providers, specified Program outcomes and a broader range of technology and services made available within the Voucher stream'.(41)

The Expert Panel agrees that a greater frequency of hearing services (such as diagnostic assessments) and the provision of new services (such as communication assessments and training) may be required to ensure that adults with complex hearing needs receive the same level of services in the voucher stream as they have previously received in the CSO stream. The Expert Panel also proposes that, for adults with complex hearing needs, consideration will need to be given to government funding for higher technology than the current technology available in the fully subsidised device range (see **Chapter 5** for more details on program technology and the Expert Panel's advice to improve technology available in the program).

## Veterans

In its response to the Expert Panel's draft report, DVA reiterated its suggestion that certain classes of veterans with high/complex hearing needs be included in the eligibility group for the CSO. The Expert Panel has considered this in the light of its consideration of moving clients with special needs – namely, adults with complex hearing needs and adults with cochlear/bone anchored implants – into the eligibility criteria for the voucher stream. Veterans who already meet the criteria for high/complex needs in the CSO stream would also have these needs. Veteran clients with specialist or complex needs would be given additional services through all contracted service providers who have the necessary skills, qualifications and capability to do so. This would include those services currently provided in the CSO, such as partially subsidised devices being provided free of charge and additional rehabilitation services. These matters would be addressed in the revision of the Schedule of Service Items and Fees (Services Schedule) proposed in **Chapter 4**. Two stakeholders also noted in both consultations that, for most veterans, hearing loss is mainly a medical issue and as such specific attention to those needs is required.(42,43)

## Community Service Obligations clients who turn 26

The CSO stream is available for young people aged under 26 years to ensure that they are able to continue to study, train and/or establish their careers. However, those aged 21–25 years can choose to receive services through the voucher stream instead if they meet one or more of the current eligibility criteria of the voucher stream.

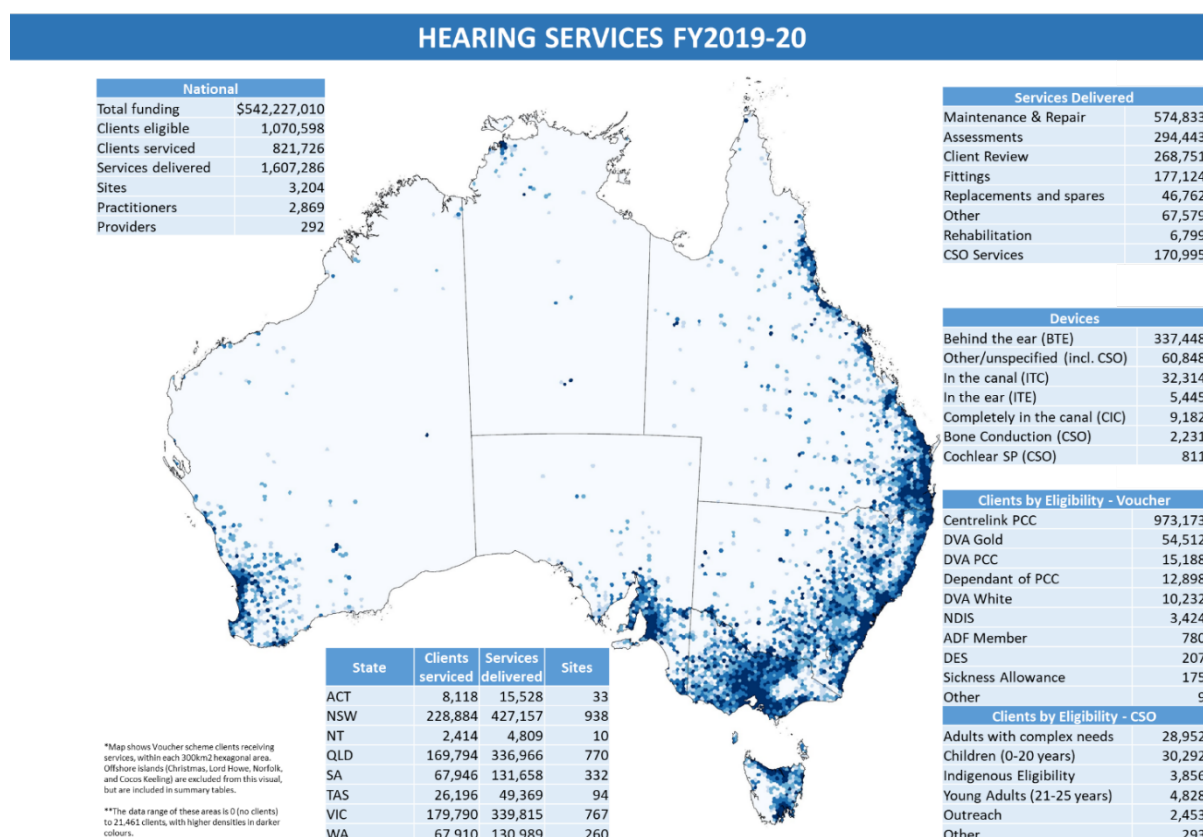
From the age of 26 years onwards, clients' access to CSO services ends unless they meet other CSO eligibility criteria, at which stage they can move to the voucher stream (if eligible) and access these CSO services. Otherwise, they would be required to seek private hearing care at their own expense.

## A profile of eligible people who are accessing the Hearing Services Program

As set out in Table 2, in the 2019–20 financial year there were an estimated 2.1 million eligible Australians with mild or greater hearing loss. Of those, 751,052 (35.4%) were active clients in the voucher stream and 70,674 (3.3%) were in the CSO stream (38.7% in total), and those 821,726 clients received a total of 1,602,188 services.

The map below (Figure 4) shows the distribution of hearing services delivered through the Hearing Services Program in the 2019–20 financial year. As expected, the distribution broadly follows that of the population overall, with a slight bias to areas that have an older population (retirement and rural areas) and a higher CSO presence in some rural and remote areas.

**Figure 4:** Distribution of hearing services delivered through the Hearing Services Program in the 2019–20 financial year



Source: Department of Health, Hearing Services Program data and statistics (internal).

ADF: Australian Defence Force; CSO: Community Service Obligations; DES: Disability Employment Services; NDIS: National Disability Insurance Scheme; PCC: Pensioner Concession Card; SP: Speech processor.

An analysis of clients under each program stream by eligibility criteria (Table 3) shows that 82% of all voucher stream clients are those who hold a Pensioner Concession Card, but they account for a slightly smaller proportion of expenditure (three-quarters). In the CSO stream, children (that is, those under 21 years of age) and adults with complex or specialist hearing needs each account for similar proportions of CSO client numbers (about 3.5%), but children under 21 years of age represent almost double the expenditure (6.9%) compared with the adults with complex hearing needs (3.55%). This is a result of children and young adults being eligible to receive cochlear implant speech processor replacements and requiring more hearing services than adults with complex hearing needs.

**TABLE 3:** Count of active clients by Hearing Services Program stream eligibility criteria in the 2019–20 financial year

Eligibility criteria	Active clients	Percentage of grand total of clients	Expenditure excluding GST (\$,000s)	Percentage of grand total expenditure
<b>Voucher stream</b>				
Centrelink Pensioner Concession Card <sup>1</sup>	675,068	82.15%	\$404,604.70	76.10%
DVA Gold Card (Health Repatriation Card)	45,247	5.51%	\$28,191.50	5.30%
DVA Pensioner Concession Card	11,542	1.40%	\$6,737.50	1.27%
DVA Veteran White Card (Health Repatriation) for Hearing Loss	7,900	≤1%	\$5,272.70	1.0%
Dependant of a concession card holder	8,183	≤1%	\$4,809.00	≤1%
National Disability Insurance Scheme	2,345	≤1%	\$1,650.70	≤1%
Member of the Australian Defence Force	414	≤1%	\$297.10	≤1%
Disability Employment Services	212	≤1%	\$132.50	≤1%
Centrelink Sickness Allowance	136	≤1%	\$90.20	≤1%
Other	5	≤1%	\$4.80	≤1%
<b>Total (voucher)</b>	<b>751,052</b>	<b>91.40%</b>	<b>\$451,790.60</b>	<b>84.98%</b>
<b>CSO stream</b>				
Children (under 21 years) <sup>2</sup>	26,185	3.19%	\$36,935.60	6.95%
Indigenous children (under 21 years) <sup>2</sup>	4,107	≤ 1%		
Young adults (from 21 to under 26 years)	4,828	≤ 1%	\$4,398.00	≤ 1%
Complex adults (clients with specialist needs) <sup>3</sup>	28,952	3.52%	\$18,982.60	3.57%
Extended Indigenous eligibility	6,309	≤ 1%	\$6,496.80	1.22%
CSO remote – other	293	≤ 1%	-	-
Other expenditure – cochlear implant upgrades and repairs and maintenance	-	-	\$9,734.20	1.83%
Other expenditure – outreach <sup>4</sup>	-	-	\$3,316.90	≤ 1%
<b>Total (CSO)</b>	<b>70,674</b>	<b>8.60%</b>	<b>\$79,864.10</b>	<b>15.02%</b>
<b>Grand total<sup>4</sup></b>	<b>821,726</b>	<b>100%</b>	<b>\$531,654.70</b>	<b>100%</b>

Notes:

- 1 As defined earlier in this chapter.
- 2 The number of children seen includes children that did not go on to a fitting and did not need further hearing health care (ie discharged); hence, this number is higher than the number of Aided Young Australians.
- 3 Expenditure for complex adults includes \$12.296 million funding from the voucher stream.
- 4 Other expenditure is used to refer to costs associated across the CSO stream in clients already counted under an eligibility criterion.
- 5 Total expenditure does not match the Department of Health annual report due to differences in the CSO expenditure.

Source: Department of Health, Hearing Services Program data and statistics (internal).  
CSO: Community Service Obligations; DVA: Department of Veterans' Affairs.

# Gaps in the Hearing Services Program eligibility criteria

On 30 October 2020 the Expert Panel released the *Hearing Services Program Review Consultation Paper* which, amongst other matters, asked stakeholders to identify which consumers should be eligible for publicly subsidised hearing care under the Hearing Services Program. The request drew a range of responses. For instance, Deafness Forum of Australia commented:

*The Hearing Services Program (HSP) should ensure that vulnerable groups, those requiring specialised programs to address their hearing needs, and people on low income have access to high quality hearing services at no cost or minimal cost.(24)*

The categories of people who should be eligible for publicly subsidised hearing services that were suggested in submissions included:

- all people living on a low income (where they are also not eligible for the NDIS), including:
  - people of working age who are unemployed or in low-paid employment (including those receiving JobSeeker Payment)
  - adults aged 65 and over with hearing loss who are on a low income, unemployed or retired (including self-funded retirees on a low income)
  - adults holding one of the numerous health care cards or concession cards generally provided to those experiencing some form of economic disadvantage
  - Low Income Health Care Card holders
- all Aboriginal and Torres Strait Islander people (not just those who live in remote communities or who are over 50 years of age) (44)
- permanent residents of aged care homes
- Commonwealth Seniors Health Card holders
- tinnitus sufferers (45)
- adults over 65 years with a cochlear implant
- people in the criminal justice system.

Expansion of the program to a wider group of people with hearing loss has also been proposed in various inquiry and research reports:

- the *Roadmap for Hearing Health* – in particular, Priority 8, ‘Additional support for people on low incomes is made available to access hearing health services’ (4)
- the parliamentary inquiry report *Still Waiting to be Heard ... Report on the Inquiry into the Hearing Health and Wellbeing of Australia, (Still Waiting to be Heard)*, which made recommendations to improve access to hearing services for Aboriginal and Torres Strait Islander peoples and which also heard from stakeholders who called for the expansion of the voucher stream to holders of the Commonwealth Seniors Health Card (46)
- the Hearing Care Industry Association *Hearing for life* report, which identified the benefits of expanding hearing services to Australians of working age who are on low incomes or who are unemployed (7)
- an Access Economics 2006 report which investigated the financial impacts of hearing loss on the Australian economy.(1)

## Expert Panel assessment of extending the categories of eligibility

The Expert Panel has examined the various public and private benefits and costs of extending public subsidies to each of these groups, and the considerations of equity, by way of changes to the eligibility criteria to enable access to the Hearing Services Program. In doing so, it has paid regard to the draft objectives outlined in **Chapter 2** (in particular, draft objective D1, which addresses individual, community and economic benefits from the program) and has been guided by the review's terms of reference.

The Expert Panel notes the additional capacity, skills and cultural awareness capabilities that might be required of contracted service providers when delivering services to these population groups and suggests that additional training for providers might be necessary to support delivery of specialised care. With this shift to the voucher stream, adults with complex needs will continue to receive the current full range of services and/or devices according to their needs.

In line with Recommendations 4(a) and 4(b) of this report – that all adults be moved to the voucher stream – all modelling of indicative costing for the expansion of eligibility to the groups discussed below has used current voucher stream costs, while recognising that those who have complex needs and require CSO specialist services will receive them.

### Low income earners

Hearing loss can limit a person's ability to gain employment or even keep their current job. Hearing loss can impact a person's capacity to engage in the working environment and achieve success in their educational and employment pursuits. The recent *World Report on Hearing* by the World Health Organization highlighted that:

*Hearing loss can have a long-lasting impact on the academic outcomes of an individual ... those with hearing loss have reduced school performance, slower progression through the academic system, a greater risk of dropping out of school, and lower likelihood of applying for higher education, compared with their hearing peers ... Students with hearing loss often demonstrate a lack of career-planning and decision-making which are required for success in the workplace. Overall, adults with hearing loss have increased odds of unemployment or underemployment ... often earn lower wages and retire earlier than their hearing peers.(47)*

The Expert Panel also acknowledges the Hogan et al. 2009 study that showed that those with hearing loss are more likely to be over-represented in lower socio-economic occupations and that:

*Among people in the labour force with hearing loss and communication difficulties, nearly two out of three report that their disability restricts their employment, most notably in their type of work or with difficulties in changing jobs or securing preferred jobs.(48)*

This summation is supported by a 2017 report prepared by Deloitte Access Economics for the Hearing Care Industry Association that calculated that untreated hearing loss resulted in \$12.8 billion in productivity losses per year (amounting to approximately \$3,566 per person with hearing loss), of which the majority was associated with reduced workforce participation of people with hearing loss (including absenteeism and reduced productivity at work).(7)

There is little empirical evidence of the impact of increased access to hearing health care and use of hearing devices among Australians of working age. However, international evidence from the United Kingdom, where hearing devices are free of charge under the National Health

Service to all citizens who need them, suggests that unemployment of those with hearing loss is reduced when they have access to hearing services.(49) Further, a 2010 study of 40,000 households in the United States found that:

*Hearing aids were shown to mitigate the impact of income loss by 90%–100% for those with milder hearing losses and from 65%–77% for those with severe to moderate hearing loss.*

*Unemployment rates for aided subjects were not significantly related to degree of hearing loss.*

*There was a strong relationship between degree of hearing loss and unemployment for unaided subjects. Those with severe hearing loss had unemployment rates (15.6%), double that of the normal-hearing population (7.8%) and nearly double that of their aided peers (8.3%).(50)*

The Expert Panel recognises that access to the Hearing Services Program would provide opportunities for low income earners and those who are unemployed to improve their work prospects by gaining employment, working more hours or undertaking more complex/skilled work and/or to undertake vocational or higher education.

A precedent has been established which recognises the value of providing hearing services to people in order to improve their prospects of gaining employment. The Hearing Services Program already includes eligibility for participants of the Department of Social Services Disability Employment Services (DES) program, which helps people with disability prepare for, find and keep a job. Assistance provided through the DES program can include career advice, employment preparation, resumé development and training, as well as ongoing support at work, including funding for necessary workplace modifications and wage subsidies to employers. Participants in the DES program can be referred to the Hearing Services Program if their hearing loss is considered a factor and they will be assessed for their eligibility under the voucher and CSO streams depending on the complexity of their hearing needs.

Given the significant contribution that hearing services make to maximising participation in employment and in the community, the Expert Panel proposes using the Low Income Health Care Card as the basis for eligibility. The Australian Government, through Services Australia, assesses the eligibility of Low Income Health Care Card holders through the use of an annual income test (including incomes from paid employment, rental income, payments from the Australian Government and so on).

**TABLE 4:** Income test threshold for the Low Income Health Care Card (as at 16 July 2021)

Status	Weekly income
Single, no children	\$576.00
Couple combined, no children	\$993.00
Single, one dependent child	\$993.00
Couple combined, one child	\$1,027.00

Source: Services Australia.

Extending eligibility to this cohort of Australians would also support recommendation 11 of the *Still Waiting to be Heard* parliamentary inquiry, which stated that the Hearing Services Program should ‘be extended to provide hearing services to hearing impaired Australians aged 26 to 65 years on low incomes or who are unemployed and qualify for lower income support’.(46)

The Expert Panel agrees with the intent of the parliamentary inquiry and considers that expanding access to the Hearing Services Program to those aged from 26 to Age Pension eligibility age who hold a Low Income Health Care Card and are experiencing hearing loss would increase the likelihood of them being able to gain and maintain meaningful employment or seek higher skilled employment as a result of their access to affordable (or fully subsidised) hearing care. While the recommendation of the *Still Waiting to be Heard* parliamentary inquiry stipulated that this population group should have access to the CSO stream of the Hearing Services Program, the Expert Panel recommends that the Government fund this group, along with all other adults, under the voucher stream in line with Recommendation 5(a).

Taking the above evidence into consideration, along with data on the prevalence of mild and greater hearing loss, Table 5 provides an indicative estimate of the additional number of clients who have mild or greater hearing loss and the annual cost per year over the 2019–20 year to the Hearing Services Program by extending eligibility of the voucher stream to low income earners who hold a Low Income Health Care Card and are aged from 26 until Age Pension eligibility age. Over the 4 years to 2024–25 there would be an estimated additional 58,890 clients, increasing the voucher stream expenditure by approximately \$83.95 million over that period.

**TABLE 5:** Indicative financial implications to extending access to the Hearing Services Program to Low Income Health Care Card holders (based on costings associated with the voucher stream)

	Financial year increase on financial year 2019–20			
	2021–22	2022–23	2023–24	2024–25
Expected increase in number of clients	13,802	14,154	14,551	14,907
Total expected nominal increase in cost (\$'000s)	\$17,048.09	\$17,733.03	\$22,106.72	\$27,062.69
Expected annual compound growth increase (%) compared to financial year 2019–20	1.59%	1.10%	1.02%	1.00%

Source: Department of Health, Hearing Services Program data and statistics (internal).

**Assumptions:** These estimates have been modelled using existing Department of Social Services historical data. Assumptions have been made that the behavioural characteristics of the modelled population will match the current Pensioner Concession Card population and their level of hearing loss will match the prevalence rate in the UK study by Davis.(32) The rate of access to the Hearing Services Program has been modelled on the existing voucher stream new client access rate. The cost of service provision assumes that they will receive their hearing services in the voucher stream and their rate of returning for services will match the existing voucher population. The costing model also assumes a new client cost in the first year of entry and then they move onto the maintenance costs after that. It cannot be assumed that all clients who join will actually use all the services. Based on historical client behaviour patterns we have assumed that client behaviour effects their utilisation of hearing services in that not all clients will utilise all the hearing services available to them.



Commonwealth Seniors Health Card holders who might be eligible for the Low Income Health Care Card but who are over the Age Pension eligibility age have been excluded from the model, as the level of active engagement with the labour force reduces steadily as age increases beyond the Age Pension eligibility age, as described in Table 6 below.

**TABLE 6:** Workforce participation by age from 55 years of age as of June 2019

Age range	Percentage of age group working or looking for work
55–59	75%
60–64	59%
65–69	32%
70–74	15%
75–79	6.6%
80–84	3%

Source: Ai Group Economics Fact Sheet.(51)

Those on the JobSeeker Payment (singles and couples with no caring responsibilities) and those who hold a Commonwealth Seniors Health Card already have access to a health care card. Therefore, there is currently no incentive for them to apply for a Low Income Health Care Card, despite being entitled to one. Opening eligibility for Low Income Health Care Card holders to the Hearing Services Program may become an incentive. The Expert Panel notes that care must be taken to ensure that those eligible for the program would not be subjected to extra registration paperwork, which may cause additional barriers to them accessing the program.

## Aboriginal and Torres Strait Islander peoples

Hearing loss is a significant problem for Aboriginal and Torres Strait Islander peoples and, as the World Health Organization reports, their children experience some of the highest rates of ear disease and associated hearing loss in the world.(52)

In 2018–19 the National Aboriginal and Torres Strait Islander Health Survey reported on data from a voluntary hearing test, which indicated that more than 4 in 10 people aged 7 years and over (43% or 290,400) had a hearing impairment in at least one ear at the time of interview. Of these:

- 20% (135,800 people) had a hearing impairment in one ear only
- 23% (154,300 people) had a hearing impairment in both ears:
  - 15% (99,400 people) had a mild impairment
  - 3.6% (24,600 people) had a moderate impairment
  - 4.4% (30,100 people) had a severe or profound impairment, based on the ear with the lowest level of impairment.

The proportion of people with a hearing impairment measured in at least one ear at the time of interview:

- was higher for people living in remote areas (59%) than non-remote areas (39%)
- increased with age from 35 years and over, doubling from 41% of people aged 35–44 years to 82% of people aged 55 years and over.(53)

The Expert Panel is aware that the Indigenous Health Division of the Department of Health manages a number of programs aimed at reducing the incidence and impact of hearing loss among Aboriginal and Torres Strait Islander peoples. The programs have a particular focus on improving ear and hearing health in Aboriginal and Torres Strait Islander children and represent an investment of \$59.79 million over 4 years to:

- increase access to clinical services such as audiology, ear nose and throat (ENT) consultation and speech pathology
- strengthen ear and hearing health services in primary care through provision of training, equipment and ear health coordinator positions
- promote ear and hearing health among families, health professionals and educators
- develop quiet spaces in clinics to assist with hearing checks.

Each of these actions will help to address the hearing and ear health issues facing the youngest generation of Aboriginal and Torres Strait Islander children and should reduce the impact currently being experienced by older age groups, as will the *Roadmap for Hearing Health* investment of \$5 million for early identification of, and improvements in overcoming, hearing and speech difficulties for Aboriginal and Torres Strait Islander children (as noted in **Chapter 1**).

The Expert Panel recognises there is a series of complex, interrelated issues which relate to the matters of both eligibility and access to hearing services by Aboriginal and Torres Strait Islander peoples. They include ensuring that those people who are currently eligible are able to, and seek to, access the services, as well as considering whether those who are not currently eligible should become so under an expanded set of criteria. The former issues revolve in part around local availability, culturally safe delivery and utilisation of the existing network of Aboriginal Community Controlled Health Organisations, and these matters are addressed separately in **Chapter 4**.

In examining the latter issue of expanding the eligibility criteria in this chapter, there are an estimated 164,408 Aboriginal and Torres Strait Islander people between the ages of 25 and 49 years who have mild or greater hearing loss. This group is not covered by the current eligibility criteria, unless they are eligible through other criteria – for example, Pensioner Concession Card holders, eligible DVA card holders or those receiving services as complex adults. While the data are not complete, it is estimated that these other eligibility pathways would marginally reduce the numbers of Aboriginal and Torres Strait Islander people with hearing loss who are not covered to 130,433. Should the government accept the proposal that people with hearing loss who have a Low Income Health Care Card should become eligible under the program, this would further marginally reduce the number of people who are not covered to 129,880.

The question then arises as to the rationale for providing subsidies for Aboriginal and Torres Strait Islander people who are not supported under other existing or proposed eligibility criteria. The National Aboriginal Community Controlled Health Organisation (NACCHO) stated:

*Hearing health for our Aboriginal and Torres Strait Islander communities should be a national priority, as defects in hearing can lead to lifelong issues in education, employment, and health. There are currently inadequate services to deal with the demand of ear and hearing health problems among Aboriginal and Torres Strait Islander communities and wait times can be years to access much needed treatment.(44)*

The *Still Waiting to be Heard* parliamentary inquiry similarly highlighted that hearing loss and impairment among Aboriginal and Torres Strait Islander peoples had a significant impact on their ability to remain in education, increased their interactions with the criminal justice system, and

increased their likelihood of experiencing isolation, as they are unlikely to use Auslan or a signing system recognised outside their own country.(46)

These factors, along with recognition of the broader disadvantage experienced by Aboriginal and Torres Strait Islander peoples, supports the expansion of the Hearing Services Program to include all Aboriginal and Torres Strait Islander peoples, regardless of other eligibility criteria. In accordance with the proposal that all adults be brought under the voucher stream, this would also apply to Aboriginal and Torres Strait Islander people aged between 21 and 26 years, while ensuring that those with special needs would continue to be able to access higher level services from Hearing Australia or from other contracted service providers who have the necessary skills, qualifications and capability to do so.

In its response to the Expert Panel’s draft report, NACCHO supported this expansion, noting that:

*As acknowledged by the formal Partnership on Closing the Gap, all Governmental organisations, share accountability to provide culturally safe and responsive participatory measures for all Aboriginal and Torres Strait Islander people, including through their funded measures.(54)*

Table 7 provides an estimate of the expected increase in number of clients and the annual cost per year to the Hearing Services Program over 4 years by extending eligibility to all Aboriginal and Torres Strait Islander peoples. The total additional spend over the 4 years would be about \$105.1 million.

**TABLE 7:** Indicative financial implications to extending access to the Hearing Services Program to Aboriginal and Torres Strait Islander people aged 25–49 years with hearing loss (based on costings associated with the voucher stream)

	Financial year increase on financial year 2019–20			
	2021–22	2022–23	2023–24	2024–25
Expected increase in number of clients	17,279	17,735	25,427	33,461
Total expected nominal increase in cost (\$'000s)	\$21,341.90	\$22,219.00	\$27,661.80	\$33,907.90
Expected annual compound growth increase (%) compared to financial year 2019–20	1.99%	1.37%	1.28%	1.24%

Source: Department of Health, Hearing Services Program data and statistics (internal).

**Assumptions:** These estimates have been modelled using Australian Bureau of Statistics (ABS) Aboriginal and Torres Strait Islander population projections. Assumptions have been made that the behavioural characteristics of the modelled population will match the current Pensioner Concession Card population and their level of hearing loss will match the measured prevalence rate in the ABS 2018–19 National Aboriginal and Torres Strait Islander Health Survey. The rate of access to the program has been modelled on the existing voucher stream access rate. The cost of service provision assumes that they will receive their hearing services in the voucher stream and their rate of returning for services will match the existing voucher population. The costing model also assumes a new client cost in the first year of entry and then they move onto the maintenance costs after that. It cannot be assumed that all clients who join will actually use all the services. Based on historical client behaviour patterns, we have assumed that client behaviour affects their utilisation of hearing services in that not all clients will utilise all the hearing services available to them. Therefore, not all of the above 129,880 people would seek to access services.

## Permanent residents of aged care homes

Poorly managed hearing loss for an individual living in an aged care home has a significant impact on their quality of life, including their physical safety and ability to communicate, socialise, participate in activities and effectively communicate their care preferences to staff.(55)

Currently some, but not all, permanent residents of aged care homes are eligible for services under the Hearing Services Program (for example, Pensioner Concession Card holders or DVA Veteran Gold Card or Veteran White Card holders). This can lead to a situation where one resident may be eligible for and receive hearing health services under the program, while another with different financial and eligibility circumstances is required to access the private system. Another issue affecting this cohort is inadequate aged care staff awareness of residents' hearing needs. This is addressed in more detail in **Chapter 4**.

Permanent residents of aged care homes experience a combination of poorer health, frailty and/or cognitive impairment, including dementia. Several stakeholders, in their responses to the draft report, specifically noted the increased vulnerability of residents in aged care homes and advocated strongly for their inclusion as an eligible group for the Hearing Services Program. (40,41,56,57)

The Expert Panel has taken note of this advice, in addition to the Australian Government's response to the final report of the Royal Commission into Aged Care Quality and Safety. Although some permanent residents of aged care homes may have significant income or wealth that would enable them to acquire hearing services in the private market (and may indeed do so), the Expert Panel considers that the inclusion of all permanent residents in the eligibility criteria for the Hearing Services Program would facilitate equitable access to hearing health care for this very vulnerable population.

Table 8 provides an indicative estimate of the expected increase in number of clients and the annual cost per year to the Hearing Services Program over 4 years by extending eligibility to all permanent residents of aged care homes. The total additional spend over the 4 years would be about \$42.3 million.

**TABLE 8:** Indicative financial implications to extending access to the Hearing Services Program to all permanent aged care residents (based on costings associated with the voucher stream)

	Financial year increase on financial year 2019–20			
	2021–22	2022–23	2023–24	2024–25
Expected increase in number of clients	7,473	7,356	10,153	12,905
Total expected nominal increase in cost (\$'000s)	\$9,230.65	\$9,216.35	\$10,973.58	\$12,901.99
Expected annual compound growth increase (%) compared to financial year 2019–20	0.85%	0.56%	0.50%	0.47%

Source: Department of Health, Hearing Services Program data and statistics (internal).

**Assumptions:** These estimates have been modelled using existing Department of Health historical data. Assumptions have been made that the behavioural characteristics of the modelled population will match the current Pensioner Concession Card population and their level of hearing loss will match the prevalence rate in the UK study by Davis.(32) The cost of service provision assumes that they will receive their hearing services in the voucher stream and their rate of returning for services will match the existing voucher population.

**Limitations:** Clients who are either temporary or are receiving respite care, or have an unknown pension status, have been excluded from this model. Data provided by the Department of Health counted multiple clients, as some clients moved between facilities or had multiple entries when they changed their pension type. These data have been weighted based on age groups, so that they match the total reported number of aged care residents. Forecasts of the total number of permanent aged care residents have been based on historical aged care data.

Due to the way that residents are registered when their eligibility for aged care is assessed, it is not possible to identify all residents who may already be eligible for (and receiving) services through the Hearing Services Program under existing eligibility requirements. While most residents identify whether they are receiving a government pension, there are approximately 35,000 permanent aged care residents whose pension status is unknown. For simplicity this group of people has been excluded from the costing model, although not from eligibility under the recommendation. The Expert Panel understands that modelling the cost of expanding eligibility to all permanent residents of aged care homes, irrespective of their Age Pension status, could be in the order of approximately \$193.0 million over 4 years.

The Expert Panel also highlights that those currently eligible for the program may not be receiving services due to accessibility issues, as noted above and explored in more detail in **Chapter 4**.

The Expert Panel recognises that this could mean fluctuations in the numbers of clients and costs associated over the forward years and understands that the Department of Health would need to undertake further analysis and investigation in association with other areas of government to refine the estimated budgetary costs.

## Commonwealth Seniors Health Card holders

Although hearing loss is more prevalent in people aged 60 and above, the Hearing Services Program is generally only accessible to older people who hold a Pensioner Concession Card, hold a DVA Veteran Gold Card or Veteran White Card, are a member of the Australian Defence Force, or are eligible under the CSO stream. This means that many older Australians are potentially missing out on or are avoiding seeking professional hearing care due to the costs associated with paying for care privately, although motivation, accessibility and other factors also play a part.(58)

There are other programs within Australia's social services systems through which older people can receive subsidised services based solely on their age rather than financial or other criteria. The debates inevitably centre on the balance of public and private benefits, equity of access, and capacity and sustainability to pay. A particular example is the Medicare item which allows people aged 75 years and older to access a health assessment. That assessment may also consider their social isolation, oral health, nutrition and need for community services but does not specifically require the GP to discuss hearing health issues or assess a person's level of hearing.(59)

Similarly, Commonwealth Seniors Health Card holders receive assistance with the cost of their health services, but again this does not include hearing care. The Expert Panel acknowledges that there are undiagnosed and under-treated hearing problems experienced by this population group which may restrict them from participating in a wide range of personal and public activities. This includes the role they play in the unpaid workforce as carers of elderly parents and/or grandchildren and as volunteers. Untreated hearing loss can also lead to reduced health-related quality of life and this in turn can result in higher ongoing costs to the health system. In calculating the cost of hearing loss for Australia in 2019–20, the Hearing Care Industry Association identified health system costs of approximately \$1.0 billion, which would include these costs incurred by Commonwealth Seniors Health Card holders.(7)

The Australian Government, through Services Australia, manages the eligibility for the Commonwealth Seniors Health Card, which includes being of Age Pension eligibility age; living in Australia (with citizenship or permanent visa); not receiving a DVA or Australian Government payment; and meeting an income test as outlined in Table 9 below.(60)

**TABLE 9:** Income test threshold for the Commonwealth Seniors Health Card (from 20 September 2020)

Status	Annual income
Single, no children	\$55,808
Couples	\$89,290
Couples separated by illness, respite care or prison	\$111,616

Source: Services Australia.

The Commonwealth Seniors Health Card was introduced in 1994 to give low-income retirees (people who are not pensioners but who have the same or lower income as age pensioners) access to similar Commonwealth concessions as holders of the Pensioner Concession Card. This included access to concessional prescription medicines under the Pharmaceutical Benefits Scheme (PBS), certain free basic dental services, and free hearing devices and hearing services through the Hearing Services Program. However, in 1997 the Australian Government removed Commonwealth Seniors Health Card holders' eligibility for the Hearing Services Program as part of a general government policy change to focus on the most vulnerable Australians accessing government services.(61)

In examining the options for extending eligibility, the Expert Panel noted that the current range of health benefits available to this group is quite limited. Specifically, they include only a discount on medicines under the PBS, the ability to be bulk billed by a GP (provided the GP agrees), limited Medicare claiming for audiological assessments (where referred by a GP or ENT specialist) and a refund for medical costs when they reach the Medicare Safety Net.(62) Some states and territories also reduce some health costs and these may include ambulance, dental and eye care.

One option considered by the Expert Panel would be to include this group of people in the voucher stream of the Hearing Services Program. However, as Table 10 shows, this would see over 235,000 people with mild or greater hearing loss joining the Hearing Services Program, with an estimated additional spend of \$265.85 million over 4 years. Additionally, this level of subsidy would be out of keeping with the types of benefits received for other health care for Commonwealth Seniors Health Card holders.

**TABLE 10:** Option 1: Indicative financial implications to extending access to the Hearing Services Program to Commonwealth Seniors Health Card holders (based on costings associated with the voucher stream)

	Financial year increase on financial year 2019–20			
	2021–22	2022–23	2023–24	2024–25
Expected increase in number of clients	39,834	43,463	64,994	88,631
Total expected nominal increase in cost (\$'000s)	\$49,201.80	\$54,451.70	\$71,193.80	\$91,004.10
Expected annual compound growth increase (%) compared to financial year 2019–20	9.07%	4.90%	4.20%	3.95%

Source: Department of Health, Hearing Services Program data and statistics (internal).

Assumptions: These estimates have been modelled using existing Department of Social Services historical data. Assumptions have been made that the behavioural characteristics of the modelled population will match the current Pensioner Concession Card population and their level of hearing loss will match the prevalence rate in the UK study by Davis. The cost of service provision assumes that they will receive their hearing services in the voucher stream and their rate of returning for services will match the existing voucher population. The costing model also assumes a new client cost in the first year of entry and then they move onto the maintenance costs after that. It cannot be assumed that all clients who join will actually use all the services. Based on historical client behaviour patterns, we have assumed that client behaviour effects their utilisation of hearing services in that not all clients will utilise all the hearing services available to them.

A second option, more in keeping with the principles underlying the other benefits available to Commonwealth Seniors Health Card holders, would be to provide important assistance while recognising the ability of this group to make personal contributions. In this respect, the Australian Government funds an annual health assessment for people aged 75 and older:

*[The assessment aims to] help identify any risk factors exhibited by an elderly patient that may require further health management. In addition to assessing a person's health status, a health assessment is used to identify a broad range of factors that influence a person's physical, psychological and social functioning.*(59)

Such an approach is consistent with the Expert Panel's proposed objective A1 (which addresses issues of cultural safety, equity and appropriateness of services) and objective D1 (which addresses individual, community and economic benefits from the program) for hearing services as outlined in **Chapter 2**.

Currently the Department of Health's suggested form for GPs for the 75+ health assessment includes, as one of the 'Optional Components as relevant to the patient', a section for the GP to report on the results of 'Assess hearing'.(63) However, this is not mandatory and does not equate to a full diagnostic hearing assessment. Many people aged 75 or older will already have received a full diagnostic hearing assessment as part of their participation in the Hearing Services Program. Many others who are eligible but are not active participants could also receive such an assessment if it was warranted, but do not – perhaps in part due to the separation of the hearing industry from general practice and other health care; and an assumption by GPs and individuals that hearing loss is a normal part of ageing.(64,65)

The Expert Panel considers that there would be benefit in using the annual 75+ health assessment as a prompt for many older people to focus on their hearing by funding, when warranted, a full diagnostic hearing assessment as part of the health assessment for those who are not already eligible under the program. Medicare audiological assessment items are available to Medicare holders when referred by a GP or ENT specialist and would be available to people experiencing hearing loss who are not eligible for the program but need comprehensive hearing testing. As currently applies to the option to 'Assess hearing', this assessment would be optional, and the GP and their patient may choose to forgo it in any year in which there is no evidence of a significant increase in hearing loss.

Based on the number of people aged 75 and older who have a health assessment each year, the maximum likely annual cost of a full diagnostic hearing assessment would be in the order of \$107.4 million. However, the actual number of instances where it is agreed between the patient and the GP that such a test is warranted is likely to be lower due to the factors mentioned above.

Stakeholder responses to the Expert Panel's draft report also noted the potential value of including hearing loss in the health assessments for people under the age of 50 years. (30,39–41,56,57,66–68) The Expert Panel considers that inclusion of hearing loss in relevant existing Medicare health assessments could facilitate early identification and intervention, which might include communication support and education.

The Expert Panel has identified the following current Medicare assessment items as being relevant:

- a health assessment for people aged 75 years and older
- a health assessment for people aged 45–49 years who are at risk of developing chronic disease
- a comprehensive medical assessment for permanent residents of aged care homes

- a health assessment for people with an intellectual disability
- a health assessment for refugees and other humanitarian entrants
- a health assessment for Aboriginal and Torres Strait Islander people (children and adults).

Accordingly, the Expert Panel has included these health assessments in its recommendation. It suggests that the Department of Health consult internally on the costs associated with this proposal and refer the matter to the Medical Services Advisory Committee as appropriate.

### Tinnitus sufferers

The medical condition tinnitus can be a cause of hearing loss, but it can be treated medically as a standalone condition through the use of tinnitus inhibitors and other types of rehabilitation. While tinnitus cannot be the sole reason to provide hearing devices under the Hearing Services Program, there is already a provision under the program that allows for fitting where it can be shown to address mild hearing loss and reduce severe or constant tinnitus that significantly affects quality of life. Documented evidence submitted by providers must show that aiding the client has had successful outcomes for both their hearing loss and tinnitus relief.(69) Accordingly, the Expert Panel considers that tinnitus by itself does not warrant the provision of all services under the Hearing Services Program.

Instead, the proposed reforms, which aim to encourage more holistic care focus on communication and education needs as opposed to just hearing loss (detailed in **Chapter 4**), and the suggestion of a phased communication/rehabilitation services delivery model, would mean that those eligible to access the program who suffer from tinnitus may be able to receive services similar to those who are below the MHLT levels. These reforms might help people suffering from tinnitus to deal with their condition and improve their communication and daily functioning.

### Adults over 65 years with a cochlear implant

The Expert Panel is advised that the Department of Health has contracted the National Acoustics Laboratory (NAL) to conduct an evaluation of the clinical effectiveness and cost-effectiveness of upgrading cochlear implant sound processors through the Hearing Services Program. The NAL report is anticipated at the end of 2022. Any recommendation on this matter should await the completion of that evaluation.(70)

### People in the criminal justice system

The provision of health services (including hearing health) to prisoners is the responsibility of the state and territory governments and is therefore outside the scope of this review. From the perspective of the Hearing Services Program, people who are already voucher stream clients at the time of incarceration are entitled to receive the services available on their voucher for the remaining period of that voucher where practicable to receive them. If the prisoner has lost their eligibility as they are now incarcerated – for example, they no longer hold a Pensioner Concession Card – then, when their existing voucher expires, they will not be able to receive a new voucher until they become eligible again. CSO clients do not lose eligibility for the CSO stream as result of incarceration. Access to services from prison, however, will depend on the health services that jurisdictions provide to prisoners; local prison arrangements and locations; and the qualifications and skills of prison health service personnel.



The Expert Panel also supports the following key actions of the *Roadmap for Hearing Health* that hope to increase the identification of hearing loss among those who are incarcerated:

*State and Territory prison health services undertake an audit of existing services and funding relating to the hearing health of prisoners, including hearing screening, access to diagnostic and rehabilitative hearing services and to specialist ENT services ...*

*State and Territory prison health services implement routine hearing screening of at least high-risk people, including Aboriginal and Torres Strait Islander prisoners, and referral to further services as appropriate to their hearing health needs and period of incarceration.(4)*

## Recommendations

### Recommendation 2: Modernising the voucher stream terminology

The Australian Government should replace the term ‘voucher stream’ with a term such as ‘Hearing Benefits Scheme’ to modernise the program terminology and better reflect the purpose of the stream (noting that the current term ‘voucher stream’ has been retained throughout this report).

### Recommendation 3: Clearer delineation of Community Service Obligations stream clients

The Australian Government should retain the eligibility all young Australians and young adults under 26 years of age to access hearing services through the Community Service Obligations stream, as currently provided for in the Australian Hearing Services (Declared Hearing Services) Determination 2019.

### Recommendation 4: Greater choice of provider for young adults and for adults with complex hearing needs

The Australian Government should enable adults from 21 years of age to have greater choice of provider on the following basis:

- 4(a) Subject to Recommendation 4(c), young adults from 21 to 25 years of age with hearing loss should be able to access hearing services from any Hearing Services Program Provider of their choice.
- 4(b) Subject to Recommendation 4(c), all voucher-eligible adults from 26 years of age who have complex hearing or communication needs and/or cochlear/bone anchored implants should be able to access appropriate specialist services from any Hearing Services Program provider of their choice.
- 4(c) The Australian Government should require all contracted service providers who intend to provide specialist services to people from 21 years of age who have complex hearing or communication needs and/or cochlear/bone anchored implants to demonstrate that they can support these clients with the capacity, skills and cultural awareness capabilities that accord with the standards and guidelines developed by the Practitioner Professional Bodies. The Australian Government should implement a system of audits to ensure that providers are appropriately claiming for specialist services delivered in accordance with this recommendation.

### **Recommendation 5: Extension of eligibility to additional priority populations**

The Australian Government should expand the categories of eligible people under the voucher stream to include:

- 5(a) people who are Low Income Health Care Card holders from 26 years until Age Pension eligibility age
- 5(b) Aboriginal and Torres Strait Islander people from 26 years of age
- 5(c) permanent residents of aged care homes.

### **Recommendation 6: Making better use of Medicare**

The Australian Government, through its management of Medicare, should encourage general practitioners (GPs) to undertake awareness raising of hearing health and, where considered warranted by the patient and GP, provide a referral for a full diagnostic hearing assessment for the following Medicare claimable items:

- a health assessment for people aged 75 years and older
- a health assessment for people aged 45–49 years who are at risk of developing chronic disease
- a comprehensive medical assessment for permanent residents of aged care homes
- a health assessment for people with an intellectual disability
- a health assessment for refugees and other humanitarian entrants
- a health assessment for Aboriginal and Torres Strait Islander peoples (children and adults).

# Chapter 4

## Improving the client experience and assessing need for support

### KEY POINTS

- The Department of Health routinely seeks consumer input on various aspects of the Hearing Services Program, but this could be formalised by establishing a consumer consultation process.
- There is consensus amongst existing clients and service providers that clients should have early access to information and resources to help them make informed choices about how to manage their hearing health, including selecting a contracted service provider, understanding the services that are available to meet their needs and having control over how those services are delivered.
- Positive outcomes from wearing hearing devices depend significantly on client motivation and support. Delayed use of hearing devices is often the result of an actual or perceived stigma associated with wearing a device, together with poor client readiness.
- Hearing impairment is complex, and the Hearing Services Program relies solely on the clinician's assessment of the client to determine if their hearing care needs are being fully identified and comprehensively addressed.
- Clinical need is evaluated primarily using pure tone audiometry assessment of hearing loss. Recent evidence indicates that this should not be the sole assessment option or the indicator of choice of hearing devices and/or rehabilitation services.
- There is limited information on the rehabilitation services being delivered to clients, in part due to the current bundling of fees. While addressing hearing loss with a hearing device is an integral part of hearing care, the scope and quantum of standalone services that aim to address communication, education and rehabilitation appear to be minimal.
- The Schedule of Service Items and Fees (Services Schedule) should be reviewed to ensure that items with a strong focus on communication and education support and rehabilitation are appropriately remunerated. The Services Schedule review should assess whether there is an unintended bias in profit margins which favours the supply and fitting of hearing devices ahead of providing these more holistic interventions. The outcome of the Services Schedule review could lead to a rebalancing of the fees.
- More flexible options for service delivery will be welcomed by some clients, including teleaudiology and settings-based service delivery models.
- There are high-priority diverse populations that experience additional challenges in receiving the care and treatment they require for hearing loss. As only approximately 39% of eligible people with mild or greater hearing loss actively participate in the Hearing Services Program, the barriers to access for the other 61% should be identified and addressed.
- One barrier to health care for Aboriginal and Torres Strait Islander people is the difficulty in accessing culturally appropriate hearing services. A second barrier is the low numbers of trained Aboriginal and Torres Strait Islander people delivering hearing health services.
- Barriers to accessing the services available through the Hearing Services Program are also experienced by people from culturally and linguistically diverse (CALD) backgrounds, those who live in rural and remote areas, and those living in aged care homes. This report proposes a range of initiatives that could reduce those barriers.

At the start of **Chapter 3** the point was made that, in terms of increasing access to the Hearing Services Program by people with hearing loss, there are 2 separate but related issues. The first, as dealt with in **Chapter 3**, is to broaden the scope of categories of eligible people under the program and open some cohorts to the private market. The second is to address barriers facing people who are eligible but do not access – or who have difficulty accessing – the available hearing services. Some of these barriers arise from their personal (or anticipated) experiences in accessing program services, as examined in this chapter. Other barriers, while interrelated, are more to do with issues of service delivery and are dealt with in **Chapter 5**.

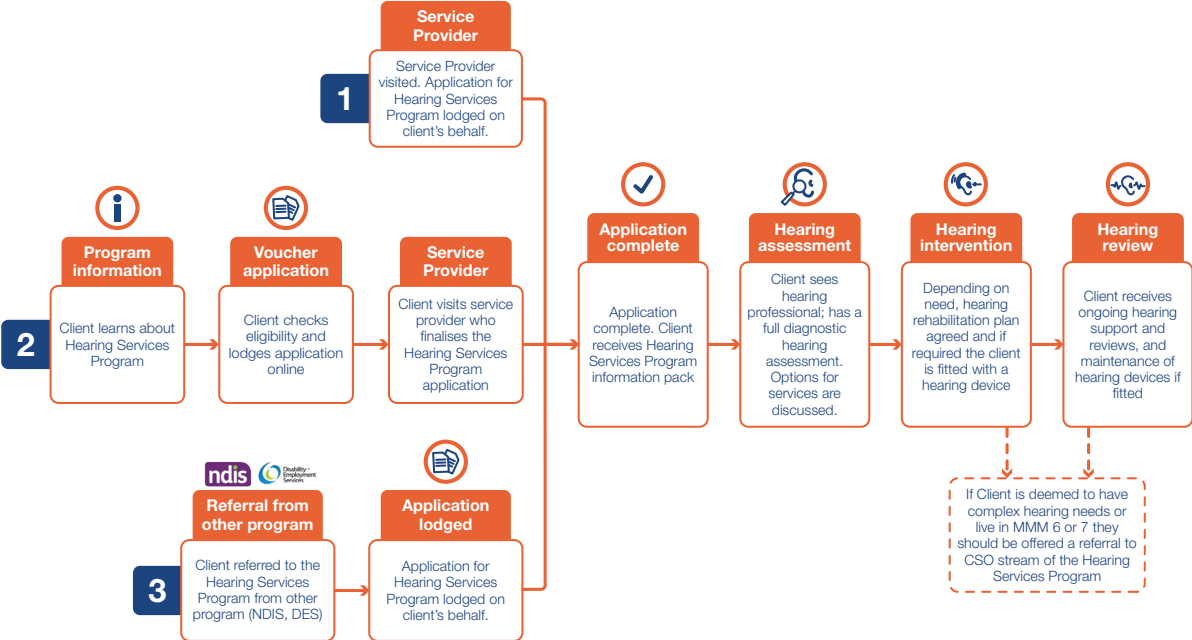
The experiences of people living with hearing loss when they are contemplating and preparing to access support services, and the experiences of those who do progress to being clients, determine whether the benefits of those services are equitably, effectively, efficiently and sustainably achieved – at personal, family and societal levels.

Of the estimated 2.1 million eligible people with mild or greater hearing loss, only 0.82 million (39%) are active participants in the Hearing Services Program (see Table 2 in **Chapter 3**), but not all of them are receiving the full range of services that could assist with their communication difficulties. Importantly, even greater gains can be achieved by also addressing the concerns and barriers facing the 61% of people with hearing loss who are eligible but who are not active in the program and do not receive care/services. There is considerable scope to reduce the current burden of hearing loss by addressing the hearing issues that affect their daily living.

## The client journey

Before looking more closely at the assessment of need and client experiences of the Hearing Services Program, it is useful to understand the typical client journey through the program. Figure 5 provides a visual representation of the main pathways through the voucher stream and Figure 6 through the Community Service Obligations (CSO) stream.

**Figure 5:** Client pathways in the Hearing Services Program (voucher stream)

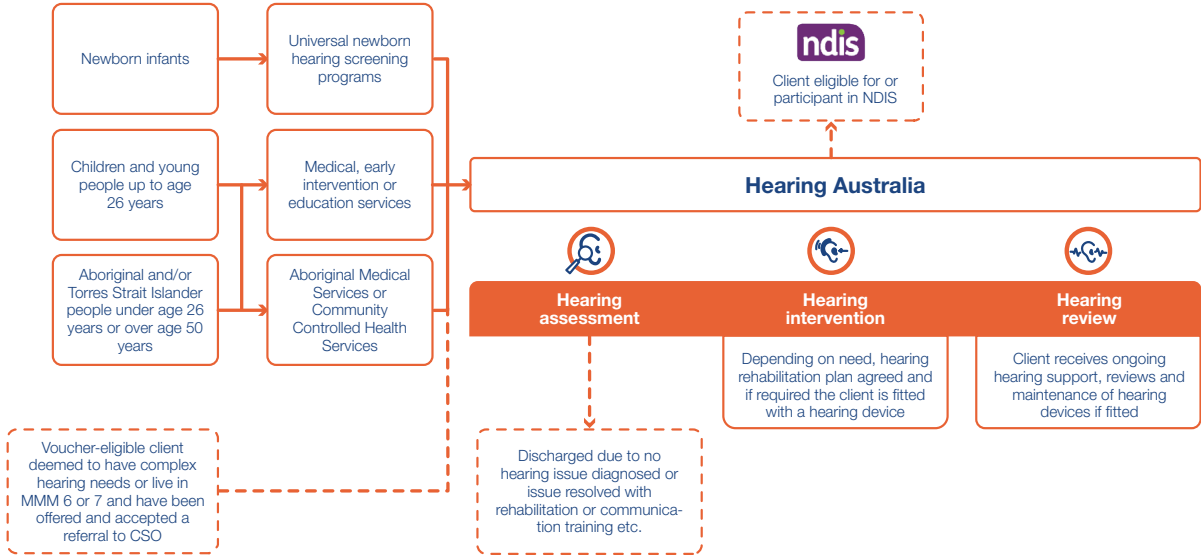


DES: Disability Employment Services; CSO: Community Service Obligations; MMM: Modified Monash Model; NDIS: National Disability Insurance Scheme.

As set out above, there are 3 main pathways a person with hearing loss can follow to receive publicly funded support under the voucher stream:

- They visit a hearing health clinician who is a contracted service provider. This often involves a hearing screening. The clinician informs their client whether they are eligible to access the program and lodges an application for a voucher on their client's behalf (90%).
- They learn about the program (for example, from a friend) and check eligibility. They lodge an application for a voucher online.
- They are already receiving services from another program, such as the National Disability Insurance Scheme (NDIS) or the Disability Employment Service (DES), and are referred to the voucher stream of the program.

**Figure 6:** Client pathways in the Hearing Services Program (Community Service Obligations stream)



CSO: Community Service Obligations; NDIS National Disability Insurance Scheme.

For access to the CSO stream:

- newborns are referred to the service once diagnosed as having a hearing loss through the Universal Newborn Hearing Screen or other similar neonatal service
- children and young people (up to the age of 26) are referred through medical, early intervention or education services
- Aboriginal and Torres Strait Islander people under 26 and over 50 years of age are referred through their provider (mainstream health and medical services or through an Aboriginal Medical Service or a service run by an Aboriginal Community Controlled Health Organisation (ACCHO))
- clients who are voucher and CSO eligible can access the CSO stream through the voucher stream or directly with the CSO stream.

Participants in the program who are eligible for or participants in the NDIS may be eligible for additional support under the NDIS, depending on their NDIS plan.

A second antecedent to this chapter is to understand the significance of delivering person-centred care and the characteristics of that modality.

## Providing a person-centred approach to hearing care and enhancing choice and control

A primary objective for the program, as proposed in **Chapter 2**, is that people with hearing loss should be able to exercise informed choice about, and control how to live with, hearing loss and to be supported in addressing their needs.

Numerous submissions to this review reported that clients of the Hearing Services Program express overall satisfaction with the hearing care they receive across both streams of the program.(24,25,71–78) Of note, many of these submissions were from organisations that have clients' interests as a part of their core role or have conducted client surveys as part of their role (for example, Deafness Forum of Australia; First Voice; NextSense, which was formerly known as the Royal Institute for Deaf and Blind Children; and Hearing Australia). However, as will be explored in these next 2 chapters, neither the client experiences nor the service delivery live up to best practice in facilitating choice and control.

While Australia's Practitioner Professional Bodies' codes of conduct and scope of practice include elements of client-centred care, there is no formal definition of 'patient-centred care' for the profession of audiology.(79) In contrast, the United Kingdom (UK) National Institute for Health and Care Excellence (NICE) published clinical guidance in 2018 in which it advised that audiological assessments should include:

1. the person's hearing and communication needs at home, at work, in education and in social situations
2. any psychosocial difficulties related to hearing
3. the person's expectations and motivations with respect to their hearing loss and the listening and communication strategies available to them.(80)

The NICE guidelines propose that hearing devices be 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', rather than to those who meet a minimum hearing threshold. This approach is based on individual need, with the best outcomes for the client at the forefront.

Similarly, though in the broader health context, the Australian Commission on Safety and Quality in Health Care defines patient-centred care as an approach to the planning, delivery and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients and families.(81) The commission states that the key dimensions of patient-centred care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of carers and family, and access to care.

This aligns with one of the guiding principles of the *Roadmap for Hearing Health* - 'that services are delivered in a person- and family-centric way – and ensure that individuals and their families can effectively exercise choice and control'.(4)

The current Hearing Services Program could be characterised as having a foundation of consumer sovereignty – consumers can choose to have their hearing screened and clinically assessed and can say yes or no to a hearing device (and then decide whether they will use it). However, many submissions reported that there are serious shortcomings in the program’s design and operation, as described below.

In a practical example, the Hearing Health Sector Alliance suggested:

*The Program, however, could enhance consumer choice and control. Consumers would benefit, for example, from more information about rehabilitation options available within the Program to support better informed choices. Consumer organisations could play an important role in disseminating this information. Providers, with appropriate reimbursement of their time, could spend more time with their clients explaining options and, if a hearing device is selected, how to maximise communication outcomes.(26)*

In support of this view, numerous submissions commented that the Hearing Services Program focuses too much on technological solutions and that, too often, the service offered is a prescription for a hearing device.(24,25,71–78) Because providers fail to offer clients a range of rehabilitation options, many clients find that their only decision is whether to accept a hearing device. Other care options are often only provided after a device has been declined. This behaviour of contracted service providers can be more driven by their business model than by the limitations in the program, although the structure of the Services Schedule is a contributory factor.

Additionally, Hearing Services Program funding does not allow for a client to receive independent support, such as through a case coordinator or case planner,(4,82) and the client often makes decisions that are not underpinned by comprehensive information.(26,71,72,82,83) Rehabilitation service items can be delivered by consumer and non-government organisations (NGOs), but currently those items must be coordinated and claimed by the contracted service provider. Each provider decides how those services are run and how the client is informed of this option.

In recognition of the importance of a person-centred approach to hearing care and the centrality of client choice and control, the Expert Panel has undertaken its review of the program through these lenses in accordance with its proposed objectives for the program.

The journey of having hearing loss assessed and managed can be challenging for people experiencing hearing loss and for their families. As explored next, the biggest initial challenge is to improve people’s understanding of hearing impairment and to help overcome any lack of motivation associated with receiving assistance.

## Overcoming barriers to addressing hearing impairment/loss

Measurement of a client’s communication ability and motivation to receive assistance is increasingly proving integral to improving client hearing outcomes. Research findings point to the complex factors that influence a person’s response to their hearing loss.

It is well established that a large proportion of people who have a hearing impairment choose not to seek help or have hearing devices.(84,85) Others delay seeking help and, as most age-related hearing loss happens gradually, it can take an average of about 9 years for a person to move from a stage of contemplation to action.(86)

Echalier has identified a number of factors that contribute to this delay:

- other priorities including health problems, disabilities or caring responsibilities
- a previous experience with hearing professionals or an attempt at wearing hearing devices that was unsuccessful
- only losing their hearing in one ear or being able to manage
- not seeing themselves as someone with hearing loss or a hearing device
- denial of any sign of the ageing process, including hearing loss.(87)

One audiologist submission to the review drew a comparison between the current personal acknowledgement of hearing loss with the high level of confidence most people have when seeking care for visual impairment:

*very few wait until their vision problems are so bad they lose their driving licence, or can no longer read. On average, people with hearing loss (and their families) endure the consequences of deteriorating communication for at least 10 years before seeking help.(82)*

Initially, the biggest challenge is at the contemplation stage, including helping people accept that they do have hearing loss and improving their level of readiness to receive help. People will usually only contemplate assistance if there are impacts or signs, such as concerns raised by family members or self-perceived indicators of hearing loss.(88)

Support to move from contemplation to action can include helping people become more informed about their options—for example, through community education and in pre-appointment screening as well as in services which improve readiness and motivation for receiving support and using a hearing device. Managing expectations and overcoming scepticism about the benefits of receiving care and support are other factors – research shows that a large proportion of those who do not seek care believe that hearing devices do not work.(50)

## Overcoming the stigma associated with hearing loss

For many, overcoming any actual or perceived stigma associated with their hearing loss is also a seminal early step.(89) Southall et al. (2010) found there can be a perceived association of hearing loss with old age as well as with incompetence, cognitive impairment and social impairment.(90)

Similarly, other research results point to ‘the pervasiveness of perceived stigma associated with hearing loss and use of hearing aids and their close association with ageism and perceptions of disability’.(91)

The 2019 *Roadmap for Hearing Health* refers to the stigma of hearing loss, calling it the ‘hidden or invisible disability’, where people with hearing loss are viewed as being cognitively impaired or less able or they are simply ignored. The Roadmap aims to eliminate this stigma by ensuring that, when people recognise that they or a family member may have a hearing loss, they know how to get help and are encouraged to do so quickly.(4)



## Improving availability of information to facilitate choice and control

Central to a person with hearing loss being able to make an informed choice is the availability of accessible and objective information. While a person's preparation to take action about their hearing loss depends on them having sound information, it is the view of some stakeholders that this level of information is not readily available through the Hearing Services Program.

Hearing Australia noted that:

*Consumer choice is driven by transparency and unfortunately there is incomplete information about eligibility, providers, services and devices – all the necessary building blocks to place the choice and control into the hands of users.(74)*

This view is supported by Deafness Forum of Australia, which stated:

*The HSP has some written information available on its website (about) partially subsidised devices but this is not sufficient from a consumer perspective.(24)*

It is recognised within the Department of Health that the Hearing Services Program has traditionally placed the responsibility for promoting program eligibility and hearing services with contracted service providers. However, an unintended consequence is that the current arrangements enable the service provider to determine both the information that the client receives and the timing and type of hearing services provided to them.

The PricewaterhouseCoopers (PwC) *Review of services and technology supply in the Hearing Services Program* (2017) concluded that clients have minimal access to vital information that could improve the quality of their decision-making and that more was needed to educate clients and increase client health literacy.(92) The 2017 Australian Competition and Consumer Commission (ACCC) inquiry into the hearing sector and the parliamentary inquiry *Still waiting to be Heard ... Report on the Inquiry into the Hearing Health and Wellbeing of Australia (Still Waiting to be Heard)* identified contributing factors as including the vertical integration in the industry (ownership or control of clinics by manufacturers or distributors) and the lack of disclosure of sales incentives to consumers.(46,93)

Manufacturers and industry associations, however, had a strong view that clients do receive independent advice and saw no need to introduce mechanisms to address the concerns raised by the ACCC.

The current situation is not consistent with research which reports that clients want a therapeutic relationship with their clinician. They want to be informed and involved, and they want individualised care. As Hickson noted:

*It is clear from the research that choices provided to clients are typically not offered in a way that facilitates shared decision making (a central tenet of person- and family-centred care) and information that is provided focuses on the device alone and does not include communication education or counselling.(78)*

Numerous submissions commented on the need for greater transparency of information to improve client choices and control over their services.

The Hearing Health Sector Alliance, which includes consumer representation, suggested providing greater transparency about what is available to clients to enable them, together with their provider, to make better informed decisions about their options.<sup>(26)</sup> Audiology Australia suggested simplifying and ‘unbundling’ the model of claiming under the Hearing Services Program so that the cost of devices and audiology services would be itemised and separated out. The organisation argued that this could help improve transparency (particularly of the voucher stream) and enable clients to better understand where the expenses lie. In many cases the expense lies with the device.<sup>(25)</sup>

The Expert Panel considers that there are 4 possible approaches to increasing the availability of information for clients to make informed decisions about, and have control over, their hearing care. These are examined below.

## Improving the Hearing Services Program public information website

Improvements to the Hearing Services Program website and the creation of a range of illustrative client pathways are options to facilitate improved and informed decision-making by clients.

Hearing Australia considered that the program’s website is difficult to navigate, it is difficult to find information quickly and, as such, the website is not client-centred. It recommended an overhaul of the website and listed the following priorities:

- improve the eligibility search function
- remove the disclosure of personal information as a gateway to information about eligibility
- clearly state the pathway for parents seeking information about child eligibility and access
- expand information and functionality of the provider search function
- integrate with other government information portals, including the government’s myGov and Healthdirect Australia portals
- expand the types of information channels that are available, including online chat, and provide information in languages other than English (including Australian Sign Language).

The My Aged Care website is an example of client or consumer-focused information that aims to instil confidence among consumers needing critical services.<sup>(94)</sup> The information on this website maps the journey from the initial decision to explore aged care, provides details of eligibility and assessment criteria, links potential consumers to providers and helps consumers manage their services through an online account.

The My Aged Care website has undergone several enhancements since it was first introduced in 2013. The final report of the Royal Commission into Aged Care Quality and Safety, released in February 2021, called for more accessible and usable information on aged care to be included on the website. Its recommendation 27 stated:

*The Australian Government should continue to enhance My Aged Care to ensure it is the Government’s official source of consistent, accessible, inclusive, reliable and useful information about the aged care system and aged care providers.<sup>(95)</sup>*

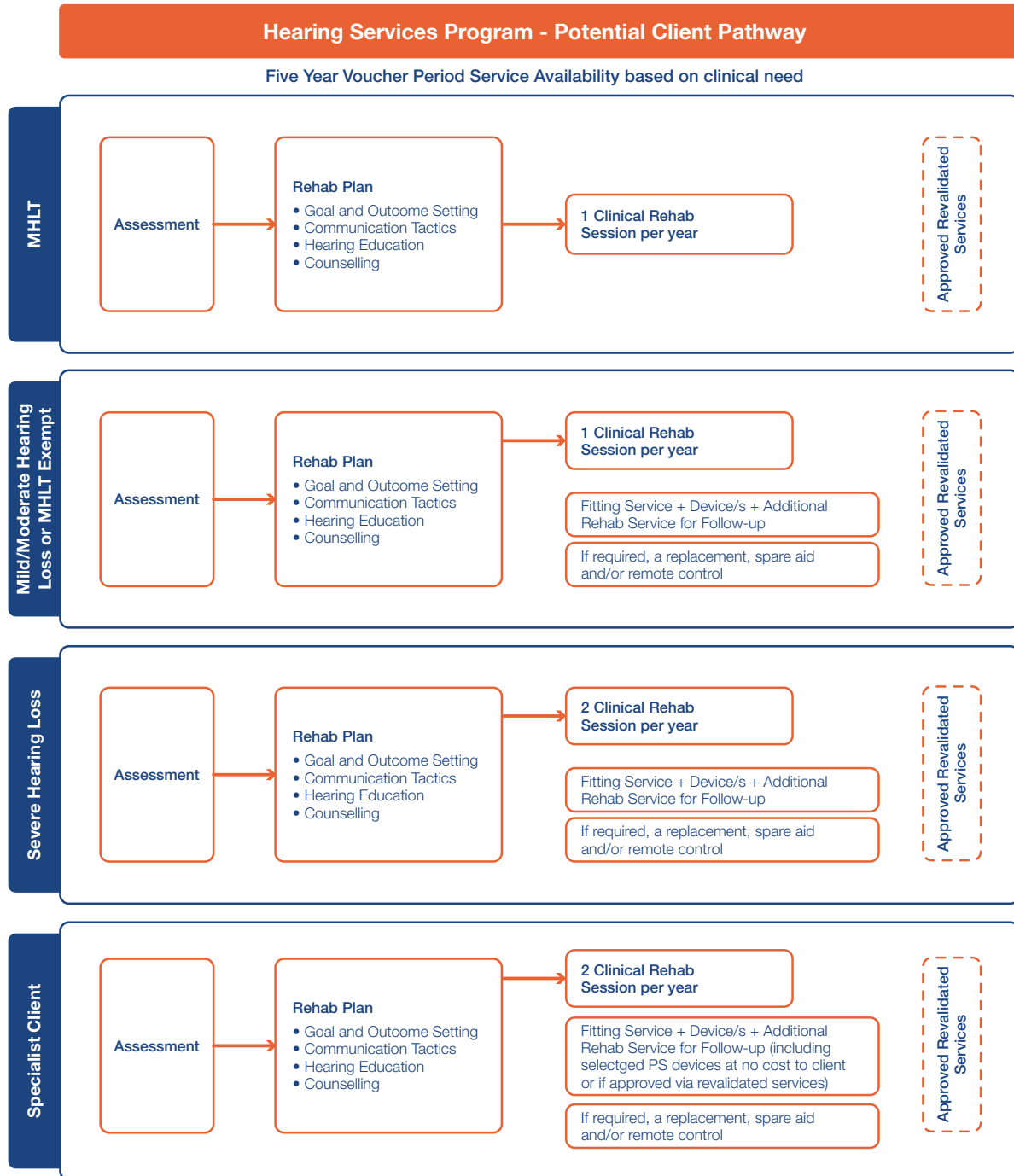
The Royal Commission’s report suggested creating a comprehensive provider search function that allowed consumers to review and compare more details on service providers.

The Hearing Services Program website is the primary communication channel for information relating to the program for professionals and clients. It also hosts the Hearing Services Online portal. The Expert Panel considers the current program website needs significant renovation to provide clearer and more informative guidance to those people experiencing hearing loss and to their family, friends, workplaces and others. Greater transparency about contracted service providers, the services they actually deliver and their links with manufacturers should also be included.

The Expert Panel acknowledges that, in response to previous feedback about this issue, a scientific writing company has been contracted by the Department of Health to review the website and its contents and to make recommendations for improvement. At the time of issuing this report, the contractor has been conducting user research with internal and external stakeholders to determine how people interact with the website. A final report and recommendations are due in August 2021.

The Expert Panel considers that it would be valuable for people with hearing loss if the Department of Health developed a range of illustrative client service pathways on the website that clearly show the treatment options and referrals for clients who are eligible for hearing services in the voucher stream and the CSO stream. Figure 7 shows a simple, illustrative set of pathways that describe the range of services possibly open to 4 categories of program clients (described later in this chapter under 'Enhancing the delivery of communication support and rehabilitation'). As stated in Recommendation 8, the Expert Panel envisages that there be stakeholder consultation on developing service pathways and decision aids.

Figure 7: Hearing Services Program – potential client pathways



MHLT: Minimum Hearing Loss Threshold.

The pathways will help clients to understand the various service options, depending on need, and would include links to appropriate services or information. Links to other programs and departments involved in hearing health and/or disability would be included. Service pathways should be developed with all relevant hearing health stakeholder groups, including those representing diverse consumer groups. Such an approach was well supported by stakeholders who responded to the Expert Panel's draft report.(29,39–41,54,57,68,96–98)

Audiology Australia also suggested:

*[These pathways] should include information about what level of hearing aid and assistive listening technology is available through the CSO stream, counselling services offered, and other services not related to technology. The pathways should highlight how the Program interacts with other programs/services such as the NDIS, Medicare, private health funds, employment assistance programs, education services, and identify costs that may still need to be funded by the individual.(41)*

The website should also improve its guidance to people who are not eligible for the Hearing Services Program but who are seeking assistance with managing their hearing loss. This could be provided through the service pathways.

The Expert Panel considers that, following any changes to the Hearing Services Online website made on the basis of the recommendations of this review, the website should be re-evaluated in 2023 to assess whether these changes are proving effective in informing and empowering people with hearing loss and other people who provide care and support. The Department of Health should continue to monitor better practice across other social service websites.

## Engaging with consumer organisations

There are several organisations which provide a consumer voice about hearing health. They offer support and education for children, adults and families, and some have a stronger advocacy role. Deafness Forum of Australia is a peak national body that represents the interests of all Australians with hearing loss and includes smaller and more specific consumer groups. It has a mission to make hearing health and wellbeing a national priority in Australia (99) and is an active member of the Hearing Health Sector Alliance. The Hearing Health Sector Alliance argued that there are strong benefits in improving collaborations with consumer groups to assist with developing and disseminating client information.

Deafness Forum of Australia considered that consumer organisations can play a more active role in supporting consumers. For instance, in relation to the selection of a hearing device, it stated:

*Understanding the range of devices available under the Voucher Program is overwhelming for a client's perspective. Consumers are generally more interested in how the device can help them rather than the brand name of the device ... it is difficult for consumers to compare devices. Consumers also need to make decisions on whether the fully subsidised devices will be adequate for their needs or whether they should invest in higher level technology ... Consumer organisations or an independent help line could help provide clarity for those clients who want to consult with someone else before making a decision.(24)*

First Voice suggested that the Hearing Services Program could establish a 'National Hearing Loss Family Support Service', where:

*[Providers] offer effective counselling and support for families at the various stages of their child's life to support choices that impact on their development ... [and] support families of children with a permanent hearing loss minimise the time between a child's diagnosis and uptake of the required support and services; ensuring access for all Australian children with hearing loss to the best possible supports.(100)*

The Expert Panel agrees that there is scope for more formalised consultation between the Hearing Services Program administration and consumer groups to enable the latter to be of greater value to people with hearing loss as they navigate the program and the hearing services sector more generally. A hearing services consumer consultation forum could be established with consumers and representative consumer organisations to facilitate information exchange and to seek advice on improving the equitable, effective, efficient and sustainable functioning of the program and associated hearing activities. This suggestion in the Expert Panel's draft report was positively received by organisations representing consumers, with Deafness Forum of Australia noting that:

*consideration could be given to funding the time to attend these consultations, to consult with members to get a representative view and to communicate any finding with the members. Consumer representatives may also benefit from receiving some training in how to be balanced and informed advocates as they can feel intimidated in consultations involving industry experts. Any consumer consultation must always be communications accessible with real-time captions provided and a hearing loop and interpreting available on request.(40)*

Connect Hearing went further, advising that beyond the suggested client or consumer consultation, it would like to see 'stakeholder groups charged with creating tangible action plans as a Hearing Services Program partner to address education and motivation issues behind access'.(67)

Several provider and professional organisation stakeholders suggested this forum should be formalised as a standing committee, with representation from across the sector.(29–31,39,66,67) However, the Expert Panel considers that this forum should be specific to consumers, so that the consumer and client voice will be clearly heard. It should be structured to reflect diversity, language and different modes of communication across the different consumer communities, including paying attention to the voices of veterans. Representative consumer organisations would be supported to build consumer capability and enable informed consumer input into the Hearing Services Program.(101)

The proposed forum would be one component of the comprehensive consultative processes employed by the Hearing Services Program and does not preclude ongoing consultation with the broader hearing health stakeholder network.

In addition, there would be scope for consumer organisations to be considered as suppliers for some services such as rehabilitation and support, with the organisations to be funded as (non-audiologist/audiometrist) contracted service providers through the program.

## Using decision aids for hearing health care

Providing clients with a pre-assessment decision aid to help them understand the signs and consequences of their hearing impairment can assist them make more informed choices.

A 2016 study by Pryce et al. identified that:

*Decision making occurs before meeting with an audiologist and preferences and values shape the decision to seek clinical help. The way in which the individual decides to seek help is an important context for the decision making that occurs during clinical appointments ... Participants all described a gradual process of evaluating signs and symptoms before seeking help and a gradual evaluation of hearing behaviour as atypical.(102)*

Ottawa Hospital Research Institute defines decision aids in the following way:

*[Decision aids are] tools that help people become involved in decision making by making explicit the decisions that need to be made, providing information about the options and outcomes, and by clarifying personal values. They are designed to complement, rather than replace, counselling from a health practitioner.(103)*

Decision aids summarise intervention options and the expected outcomes of each option according to recent scientific literature, and they can be presented in a simple visual format which adheres to health literacy principles. According to Hargraves et al., such aids should address the 6 elements of shared decision-making: situation diagnosis, choice awareness, option clarification, discussion of harms and benefits, patient preferences deliberation, and making the decision.(104) Hickson argues that this contrasts with the current practice in audiology, which remains hearing device focused.(78)

Laplante-Levesque et al. (2012) offered 153 adults with untreated hearing loss options for treatment using decision aids. They found that only 43% obtained hearing devices using this approach, while 18% completed communication programs and 39% decided to take no action. (105) An international systematic review of over 100 research studies found that, when people use decision aids, they improve their knowledge of the options and feel better informed and clearer about what matters most to them.(106)

The Australian Commission on Safety and Quality in Health Care has guidance on the use of decision aids, with the aim of encouraging a more client-centred service delivery.(107) Guidelines to support the content, development, implementation, and evaluation of decision aids are also available through the International Patient Decision Aid Standards (IPDAS) Collaboration.(108)

The Expert Panel has considered 2 options for the greater use of decision aids.

**Option 1** would incorporate a privacy-protected decision aid tool in the Hearing Services Program's website to enable prospective clients to test their motivation to address their hearing impairment as part of their consideration as to whether to join the program. This may be of particular help to those who are experiencing hearing loss and who are not currently accessing the program. The cost of including a decision aid tool on the website would be minimal, as it would be limited to the cost of development, user testing and certification prior to being put into production, and the cost of updating it as the scientific literature evolves and user feedback identifies worthwhile modifications.

Most stakeholders responding to the Expert Panel's draft report were supportive of the development of decision aid tools and their availability on the Hearing Services Program website, on the proviso that they were co-designed with the broad range of stakeholders, were rigorous, clearly showed links to related programs and services, did not constitute an extra step (and therefore a barrier) to clients seeking to access the program, and did not override or supersede clinical advice.

**Option 2** would require the inclusion of a decision aid tool in the hearing assessment process, with the data stored in the client's clinical file. This would require clinicians to receive additional professional training on how to incorporate a decision aid tool, as an adjunct to usual clinical assessment and documentation, if they do not have that skill set. The additional documentation would reflect an assessment of psychosocial and lifestyle factors, conducted in conversation with clients, that need to be taken into consideration as part of a comprehensive hearing health assessment.

The benefits of this second option would include greater transparency of decision-making by displaying the options for treatment more openly to clients and involving them more in this step of their care. Evidence suggests there would be no adverse effects on health outcomes or satisfaction.(106)

This option would increase the amount of time taken to undertake the hearing assessment. Assuming in broad terms an additional 5 minutes per assessment, and approximate costing for 300,000 assessments (the equivalent of 25,000 hours at \$144 per hour), this option may require an investment of approximately \$3.6 million per year.

In response to the Expert Panel's draft report, some service providers advised that they already use decision aid tools in their interactions with clients and queried the administrative burden associated with this option.(29,30,66,101)

The Expert Panel concludes that decision aids could be valuable tools to enable people with hearing loss to exercise informed choice about, and control, how to live with their hearing loss. The Expert Panel further considers that Option 1 should be adopted initially following full consultation with stakeholders and a co-design approach. There should be a review undertaken with relevant stakeholders within 2 years of commencement of the use of website decision aid tools, to assess whether Option 1 is adequate and/or whether Option 2 should be trialed before possible full implementation.

## Availability of translation, interpreting and Auslan services

The greater use of translation and interpreting services may improve the quality of information and service provision in this challenging area of health care for those from culturally and linguistically diverse backgrounds and those whose first language is an Aboriginal and Torres Strait Islander language.

The Australian Commission on Safety and Quality in Health Care report on consumer health information needs and preferences states:

*Providing understandable and accessible health information can improve people's knowledge, understanding and recall about their health and care. It can also increase their feelings of empowerment, improve their ability to cope, increase satisfaction, support shared decision making and contribute to improved health literacy, so that people can be partners in their health care. (109)*



The national Translating and Interpreting Service (TIS) provides free services to non-English speaking Australian citizens and permanent residents when they communicate with 'approved groups and individuals'. However, audiologists and audiometrists have not been declared as approved groups or individuals. There remains an ongoing challenge where practitioners are relying on family members or carers for interpretation, and this is likely to impact on the quality of information flows.

The NDIS funds interpreting and translation services for all deaf people eligible for the scheme (children and adults under 65). Unlike the NDIS, the Hearing Services Program does not currently fund translation, interpreting or Auslan services, despite recommendations from the *Roadmap for Hearing Health* and previous hearing sector inquiries.(4,46,110)

Auslan services are available to deaf, deafblind and hard of hearing people of all ages through numerous avenues. There are also a number of Australian Government funded programs currently available and described below, as well as the NDIS option described above.

The National Auslan Interpreter Booking and Payment Service (NABS) provides interpreters for deaf, deafblind and hard of hearing people who use sign language and need an interpreter for private health care appointments. The program does not cover public or private hospitals. NABS is free to people who are not eligible for NDIS, such as people over 65 years, and for their health care provider. It is funded by the Department of Social Services and is managed by Wesley Mission. Health care appointments which are covered by the NABS program include appointments with general practitioners, specialists and specified health appointments, such as appointments with audiologists, Aboriginal Health Workers, dentists, medical imaging technologists, mental health specialists, optometrists, physiotherapists and speech pathologists.

The free sign language interpreting service for deaf seniors (over 65) is funded by the Department of Health. This service supports engagement with and access to the aged care system, attendance at essential appointments and transactions (for example, banking, insurance, real estate, and medical appointments not covered by the NABS program) and social events (for example, weddings, funerals and graduations). Face-to-face and video remote interpreting services are available under the service.

Patients, their families, and carers who do not speak English as a first language or who are deaf can also access free, confidential and professional interpreting services when they use public health services funded by state and territory governments. This covers more than 100 languages and Auslan.

The Expert Panel considers that free and equitable access to interpreters and translation services for all clients of the program is very important. It advises that the program should ensure that audiologists and audiometrists are aware of the Auslan services available under the NDIS and the NABS program and know how to access these services. The Expert Panel supports audiologists and audiometrists being included as 'approved groups and individuals' with TIS.

## Assessment of hearing loss and communication needs

Currently under the voucher stream, every client is entitled to an assessment under the program and, depending on the assessment results and their hearing goals and needs, they are entitled to receive an appropriate support program which includes the supply and fitting of a hearing device if appropriate. Where there is a demonstrated clinical need, contracted service providers are able to apply on behalf of their clients for a subsequent revalidated service which, if approved, allows for the provision of an additional funded assessment or fitting service if that service has already been used on their current voucher.

The program currently sets criteria around the minimum level of hearing loss that a vouchered person needs to have in order for them to be eligible to receive a fitting of a hearing device to the ear being tested. This is the Minimum Hearing Loss Threshold (MHLT). There are exemptions under the program for clients whose hearing loss is below the MHLT, but the presumption (although not necessarily the fact) is that these clients would be provided, instead, with a rehabilitation service which delivers communication training and strategies to manage their hearing loss.(69)

The PwC review (2017) found that the current MHLT, and practices for measuring it, do not align to international definitions. MHLT does not align with the World Health Organization's (WHO's) definition of disabling hearing loss (measured on 4 FAHL) and it does not adopt the most common form of Frequency Average Hearing Loss measurement used by practitioners (4 FAHL, consisting of measurements at 0.5, 1, 2, and 4 kHz).(92)

The PwC review noted that state-based workers compensation schemes adopt different stances on measuring eligibility due to hearing loss. For example, the State Insurance Regulatory Authority New South Wales evaluates impairment through binaural hearing impairment evaluations as defined by the National Acoustic Laboratories (NAL).(92)

In addition, PwC found that there is empirical evidence to indicate that the lower the severity of hearing loss, the less likely the individual is to desire to use hearing devices. The PwC review suggested this might reflect on the efficacy of the current MHLT.

It was consistently reported to the Expert Panel that use of the MHLT as the sole tool for discerning a client's eligibility for the program has limitations and that research indicates that the use of pure tone audiometry tests alone does not fully measure the impact of hearing impairment. (111) First and foremost, hearing loss is complex, and relying on a threshold set by pure tone audiometry may not be ideal for measuring hearing health. In addition, the MHLT only refers to the fitting of hearing devices and does not specifically reference the use of other interventions such as communications training or fitting an alternative listening device that may benefit a client. The UK National Institute for Clinical Excellence proposes, instead of relying on an audiogram alone, that the ability to communicate should be the prime criterion for assessment.(78)

In parallel with this review, the NAL is carrying out a project called 'Defining Eligibility for the Hearing Services Program', which will aim to develop a robust, evidence-based and clinically practicable method of determining which older adults should be fitted with hearing devices. It is likely that this project will be delivered in July 2021 and will be considered by the government in line with the final version of this report. According to the NAL website:

*The current criteria of hearing sensitivity for assessing who should be fit with hearing aid devices is a poor predictor of hearing aid use and benefit, therefore the audiogram alone is unlikely to be the best measure to identify who should get hearing aids in*

*terms of patient benefit. Instead, eligibility criteria that includes other measures such as self-reported hearing disability, readiness to wear hearing aids, expectations, and individual needs has the potential to better identify those who would benefit from and use hearing aids in the [Hearing Services Program], and thereby improve hearing outcomes from the program. (112)*

During the course of its review, the Expert Panel has been advised of a range of options to change the current MHLT in various ways. However, it considers that the better approach to this issue is to await the completion of the NAL report rather than invest in further consideration and analysis of amendments to the MHLT at this stage.

More importantly, the Expert Panel considers that hearing assessment should be redefined to be a comprehensive process that includes an assessment of an individual's communication requirements, lifestyle and life circumstances, and psychosocial needs. This will provide for a more holistic assessment and management of hearing health needs in the context of a client's life circumstance, such as culture, language, cognitive capacity and living environment. Such an assessment approach needs to be complemented by the delivery of services that address the diverse needs of people identified through the process and help them manage their situation. These issues are examined in the following section.

## Enhancing the delivery of communication support and rehabilitation services

A study on the effectiveness of hearing devices (though not including a comparative assessment of non-device hearing management such as visual aids, alert systems and other ways to improve communication without using a hearing device) found that they are a key component in comprehensive care and support for many people experiencing hearing loss and contribute to improving quality of life and communication.(113) The Hearing Business Alliance noted that hearing amplification is a fundamental and integral part of hearing rehabilitation, not an alternative.

Nonetheless, feedback on the *Hearing Services Program Review* consultation paper referred to the opportunity to use a less technology-focused approach in 2 phases of clients' hearing health care:

- as an alternative to simply being prescribed a hearing device
- to better prepare clients for using a device once the client has made that informed choice.

This is consistent with the UK National Institute for Health and Care Excellence advice in its 2018 guidelines that hearing care encompass 'the person's hearing and communication needs at home, at work or in education, and in social situations; any psychosocial difficulties related to hearing; and the person's expectations and motivations with respect to their hearing loss and the listening and communication strategies available to them'.(80)

NAL notes that:

*evidence suggests that the combination of the provision of hearing aid devices and the provision of practitioner services that includes counselling improves client satisfaction with their hearing health care.(114)*

## The role of enhancing communication and rehabilitation

Rehabilitation, as it is commonly understood in the program, is an important element of hearing health care, both prior to and as an alternative to a hearing device, and as an integral component of hearing device selection, fitting and use. Professional organisations and service providers claim that they strongly support rehabilitation services; and that audiologists are qualified to, and do, provide those services as part of assessment, hearing device selection and client follow-up. However, submissions to the Expert Panel's draft report indicated that, while some audiologists provide comprehensive 'rehabilitation' services around device fitting, others do not, for various reasons.

Some providers, professionals and consumer groups argue that audiologists are limited by time and funding in providing more, and more effective, rehabilitation support.

Audiology Australia commented that clients often experience psychosocial distress due to communication breakdown caused by hearing loss. This professional organisation believes that its members are well placed to provide support and intervention and that the program's 'Rehab Plus' code should be expanded to include support and training for not just communication but also emotional and psychosocial support and social skills training for people with and without hearing devices or assistive listening devices and at various stages of life.<sup>(25)</sup> Bennett et al. (2020) argue that time and funding are 2 key barriers preventing Australian audiologists from providing emotional support to clients, including referrals to mental health professionals.<sup>(115)</sup>

Specsavers suggested the claiming arrangements mask rehabilitative services that are already provided by some clinicians:

*Other rehabilitation services are often under claimed due to confusion around the claiming requirements and some providers are actually providing the services as part of their clinical practice but not claiming. There is also the limitation that rehabilitation services following hearing aid device fittings can only be claimed for those fitted with fully subsidised hearing aid devices and not partially subsidised. This makes no sense from an end-user perspective as the need for rehabilitation services is not determined by the financial contribution of the individual.<sup>(116)</sup>*

Audika Australia argued that rehabilitation services are important but that they cannot replace the usefulness of a hearing device for helping with hearing loss:

*These services do not and cannot replace devices; they are a critical adjunct to using a device and can help build comfort and confidence in users. Rehabilitation services provide helpful strategies to manage hearing loss but do not meaningfully delay the need for a device for someone meeting the loss criteria for the HSP.<sup>(94)</sup>*

The commercial considerations of providers were raised in a submission to the review by N and S Clutterbuck, who noted the revenue challenges for contracted service providers to provide and fit devices as well as deliver related rehabilitation services and how these affect client communication outcomes:

*There is a tendency to focus on fitting the device, rather than supporting the effective use of the device to minimise communication problems. This latter service takes time when responding to the individual needs of the client, but providers report that such time is not compensated in the current funding model. Attempts at correcting this by enhancements of the Program such as 'Rehab Plus' have not had good take up because there is no focus on rewarding successful outcomes.<sup>(82)</sup>*

People with hearing loss come to service providers with significantly different needs, reflecting their unique circumstances, yet the failure to offer all rehabilitation options to clients means that many find that their only decision is about accepting or refusing hearing devices. In the current model of service provision, addressing the client's non-device-centric communication needs – often referred to as 'rehabilitation' - should be provided and not necessarily be tied to a device fitting process. But the available evidence suggests that contracted service providers are not generally delivering these beneficial services to clients.

Dr Caitlin Barr's research (for Soundfair) observed over 60 consultations across Australia and found that all consumers who were diagnosed with any level of hearing loss or tinnitus were recommended hearing devices and that an alternative was offered in just 8% of cases. Other care options were only provided after a device was declined.<sup>(72)</sup> This is neither informed client choice nor client control. A study undertaken by Kelly et al. (2016) found that 40% of older people reported a lack of confidence in the use of their hearing devices (117) and concluded that enhanced auditory rehabilitation, access to information, and psychosocial support were all important in addressing this issue.

Clients who have received their first fitting with either a fully subsidised hearing device or an assistive listening device are able to receive one Rehab Plus program after their fitting and follow-up services. However, only 6,449 services (3.6%) were claimed for Rehab Plus out of 177,124 clients who received a hearing device fitting in the 2019–20 financial year. New clients can also access rehabilitation if they have not been fitted with a hearing device so they can receive training and learn strategies that will help them manage their hearing loss. However, in the 2019–20 financial year only 357 (0.3%) of the 121,143 new clients received this service.<sup>(37)</sup>

In addition, Hearing Services Program data show that client review services which are also rehabilitation focused and are available annually are seriously under-utilised (only approximately 30% of clients receive a client review service in a given year).<sup>(37)</sup>

Service provider responses to the draft report stated that rehabilitation was an integral component of the device fitting process, noting that this was frequently provided as part of the occasion of service, without a separate claim being made. They considered that this situation was skewing the data and giving an incorrect impression of the proportion of rehabilitation provided as part of the overall service to the client.<sup>(29,56,67)</sup> The issue of data use is addressed in **Chapter 6**.

In contrast to the providers' perspectives, consumer stakeholders were consistent in their view that rehabilitation as currently provided, if provided, was not meeting the needs of clients of the program.<sup>(68,101,118)</sup> The PwC review (2017) found that 75% of respondents to its study considered that the current rehabilitation services did not provide clients with appropriate support.<sup>(92)</sup>

Specsavers observed that measuring and publishing client-focused rehabilitation outcomes should considerably improve the range of services provided, thereby improving those outcomes and supporting those people around the individual who are also affected by the person's hearing difficulties.<sup>(116)</sup>

A recent study by Hogan et al. (2020) suggested that a device-centric approach to hearing health care is only effective in approximately half the clients accessing these services. A cost-benefit analysis was conducted as part of the study, focusing on clients who previously had rarely or never used their hearing devices. It identified that the provision of additional rehabilitation services (at a cost of \$750 per client) prior to device fitting resulted in expected

savings between \$27.1 million and \$108.8 million per financial year compared with the current service delivery model.(119)

Laplante-Levesque et al. (2011) investigated the range of rehabilitation intervention decisions made by middle-aged and older people with hearing impairment who were first-time help seekers. Using a shared decision-making approach, they found that 46% of participants did not choose a hearing device as their first option, with 26% choosing communication programs instead.(120)

The Expert Panel considered the possibility of the Hearing Services Program ‘outsourcing’ communication and rehabilitation services to fill a perceived gap in these services. Submissions to the draft report, however, indicated concerns about the engagement of rehabilitation counsellors who do not have any training in hearing health.(56,101,121,122) If these services were to be outsourced, it would be important that the contracted service provider is appropriately qualified to provide them. Consumer organisations noted the potential for them, with some training and funding, to be part of the rehabilitation service delivery arrangements in a more formal way.(40,101)

Adults with cochlear implants are also reportedly receiving care that is not specific to their needs. Cochlear Australia mentioned in its submission that, while originally designed with hearing device user needs in mind, the remuneration settings underestimate the support required to help cochlear implant candidates navigate a complex hearing health system. The settings also present ‘disincentives’ to address the needs of clients who may be eligible for implants. The result is that most providers treat cochlear implant counselling with the same resources they use for a hearing device fitting, which results in inconsistent adoption of the standard of care.(77)

Audiology Australia noted that frail, elderly clients whose dementia makes their hearing care more complex are a client cohort that also deserves greater support.(25) Use of standardised testing that involves cognition complicates the assessment process and may detract from an accurate diagnosis and management plan.

In relation to adults with complex hearing needs and adults with cochlear/bone anchored implants, the Expert Panel has recommended in **Chapter 3** that contracted service providers who intend to work in this specialist area should be required to demonstrate that they have the capacity, skills and cultural awareness capabilities to support these clients. This highlights the need for providers’ models of care to address the more complex and comprehensive hearing care needs of many groups of people with hearing loss.

In considering feedback provided in the consultation processes, the Expert Panel undertook further examination of the opportunities to augment and improve how Hearing Services Program clients can receive more, and more effective, assessment and ‘rehabilitation’ style services. It noted that these services should be available before, during and after any device fitting, and for those with milder hearing loss this may even be the sole intervention at that point in time. In summary, the Expert Panel envisages a revised set of services that provide for:

- a holistic assessment of clients’ needs which supplements an assessment of hearing loss with an understanding of an individual’s communication requirements, lifestyle and life circumstances, and psychosocial needs
- a broad scope of communication support and education alternative services prior to offering the option of being supplied and fitted with a hearing device
- rehabilitation services as part of providing a fully or partially subsidised hearing device
- communication, education and psychosocial support alongside hearing assistance

- assessment and management plans better suited to clients from diverse backgrounds.

As a final observation in this section, the Expert Panel observed that, internationally, the term ‘rehabilitation’ is commonly used to mean that people are taught to use other communication strategies and/or visual and environmental cues to adapt to their hearing loss.(123,124) However, the term in its common understanding is perhaps inappropriate for those with milder hearing loss, where a term such as ‘communication support and education’ may be more appropriate. The Expert Panel notes that these services could be provided by any qualified practitioner, provided that they can demonstrate they have the appropriate skill set as discussed earlier and have had relevant training to deliver these services.

## Revising the Schedule of Service Items and Fees

The matters raised above suggest that the Hearing Services Program Services Schedule needs revision to facilitate a more client-centred approach and greater clarity about communication support and rehabilitation. There are 2 aspects to such a revision. The first focuses on simplifying and clarifying what services should be included and how should they be structured. The second focuses on the issue of what fees should be payable to contracted service providers for the delivery of the services (and related goods such as hearing devices) that they can claim under the Services Schedule. While the 2 issues are clearly interrelated, each is addressed in turn below, including the proposal that a review process should guide the revisions.

### Simplifying and clarifying the Services Schedule

In addition to potentially expanding the types of services that should be available to program clients to enhance choice and control, there is also support for specifically and independently listing items in the Services Schedule to support more tailored rehabilitation, communication support and education plans for clients.(75)

The current Services Schedule includes over 50 separate service items and 6 categories for hearing devices. Fitting-related services such as device fitting, follow-up, rehabilitation and maintenance are currently bundled together in the one ‘Fitting’ item. Many service items focus on monaural (1) and binaural (2) hearing devices. Historically, this has meant that it has been difficult to unpack what services a client receives, and the program does not sufficiently capture data on all of the elements of hearing care that are provided.

NDIS has a funding model under which practitioners are paid by service units based on the assessment outcomes and an agreed rehabilitation plan for the client, with tiered packages based on the client’s needs.

Consumer organisation feedback on the Expert Panel’s draft report was generally supportive of the concept of de-bundling services.(40,68,101) TPI Federation noted in their response to the draft report:

*Improving and streamlining, simplifying the funding and claiming structure would allow practitioners greater autonomy when managing individual rehabilitation programs, which then reduces the program’s focus on purely technological solutions and supports a more holistic and veteran-centric service.(43)*

Several other submissions supported the review and simplification of the Services Schedule so that it can better support good clinical practice and provide appropriate payment for assessment and rehabilitation services as well as hearing devices. As Audiology Australia noted, this would:

- assess client 'readiness' for any intervention
- offer improvements to practical issues such as communication, hearing device utilisation and work practices, with a view to improving quality of life, instead of the Hearing Services Program being input driven (for example, focusing on number of episodes of care, numbers of hearing devices prescribed)
- encourage use of shared decision-making tools such as decision aids
- provide a broad range of services that aim for better client outcomes and that better reflect and recognise the range of assessment and rehabilitation options that audiologists can provide in accordance with the audiology profession's scope of practice.(25)

The Department of Veterans' Affairs agreed, proposing the following:

*It is suggested that rehabilitation and education regarding the management of hearing loss needs an increased focus going forward. Improving and streamlining, simplifying the funding and claiming structure would allow practitioners greater autonomy when managing individual rehabilitation programs, which then reduces the program's focus on purely technological solutions and supports a more holistic and veteran-centric service.(71)*

This view was not always shared by service provider stakeholders, some of whom considered this approach was unnecessary, pointing out that their current service delivery models already met this need.(31,67)

## What claimable fees should be payable to providers for the delivery of the services?

In addition to the separate identification of the range of services that may be beneficial to people with hearing loss, feedback from this review and other reviews and inquiries has identified scope for changes to the actual fees payable for the service items that can be claimed under the Services Schedule.

A review of the way services are funded was one of the recommendations of the 2017 PwC review. The recommendation was supported by benchmarking of the financial year 2016–17 schedule prices for services in the voucher stream against the private market and other government programs, which indicates that the current fees are low for a range of key services.(25)

Deafness Forum of Australia expressed similar views:

*The fee schedule needs to be reviewed so that it supports good clinical practice and provides appropriate payment for assessment and rehabilitation services as well as devices. This will result in consumers receiving a broader range of services which is likely to lead to improved device utilisation and better client outcomes.(24)*

Organisations representing audiologists noted the significant differences in fee structures between the voucher stream and other programs and suggested this be considered in any changes to the Services Schedule. For example, they noted that an assessment service with the NDIS pays \$193.99, while the voucher stream pays \$143.90, and Medicare pays lower rates for assessment services. Independent Audiologists of Australia noted that the NDIS takes into account remote and very remote service delivery with higher fee support.(75) The organisation also noted that, while clients can be charged top-up fees for hearing devices, there was no capacity to allow for gap fees for other program-funded services.



The Expert Panel sees value in undertaking a review of the current fees payable under the Services Schedule. It considers that simplifying the Services Schedule by de-bundling services and reducing the number of separate service items will help focus the services on the needs of clients and reduce the regulatory burden and confusion for contracted service providers in managing claiming. This would enable improved identification of which hearing services are received by clients and would also ensure that service items which have a strong focus on communication support and rehabilitation are appropriately remunerated. These simplified items could include:

- assessment
- communication support and education
- device fitting
- follow-up after the fitting service has been provided
- rehabilitation (standalone, associated with device fitting and post-device fitting)
- device maintenance
- hearing device review
- client review.

As part of that process, the review of services could also assess whether there is an unintended bias in profit margins which favours the supply and fitting of hearing devices ahead of providing more rehabilitative and communication support interventions. The outcome of the review of services could lead to the possible rebalancing of the fees.

## Benefits and costs of revising the Services Schedule

Revision of the fees would complement the outcome of the review of services, including any removal of the current restrictions around the use of communication support and education and rehabilitation services in the current service delivery model so that all program clients, where appropriate, would receive communication support and education, rehabilitation and/or psychosocial support services instead of, or before and after, being fitted with hearing devices.

Expanding eligibility for more communication support and education and rehabilitation services, and rebalancing the financial incentives for contracted service providers to deliver those services, would provide significant personal benefits for many people with hearing loss. There are also broader societal and productivity benefits. Deloitte Access Economics, in *The social and economic cost of hearing loss in Australia*, reported that almost 50% of the economic cost of hearing loss is due to its psychosocial impacts.<sup>(125)</sup>

A review of the Services Schedule, including both the services and their fees, is one of three reviews recommended in this report. The Expert Panel has separately examined, in **Chapter 5**, the availability and subsidisation of alternative and/or non-device technologies such as alerting systems and directional headphones, and considers a review is warranted. It has also examined the shortfalls in the minimum specifications for fully subsidised hearing devices under the Program and the criteria which guide the inclusion of those devices. Proposed terms of reference for all 3 reviews are set out in **Chapter 5**.

Based on the current Services Schedule, the numbers of clients and the following assumptions about hours of service delivered, the maximum cost of pre-fitting rehabilitation (which could be alternatively named 'addressing communication support and education needs', not 'rehabilitation' in the traditional sense of the word as described earlier) would be \$24.9 million per annum (1 hour x \$207.95 per hour x 120,000 new clients). The maximum cost of provision

of post-fitting rehabilitation services would be \$52.2 million (2 hours x \$147.35 per hour x 177,124 fitting services in the 2019–20 financial year).

## Exploring alternative models of independent provision of communication support and rehabilitation services

In New Zealand, the Ministry of Health has established an aural rehabilitation service for all citizens which is independent of hearing services providers. Life Unlimited, which operates the service, stated in their submission to parliamentary Standing Committee on Health, Aged Care and Sport Inquiry into the Hearing Health and Wellbeing of Australia that:

*The New Zealand hearing therapy service model offers a social rather than a medical model of intervention that is community-based, independent (not aligned to any one provider of audiology services and having no financial interest in the selling of hearing aids), and accessible (free to users and nationally spread).(126)*

Included in community education and training are services such as education on hearing loss prevention; information and advice on hearing protection; information on the likelihood and impact of noise-induced hearing loss; training and information for caregivers, associates, health professionals and community agencies to increase awareness of hearing-related issues and appropriate responses; services available; accessibility; and hearing device funding options.

The aural rehabilitation service does not include skilled audiological or otological interventions, social support, counselling or other services that can be provided elsewhere in the community. (127) All citizens are eligible to receive support. In the 2019–20 financial year, some 3,700 New Zealanders received 4,900 services at a cost of \$2.5 million. There is no published research that evaluates the effectiveness of the aural rehabilitation services.

There would be scope to allow NGOs and consumer groups in Australia to be funded for delivering similar services to program clients, noting the need to undertake legislative and system changes. In this respect the Expert Panel was provided with a proposal by Soundfair for a pilot study to examine a service delivery model described as ‘whole-person, person-centred hearing service’. (72) Soundfair advise that this approach is based on considerable consumer consultation and the latest evidence. It proposes 2 stages: the first stage would involve analysing the cost of delivering non-device rehabilitation programs and analysing similar funding models found in Australia and internationally; and the second stage would involve piloting the model over a 2-year period across a metropolitan and a rural site. It is possible that the pilot outcomes could provide economic modelling of the true cost and effectiveness of hearing service interventions, and that modelling could be used as the basis of provider benchmarking for quality improvement purposes.

The main aim is to enhance rehabilitation so that it moves beyond ‘rehabilitation’ purely in relation to hearing device use to include a focus on providing communication support and education, as well as psychosocial support for clients as part of a holistic approach to improving their hearing health and wellbeing. This greater delivery of a broader scope of rehabilitation would assist people with hearing loss to address their communication needs and maximise social inclusion, through social activity and economic participation and in physical and cultural pursuits, to the fullest extent possible (proposed objective A2). There would be an additional benefit from providing the aural rehabilitation services independently of Hearing Services Program contracted service providers to reduce any real or perceived conflict of interest for

the clinician. Clients would also be more informed about their hearing impairment and this may contribute to a better hearing outcome.

Recent studies by Van Leeuwen et al., however, show that allied health professionals may lack the skills, resources and support to integrate psychosocial support services into their daily clinical practices, including in audiology.(128) This provides further justification for the incorporation of broader communication support and education as well as psychosocial interventions training into audiology programs and continued professional development opportunities for audiologists currently working in the field.

The Expert Panel considers there is value in the Department of Health maintaining an active watching brief on overseas developments in establishing independent communication and psychosocial support and education services as an additional option for clients. This watching brief includes services which would be delivered by counsellors who would act within clearly defined scopes of service to deliver such services for clients, including clients with diverse needs. Contracted service providers could subcontract out communication and education, psychosocial support, and rehabilitation services to appropriately trained external parties if they so desired, provided those parties could demonstrate appropriate qualifications, including an understanding of hearing health. The existing framework could support this approach, although system changes would be required. The timing of provision of these services would depend on the service delivery model.

If the Department of Health considered that net benefits were emerging from overseas initiatives, the approach could be assessed through a trial pilot. To illustrate, the cost of providing this broader scope of hearing loss counselling for one hour per new client would be in the order of \$22.3 million per annum (\$186 per hour x 120,000 new voucher clients in the 2019–20 financial year). The cost of establishing a new rehabilitation hearing service along the lines of the New Zealand model has not been estimated.

## The role of teleaudiology

There is some evidence that many of the primary tasks defined in the scope of practice for audiologists and audiometrists can be conducted by teleaudiology, be they clinician-led, facilitator-assisted and/or self-led.(129) For services provided under the Hearing Services Program, teleaudiology is not funded for some assessments (otoscopy, pure tone audiometry and speech audiometry) or for adjustments to a fitting (unless the client's hearing device enables remote programming). These services must be delivered face-to-face. Other services can be provided via teleaudiology provided the program requirements are met, there are no issues with comfort or sound quality and the services are delivered in accordance with the Practitioner Professional Bodies' scope of practice and code of conduct. Teleaudiology assessments can be completed in aged care homes or clients' homes as long as ambient noise is managed.(130)

Providers and industry groups highlighted the benefits of recent temporary amendments to the Hearing Services Program in response to COVID-19, which enabled expanded remote and teleaudiology service delivery. This included hearing device fittings, rehabilitation services and annual client reviews. The Expert Panel has been advised by the Department of Health that they consider that telehealth service provision has worked well during COVID-19.

The National Aboriginal Community Controlled Health Organisation (NACCHO) supported the Expert Panel's finding that many of the primary tasks defined in scope of practice of audiologists and audiometrists can be conducted by teleaudiology. NACCHO also noted that since 2019 the sudden increase of teleaudiology has necessitated developing, implementing and evaluating

cultural awareness and competency strategies for all teleaudiology interactions. To facilitate culturally safe interactions when using teleaudiology, NACCHO recommended that Hearing Services Program policies embed the National Agreement on Closing the Gap.(54)

Several submissions to the review advised that the adoption of broader telehealth service models need to be evidence based and effective and must support client outcomes. In this respect multiple submissions noted the benefits of teleaudiology in terms of convenience for clients. The Department of Veterans' Affairs noted in its submission that:

*the potential benefits of telehealth, not just for rural, remote or infirm veterans but also for younger active veterans who find it convenient to not attend a clinic. However, the use of telehealth technology needs to be carefully managed to ensure that it can accommodate those with hearing difficulties.(71)*

Several submissions noted that, while teleaudiology can reduce administrative costs and time, there are questions regarding the clinical benefit to clients and whether teleaudiology contributes to better outcomes. A recent report on the evidence underpinning teleaudiology included a survey of more than 400 clients of a Western Australian audiology clinic. It found that, while clients generally have a positive attitude towards teleaudiology, the majority have not used telehealth for medical or audiology services. To date most teleaudiology services have been delivered by telephone and the clients expressed concerns about communicating effectively in teleaudiology consultations. Most advised that they would prefer face-to-face services.(129)

Concerns about the use of teleaudiology included the average age of voucher clients, rural and remote access to appropriate levels of internet and whether the client is technology literate. Not all services are well suited to, or can be provided for other reasons through, teleaudiology. This can be due to:

- the nature of the service—for example, clinical level assessments currently being not approved for provision via teleaudiology
- the client's hearing device not allowing connectivity to support remote programming—this can be particularly true of many fully subsidised hearing devices
- the client preferring face-to-face services
- the client having particular needs which are not well met through teleaudiology
- smaller providers not being able to make full use of teleaudiology due to the required investment and training in equipment and technology.(19)

Enhancing workforce capacity for teleaudiology is a part of the government support of the implementation of the *Roadmap for Hearing Health*.(4) This includes supporting the development of teleaudiology guidelines for use within the sector. Not all Hearing Services Program services will be deliverable by telehealth and some services will only be deliverable in that mode under certain situations - for example, if appropriately skilled personnel are available onsite with the client and certain equipment is in place. The teleaudiology guidelines should address issues such as these.

The Expert Panel notes the work underway in the audiology profession to develop teleaudiology guidelines to support this mode of service delivery. The Expert Panel recommends the continued use of teleaudiology in the appropriate clinical services and, even then, only when clients feel comfortable that they are receiving care that meets their needs. The Expert Panel notes that, in some instances and for some cohorts, supplementary face-to-face support from another person may be required to make the most of the teleaudiology service (for example, from a family member, Aboriginal Health Worker, aged care worker or translation service).

## Improving client experience and outcomes in the Community Service Obligations stream

While the terms of reference of this review focused on the voucher stream, numerous submissions commented on and made suggestions for improvements that could be made to the CSO stream. The Expert Panel has opted to include in this report the feedback which has been provided regarding the CSO. In addition to the following, **Chapter 6** discusses the use of client experience and outcomes measures which would support formalised feedback for service improvement across the entire Hearing Services Program, including the CSO stream.

Under current program arrangements, children have their hearing tested in a hearing health clinic, hospital (newborn screening) or private clinic to establish a diagnosis of a hearing loss before being able to access amplification and rehabilitation services provided by the sole provider—Hearing Australia. Deafness Forum of Australia noted that this creates a fragmented service delivery, particularly for Aboriginal and Torres Strait Islander children, and queried the possibility of allowing those children to access Hearing Australia in the first instance as a way of creating less friction in the system.(24)

Families of children with diagnosed profound hearing loss are then given the option to enter the NDIS. There is a priority pathway for 0–6-year-olds which is firmly established between NDIS and Hearing Australia and which ensures these applications are assessed within 2 weeks. Once a child has been approved as a participant, the NDIS coordinator is then able to discuss other support services the child may need (for example, speech therapy, occupational therapy, early intervention, audio-verbal therapy) and will refer them as appropriate.

Australian children, young adults and young participants in the NDIS with a confirmed hearing loss are eligible for a range of hearing services through the CSO until they turn 26 years of age. If voucher eligible, young people from 21 to 26 years of age can choose to receive their services through the voucher stream and/or CSO component.

While several professional organisations felt individual practitioners and other providers should also be able to offer services to CSO clients, there was overwhelming support for Hearing Australia maintaining CSO services for children and young people. Deafness Forum of Australia's Consumer Advisory Group, First Voice and the Australasian Newborn Hearing Association all expressed satisfaction with the agency.(24,73,100,131) NextSense expressed this in the following terms:

*There is no doubt that children who engage with Hearing Australia under the terms and provisions of the HSP are offered an excellent assessment service and generally gain access to appropriate amplification using strong evidence-based strategies for fitting of devices. Indeed, the Longitudinal Outcomes of Children with Hearing Impairment (LOCHI) study has established the efficacy of the device fitting procedures used by Hearing Australia for all paediatric HSP clients relative to other internationally acknowledged strategies.(73)*

Deafness Forum of Australia advised that families were concerned that any changes to existing arrangements would put the outcomes for their children at risk. Parent groups in particular felt that the program has been threatened by various reviews and initiatives, such as the potential sale of Hearing Australia and the introduction of the NDIS. They wanted to emphasise that the program is important to them and that they value having Hearing Australia as the single, independent provider of services.(24)

Despite this strong endorsement, some stakeholders identified various opportunities for improvements to the CSO stream. Not all proposals were endorsed by all stakeholders, and the Expert Panel has not evaluated the various suggestions listed below.

### Family support service

As noted earlier, First Voice advised that families could be better supported in making choices for their hearing impaired children through a 'National Hearing Loss Family Support Service', which could improve access for all eligible children and minimise the period between diagnosis and access to support and services.(100)

### Clearer 'service pathway'

Deafness Forum of Australia argued that CSO clients and their families could benefit from a guided pathway from hearing assessment and device fitting services under the program to engagement with early intervention or other providers under the terms of the NDIS or education sectors.(24) Currently this exists for those children identified in early childhood but not beyond that age.

### Improved screening

First Voice, in its role as a peak body that comprises numerous organisations that focus on early intervention for children with hearing loss, recommended the program include screening for 4-7-year-olds to make sure these young children do not 'fall through the cracks' before formally starting school.(96,100)

### Funding for initial hearing assessment

First Voice argued that additional funding is needed to allow Hearing Australia to provide initial assessment appointments, particularly for Aboriginal and Torres Strait Islander children.(100) Currently, all infants and children have their hearing assessed elsewhere in the first instance so as to establish a diagnosis of a hearing loss before being eligible to access the program. Allowing the initial and subsequent services to be delivered by the same provider would improve continuity of care for the infant and family.

## Overcoming inequitable access to hearing services

The experience of a number of particular groups of people with hearing loss within the community are such that specific initiatives are warranted to ensure that they have equitable access. As one of the objectives for the program proposes (**Chapter 2**), this should include being supported to have equitable access irrespective of their location or personal attributes and circumstances and being provided with support which is culturally safe and appropriate to them.

This section of the chapter focuses on the following groups of people and their experiences with receiving care and support for their hearing loss: Aboriginal and Torres Strait Islander peoples; people from CALD backgrounds; people living in rural and remote areas; and permanent residents of aged care homes. In **Chapter 3**, the Expert Panel recommended expanded eligibility for the Hearing Services Program to include all Aboriginal and Torres Strait Islander peoples and all permanent residents of aged care homes, along with people who hold a Low Income Health Care Card.

## Improved access for Aboriginal and Torres Strait Islander people

Currently, Aboriginal and Torres Strait Islander people under 26 and over 50 years of age, or who are voucher eligible or are current Community Development Program participants (including some previous Community Development Employment Projects participants) are automatically eligible to receive services under the CSO component of the Hearing Services Program.<sup>(132)</sup> Voucher-eligible Aboriginal and Torres Strait Islander people who have specialist hearing needs or reside in Modified Monash Model (MMM) areas 6 (MM 6) or 7 (MM 7) are also eligible for additional services through the CSO component. If the person is voucher eligible, they can receive voucher services with any contracted service provider in the voucher stream. CSO funded services are only available through Hearing Australia.

**TABLE 11:** Hearing Services Program Aboriginal and Torres Strait Islander clients by program stream and age group in the 2019–20 financial year (133)

Age group (years)	CSO stream			Voucher stream		
	Aboriginal and Torres Strait Islander	No Aboriginal and Torres Strait Islander identification	CSO total	Aboriginal and Torres Strait Islander	No Aboriginal and Torres Strait Islander identification	Voucher total
0–25	4,367	29,835	<b>34,231</b>	<5	292	<b>292</b>
26–64	3,369	8,300	<b>11,693</b>	289	69,240	<b>69,529</b>
65+	3,176	21,519	<b>24,750</b>	273	680,958	<b>681,231</b>
<b>Total</b>	<b>10,912</b>	<b>59,672</b>	<b>70,674</b>	<b>562</b>	<b>750,490</b>	<b>751,052</b>

Source: Department of Health, Hearing Services Program data and statistics (internal).  
CSO: Community Service Obligations.

As Table 11 shows, services to Aboriginal and Torres Strait Islander peoples are predominantly delivered by Hearing Australia through the CSO. This pattern of delivery applies not only to regional, rural and remote areas but also to those people living in metropolitan Australia (see Table 12 below).

**TABLE 12:** Hearing Services Program Aboriginal and Torres Strait Islander clients by program stream and Modified Monash Model (MMM) area in the 2019–20 financial year (133)

MMM area	Client count	
	CSO stream	Voucher stream
1 – Metropolitan	2,882	219
2 – Regional centres	2,174	103
3 – Large rural towns	1,341	94
4 – Medium rural towns	808	60
5 – Small rural towns	802	57
6 – Remote communities	1,677	24
7 – Very remote communities	1,228	5
<b>Total</b>	<b>10,912</b>	<b>562</b>

Source: Department of Health, Hearing Services Program data and statistics (internal).  
CSO: Community Service Obligations.

It is estimated that, in the 2019–20 financial year, 653,080 Aboriginal and Torres Strait Islander people met the eligibility criteria for the Hearing Services Program. Of this population about 230,713 are estimated to have mild or greater hearing loss. However, based on prevalence data and the National Aboriginal and Torres Strait Islander Health Survey, it is estimated that only 5% of the Aboriginal and Torres Strait Islander people who are currently eligible for the Hearing Services Program as a whole are actually accessing services under the program, predominantly through the CSO stream.

The barriers to eligible Aboriginal and Torres Strait Islander people accessing the services available through the program are many and varied. They include:

- the distribution of the services and the consequent time and cost of accessing them
- whether the services are delivered in a culturally safe and respectful manner
- access to information about the services that might be available and how to engage with those services.

Many Aboriginal and Torres Strait Islander families report waiting years to access services for their children.(134) This can be due to factors such as the remoteness, affordability and lack of cultural safety.(135,136)

The 2019 *Roadmap for Hearing Health* articulated a desired outcome of a hearing health workforce that delivers co-designed client-centred care which responds to their social and cultural needs. It also spoke to the need to have prevention activities which specifically consider the needs and circumstances of vulnerable populations, particularly Aboriginal and Torres Strait Islander peoples.

A Guiding Principle from the *Roadmap for Hearing Health* (2019) is that:

*future changes and improvements are co-designed with those directly impacted, including consumers, providers, and other relevant stakeholders.(4)*

Culturally safe hearing health care can improve engagement with hearing health services, and the quality of care received, which in turn can improve hearing health outcomes for Aboriginal and Torres Strait Islander peoples and those from CALD backgrounds.(14,136) However, the current access rate for the CSO stream delivery of hearing services to Aboriginal and Torres Strait Islanders (at 5% of those eligible for the service) is very low.

In a 2021 report (as yet unpublished) provided to the Department of Health - *Urban Hearing Pathways: The role of accessibility and availability of hearing and ear health services in avoidable hearing loss for urban Aboriginal & Torres Strait Islander children* – Hearing Australia summarises this issue as follows:

*Families and service providers know what is needed to increase uptake of services. Factors cited include: being welcoming and safe for families; working to develop trust; engaging regularly with the community; being visible at community initiatives; seeking community input; employing Aboriginal staff, which increases cultural safety; ensuring staff undertake cultural competency training; increasing coordination/co-location of services in-community; locating services where families go, in places accessible by public transport.(136)*



The National Agreement on Closing the Gap aims to improve the way governments work with Aboriginal and Torres Strait Islander communities and people, including ensuring service delivery is based on their needs, cultures and relationship to country.(137) NACCHO advises:

*Aboriginal and Torres Strait Islander people continue to feel misunderstood by mainstream providers especially if those providers have very little training or knowledge of the ways that disability or chronic conditions intersects with different cultural experiences. Often service provision forms have a 'tick box' for Aboriginal and/or Torres Strait Islander people or disability, not both.(44)*

There are 143 ACCHOs around Australia that deliver comprehensive primary health care to Aboriginal and Torres Strait Islander peoples through approximately 700 facilities. NACCHO highlighted in their submission to the review that:

*buy-in from the ACCHOs will help find those eligible for services. This can also help to distinguish the difference between the Hearing Services Program, the NDIS and other ear and hearing services available.(44)*

NACCHO also stated that:

*The most effective way to have Aboriginal and Torres Strait Islander people participate is to provide them with culturally appropriate information and system navigation to ensure their understanding of the programs.(44)*

To ensure services are provided in a culturally sensitive manner, NACCHO suggested increasing the number of ACCHOs providing services and/or improving the links to culturally appropriate mainstream services. It also advised that the regional affiliates could be supported to offer professional support and training to visiting hearing health professionals to embed their work in health service. For example, funding the hosting health service to promote the visiting services would improve engagement with and attendance at such clinics.

The Expert Panel considers there are opportunities for the Australian Government to work with NACCHO and Hearing Australia to develop alternative models of hearing service delivery for Aboriginal and Torres Strait Islanders that are culturally safe and accessible and could increase the proportion of eligible Aboriginal and Torres Strait Islander people taking part in the program.

Depending on the outcome of this co-design approach, options might include one or more of the following:

- increasing the presence of Hearing Australia providers in culturally accessible locations, such as ACCHOs
- facilitating training to improve the capability of Aboriginal Health Workers and/or Aboriginal Health Practitioners to provide hearing services and/or support Aboriginal and Torres Strait Islander clients to interact with mainstream hearing services
- utilising the expertise of NACCHO and/or state-based ACCHOs to help mainstream hearing services improve the cultural safety and accessibility of their services
- reviewing the content and appearance of the program website for cultural appropriateness and ease of navigation for Aboriginal and Torres Strait Islander people.

NACCHO, in response to the Expert Panel's draft report, was supportive of this approach. It strongly reinforced the importance of a collaborative approach that was culturally safe and respectful of Aboriginal and Torres Strait peoples and took into account the existing consultative opportunities, such as with the Ear Health Co-ordinators Network. In addition, NACCHO emphasised the importance of a holistic approach that encompassed the wider hearing health

needs of Aboriginal and Torres Strait Islander individuals and was built on the strengths of the community controlled sector.(54,138) In the light of this the Expert Panel considers there may be benefit in co-developing a comprehensive Aboriginal and Torres Strait Islander framework for hearing health with Aboriginal and Torres Strait Islander leadership, aligned with the National Agreement on Closing the Gap.

## Improved access for people from culturally and linguistically diverse (CALD) backgrounds

People from CALD backgrounds are disproportionately affected by the social determinants of health, including access to health care, education, employment, income, safe housing and food. (139) Individual/family/community issues that affect access to culturally appropriate health care for people from CALD backgrounds include:

- limited health literacy, including knowledge of the health care system in Australia
- health beliefs and cultural practices that impact on perceptions of major life events, uptake of preventative health care, help-seeking behaviour and understanding of and adherence to treatment
- high level of stigma associated with some health conditions in some cultures - for example, mental health, developmental disability, cancer
- low levels of English language proficiency, especially in newly arrived communities and ageing communities.(140,141)

These challenges are as relevant to hearing health as they are to any health services and are compounded by systems issues, particularly inconsistent identification of ethnicity and limited access to interpreters and to translated health information.(142) Services and researchers do not routinely involve CALD communities in co-designing culturally appropriate solutions to health issues.(143)

Deafness Forum of Australia and NextSense referred to a possible lack of knowledge within the Hearing Services Program about the use of the program by individuals and families from CALD backgrounds, due in part to shortfalls in data.(24,73)

The Expert Panel notes the additional challenges faced by people from CALD backgrounds, as well as the current shortfalls in program data relating to these populations. The Expert Panel considers that the program could take a co-design approach to working with peak bodies representing CALD groups to address any identified issues impacting on access to services for eligible clients. Specific issues regarding access to interpreters and the availability of information in community languages are discussed at the end of this chapter.

## Improved access for people living in rural and remote areas

Rural and remote consumers of health, hearing health and social services form a thin market due to small consumer populations and a lack of economies of scale; limited professional workforce availability; higher operating costs in rural and remote areas; consumer barriers to access (such as the costs and time of travel); and a lack of choice of providers. In terms of access, there are at least 51 communities that depend on a single provider to deliver hearing services. Several rural providers are providing services as visiting services (based on analysis of Hearing Services Program claims data in the 2019–20 financial year).

The Minister asked the Expert Panel to recommend strategies through which the Hearing Services Program services can be improved for those living in regional, rural and remote areas and in other thin markets.

There is an estimated population of more than 5 million Australians living in rural and remote areas (MMM 3–7). Based on age demographics and modelled incidence of hearing loss, an estimated 17.6% of this population (0.96 million people) experience levels of age-related hearing loss. Hearing Australia is required to provide services in MMM 6 and MM 7, which accounts for 21,684 of the 0.96 million referred to above.

The *Roadmap for Hearing Health* identified the shortage of regional, rural and remotely based clinicians as an issue in providing accessible quality services in those communities.<sup>(4)</sup> The Expert Panel supports further exploration of rural workforce issues, including regular audits of availability of and access to hearing health professionals in those areas.

To date, Hearing Australia, in its role as sole provider of CSO services, has played a critical role in maintaining access to hearing health care for eligible people living in regional, rural and remote areas, particularly in locations where thin markets make it unlikely that other providers would deliver services in an open market. Some provider groups stated that families are not provided enough choice under the CSO stream and proposed that, particularly in rural and regional areas, the Hearing Services Program could open up services to regional clinicians through a subsidy under the CSO stream, rather than have clients travel considerable distances to access Hearing Australia providers.<sup>(75,116,144)</sup>

Submissions from consumer-focused groups did not support this view. Deafness Forum of Australia expressed the concern that opening up services to competition might lead to exacerbation of current thin markets in rural and remote areas and further disadvantage people living in those areas:

*Hearing Australia provides a safety net in many rural and remote areas because of its obligations under the CSO Program making services under the Voucher and CSO Program more accessible for people in those areas. If the CSO Program became competitive then it is possible it would lead to thin markets particularly in rural and remote areas as providers are likely to 'cherry pick' and deliver programs in easy to service areas and avoid delivering services in areas where they are likely to make a loss.<sup>(24)</sup>*

In 2019 the Australian Government Competitive Neutrality Complaints Office (AGCNCO) of the Productivity Commission examined complaints that alleged Australian Hearing (since renamed) engaged in anti-competitive behaviour in the Hearing Services Program, with market advantages over competitors as a result of government ownership. AGCNCO found that most complaints were unsubstantiated and that 2 items were outside of the competitive neutrality policy. It reported that government ownership provided a minor competitive advantage to Australian Hearing as a result of undue promotion on government websites and in ministerial media releases.

The Expert Panel's *Interim advice to government – implementation of Hearing Services Program changes* (Interim Advice) considered the government's changes to the Hearing Services Program voucher stream which were announced in the October 2020 federal Budget. The suggested changes included extending the voucher period to 5 years, removing the 12-month warranty period maintenance payment, and replacing the annual maintenance payment in advance with quarterly payments in advance. The Expert Panel considered the implications of

these changes for regional, rural and remote communities and concluded they would have an effect on access to hearing services for these communities.

The Expert Panel's Interim Advice was that the government consider the following 3 policy options as possible courses of action to maintain a viable service provider sector and, in turn, to support ongoing consumer access to hearing services during the adjustment period that commences from 1 July 2021.<sup>(19)</sup> These options would provide varying levels of adjustment support to the hearing services market and help mitigate the impacts of the 2020–21 federal Budget announcements on contracted service providers, and therefore their consumers, for the 2-year period of the 2021–22 and 2022–23 financial years.

**Option 1** would provide a loading on service items delivered in rural and remote areas (MM 3–7). This option would be an effective means of ensuring that, in the light of the 2020–21 federal Budget announcements, there is ongoing access to hearing services for consumers in rural and remote areas. However, it may impact on the business models of some providers in terms of metropolitan versus regional service delivery unless the rules and policies are carefully calibrated and maintained.

There are similar issues with regard to the equity and sustainability of this option – it would introduce some inequity in order to offset the disadvantages of providing services in these geographic areas. Administering the loading would require further overheads for implementation and maintenance and also to complete the necessary audit and compliance activities inherent in the program.

The efficiency of this option would depend upon the precise nature of the implementation. It is expected that appropriate loading incentives would be calculated to efficiently balance public health outcomes and fiscal costs.

**Option 2** would provide a loading on service items delivered by small and medium service providers as defined by the Australian Taxation Office. Providing a loading to specifically support small and medium providers would be an effective means of supporting these enterprises through the most significant period of adjustment post-implementation. Given the relatively small market share of these providers, a modest loading would also be an efficient use of taxpayer resources and would come at a relatively modest fiscal cost.

This proposal would create some level of inequality in the program, mostly between the larger businesses, which are not eligible for the loading, and the others, which are. This may create some unexpected behaviour as businesses change structures and operations in order to maximise their payments and has the possibility to create inequalities between similar services.

There are some additional challenges in terms of the sustainability of this proposal, given that it would create a new payment mechanism between the program and those contracted service providers. The proposed short-term nature of the loading would limit the ability to automate these payments. However, these are not insurmountable issues and could be overcome with appropriate resourcing, policy settings and operational implementation.

**Option 3** would expand teleaudiology services available through the Hearing Services Program. Expanding the use of teleaudiology to deliver services in the program would be an effective means of improving access to some services for the majority of consumers, particularly many of those in thin markets, and would assist in addressing the revenue impacts from the 2020–21 federal Budget measures. The precise details of the implementation, particularly the applicable fees and quality controls, would impact on the efficiency of this option in terms of value to taxpayers. However, a well-designed proposal could deliver the desired effectiveness in an efficient manner.

As some teleaudiology services are already in place, expanding this offering could be undertaken in a sustainable manner, in terms of both implementation and ongoing maintenance and quality control. It would also help to address equity concerns, particularly for those consumers who are particularly vulnerable and for their providers who may be unduly impacted by the 2020–21 Budget measures. As addressed earlier in this chapter, not all services are well suited to being provided via teleaudiology or cannot be provided for other reasons.

The Expert Panel considers that the Interim Advice it provided to the government is still applicable and concludes that Options 1 and 3 are its preferred approach. The Expert Panel further notes that, given Hearing Australia receives Australian Government funding support through the Hearing Services Program, that agency should be required to diligently deliver community obligation support to those living in rural and remote areas, even if these services are also opened up to the broader private market as result of this review.

The Expert Panel notes that moving adults with complex needs to the voucher stream (as suggested in Recommendation 4(a) and 4(b)) will open up choice of providers for those living in rural and regional areas across Australia.

The Expert Panel also supports the following planned actions outlined in the *Roadmap for Hearing Health* with regard to increasing access to hearing services in rural and remote areas:

- Incentivise hearing health professionals who are servicing rural and remote areas, particularly those who are servicing Aboriginal and Torres Strait Islander communities.
- Make it easier for consumers to access health care using telehealth linked to their preferred provider, particularly for those people living in rural and remote communities.
- Develop options to address the shortage of ear, nose and throat clinicians, particularly in rural and remote regions.

## Improved access for residents of aged care homes

Older people who live in aged care homes or who receive in-home care often have complex hearing health care needs owing to other conditions, such as frailty, chronic illness, vision loss, physical disabilities and cognitive impairment, including dementia. The Expert Panel acknowledges this, as discussed under ‘Assessment of hearing loss and communication needs’ earlier in this chapter and through its recommendation to extend program eligibility to all permanent residence of aged care homes (**Chapter 3**).

Professor Hickson, in her submission, noted that residents in aged care homes were not well served in regard to hearing services and, given that they generally have other health conditions, they should be considered under the CSO stream of the Hearing Services Program as having complex hearing or communication needs.<sup>(78)</sup> Professor Hickson quoted findings from research by Bott et al. (2020) and Meyer and Hickson (2020) that hearing health services to residents in aged care homes were too device focused and did not address the fundamental communication needs of residents, these being matters considered to be of greater importance by care staff and families:<sup>(145,146)</sup>

*Essentially, audiologists, care staff and families prioritized different practices for managing hearing impairment: audiologists emphasized hearing aids while care staff and family emphasized communication strategies. Hearing aid use in aged care facilities is problematic for many reasons e.g., residents require staff support to manage them, staff workloads and lack of education about hearing aids means they are frequently unable to provide the support required, lack of clarity around responsibility and ongoing support for hearing aid use.<sup>(78)</sup>*

The average age of Hearing Services Program clients is 78 years (37) and it is likely that many clients are residing in aged care homes or receiving in home supports. Based on data from the Aged Care Division of the Department of Health and prevalence data, there are potentially over 130,000 people living in aged care homes with mild (21–40 DB) or greater hearing loss who hold a Pensioner Concession Card and could be eligible for the Hearing Services Program. However, only about 8,000 active program clients have self-identified as living in an aged care home.(37)

The parliamentary inquiry *Still Waiting to be Heard* (2017) recommended that:

*the program consider the provision of hearing services to residents in aged care facilities. This review should consider issues including: the use of assistive listening devices for aged care residents; service provision for deafblind Australians in aged care facilities; and the education of aged care facility staff.(46)*

The 2019 *Roadmap for Hearing Health* identified key issues related to hearing health in aged care. Of particular note was the lack of recognition and effective management of hearing loss and balance disorders in aged care services. The report called for short- and long-term actions, including:

- ensuring aged care assessment processes, including on entry to residential care, appropriately identify hearing loss and balance disorders (4)
- lifting the quality of hearing care in aged care facilities with a particular focus on identification, management and workforce training to ensure there is prompt recognition and action taken on hearing health
- developing and delivering hearing awareness training for aged care staff, from registered nurses to direct carers and the teams of Quality Surveyors employed by the Aged Care Quality and Safety Commission to monitor aged care facilities.

In the May 2020 Budget, following the release of the *Roadmap for Hearing Health*, the Australian Government announced funding of \$2 million for the development and testing of training programs for residential aged care workers that will help them support residents with hearing loss. This work is underway and will identify current workforce needs in the aged care sector.(4)

In their responses to the Expert Panel's draft report, a number of stakeholders expressed concern that the urgency generated by the recent findings of the Royal Commission into Aged Care Quality and Safety had not been addressed in the draft report. In particular, they requested that the Expert Panel consider the specific issues related to hearing assessment and care delivery (including acoustic modifications and assistive technologies) for residents living with dementia and cognitive impairment.(40,41,56,57,97) The Expert Panel acknowledges the Australian Government response to the final report of the Royal Commission into Aged Care Quality and Safety,(138) which contained recommendations for access to allied health services that had implications for the hearing health support for residents of aged care homes, specifically for residential aged care providers to 'have arrangements with optometrists and audiologists to provide services as required to people receiving care [recommendation 38(b)(ii)]'.(138)

The government's in-principle acceptance of this recommendation should be taken into consideration when implementing recommendations from this review (if accepted) in relation to permanent residents of aged care homes.

The Expert Panel has recommended in **Chapter 3** that all permanent residents of aged care homes should be included in eligibility criteria for the program and, in this chapter, it has recommended that specific service pathways be developed for residents of aged care homes.

## Recommendations

### Recommendation 7: Engagement with consumer groups

The Australian Government should establish a hearing services consumer consultation forum with consumers and carers, and consumer/carer organisations representative of consumer diversity and cultures. The forum would facilitate information exchange; seek advice on improving the equitable, effective, efficient and sustainable functioning of the Hearing Services Program and associated hearing activities; and explore ways to increase the opportunities for consumer organisations to support their members and assist people with hearing loss.

### Recommendation 8: Client decision-making support

8(a) The Australian Government should co-design a range of illustrative service pathways on the Hearing Services Program website that clearly show the options for clients who are eligible for hearing services in the voucher stream (including Community Service Obligations (CSO) specialist services) and the CSO stream. Pathways should identify links with related programs. These pathways should be reviewed at an appropriate time period following implementation to assess their usefulness.

Specific pathways, using appropriate language and communication modes, should be developed for clients who might benefit from targeted wayfinding information, including:

- children and young people aged under 26 receiving services through Hearing Australia
- clients with complex hearing or specialist needs
- adults with cochlear/bone anchored implants
- Aboriginal and Torres Strait Islander clients seeking hearing services
- clients from culturally and linguistically diverse backgrounds
- clients living in rural and remote areas
- permanent residents of aged care homes.

8(b) The Australian Government, following consultation with stakeholders, should incorporate a set of privacy-protected decision aid tools into the Hearing Services Program's website to assist prospective clients to make more informed choices about managing their hearing loss and to be informed of the services available through the program. This initiative should be reviewed within 2 years of implementation to assess its effectiveness and advise on improvements.

8(c) Subject to the outcome of the review recommended in Recommendation 8(b), the Australian Government should consider trialling a set of decision aid tools in the hearing assessment process, with the data to be stored in a client's clinical file and made available to them.

### **Recommendation 9: Availability of translation, interpreting and Auslan services**

The Australian Government should ensure that audiologists and audiometrists are made aware of the Auslan services available under the National Disability Insurance Scheme and the National Auslan Interpreter Booking and Payment Service programs and how to access these services. Audiologists and audiometrists should be included as ‘approved groups and individuals’ who are able to freely access the national Translating and Interpreting Service.

### **Recommendation 10: Delivering rehabilitation and other holistic support services**

10(a) The Australian Government should amend the scope of the Hearing Services Program to require contracted service providers to offer a more holistic assessment of clients’ communication and hearing needs and a broader range of services to better address those needs. This should include:

- a holistic assessment of client needs which supplements an assessment of hearing loss with an understanding of an individual’s communication requirements, lifestyle and life circumstances, and psychosocial needs
- a broad scope of communication support and education alternative services prior to offering the option of being supplied and fitted with a hearing device
- rehabilitation services as part of providing a fully or partially subsidised hearing device, or as a standalone intervention
- communication, education and psychosocial support alongside hearing assistance
- assessment and management plans better suited to clients from diverse backgrounds.

10(b) The Australian Government should require qualified practitioners who deliver these services to ensure that they can be safely and appropriately provided, in line with Practitioner Professional Bodies’ scope of practice and codes of conduct.

### **Recommendation 11: Access to teleaudiology**

The Australian Government should continue its current support and funding for teleaudiology as a service delivery option for Hearing Services Program clients. Providers of teleaudiology should ensure that the service meets the needs of their client, is provided with appropriate comfort and sound quality, and is delivered in accordance with Practitioner Professional Bodies’ scope of practice and code of conduct. The Expert Panel notes that:

- this may be an appropriate mode of service delivery for many rehabilitation and communication/education services
- in some instances and for some cohorts, contemporaneous face-to-face support from another person may be required to make the most of the teleaudiology service (for example, from a family member, Aboriginal Health Worker, aged care worker or translation service).



## Recommendation 12: Streamlining the Schedule of Service Items and Fees

The Australian Government should undertake a review of the current Schedule of Service Items and Fees (Services Schedule) to:

- clearly define and describe communication support and education, and rehabilitation services, as they relate to the Hearing Services Program
- simplify the services defined in the current Services Schedule, including by removing any current restrictions around the use of communication support and education, and rehabilitation services, in the current service delivery model
- review the current fees payable under the Services Schedule to ensure that service items which have a strong focus on communication support and education, and rehabilitation, are appropriately remunerated; and undertake any necessary rebalancing of the fees.

## Recommendation 13: Improving access for Aboriginal and Torres Strait Islander peoples

13(a) The Australian Government should co-develop an Aboriginal and Torres Strait Islander framework for hearing health, with Aboriginal and Torres Strait Islander leadership, aligned with the National Agreement on Closing the Gap. This should include alternative models of hearing service delivery that are culturally safe and accessible to increase the proportion of eligible Aboriginal and Torres Strait Islander people with hearing loss taking part in the Hearing Services Program.

13(b) The Expert Panel endorses the proposed actions in the *Roadmap for Hearing Health* to improve access for Aboriginal and Torres Strait Islander peoples and recommends that the Australian Government implement and evaluate the following short-term action regarding enhancing the Sector's workforce:

*Strengthen the Aboriginal and Torres Strait Islander workforce to deliver hearing health services. This would include support for Aboriginal Health Workers to develop skills in hearing health.*

## Recommendation 14: Improving access for people from culturally and linguistically diverse backgrounds

The Australian Government should identify and analyse shortfalls in engagement with, and outcomes from, the Hearing Services Program for culturally and linguistically diverse populations, including issues related to availability of information and advice in community languages (see Recommendation 9). The Australian Government should undertake a co-design approach to working with peak bodies representing these groups to address any identified issues impacting on access for eligible clients to the Hearing Services Program.

## Recommendation 15: Improve access for regional, rural and remote communities

15(a) The Expert Panel recognises the ongoing challenges for regional, rural and remote communities in accessing hearing health services and references its previous advice to the Australian Government regarding the changes to Hearing Services Program voucher stream. The preference of the Expert Panel remains for Option 1 – Provide a loading on service items delivered in rural and remote regions (MM 3–7), irrespective of the size of the provider – as one of the ways to ameliorate the transition impacts of the changes to the program. The Expert Panel also continues to also support Option 3 – Expand teleaudiology services available through the program.

- 15(b) The Expert Panel endorses the proposed actions in the *Roadmap for Hearing Health* to improve access for people experiencing hearing loss in regional, rural and remote communities; and recommends that the Australian Government implement and monitor the outcomes of the following action regarding enhancing the sector's workforce capacity to support these people:

*Telehealth is made more accessible for hearing healthcare practitioners to provide services to consumers, particularly those living in rural and remote communities.*

### **Recommendation 16: Improve access for residents of aged care homes**

- 16(a) The Expert Panel endorses the proposed actions in the *Roadmap for Hearing Health* to improve access for older Australians living in aged care homes and/or receiving aged care services; and recommends that the Australian Government implement and monitor the outcomes of the following actions:

*Enhancing awareness and inclusion: Lift the quality of hearing health and care in aged care across the country, with a focus on identification, management and workforce training.*

*Identify hearing loss: Ensure aged care assessment processes, including on entry to residential care, appropriately identify hearing loss and balance disorders.*

- 16(b) In line with the Australian Government's response to the final report of the Royal Commission into Aged Care Quality and Safety, the Expert Panel encourages further action to ensure aged care providers include routine opportunities for their residents to have access to hearing services. Models of care should match both residents' specific needs (for example, their cognitive impairment) and the environment in which they live.

# Chapter 5

## Contemporary service delivery

### KEY POINTS

- Informed choice and control by clients over how to live with and manage their hearing loss should be the underlying principle guiding service delivery.
- Largely unbeknown to clients, their choice of service provider can affect what services they are offered and how they receive those services (education and counselling and/or a hearing device) and the quality of services received. It may even determine the range of hearing devices they are offered.
- Decisions made by contracted service providers about the types of services and hearing devices to be offered to clients can be shaped by corporate concerns such as their vertical integration with hearing device manufacturers.
- There is a community expectation of increased transparency and accessibility of information to consumers on all areas of health, including hearing health. This report argues that people with hearing loss should be able to exercise informed choice about, and control how they can be engaged in the planning, assessment, selection and delivery of, the services offered to them; and they should also be able to exercise informed choice about and control over the selection of their contracted service provider and have access to clear and independent processes for resolving any complaints. Consistent with this, additional information is required on:
  - the range and function of available hearing devices
  - the pricing of partially subsidised hearing devices
  - the qualifications and accreditation details of providers
  - a mechanism through which clients can provide feedback on service experience and outcomes.
- The availability of fully and partially subsidised hearing devices under the program may be creating a perverse incentive for contracted service providers to market partially subsidised hearing devices in place of suitable fully subsidised hearing devices.
- Technological advances are shaping consumer demand and contracted service provider offerings to clients. However, the program's Schedule of Service Items and Fees (Services Schedule) is not reflecting these advances. Separate to the review of the Services Schedule's services and fees as proposed in **Chapter 4**, there is an opportunity to update minimum specifications of fully subsidised devices and undertake a comprehensive review of program technologies, with input and advice from stakeholders.

Whereas **Chapter 4** addressed barriers to accessing the available hearing services which arise from an eligible person's actual (or anticipated) experiences, this chapter addresses the closely interrelated issues of service delivery. Client experience and provider service delivery are 2 sides of the one issue.

## Hearing health care professionals and service providers

Under the voucher stream, approximately 300 registered contracted service providers across Australia must ensure that the Hearing Services Program is delivered by a qualified practitioner (QP) or by a provisional practitioner under the supervision of a QP. There are 3 recognised Practitioner Professional Bodies (PPBs) to which audiologists and/or audiometrists may have membership:

- Audiology Australia (AudA): 2,907 members in the 2019–20 financial year (147)
- Australian College of Audiology (ACAud): 727 registered members (105 audiologists and 431 audiometrists currently working; the residual registered members not working) in the 2019–20 financial year (148)
- Hearing Aid Audiology Society of Australia (HAASA): 135 audiometrist members in the 2019–20 financial year (149).

The scopes of practice for the 2 hearing health professions are differentiated below. The functions of each professional group are outlined in the joint PPB scope of practice:(150)

- **Audiologists** work with clients of all ages – from infants to older adults – and clients with complex needs. They can assess hearing and auditory function, vestibular (balance) function, tinnitus, auditory processing function, and neural function by performing diagnostic tests. Audiologists provide rehabilitation as well as communication training, counselling and the prescription and fitting of hearing devices. Audiologists must have completed at least the equivalent of an Australian university masters-level degree in clinical audiology
- **Audiometrists** primarily work with adult clients (including older adults) and provide a range of services to school-aged children. They focus on hearing and auditory function assessment and rehabilitation by applying a range of diagnostic tests and approaches including counselling and the prescription and fitting of non-implantable hearing devices. Audiometrists may also provide rehabilitation for tinnitus using education and hearing aid devices. Audiometrists must have undertaken at least the equivalent of an Australian diploma-level Technical and Further Education (TAFE) vocational qualification in audiometry or a Bachelor of Audiometry from an Australian university.(151)

Audiology is a self-regulated profession that is not included as a specialty practice by the Australian Health Practitioner Regulation Agency (AHPRA). Like other unregistered health care practitioners, audiologists and audiometrists are covered by the National Code of Conduct for Health Care Workers.(152) The joint PPB code of conduct (153) is founded on the national code. Audiology Australia, on behalf of the Hearing Health Sector Alliance, is currently developing National Competency Standards for Audiologists (154) and is developing standards and/or guidelines for paediatric audiology and teleaudiology.

Audiologists and audiometrists can only provide services to Hearing Services Program clients if they have applied for a QP number and work for a service provider who holds a current service provider contract with the Department of Health (see **Appendix D**).

The program services that are available to eligible clients through the voucher stream are set by legislation and outlined in the Services Schedule. While there is a suite of services available, the specific services are funded on the basis of the clinical needs of the client and the service conditions being met. Services provided under the voucher stream and delivered by audiologists and audiometrists are:

- hearing assessment, including:
  - an accurate and complete assessment of the client's clinical and audiological history
  - identification of communication goals
  - identification of client attitude and motivation towards hearing rehabilitation
- provision of rehabilitation services, including:
  - education about the effects of hearing loss
  - communication tactics and strategies
  - informing the client about technology options suitable to their needs (if appropriate)
  - referral to medical practitioners and/or support organisations
  - follow-up services, including evaluation of outcomes and long-term support
- fitting of hearing devices, where appropriate
- device maintenance, repairs and replacements.

The first 3 services - assessment, rehabilitation and fitting of hearing devices – were dealt with in **Chapter 4**. This chapter deals with service delivery more broadly and the supply, maintenance and replacement of devices, as well as other 'supply-side' issues.

For the Community Service Obligations (CSO) stream, Hearing Australia is the sole provider. Audiologists and audiometrists, whose scopes of practice are the same as that described for the voucher stream above, are the main practitioners delivering services. Services are outlined in the *Australian Hearing Services (Declared Hearing Services) Determination 2019* and vary depending on the class of eligible person. Generally, the services available align with those for the voucher stream above; however, children and young people (Class 1) are also able to access replacement cochlear implant speech processor units.

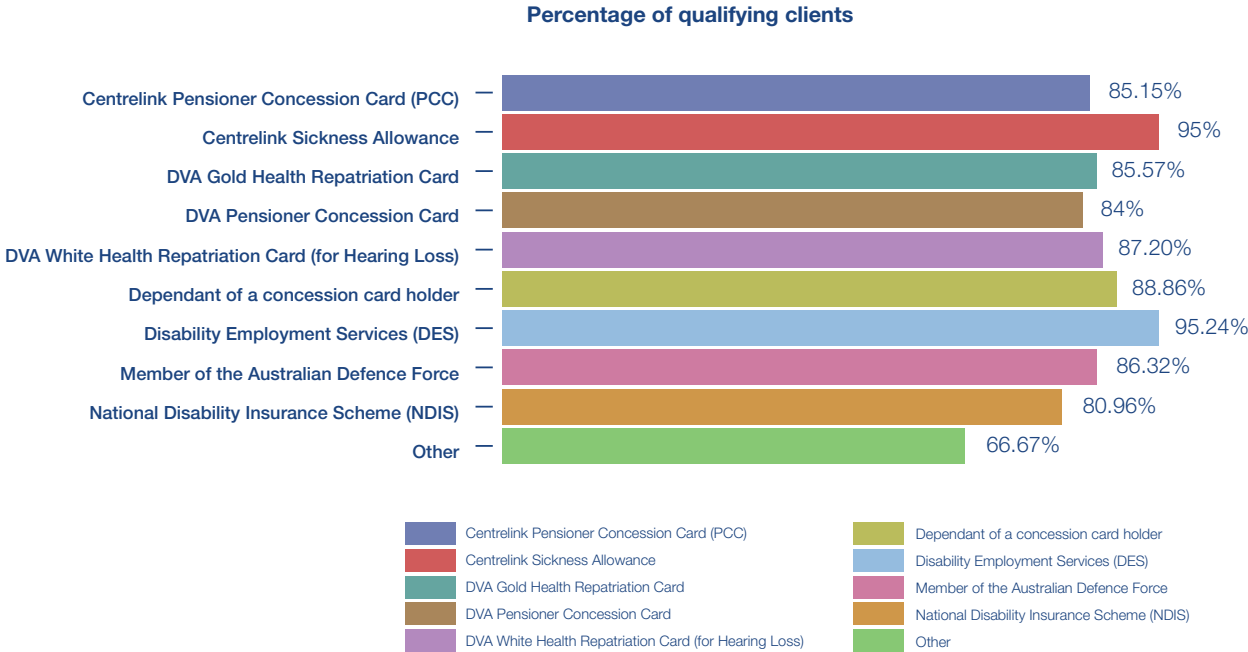
## Client selection of a provider or practitioner

Selection of a provider of hearing services under the voucher stream is one of the most important decisions made by a prospective client (and/or their supporting family/friends). In practice, this decision will affect what services they are offered (education and counselling and/or a hearing device), how they receive those services, the quality of services, and probably even the range of hearing devices they are offered.

The importance of this decision appears to be largely unrecognised by new clients of hearing services and reinforces the need to improve the early availability and accuracy of the information provided to people with hearing loss so that they can make informed choices. Many submissions inferred that there are not enough readily available data or information on clinical or program outcomes for clients to be able to make an informed choice about their contracted service provider. Other relevant factors were discussed in **Chapter 4**, which explored the client experience, including the need for providers to deliver services in a culturally safe manner to Aboriginal and Torres Strait Islander peoples and to people from culturally diverse backgrounds.

Further, as shown by Figure 8 (below), there is very little client movement between providers – at least 80% of clients remain with their ‘chosen’ provider for at least 3 years. There is no evidence before the Expert Panel which would enable it to comment on whether this indicates client satisfaction with the provider, or whether it means clients do not have enough knowledge about the sector to make an informed choice to change providers.

**Figure 8:** Proportion of voucher clients by eligibility type who choose to remain with their hearing service provider, aggregated 3 years (from financial year 2017–18 to 2019–20)



Source: Department of Health, Hearing Services Program data and statistics (internal).

## Supply side issues

### Vertical integration in the industry

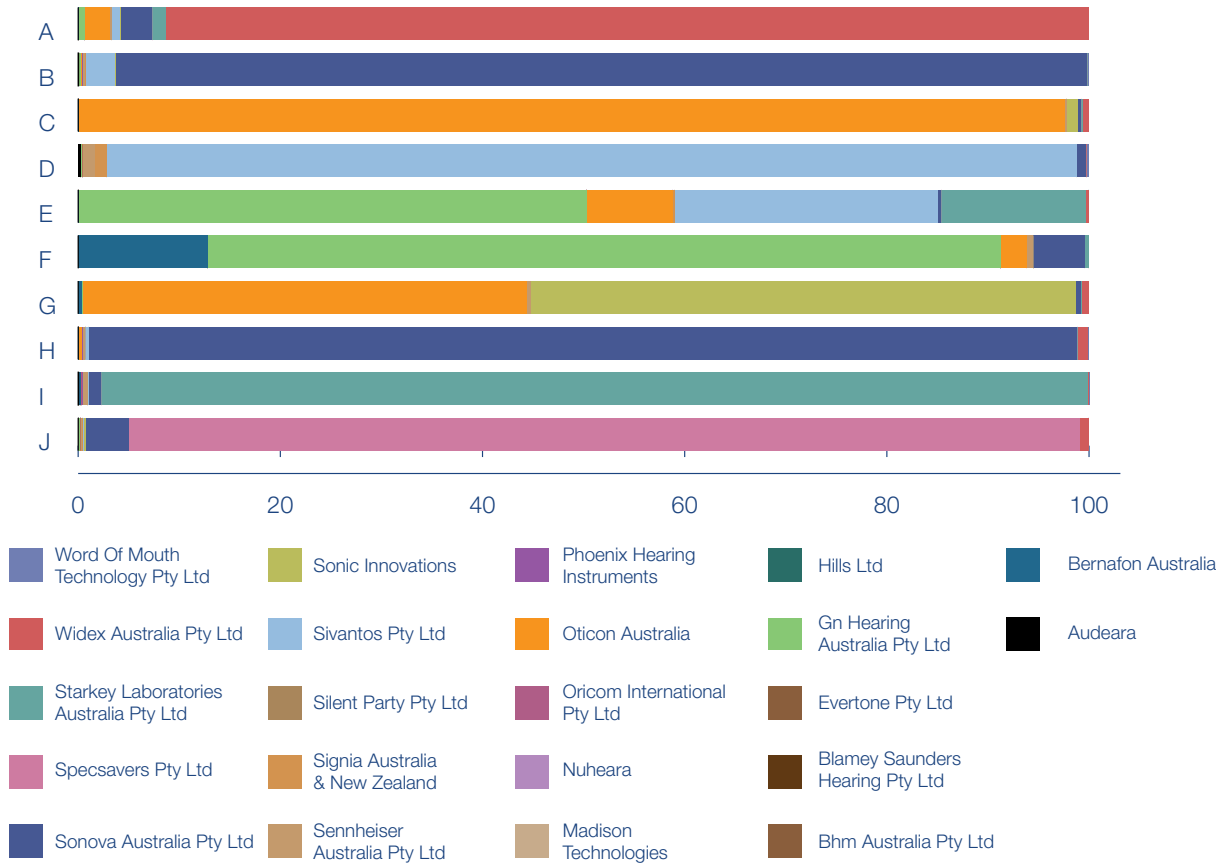
The structure of the hearing services industry has a significant bearing on the achievement of the program objectives proposed in **Chapter 2**. In particular, the structure affects whether contracted service providers are supplying and pricing services and, specifically, hearing devices in a manner which knowingly or otherwise inhibits people exercising informed choice about, and control over, the selection of their hearing care options. It also affects how clients are engaged in the planning, assessment, selection and delivery of the services, hearing devices and other support provided to them.

Many of the larger contracted service providers are ‘vertically integrated’ with manufacturers and suppliers of hearing devices in one form or another, meaning that providers can be owned and/or controlled and/or operated by hearing device manufacturers or suppliers. Given trading names differ between providers and manufacturers, it is difficult to measure the extent of vertical integration, but the PricewaterhouseCoopers (PwC) review (2017) suggested that it is commonplace in the Australian market:

*Stakeholder feedback, anecdotal reports, and recent government reports (including the Australian Competition and Consumer Commission) all support this and suggest consolidation through vertical integration is becoming common place. However, there is limited publicly available information to verify such a claim.(92)*

The Expert Panel’s analysis of device brand choice by contracted service providers shows that, of the 10 largest hearing providers (who provide hearing services to 80% of clients in the voucher stream), only 3 delivered high-volume device supply arrangements across a number of hearing device manufacturers. Seven of the 10 providers supplied over 90% of devices to their clients from only one manufacturer in each case. This evidence supports concerns that consumer choice is being constrained.

**Figure 9:** Distribution of hearing devices supplied to clients by hearing device manufacturer for major hearing service providers, aggregated 3 years (from the 2017–18 to the 2019–20 financial year)



Source: Department of Health, Hearing Services Program data and statistics (internal).

## Product disclosure

Disclosure of vertical integration is addressed in one of the current legislative instruments which underpin the Hearing Services Program. The *Hearing Services Program (Voucher) Instrument 2019* (section 28) requires that contracted service providers disclose their hearing device supply arrangements:

*A contracted service provider must inform a voucherholder of device supply arrangements in accordance with the guidance published on the program website.(38)*

Under the current (standard provider contract):

*[Providers must] disclose in writing to the Voucher-holder whether or not*

- A. the Service Provider or any Service Provider Personnel receives any direct or indirect benefit (whether pecuniary or non-pecuniary) in relation to, or in connection with, the Service Provider's purchase of Supplies from an Appointed Supplier, including, without limitation, exclusive supply arrangements, price discounts (including volume discounts), commissions, gifts or rewards*
- B. the Supplies are provided or manufactured by
  - i. a Related Party or*
  - ii. a person or entity which has provided significant financial support to the Service Provider, or has a financial interest in the Service Provider, or to whom the Service Provider has provided significant financial support or**
- C. the Service Provider is also an Appointed Supplier, and Supplies are those supplied by the Service Provider.(155)*

There are also legislative requirements on providers to offer a range of hearing devices (noting that 'a range' is not defined and could be considered the type of hearing device, not just the brand). In addition, there is a requirement that clients be offered a fully subsidised hearing device in the first instance as an indication of support for vulnerable Australians (section 46 of the *Hearing Services Program (Voucher) Instrument 2019*).

The PPB code of conduct and program standards also require providers to ensure they meet client need and recommend a hearing device that best suits the clinical need (it should not, for example, be driven by the profit margin). Standard 6 of the PPB code of conduct states:

*6.2: Members must make recommendations to clients based on clinical assessment and the client's needs, not on the basis of financial gain on the part of the member.(153)*

The instrument and standard referred to above aim to ensure that there will be client choice as to the hearing device that they are most comfortable with and which has the functionality that they consider most appropriate to their hearing and lifestyle needs. However, the 2017 Australian Competition and Consumer Commission (ACCC) report *Issues around the sale of hearing aids: consumer and clinician perspectives* (ACCC Report) identified that clients had concerns about the transparency of hearing device supply and incentives paid to practitioners and upselling, dissatisfaction with the hearing device features and performance and confusion over the lack of standard language about hearing devices.(93) The ACCC raised particular concerns about contracted service providers' use of finance arrangements where vulnerable clients were being sold partially subsidised hearing devices at considerable mark-up and tied to ongoing financial payments.



Despite the legislated requirements of the Hearing Services Program, several submissions reported that clinicians whose clinics were supported by hearing device manufacturers might give preference to that brand of hearing device (as evidenced in Figure 9 above) and/or might upsell hearing devices beyond clients' needs (including clients who are veterans). In their view, the business or profit motive instead of the need of the client influenced the offer of a hearing device.(82,83,156)

In the consultations on the Expert Panel's draft report, a smaller independent audiologist (in a confidential submission) advised of a disadvantage around the administration of their business and product pricing compared with clinics that are owned by parent companies that also own manufacturers, large multinational chains and discount stores.

The 2017 House of Representative Standing Committee Inquiry into Hearing Health (46) recommended the Hearing Services Program ban the use of commissions and other similar sales practices that were in place which could undermine the ability of hearing practitioners to provide independent and impartial clinical advice (recommendation 12). The recommendation that the program ban commissions has not been adopted. The Expert Panel has been advised that this is in part due to the challenges in defining commissions and incentives.

The Department of Health chose instead to implement an expanded disclosure statement in 2019. To address the risks of vertical integration and commissions and to address other issues identified in the parliamentary inquiry and the 2016 ACCC investigation (such as upselling and being pressured into buying a hearing device immediately), contracted service providers are now required to give a hearing device quote to all clients who are considering fully and partially subsidised hearing devices through the program. Any quote must include the value of the government subsidy; client contributions, if any; maintenance; and returns and warranty policies. Prior to these 2019 changes, this was only required for partially subsidised hearing devices.

All contracted service providers are required to offer a fully subsidised hearing device option if considering a fitting, and clients can also choose to use the government subsidy to purchase a partially subsidised hearing device. The disclosure and quote requirements aim to help give clients time to make a decision about hearing devices. To the extent there is information available across the sector, this may enable some clients to assess whether their provider is offering a limited range of hearing device options, assess whether there are sales incentives in place, understand the value of fully subsidised hearing devices, compare prices, get a second opinion, or seek alternative quotes from other contracted service providers.

It is apparent that, in the current process, the information provided to a client is only available once the client has engaged with a particular contracted service provider and has progressed to receiving a quote for a specific device.

In addition, the full features of the hearing devices are not required to be shared with the client. Providers often have their own basic hearing device specification sheets, which usually refer to tiers of hearing devices and the different circumstances they benefit. Fully subsidised hearing devices are generally promoted as basic or entry level.

The 2019 disclosure changes to the program have been implemented through a variation to the providers' contracts with the Department of Health. All contracted service providers must complete an annual self-assessment which requires providers to review their policies and procedures, including certifying that their hearing device quotes and disclosure statements are compliant with legislative and contractual requirements. The 2020 Transition Readiness Survey, which supported the implementation of the 2019 legislation changes, sought certification that

providers have or would have the updated disclosure statement and the expanded quote requirements ready for the following April. Some contracted service providers check for compliance by submitting their templates for review prior to use.

The Department of Health's compliance activities are risk based. During compliance monitoring activities client files, including their hearing device quotes and disclosure statements, are reviewed. If the quote/disclosure statement is not adequate, the contracted service provider is given an opportunity to rectify the issues. To date, there has not been any evaluation of these latest requirements.

In bringing these issues together, the Expert Panel concludes that, although information is currently made available to a client before a fitting, there is a paucity of comparative information on hearing devices, their functionality and the prices that are being offered by competing contracted service providers that the person with hearing loss can research prior to undertaking the assessment and hearing device choice journey with a particular provider, as well as during that journey. This is particularly relevant considering the significant variation that exists between providers in the features and prices of partially subsidised hearing devices.

## Hearing device price disclosure

Transparency of pricing of hearing devices is limited: very few contracted service providers publicly list the retail price of their hearing devices. Australian consumer law does not require business to disclose the price of their goods and services. However, the ACCC states on its website:

*Prices displayed by a business must be clear, accurate and not misleading to consumers.(157)*

When or where a business chooses to set a price for a good or service, or advertise a price, they need to be aware of any restrictions that various pricing activities (157) might have on transparency.

Publication of the prices and features of hearing devices would enable clients to be better informed and would potentially increase competition between the hearing service providers. The normalisation or price benchmarking of hearing devices could also negatively affect the current profits being made by some hearing service providers.

In its draft report, the Expert Panel considered options to improve transparency of pricing and improve client choice and control over hearing devices (introducing a Recommended Retail Price; requiring contracted service providers to publish the price and features of the hearing devices they supply under the program; and undertaking a feasibility study on deleting partially subsidised hearing devices). The Expert Panel received significant feedback on this topic, including that:

- the current system, which has evolved over the past 20 years, makes it virtually impossible for the client to compare products and prices. Specsavers reported that: the industry has gone out of its way to avoid the possibility of comparison by using vastly different terms and feature names to describe similar pieces of technology
- the program should include independent information on features, limitations, and quality of the hearing devices to help clients compare products and services
- clients may be interested in factors beyond hearing device price. It may be more useful to publish provider qualifications and data on the quality of the service

- having to publish prices might disadvantage small providers, adding significantly to their administrative burden
- deleting partially subsidised hearing devices would significantly restrict client choice. (30,39,40,68,121,122,158–160 and a confidential submission).

In considering this feedback, the Expert Panel reaffirms that consumer sovereignty is key. In relation to the disclosure of both product features and prices, the Expert Panel considers there is a need to improve on how manufacturers and contracted service providers provide detailed information that enables a client to compare the range of services, hearing device products and their features and the prices of partially subsidised hearing devices offered by their provider and/or other providers, as well as the QP and/or contracted service provider's qualifications and accreditation status. The information should also include giving clients information on how they can provide feedback on the service they have received, enabling transparency about the client experience of care and continual improvement of service delivery. This information should be available to clients prior to and throughout their journey in making a decision about hearing devices.

The requirements should be strengthened in consultation with consumers to reorient the program to be more responsive to client needs, be transparent and support clients in making informed choices, exercising control and receiving more client centred care.

## Hearing device product and pricing reform

The Expert Panel is proposing that Hearing Services Program contracted service providers should publish:

- the range of services and all of the fully subsidised and partially subsidised hearing devices they choose to provide under the program (including quality and any limitations)
- their prices for the partially subsidised hearing devices they choose to offer to clients
- the qualifications and accreditation details of the provider/s
- guidance on how clients can provide any feedback on a service.

The Expert Panel recognises that these requirements may result in some providers rationalising the range of products they offer – particularly those hearing devices that would be only partially subsidised. This latter issue is explored in greater depth in the following subsection on upselling.

To the extent that some providers may not, under their current purchasing arrangements, have the same bargaining powers with manufacturers or intermediary suppliers, the requirements would enable them to promote their comparative benefits in the range, quality and personalisation of services they offer their clients, their locational advantages, their contribution to the local community and other benefits that may be attractive to clients.

## Upselling

The issue of upselling of hearing devices has been regularly raised with the Expert Panel. There are at present more than 240 models of hearing devices available on the fully subsidised list. In addition, there are more than 1,900 hearing devices on the partially subsidised list (noting that the same hearing device might be listed multiple times).

The analysis in Table 13 of patterns of supply identify that, although a little over two-thirds of all clients fitted with a hearing device are fitted with a fully subsidised model, nearly one-third are sold a device that is only partially subsidised. Clients make up the rest of the cost from their own resources, despite the limited comparative information made available to them. This

suggests that either there is evidence of upselling or the list of fully subsidised hearing devices is significantly inadequate for meeting the hearing needs of most clients. This section examines upselling, while the latter issue is addressed later in this chapter.

**TABLE 13:** Number of hearing devices issued to clients annually, including proportion of fully subsidised and binaural fittings in the financial years of 2015–16 to 2019–20 (37)

Type	Financial year				
	2015–16	2016–17	2017–18	2018–19	2019–20
Device issued to clients	382,384	395,829	404,912	398,874	392,598
Fully subsidised devices (%)	68%	68%	69%	69%	64%
Binaural fittings (%)	85%	86%	86%	87%	89%

Source: Department of Health, Hearing Services Program data and statistics (internal).

The Department of Veterans’ Affairs (DVA) expressed concerns regarding the marketing of hearing devices to veterans, including that fully subsidised hearing devices were being promoted as basic hearing devices rather than being technologically advanced. Some of the marketing materials used by providers, such as lifestyle charts, were giving the perception that veterans were being provided inferior hearing devices unless they bought a partially subsidised model and paid the balance.

The cost to clients for partially subsidised hearing devices varies considerably between contracted service providers, ranging from zero cost to the client to contributions of between \$200 and \$15,000 for a pair of hearing devices. Some clients can pay as much as twice the average price of a device. Providers can also charge clients a higher co-payment amount for maintenance. Clients can be unaware of the ongoing costs, including having to pay the client co-payment again if they lose the hearing device/s. The Expert Panel concluded that all initial and ongoing costs—for example, batteries, fitting adjustments and device maintenance—should be made clear to clients prior to purchase.

PwC noted that there are questions about the validity of the partially subsidised hearing device schedule and its perceived role in the upselling of assisted hearing technology (Finding 10). However, industry members support the retention of the partially subsidised hearing device schedule, citing clients being able to use the government subsidy towards higher technology hearing devices such as Bluetooth.

As mentioned earlier in this chapter, the Expert Panel initially explored the proposition that the partially subsidised schedule be deleted from the voucher stream of the program as suggested by PwC. The Expert Panel decided against this in preparing this final report, citing stakeholder feedback that this would detract from client choice.(29,56,66,68,121,161) Stakeholders also reported that, when clients contribute to the cost of their hearing device, this sometimes improves engagement with (and therefore the success of) their hearing device. (30,56,67,162–164) The Expert Panel notes that the provision of partially subsidised hearing devices is recognised by the National Disability Insurance Scheme (NDIS) as best practice in supporting client choice.(161)

The Expert Panel considers that the extent of any unwarranted upselling and excessive profit margins would be ameliorated by the competitive benefits of the disclosure of product features and prices proposed in the preceding subsection, together with a review and expansion of the minimum specifications for fully subsidised hearing devices (92) as proposed later in this chapter.

The Expert Panel suggests ongoing monitoring of the impact of these changes on the participation rate of manufacturers and contracted service providers in the program, noting that some may choose to withdraw from the program if they are unable to generate additional profits from partially subsidised hearing devices. Any such reduction in participation and lessening of consumer choice should be assessed against the additional benefits to clients overall from paying less for partially subsidised hearing devices.

## Hearing device technologies and governance arrangements

### Broadening the scope of technology

Manufacturers and suppliers sign a Deed of Standing Offer with the Department of Health that covers minimum specifications for hearing devices. Further, the Hearing Aid Manufacturers and Distributors Association of Australia (HAMADAA) noted that market competition at the manufacturer level means that eligible clients could potentially have access to a wide range of the latest hearing device technology, some of which exceeds the minimum specifications.<sup>(165)</sup>

All hearing devices have warranties and consumer guarantees, trial periods (offered by the service providers and supported by the manufacturers) and maintenance support within the program. This includes the fully subsidised hearing devices (more than 240) and partially subsidised hearing devices (more than 1,900 products). However, as discussed earlier, the limitations faced by clients in having information available and in their dealings with providers significantly lessens the level of competition at the retail end.

Deafness Forum of Australia noted that clients would like to see Hearing Services Program service delivery and hearing devices keeping pace with technology developments.<sup>(40)</sup> DVA acknowledges that the control its clients have over services that are best suited to their needs may be limited by insufficient technical knowledge. This often leads to unrealistic expectations of the program (noting that a true picture of this issue is difficult due to the lack of data on outcomes).<sup>(98)</sup> Submissions to both consultations discussed several opportunities for the Hearing Services Program to broaden its technological options as detailed below.

### Alerting devices

The CSO stream currently provides assistive alerting devices which react to alarms in order to let a hard of hearing person know that a condition is occurring (for example, amplified ring, flashing light vibration alert for the phone, visual smoke alarms, alarm clock timer and watch, visual doorbell and intercom for CSO clients). DVA clients are also able to access this technology through the DVA Rehabilitation Appliances Program.<sup>(166)</sup> The inclusion of this technology in the voucher stream would lead to improvements in the safety and lifestyle of many more hearing-impaired clients.

### Assistive Listening Devices

Some stakeholders raised concerns about the limited range of Assistive Listening Device (ALD) technology available through the Hearing Services Program and that ALDs are not available to clients if they are fitted with a standard hearing device.<sup>(92)</sup> PwC (2017) noted that the variety of, and access to, ALDs under the program should be expanded (Finding 9).<sup>(92)</sup>

Such devices include hearing aids, hearables, remote microphone technology and cochlear and other implant technology. Hearing Australia noted that it is estimated that between 10% and 15% of adults with a normal audiogram raise concerns about difficulty understanding speech when there is background noise, and these people may benefit from hearing support through ALDs.(74)

Hearables offer hearing enhancement but are not traditional hearing devices. They are less complex and cheaper than purchasing a traditional hearing device, but they still provide some improvement to the hearing experience of the listener by filtering out background noise. For people whose hearing loss does not yet warrant the use of a hearing device, hearables are a more cost-effective form of assistance.(74)

### Directional microphones

The introduction of wireless audio streaming between both sides of the head has allowed the development of binaural beamformer technology.(167) Most of the behind-the-ear and in-the-ear hearing devices supplied in the program have directional microphone technology which can improve the experience for the user of sounds in front of them. New Omni directional microphones capture sound in a 360-degree field around the user. Hearing devices that have both directional and omni-directional microphones can automatically (or allow the user to manually) switch the sound capture mode depending on the sound environment. The use of directional microphones has been shown to improve the speech understanding in a noisy environment for people with all levels of hearing impairment.(168)

### Cochlear and other implants

These implants replace the function of the ear for those without a fully formed ear or those with severe or profound hearing loss. There are 3 main types:

- **cochlear speech implant**, which bypasses damaged hair cells in the inner ear and directly stimulates the nerve (replacing the inner ear) for people with severe or profound hearing loss
- **middle ear implant**, which works by converting external sound signals to vibrations that are then picked up by the small bones of the middle ear to create sound for people with mixed or conductive hearing loss or have allergies to ear mould or skin problems in their ear
- **bone anchored hearing device**, which conducts the sound vibrations received in the skull to the inner ear for people who have severe outer or middle ear malformations or those with unilateral hearing loss.

Currently only children and young adults are eligible through the Hearing Services Program to receive replacement speech processors for the most popular implant - a cochlear implant speech processor.

### Data logging

Some of the hearing devices in the program use a technology known as data logging. Data logging enables the collection and analysis of data about how the client uses their hearing device and the environment in which it is used. The information provides an objective perspective on the use of the hearing device in different listening environments. Qualified practitioners can download this information when the client comes in for an appointment to help them analyse the client's use of the hearing device and fine tune the hearing device or identify areas where the client needs further device rehabilitation counselling.(169)

## Improving connectivity

Hearing devices can now include connectivity using Bluetooth - a wireless communication platform that seamlessly transfers sound from audio music players, phones, assistive listening devices and other media devices such as televisions, tablets, and computers directly to the hearing device. Bluetooth technology in hearing devices improves the hearing device wearing experience and greatly improves the convenience for users.

## Mobile apps

The use of smartphones is changing the landscape for health care delivery. For those with tinnitus, it offers a more personalised form of therapy targeted towards the individual's specific area of need.<sup>(45)</sup> Accessing therapies via a mobile phone will also provide the conveniences of other telehealth services. It has the potential to deliver a sound therapy library as well as cognitive behavioural strategies to alleviate anxiety and depression induced by tinnitus. For patients who require a more intensive degree of intervention, a referral to a qualified psychologist (including through videoconferencing) would be appropriate.

## Multi-channel processing

Some of the hearing device technologies are limited to filtering 4 channels of sound. An increase in this range to 8 channels enables the hearing device to separate the sound into different frequency regions for separate analysis and processing and reproduction for the user. This improves the audibility of sound in more listening situations (such as in the presence of background noise) and improves the experience for the user.<sup>(170)</sup>

## Rechargeable hearing devices

Stay Tuned noted that the Hearing Services Program could consider funding rechargeable hearing devices, claiming that many of the program's clients are older with other medical problems such as poor vision and poor dexterity. Rechargeable hearing devices would allow for ease of use and therefore contribute to higher hearing device retention and use. This would have the added advantage of reducing the number of button batteries in circulation given they are dangerous to children and very difficult to recycle.<sup>(171)</sup>

## Ongoing role of audiologists and audiometrists

Despite the ongoing development of all of these technological options, submissions acknowledge the important ongoing role of a hearing care professional in properly addressing patient needs in delivering high quality patient outcomes. Audiologists and audiometrists are required to assess and review which hearing devices provide the greatest value and best outcomes for their clients, in accordance with their obligations under the Hearing Services Program's service provider contract and professional body code of ethics.

## Maintenance agreements

In the 2019–20 financial year, maintenance and repair claims accounted for 40% of the number of claims paid by the program, resulting in over \$111 million in funding (some 24.4% of total voucher stream costs).(37) The actual costs paid by contracted service providers for maintenance and repairs of program hearing devices is not clear. The minimum hearing device warranty requires the hearing device manufacturer to remedy defects and faults attributable to the design, workmanship or component failure at no additional cost. There is still a cost for the consumables (domes, tubing and so on) and the client also makes a co-payment for the cost of hearing device batteries.(172) The costs can vary significantly depending on the location of the client, the hearing device age, and the fitting arrangement and length of time since the fitting of a hearing device.

Nearly all program clients are reported to be on a maintenance agreement. This creates a significant administrative burden for contracted service providers and the program given it is attended to annually and for such a large proportion of the clients. Improvements to how the program supports maintenance can be made both administratively and via review and simplification of the structure of the Services Schedule. Annual maintenance agreements, client payments and claiming could be substantially reduced by:

- the program paying only for the actual repairs and costs of consumables for hearing devices outside the warranty period
- increasing device warranty to 3 years, which is the industry standard (except Hearing Australia, which has negotiated a very low unit price cost in lieu of 3 years of warranty and has a one-year warranty instead)
- making maintenance agreements which would be current for the life of the hearing device as long as the client is confirmed to still be using their hearing device
- paying providers automatically every quarter for the number of clients with hearing devices to cover any maintenance costs.

The Expert Panel notes that, under the changes to the hearing device maintenance arrangements in the 2020–21 Budget, the government will no longer fund hearing device maintenance payments during a minimum warranty period of 12 months after a hearing device has been fitted. However, the Expert Panel considers that further reform to maintenance payments may be required as part of any future review of the Services Schedule to unbundle rehabilitation, device fitting and maintenance services.

## Replacements of hearing devices

Currently the Hearing Services Program allows clients to receive an unlimited number of replacements of fully and partially subsidised hearing devices if they are lost or damaged beyond repair. When a hearing device is lost, the client is asked to sign a statutory declaration documenting when and how the hearing device was lost and to pay a small replacement fee. The device should be replaced with the same model as the lost device unless it is no longer on the Services Schedule. Clients with a partially subsidised device have to pay the balance between the program subsidy and the provider's cost. Sometime clients choose to replace a lost partially subsidised device with a fully subsidised device instead.

For hearing devices damaged beyond repair, a letter from the manufacturer must be provided which states that the hearing device cannot be repaired.



A replaced hearing device is not currently considered a fitting under the Hearing Services Program. This enables clients to receive a new hearing device 5 years after their original fitting, irrespective of how many replacement hearing devices they have had since the original fitting. Table 14 compares the number of claims and the co-payments paid by clients for fittings, maintenance and replacements, across the 2017–18 to 2019–20 financial years.

**TABLE 14:** Approximate values of all co-payments by clients in financial years 2017–18 to 2019–20

Service type	Total number of claims for services	Total client co-payment to service provider	Average client co-payment per claim
Partially subsidised hearing device fittings where the client pays the difference between the standard device subsidy and the retail price of the device (excluding zero cost devices)	190,762	\$351,553,616	\$1,842.90
Partially subsidised hearing device replacements where the client pays the difference between the standard device subsidy and the retail price of the device (excluding zero cost devices)	30,386	\$21,849,735	\$719.10
Client device maintenance co-payment for fully and partially subsidised hearing devices <sup>1</sup>	1,654,800	\$55,403,201	\$33.48
Client co-payment for replacement of fully and partially subsidised hearing devices <sup>2</sup>	135,861	\$837,520	\$6.16

**Notes:**

- 1 All clients who choose to have a hearing device maintenance with their service provider are obliged to pay a co-payment fee. For fully subsidised hearing devices it is a set fee and for partially subsidised devices the fee is set by the service provider. Service providers were able to waive the client co-payment fee in 2019–20 during the COVID-19 period in order to automatically process claims for hearing device maintenance. In October 2019 this client co-payment was charged on a per device basis.
- 2 All clients who receive a replacement hearing device from their service provider are obliged to pay a co-payment fee irrespective of whether it is a fully or partially subsidised hearing device. Note that service providers were able to waive the requirement for the client statutory declaration during the 2019–20 COVID-19 period in order to automatically process claims for hearing device replacements. In October 2019 this client co-payment was charged on a per device basis. Note that many service providers choose to waive this fee for clients.

Source: Department of Health, Hearing Services Program data and statistics (internal).

On average, a client receives one replacement of one device every 3 years. However, there are some outliers, with clients receiving up to 10 hearing devices over a 5-year period. Anecdotal evidence, including notification from contracted service providers, has identified that hearing devices are sometimes reported as lost in order to obtain newer hearing devices. As noted above, clients can be asked to pay a co-payment for a partially subsidised replacement hearing device, irrespective of whether the client is monaurally or binaurally fitted, with taxpayers picking up the majority of the cost.

Table 14 above includes data over 3 financial years (2017–18 to 2019–20). For the single year reporting period of 2019–20, replacements and spare hearing devices accounted for 3.3% of claims submitted to the Hearing Services Program at a cost of \$35.8 million (6.6% of expenditure of the Hearing Services Program).

# Incorporating new technologies into the Hearing Services Program

Given the evidence put forward in the prior sections of this chapter, the Expert Panel considers that there is an opportunity to review the technologies offered by the Hearing Services Program, and their costs, so that clients have improved access to up-to-date technologies.

## Stakeholder input about technologies

Soundfair suggested that a review include non-device technologies as well as device technologies (for example, alerting devices and psychosocial supports provided through technologies).(68) Deafness Forum of Australia advised that any review also needs to include changes to ancillary products that are required to support hearing devices to ensure that clients are not bearing more cost to access these devices.(40) It felt it would be helpful if this process included investigating the availability of hearing devices that are required to meet the specific needs of smaller client cohorts. Soundfair went further, suggesting that any review could include looking at the benefits and continuing challenges of balancing client need and economics in hearing device fitting funding programs such as Workcover (which does not have any partially subsidised aids). MEDEL mentioned the possibility of considering new technology that will fill a gap for those with more profound hearing loss.(173)

Given that implants and sound processors are already subject to an assessment of quality, safety, efficacy, effectiveness and cost-effectiveness through existing pathways related to registration of medical devices, Cochlear Australia suggested that any proposed changes to the technologies under the Hearing Services Program needs to align with existing decision-making pathways and not be duplicative. This view was supported by Attune, CICADA, Ear Science Institute, Hearing Implants Aust, HEAR centre, Neurosensory, NextSense and South Australia Cochlear Implant Centre.(97) The Expert Panel agrees that any assessment of medical devices for registration purposes should not be required to undergo a duplicative process. However, the registration process does not address whether and how technologies should be subsidised through the Hearing Services Program.

Some stakeholders believe there is no need to undertake a technology or minimum specifications review for the purpose of being included in the Hearing Services Program. HAMADAA indicated that there is already a good variety of products available to clients and the program has safeguards in place to protect clients. If a review was to go ahead, HAMADAA made the important point that there needs to be an assurance of appropriate funding available to support the additional costs of broadening the scope of technology made available within the Hearing Services Program.(56)

As noted earlier in this chapter, the Expert Panel is proposing a review and expansion of the minimum specifications for fully subsidised hearing devices (noting that the minimum specifications for fully subsidised hearing devices have not been reviewed for over 10 years) together with the convening of a stakeholder working group to provide advice. Some of the technologies discussed above are now so mainstream that clients, and the taxpayers who fund the subsidies, are likely to expect them to be available as part of the program. Such technologies include rechargeable hearing devices; multi-channel sound processing; Bluetooth connectivity; and remote switching between listening, phone answering and other connectivity.

The Expert Panel notes, however, that the Hearing Services Program needs to develop procedures by which it is responsive to evolving technology on an ongoing basis, needs to provide clarity in program deeds for manufacturers and contracts for providers about this

technology, has to be aware of any program funding constraints and has to balance these considerations while meeting client needs.

Challenges in considering the inclusion of emerging technologies in the Hearing Services Program include:

- the current 5-year voucher has a set range of services available depending on the client's hearing loss and other communication issues
- services delivered with this voucher are variable and how clients use these services can vary (including hearing assessment, fitting of devices, maintenance, rehabilitation, annual review, replacements)
- the Hearing Services Program pays a set amount for the device according to the type of technology. This payment is made irrespective of whether the device is fully subsidised (where the client makes no further payment) or partially subsidised (where the device is listed on the Services Schedule and the client pays the difference between the subsidy and the retail price, noting that in some cases the contracted service provider may provide partially subsidised devices at no charge to the client)
- for clients who choose to enter into a maintenance agreement, a client maintenance payment is capped by the program for fully subsidised hearing devices and contracted service providers can seek a higher amount from the client for a partially subsidised hearing device
- the range of hearing technology that should be considered for addition to the program, either as standalone devices or enhancements to the current technology in the fully subsidised hearing device range (described earlier), will need to be determined
- for every increase in any voucher/subsidy, there is a significant flow-on increase in the cost for the Australian Government over the 5-year voucher period
- there will be a need to evaluate the benefit to clients and the value for money to taxpayers in consideration of available hearing technology, the minimum specifications and the determination of a fair price for the government to pay for devices.

The possible future review of device minimum specifications and the updating of Hearing Services Program technologies has attracted the interest of stakeholders. Submissions to the Expert Panel's draft report indicated keen interest from a range of stakeholders (including DVA, Deafness Forum of Australia, industry groups and providers) to participate in the review and related working group). The Hearing Care Industry Association suggested that the working group be formally established and members have the appropriate skills or background to contribute to the review.(30)

Such a review would look at the need of clients and assess these against:

- the tiers of devices – possibly expanding the number of these tiers to cover an expanded number /types of technologies
- what devices need to be listed or decommissioned
- the deed of supply arrangements
- the value of the voucher'
- the criteria for placing a hearing device on the fully subsidised list
- the clinical benefit of the hearing device compared with the lifestyle needs of clients
- incentives and disincentives for contracted service providers
- value for money.

The Expert Panel acknowledges that this is a significant undertaking and it should be appropriately resourced; and that a stakeholder working group should be convened to provide the perspective and advice from all sectors.

## Reviews of Schedule of Service Items and Fees, program technologies and minimum specifications of fully subsidised devices

In **Chapter 4**, the Expert Panel recommended a review of the Services Schedule to, among other aims, ensure that service items which have a strong focus on communication support and rehabilitation are included, separately identified and appropriately remunerated. In the above sections of this chapter, the Expert Panel has proposed reviews of Hearing Services Program technologies and minimum specifications of fully subsidised devices. Indicative terms of reference for the 3 reviews are brought together here.

1. Undertake a review of the Services Schedule, with particular attention to:
  - Reviewing the **items** set out in the Services Schedule:
    - reducing the complexity of the current Services Schedule - de-bundling items (for example, communication/rehabilitation items and device fitting items) and reducing the number of separate service items
    - articulating and describing what the service items might be
    - considering the impact and desirability of removing current restrictions around the use of communication support and education, psychosocial and rehabilitation services in the current service delivery model and any necessary changes to the Services Schedule.
  - Reviewing the **fees** set out in the Services Schedule:
    - ensuring services which have a strong focus on communication support and rehabilitation are appropriately remunerated
    - considering whether there is a need to rebalance fees to address unintended bias in profit margins which favours the supply and fitting of hearing devices ahead of non-device support (incentives and disincentives for contracted service providers)
    - considering value for money.
2. Undertake a review of Hearing Services Program technologies which should be listed under the Hearing Services program, including but not limited to:
  - the tiers of devices – advising on expanding the number of these tiers to accommodate an increased number/types of technologies, including non-hearing device technologies
  - the benefits and costs of hearing technologies to identify which ones should be to be listed, decommissioned or delisted
  - the clinical hearing and non-hearing lifestyle benefits of the hearing technologies.

3. Undertake a review of the minimum specifications for Hearing Services Program fully subsidised hearing devices outlined in manufacturers' Deeds of Standing Offer, including:
  - developing the criteria for placing a hearing device on the fully subsidised list
  - establishing a process for the ongoing assessment of hearing devices which meet the criteria and therefore should be placed on the fully subsidised list.

## Recommendations

### Recommendation 17: Supply and client choice

The Australian Government should enable improved consumer choice by amending the contract with providers to require them to publish (as a minimum, on their website in an easily accessible manner):

- the range of services they provide and the features (including quality and limitations) of all devices (fully and partially subsidised) that they supply under the program
- prices of the partially subsidised devices that they provide under the program
- qualifications and relevant accreditation status of the provider
- information on the mechanism through which clients can provide feedback on service experience and outcomes.

### Recommendation 18: Broadening the scope of technology to facilitate client choice

18(a) The Australian Government should evaluate the benefits and costs of including developing technologies, such as rechargeable devices and batteries, directional microphones, alerting devices, mobile applications, and remote controls, in the Schedule of Service Items and Fees.

18(b) The Australian Government should commission the following reviews and convene one or more broad sector working groups of stakeholders, including consumer representatives, to participate in them:

- a review of hearing technologies which should be listed under the Hearing Services Program
- a review of the minimum specifications for fully subsidised hearing devices under the Hearing Services Program as outlined in manufacturers' Deeds of Standing Offer and the criteria which guide the inclusion of those devices in the Deeds of Standing Offer.

# Chapter 6

## Program design and administration

### KEY POINTS

- Improvements can be made to the current administration of the Hearing Services Program to ensure that program objectives are being met; that the contracted service providers, workforce and suppliers are appropriately regulated; and that the program demonstrates value for money and has flexibility to adapt to emerging developments in managing hearing loss and improving peoples' communication and lifestyles.
- There is a complex legislative, contractual and policy framework underpinning the delivery of services through the Hearing Services Program. Positive steps have been made in simplifying the regulatory framework for the program, but there is agreement that further work is needed to ensure its effective and efficient operation.
- As there are several Australian Government programs that interface with the Hearing Services Program, it is important for the delivery of client-centred care that all programs are designed and administered so that their interfaces are as seamless as possible.
- There is a need for clear and appropriate:
  - standardised clinical client outcome measures and client reported experience measures
  - program outcomes and associated measures
  - program monitoring and evaluation activities
- A more strategic and comprehensive collection, analysis and reporting of client-centred administrative and clinical information is a necessary part of continual improvement of the program into the future.

This chapter addresses the following issues:

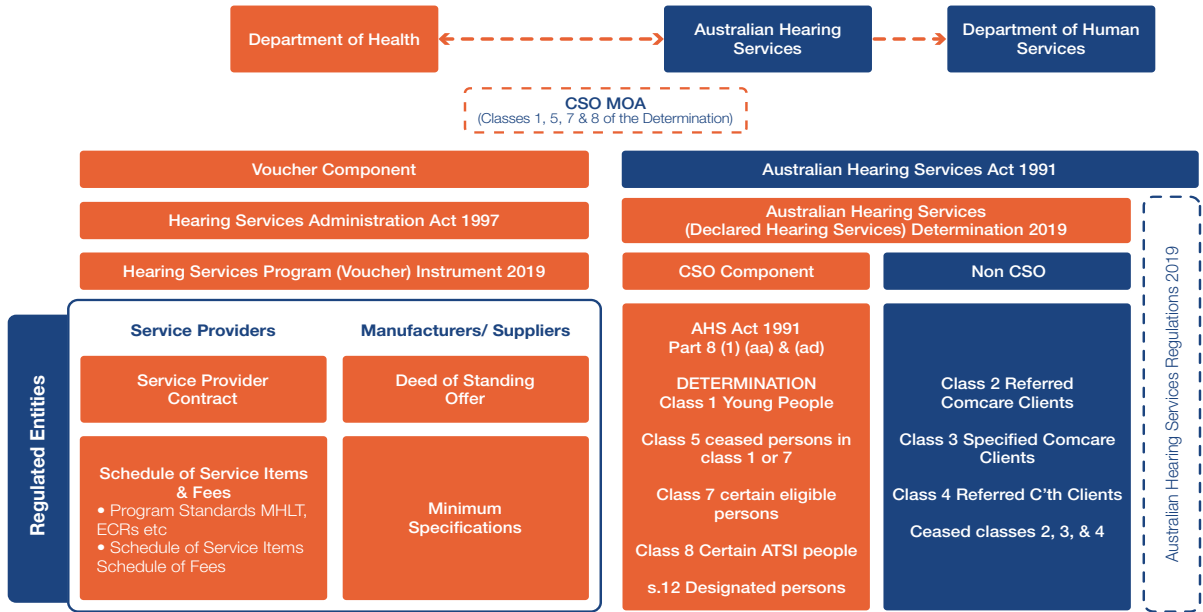
- program design, regulation and administration
- impact of program design on demand and costs
- hearing data collection and analysis
- measuring, monitoring and evaluating program outcomes
- establishing a national hearing health data service.

# Design of the Hearing Services Program

## Administration and governance of the Hearing Services Program

The Department of Health’s administration of the Hearing Services Program is governed by specific legislation for the voucher and Community Service Obligations (CSO) streams and is supported by contractual and program standards. The legislative and contractual overview is outlined in Figure 10 below. (Note that Australian Hearing and Hearing Australia – renamed in 2019 – are the one entity).

**Figure 10:** Legislative and contractual overview of the voucher and Community Service Obligations streams of the Hearing Services Program



ECR: Eligibility Criteria for Refitting; MHLT: Minimum Hearing Loss Threshold.

Recent efforts to improve the regulatory practices of the Hearing Services Program are summarised in **Appendix C**. It includes the 2019 decision to replace 5 pieces of subordinate legislation with one consolidated instrument for the voucher stream, as well as other regulatory changes that have occurred since that date.

## Voucher stream

The voucher stream is governed by the *Hearing Services Administration Act 1997* (the Act). A 2017–18 review (174) of the Hearing Services Program identified significant duplication and inconsistencies across the Hearing Services Program’s underpinning 5 legislative instruments, and these were repealed in 2019 and replaced with a single simplified instrument – *Hearing Services Program (Voucher) Instrument 2019* (the Instrument).

Entities that are regulated under the Act and the simplified Instrument include:

- **contracted service providers:** regulated via the service provider contract, which includes program standards and the Schedule of Service Items and Fees (Services Schedule)
- **hearing device manufacturers and suppliers:** regulated via a Deed of Standing Offer with the Department of Health. The deed is legally binding and outlines the obligations and arrangements for the supply of hearing devices to contracted service providers. The deed also establishes the minimum specifications for fully and partially subsidised hearing devices supplied through the Hearing Services Program. Deeds are in perpetuity until terminated or renegotiated if either party (Department of Health or the supplier) request it -for example, if the supplier changes its products. There is no time period specified in the deed.

## Community Service Obligations stream

The CSO stream of the Hearing Services Program is governed by the *Australian Hearing Services (Declared Hearing Services) Determination 2019* (Declared Hearing Determination) and the *Australian Hearing Services Act 1991*. Not all classes of eligible people listed in the Declared Hearing Determination are covered by the CSO stream. A memorandum of agreement (MOA) between the Department of Health and Hearing Australia provides more information about those eligible, outlining that it is those in classes 1, 5, 7 and 8 who are eligible, and section 12 lists other designated persons. This MOA has recently been revised and has been replaced with a memorandum of understanding. The Declared Hearing Determination regulations further specify the types of services that are available to each class of people.

The Declared Hearing Determination sets out the eligibility for CSO clients including for ‘young Australians’ under age 21 and ‘young adults’ aged from 21 to 26 years. Stipulated services in the Declared Hearing Determination include ‘Services that are necessary to assess and measure the nature and extent of any hearing loss in the person’, and the provision of various hearing interventions including hearing device fittings, monitoring and advice about rehabilitation. *The Australian Hearing Services Act 1991* states that Hearing Australia has a function to provide declared hearing services to young Australians, and the MOA with the Department of Health reiterates this function.

In addition to the Hearing Services Program specific legislation, other legislation applies to how the broader program operates, including:

- *Privacy Act 1988* and the Australian Privacy Principles
- Australian Government and state and territory consumer laws
- *National Archives Act 1983*
- *Public Governance, Performance and Accountability Act 2013*.

More details on the administration of the voucher and CSO streams are provided in **Appendix D**.



# Improving program regulation and administration

## Earlier proposals to improve efficiency

Numerous reviews and inquiries into aspects of the Hearing Services Program and/or the hearing sector have been conducted over the past 15 years and have highlighted areas where existing program administration can be improved (**Appendix A**). They have identified that clearer guidance is needed about the Hearing Services Program and its administrative requirements. Over the years, some contracted service providers and industry groups have also raised concerns about the levels of red tape.

As for more recent analyses, the PricewaterhouseCoopers (PwC) 2017 review (92) recognised the strength of the current service delivery model. Notwithstanding differing opinions on what changes were needed to improve that model, however, PwC reported options for more major reforms, including:

- incorporating program delivery through the Medicare system, similar to the dental and mental health programs that have been established in recent years
- adopting a National Disability Insurance Scheme (NDIS) model of individual client plans and funding mechanisms
- using cash-out arrangements, with funding provided direct to clients
- using activity-based costing models.

The 2018 Department of Health program assurance review identified a need for improved Hearing Services Program governance documentation, including a program logic, governance structures, roles and responsibilities, overall program risk management and a change management strategy:

*The Hearing Services Program has demonstrated that oversight arrangements, compliance and controls are in place for providers and for administering the Program. The Program is strong in stakeholder and communications, quality, and legal and compliance with multiple channels providing access to information and for receiving feedback. Overarching program management was not as strong in risk, governance and change and the Program Assurance Team advise the Program to develop an approach and documentation to address these areas.(22)*

This was supported by the 2020 internal report which also identified that a lack of clear program objectives was hampering the achievement of program outcomes, while also noting:

*[The Hearing Services Program's compliance activities are] operating effectively driven by an effective and skilled team [and] ... the program's Compliance team had adopted a flexible approach to regulation.(23)*

These reviews, including the current Expert Panel review, point to the need for improvements in the administration of the Hearing Services Program, acknowledging ongoing fiscal restrictions which have been exacerbated by COVID-19. Some activities are already underway, though, including consolidation of a range of program standards and schedules into a single-source program requirements document (the Services Schedule), digitising client records, website redevelopment to improve communication, and Hearing Service Online (HSO) portal redevelopment to support provider engagements with the program.

## Improved service planning and coordination

There are a number of hearing service and support programs available to eligible Australians (voucher, CSO, NDIS, Department of Social Security, Department of Veterans' Affairs (DVA)) and it can be confusing for clients trying to navigate their way through the system to find the right services for their needs.

Deafness Forum of Australia reported that:

*There is a lot of confusion about the various programs, how to access them and what supports will be provided. This includes not only the HSP and the NDIS but also the Employment Assistance Fund and state and territory health and education services and the aged care system. The referral pathways, eligibility arrangements and the services and devices provided are different for each Program and people could miss out on the services and supports they need because it's too complicated to navigate the different systems or just too hard to understand the various programs and how they might help particularly for those with low health literacy or from culturally and linguistically diverse backgrounds. There needs to be improved advice and information for consumers, more streamlined access pathways and more communication between Programs regarding individual clients.(24)*

Receiving the hearing device that meets a veteran's specific needs is often a challenge for many of them, as they need to go through an additional approval process with DVA.(43,118) Hearing Services Program audiologists are sometimes not aware of veterans' eligibilities to 'exceptional circumstances' hearing support services from DVA. One veteran said:

*No wonder then that audiologists react in frustrated and less than helpful ways to requests for clinical reports to be provided to DVA to support a 'prior approval' request.(118)*

The current process suggests that there is an opportunity for improved coordination of services for veterans between their clinicians, the Department of Health and DVA. This would result in improved awareness of what DVA requires from the clinical reports and recommendations before these are submitted by the clinicians. Clinicians' reports should also recognise the exceptional circumstances that have led to the veterans' hearing injuries.

DVA advises that a seamless interface between the Hearing Services Program and other DVA programs, such as the rehabilitation program, as well as better attention to tracking outcomes, could allow DVA to ensure veterans are not missing out on support they may be entitled to. It may also assist in tracking wellbeing, including psychosocial and/or vocational outcomes, for veterans who have hearing impairments and are also participating in the DVA rehabilitation program.(98) The Department of Health is addressing these issues separately with DVA, as the issue is broader than just the Hearing Services Program.

More generally, all clients would benefit from greater transparency about the services they can access, the eligibility thresholds, the providers and the costs and quality of their services, and any other consumer costs. The Expert Panel recommended in **Chapter 4** the development and publication of a range of illustrative pathways on the Hearing Services Program's website that clearly show the options for clients who are eligible for hearing services, as well as the provision of advice to non-eligible people to help them manage their hearing loss.

## The Hearing Services Online portal

The introduction of the current HSO portal significantly improved the administration of the Hearing Services Program, including by reducing wait times for clients to obtain a voucher and supporting contracted service providers to more effectively engage with the HSO portal. It is recognised positively by both providers and manufacturers.

Nonetheless, contracted service providers' experiences with the HSO portal and the Department of Health's use of it as a data source could be further improved with consideration of the following matters:

- Providers have to manage an array of patient management systems to engage with the Hearing Services Program, including Medicare claiming systems, HICAPs, patient records management and the HSO portal system for program clients and for claiming.
- While consumers can access their records under consumer and program legislation and policies, consumer choice would be enhanced by allowing clients to obtain a copy of their audiogram and other critical assessment information and being able to access their own information in the HSO portal.
- The HSO portal could be expanded to improve provider interaction with the Hearing Services Program and to improve administration of the program through integration of other program administration functions such as accreditation and revalidations, which are all currently managed offline. The HSO portal could also play a greater role in preventing invalid claiming by strengthened claiming rules and informing audit and compliance activity.
- The HSO portal could be used and greatly expanded to improve the collection of qualitative and quantitative data for outcomes measurement and support improved data collection and analysis of the Hearing Services Program – provided each information item was justified given the cost to industry of capturing and supplying data.

## Hearing Services Program monitoring of provider compliance

Several submissions noted the need for clearer guidance on program requirements to allow contracted service providers to fulfil compliance requirements - for example:

*provide greater protection and policing of the regulations: firstly, to ensure consumers are provided with the appropriate information regarding the services available to them; and, secondly, to prevent providers from taking unfair advantage of the system with inappropriate claims and behaviours as outlined in the 2017 ACCC report on the audiology industry; practices which continue to this day.(116)*

Independent Audiologists Australia raised concerns that enquiries were sometimes answered with rote responses without interpretation, which left the provider having to determine how to interpret the Hearing Services Program requirements. This was of particular concern as there were punitive consequences if the contracted service providers failed to comply.(75) DVA noted it had a strong relationship with the Department of Health; however:

*[DVA] found it difficult to report on and manage audit and potential compliance issues related to hearing service requests and complaints to DVA.(71)*

The Expert Panel supports the view that program monitoring can play a more important role in the quality of service delivery. In this respect, N and S Clutterbuck noted the need to move towards outcomes-based compliance monitoring, such as monitoring poor treatment effectiveness, rather than simply monitoring compliance with the contract.(82)

## Hearing data collection and analysis

Administrative data collected by any program can be a rich source of evidence from which to understand the state of the relevant sector to inform policy development,(18) to design and administer programs and to monitor and evaluate the effectiveness of government interventions. The current collection and analysis of data under the Hearing Services Program has not kept pace with accepted standards such as the Australian Institute of Health and Welfare's (AIHW) metadata online registry (METeOR).(175) Having basic metadata on the information that is collected is essential if the aim is to make program data more transparent and accessible to both internal and external researchers and other relevant stakeholders.

The following sections expand on how the Hearing Services Program can improve on the range of data that are collected and analysed to more effectively monitor the program as its reach increases, and its outcomes are more clearly articulated with the reforms suggested in this report.

### Client record

Providers are required by their contracts to have client records (classified as Commonwealth Records according to the legislation). Providers upload to the HSO portal details about the client's program eligibility, hearing history, assessments, average hearing loss at the low to mid tone frequencies for each ear, audiograms, progress notes, any hearing device prescription and all claims made. Providers cannot record those clients who have better than normal hearing or have a 'no response' to the hearing test or have hearing loss at higher frequencies. The client record is not uploaded by the provider onto the client's electronic My Health Record, should they have one.

While there is little information sharing between contracted service providers, most transfer their client record in the event of any transfer of clinical care, subject to the client's consent. The HSO portal registers the different provider number so that each HSO portal client record shows when the client changed provider and who the new provider is.

### Department of Health's use of data

The Hearing Services Program releases de-identified program statistics and information through the website and periodically responds to data requests from the sector, as governed by the terms of relevant legislation.(18) Published data mostly relates to outputs such as vouchers issued, number of hearing assessments and hearing devices fitted. Hearing Australia provides CSO stream data to the Department of Health each quarter. This comprises data on client numbers, client sex, and the number and type of services accessed for that time period (including the types of services provided in Hearing Australia's outreach and standard programs).

The Department of Health accesses provider and practitioner information and claiming data to support risk-based compliance monitoring. Compliance data analytics examine variances in claiming patterns outside the Hearing Services Program average, including rates of partially subsidised hearing device fitting, client reviews and Minimum Hearing Loss Threshold (MHLT) fittings, as well as costs to the client.

In all data-sharing activities and eligibility checking, the Department of Health follows the *Privacy Act 1988* and other cross-government data provisions, some of which are discussed further under 'Governance of a national data service' in this chapter. The limitations of the Department of Health's data collection are that it can only report on basic demographics and claims for service items described above, but it does not indicate how the intervention has affected the client and is not able to report on client outcomes, effectiveness of interventions or the quality of the clinical care.<sup>(82)</sup> Information on the type and effectiveness of audiological hearing rehabilitation provided to clients is difficult to attain, as rehabilitation services are often provided as part of a claim for a service that bundles the fitting, follow-up and rehabilitation services together (as discussed in **Chapter 4**).

Submissions from the second consultation process advised on measuring and collecting client reported experience rather than client satisfaction.<sup>(68,98)</sup> This aligns with outcomes measurement in other areas of health, where both Patient Reported Experience Measures (PREMs) and Patient Reported Outcomes Measures (PROMs) are routinely collected using standardised tools.<sup>(176)</sup> As would be expected, PREMs capture the person's experience of their care, including the physical environment in which care is provided and the interactions with their health care provider, while PROMs collect information on the person's view of their health outcomes. Both sets of measures use validated and condition-specific tools and both are considered important in taking a person-centred approach to care.

Information on the costs to business for service delivery in terms of transport, workforce, capital and equipment costs and the supply cost of hearing devices is not provided to the Department of Health by either service providers or manufacturers who participate in the Hearing Services Program. There is no current information on the hearing workforce capacity or the time taken to deliver hearing services, although it is collected in some form and analysed by professional organisations such as Audiology Australia. The Department of Health's health workforce area tracks and reports on more broad health workforce data, but not specifically data linked to the Hearing Services Program.

A more strategic and comprehensive collection and analysis of client-centred administrative and clinical information, including their hearing impairments and their satisfaction and/or experience within the program, is a necessary part of continual improvement of the Hearing Services Program into the future.

### Prevalence data

Data about hearing and the prevalence of hearing loss in the general community is a critical input into government decision-making, especially in relation to forecasting demand and funding, identifying groups at risk of hearing loss for targeted outreach and developing public educational campaigns about hearing loss and protecting hearing.<sup>(94,165)</sup>

The Hearing Services Program does not collect data on the prevalence of hearing loss or other hearing health issues. The *Roadmap for Hearing Health* (2019) identified this as a research gap, and it is one of the activities funded by the 2020 Australian Government Budget. The National Health and Medical Research Council (NHMRC) is being funded \$7.3 million to undertake research into various issues, including the prevalence of hearing loss. This will go some way toward addressing this data gap.

The Hearing Services Program does not link client service items or demographic data with other data sources such as Medicare, the Pharmaceutical Benefits Scheme, Aged Care, DVA or the NDIS; hence, little information is known to the program about a client's non-hearing health status.

Any data associated with or collected through the Hearing Services Program should continue to be held by the Department of Health as the Hearing Services Program owner (71,78) but should be shared with other relevant agencies, industry and researchers under strict privacy and relevance protocols. As discussed later in this chapter, information on Hearing Services Program performance and outcomes should also be publicly available in the interests of transparency and accountability and to guide reform.

### Data arising from program administration

The publication of outcomes and satisfaction with a program are commonplace, with examples being the MyHospitals website (177) and Australian Institute of Health and Welfare (AIHW) primary health network data publications.(178)

As Hickson argues, data on outcomes should be made available to providers and published to inform consumer choice.(78)

*The outcomes data should be collected and held by the government department that funds the program and the data should be made available to providers and published to inform consumer choice. Such publication of outcomes and satisfaction with a program are common place in other sectors e.g. the Quality Indicators for Teaching and Learning for higher education ... (179)*

Various submissions provided suggestions about the type of program data that can be published for different population groups and why.

### Voucher stream

Submissions suggested the Hearing Services Program report on and benchmark a range of data, including but not limited to:

- the number of services provided in each category on a year-on-year basis
- the total number and breakdown of hearing devices provided
- client reported experience rather than client satisfaction
- individual claim items (to provide further clarity of the services being received)
- Hearing Rehabilitation Outcome statistics (reported by the contracted service provider) to help demonstrate the quality of services being provided and to guide the Australian public in their choice of provider.

Specsavers felt that, by using population demography, this data will allow for the modelling of prevalence and future requirements for the provision of hearing services across the community.(116)

DVA recommended that there be more formal, quarterly reporting on the voucher stream (similar to Hearing Australia reporting on the CSO stream). In addition, more granular or in-depth data would be useful for policy, program and service delivery. Examples could include the numbers of veterans receiving services, their location and the number of hearing devices provided. DVA considered that this would show trends about the impact of prevention activities and better hearing protection.(71)

Cochlear Australia, Australia's branch of a global company that invests more than \$160 million a year in research and development of implantable devices,(180) suggested publishing data on the referral of Hearing Services Program clients for specialist hearing services under *Australian Hearing Services (Declared Hearing Services) Determination 2019* to support analysis of the effectiveness and timeliness of summing potential sensorineural hearing loss (S-P SNHL) diagnosis.(77) All contracted service providers are under an obligation to notify the Department of Health if they

believe a voucher holder client is eligible for specialist hearing services, which includes those with S-P SNHL (*Hearing Services Program (Voucher) Instrument 2019*, section (50)). This should provide a starting point for understanding and tracking the treatment pathway of consumers with S-P SNHL through the Hearing Services Program. This may be difficult to implement, but, as a minimum, Cochlear Australia argued that the Department of Health should be publishing data about the notifications.

### Data on the hearing health of infants and children

Several submissions referred to the coexistence of 2 systems for children: a jurisdictional Universal Newborn Hearing Screening Program and the Hearing Services Program CSO stream. The Australasian Newborn Hearing Screening Committee reports that these 2 systems operate entirely independently of each other regarding data management and client tracking.(181) The AIHW, in its report *Australian children* (2020) (182) has also identified national data on newborn hearing screening as a gap.

A range of stakeholders considered that a national database would improve this situation and be beneficial for clients, providers and the Department of Health. Deafness Forum of Australia, Hearing Australia and the Australasian Newborn Hearing Screening Committee strongly advocated for a national approach to data collection and management about hearing screening and hearing service delivery to infants and young children.(24,74,181) First Voice advocated that data be collected 'end-to-end' for the system, from universal newborn hearing screening through to engagement with specialist early intervention. These data could be standardised and publicly reported.(100) Such a database exists in the United States -it is collated and reported by the Centres for Disease Control and Prevention, with 45 states contributing.(183)

Deafness Forum of Australia and NextSense added that more information on the outcomes for children should include longer term outcomes such as the level of educational attainment and employment.(24,73) The Australasian Newborn Hearing Screening Committee also suggested that this national database should include data on permanent childhood hearing impairment so that Australia can have data on severity, aetiology, age of onset and manner of detection collected across every state, territory and health region of Australia.(181)

Hearing Australia also supports such a national database, reporting that it would help monitor the effectiveness of programs and ensure that no children fall through the gaps between screening, diagnosis, hearing rehabilitation and early childhood early intervention programs.(74)

The Expert Panel considers that, without a national database of children screened (newborn and through other universal early childhood developmental screening), it is not possible to know if there are children and families in need who do not receive a service. It agrees with the Hearing Health Sector Alliance that collecting and sharing data from newborn hearing screening through to the point of engagement with a specialised early intervention provider is possible and should be seriously considered.(57) The Hearing Health Sector Alliance suggested this database be funded for its management and operation, including technology requirements, and that the National Immunisation Register and Queensland Department of Health databases are useful models.

Integrated and national ear health checks of children could contribute to such a national database. Cochlear Australia, First Voice and Telethon Speech and Hearing suggested different approaches to such screening activities across a range of ages - for example:

- those aged 0–6 years and in particular those from Aboriginal and Torres Strait Islander communities should have regular ear health checks and the results of these checks should be recorded in a national database with the objective of no child 'slipping through the cracks'(77)

- the Hearing Services Program should be expanded to deliver a national screening program for children 4–7 years of age.(77,100,184)

These organisations also proposed that the Hearing Services Program similarly consider screening programs at other certain life cycle intervals – for example, those turning 60 years of age – and capturing the results in a national database.

Effective strategies for data sharing would be a part of the discussion on a national database and/or data service. In particular, there is an opportunity to consider creating a common identifier for children within the data management systems of Universal Newborn Screening programs, the Hearing Services Program and the NDIS. Such a development has the potential to reduce the need for duplicate records about children across the various systems and programs.(73) In order to effectively measure outcomes, Deafness Forum of Australia proposes that information come from a range of sources, including the Department of Health, the Department of Education and the NDIS.(24)

### Data on the hearing health of Aboriginal and Torres Strait Islander peoples

The National Agreement on Closing the Gap (185) demonstrates a commitment from all levels of governments to changing the way policies and programs affecting Aboriginal and Torres Strait Islander peoples are developed and delivered. Shared decision-making between Aboriginal and Torres Strait Islander peoples and government, strengthening the community controlled sector, improving mainstream institutions, and improving data collection and access to Aboriginal and Torres Strait Islander data are the priority reforms that underpin the agreement.(44)

The Expert Panel considers that the Australian Government should ensure that program data captures those who identify as Aboriginal and Torres Strait Islander so that data can be available to provide a greater understanding of hearing health and hearing needs and to supplement data from other hearing programs that are specifically provided to this population group. In this respect, the Aboriginal Community Controlled Health Sector may also have hearing health data that would complement the data drawn from the program.

## Measuring, monitoring and evaluating program outcomes

Consistent with this review’s scope, and as the preceding sections of this chapter suggest, the heart of the consumer experience should be an affirmation that service providers understand the person and their communication and related needs, respond to that person and deliver services that produce outcomes specific to their needs. Stakeholders have been clear that capturing client reported experience measures and outcomes is a priority issue.

Currently there are no national guidelines in Australia on the client outcome measures that should be used, when, how, why or for which populations, under the Hearing Services Program. Numerous submissions expressed the view that monitoring and evaluation are hindered by the lack of clear measurable client and program outcomes.(24–26,73–76,82) Another argued that collecting and using client outcome data is important to ensure client satisfaction and to continually improve the client’s journey within the Hearing Services Program, regardless of whether or not they are supplied and fitted with a hearing device.(24) An additional observation was made by one stakeholder that the program has a transaction-level view of the type and number of services delivered, and as such the Department of Health can only assume that these transactions will reduce the burden of disease.(82)



The 2017 PwC review highlighted the need for the program to transition to an outcomes-focused model of care and proposed that the hearing industry take the lead on this action.(92)

DVA noted in its submission that some veterans described their hearing needs as not being fully met through the program. In this respect the DVA observed:

*It is difficult to determine whether consumers are appropriately advised given the limited availability of reportable outcomes. The ability to report on the advice provided by hearing providers to clients would likely improve the consistency of outcomes.(71)*

## Domains for measuring program outcomes

The need for clear and measurable outcomes for the Hearing Services Program was highlighted in a recent project by the National Acoustic Laboratories (NAL), Defining Outcomes for the Hearing Services Program (2020), conducted on behalf of the Department of Health. NAL consulted with key stakeholders to define which standardised client-centred outcome measures should be used by the program as well as when and how.(186)

**Chapter 2** of this report sets out the Expert Panel's views on an appropriate set of objectives for the Hearing Services Program. First and foremost are objectives directed to people with hearing loss which address their quality of life issues, such as being able to exercise informed choice and control over how to live with hearing loss, how to address communication needs and how to be supported in social and economic participation.

The Defining Outcomes for the Hearing Services Program identified the following domains which have a bearing on quality of life when living with hearing loss and addressing communication needs:

- **Communication ability:** including communication with other people in general, communication specifically with family members, and communication in group situations
- **Wellbeing:** the presence of positive emotions and moods, the absence of negative emotions, satisfaction with life, fulfilment and positive functioning
- **Personal relationships:** the interpersonal interactions that people have, and the relationships that they develop as a result of those interactions
- **Reduction in participation restrictions:** including in social, vocational, and recreational activities.(186)

Several other program objectives focus on the Hearing Services Program's clinical outcomes delivered through rehabilitation services and the supply and fitting of hearing devices and other support. The objectives for people with hearing loss include having equitable access to services, being engaged in the planning, assessment, selection and delivery of program services and being able to exercise choice and control over the selection of contracted service providers. Objectives for providers and professionals include reference to them always acting in the best interests of the clients, providing culturally appropriate services and meeting all program and professional standards and requirements.

Appropriate domains could include:

- achievement of the client's desired communication outcomes
- provision of hearing device technology that was, or was not, fit for purpose
- maintenance of clinical gains over time
- client experience of the quality of service provision, including the cultural appropriateness of the care and support provided
- provider claiming practices being compliant with program standards
- provider and professional workforce compliance with all contractual and professional requirements and standards.(39,41,161)

## Tools to measure client outcomes

It is essential to have appropriate and sensitive outcome measures that are relevant to the areas of hearing health need. As noted in the 2020 NAL report:

*These are not only helpful but are essential to both measuring an individual's progress towards desired goals as well as evaluating the overall effectiveness of audiology services and providers of hearing healthcare.(186)*

The NAL report further reported on the current problem of having a large number of tools which are available for a variety of outcomes but which are not standardised for use across Australia:

*The evidence is clear that auditory rehabilitation research lacks a single or even a few outcome measures that are widely used and accepted as being gold standard instruments. Furthermore, even though there is a large number and variety of measures out there, clinical trials of adult auditory rehabilitation interventions have overlooked outcomes such as adverse effects and quality of care that may be important to key stakeholders, especially patients, hearing healthcare professionals and commissioners of hearing healthcare.(186)*

Other suggestions for improving data on outcomes include the mandatory use of tools such as the Client Oriented Scale of Improvement (COSI) at assessment, follow-up and annual reviews. The COSI is a clinical tool developed by NAL for outcomes measurement. It is a validated subjective assessment questionnaire for clinicians to use which allows them to document their client's goals/needs and measures subjective improvements in hearing ability.(187)

The COSI is useful for adult clients but is not appropriate for capturing the goals and needs of children, which are likely to be much more diverse than those of adults. (The COSI has scales that use the terms 'Degree of Change' and 'Final Ability', for example). The Client Oriented Scale of Improvement for Children (COSI-C) has been designed to try to incorporate the basic design of the COSI with some changes to make it more suitable to use with children.

Identifying, defining and testing measures for hearing clinical outcomes and quality of life outcomes could be a research priority, and it is captured as such in **Chapter 7**, so that Australia can have a set of standardised measures which are used and reported against across the country.

The perception of the industry is that layers of modifications over years appear to have obscured the original intent of many program rules, and the intended outcomes may no longer be relevant to contemporary practice. Independent Audiologists Australia submitted the following examples of decisions which, in their view, are not being driven by data:

*ongoing and unexplained requirements to use tools that are not underpinned with evidence, for example the Wishes and Needs Tool (WANT) but at the same time the guidelines for providers ask that interventions are evidence-based; and*

*introduction of the rehabilitation plus service item that is restricted to new clients who have had their first hearing aid fitting which signals a focus on a hearing aid device distribution model rather than a person-centred audiological rehabilitation model.*(75)

The design of outcome measures and tools could be the focus of a commissioned research activity, as also discussed in **Chapter 7**. An initial Department of Health review of the program using these purpose-built measures and tools could be undertaken in 2023, with a more formal independent evaluation within a further 5 years.

In summary, the Expert Panel believes that the Hearing Services Program would benefit from having a well-consulted and well-developed monitoring and evaluation framework that will help the program achieve its objectives as described in **Chapter 2**. While the Hearing Care Industry Association sought a feasibility, cost-benefit and legal assessment of such a framework, many submissions supported such a framework and welcomed broad consultation in its development. Additionally, linking client data with other data sources such as Medicare, the Pharmaceutical Benefits Scheme, the Department of Aged Care, DVA and the NDIS (subject to privacy considerations) was described by one stakeholder as a means of creating a fuller picture of participants' health status.(165)

## Establishing a national hearing health data service

One of the objectives contained in the NAL study into outcomes measurement is 'to identify mechanisms and systems for reporting of outcomes, and scope the potential for a national outcomes database', and it subsequently recommended that an independent body be responsible for such a venture.(186)

To make progress on data reporting there is an opportunity to establish a national hearing health data service. Hearing Australia has proposed that such a service should have the following goals:

- provide more clarity regarding the right/licence to use client data such that the data collection remains customer focused, secure and consistent with Australian Privacy Principles
- improve data management and client tracking
- establish a robust open data framework that encourages innovation
- publish Australia's hearing health indicators on a more real-time basis so that citizens, organisations and policy makers can make better decisions
- leverage Artificial Intelligence to support evidence-based public health policy decision-making.(74)

Good data governance would be critical to the success of this venture, to ensure safe data practices. The Department of the Prime Minister and Cabinet, in its 2020 guide *Trust in government data use*, describes the key elements of good data governance, examples of which are described below for its framework comprising people, policies, process and products:

- **People:** good leadership and clarity of roles; possibly involving a data ethics panel or committee
- **Policies:** guidance about data responsibilities under whole-of-government and agency-specific legislation
- **Process:** comprehensive decision support through complete and consistent processes; privacy by design embedded in data initiatives
- **Products:** data collection and use statements should be clear and accessible; catalogue of official data collections (for example, scope, coverage, quality, and custodian).(188)

Another relevant key Australian Government resource is the Australian Data and Digital Council's *State of the data and digital nation: An overview of data and digital government initiatives across the nation*.(189)

A national hearing health data service would provide a data repository not only for the agencies involved but also for the AIHW in their reports on Australia's health and for other research projects (for example, the Murdoch Children's Research Institute's Generation Victoria.(190)). It would not be just a repository but would also allow data linkage and provide a base for data on Hearing Services Program performance and outcomes.

## Impact of program reforms on the demand for, and public expenditure on, hearing services

The design of the Hearing Services Program can impact the level of delivery of hearing services and the quantum and efficiency of expenditure on these publicly funded services. This includes such design features as the eligibility criteria, the services provided, how contracts are established and monitored, what and how outcomes are measured, and program evaluations. Reforms to the program have the potential to enhance the lives of many Australians with hearing impairment and their families, fellow workers and society more generally. Reforms arising from this review will also have consequential impacts on the level of delivery and public expenditure, as well as on legislation.

### Impact on the level of service delivery

The underlying demand for hearing services is largely determined by the number of older people in the population. The average age of voucher clients is currently 78 years. Australia's population is continuing to age and therefore, on that basis alone, the numbers and proportion of people with hearing loss is growing. The number of people with hearing impairment is expected to increase by 12% to 4.88 million by 2030. (7) Compared to 1 in 6 Australians having some form of hearing loss in 2016, it is estimated that this number will grow to 1 in 4 by 2050.(92)

A second significant driver is the number of people with hearing loss who are eligible for a publicly funded service under the Hearing Services Program, and any broadening of the eligibility criteria will impact on Budget expenditure.

As of 30 June 2020 over 1.07 million clients were registered in the Hearing Services Program, with more than 90% of voucher clients being aged 65 years and over. The growth in demand

for services in the voucher stream of the program from financial year 2015–16 to 2019–20 is shown in Table 15 below, as seen by the number of new applications for vouchers and second or subsequent vouchers issued to a voucher client ('return' voucher).

**TABLE 15:** Vouchers issued between the 2015–16 and 2019–20 financial years

Financial year	New vouchers	Return vouchers
2015–16	106,018	218,779
2016–17	108,136	227,227
2017–18	110,501	201,193
2018–19	109,519	227,049
2019–20	121,143	265,277

Source: Department of Health, Hearing Services Program data and statistics (internal).

### Impact on expenditure

The Office of Best Practice Regulation reports that expenditure on the voucher and CSO streams of the program in 2019–20 represented approximately 53.9% of total hearing expenditure (other expenditure being on hospital admissions, pharmaceuticals, GP costs, other hearing devices, research, cochlear implants and other professionals) and 6.36% of total health expenditure.(191)

Historically, the total Hearing Services Program (administered) and departmental expenditure (as reported in the yearly Department of Health annual reports) has grown at 2.5 times the growth in client numbers, with the rate of growth reported in 2017 outstripping growth in broader health spending.(92)

As detailed in **Chapter 3**, the expected annual expenditure increases (based on 2019–20 expenditure) for the 4 financial years from 2021–22 to 2024–25, if the Australian Government accepts the recommendations of this report that eligibility be broadened to include the following groups, would be:

- **Low Income Health Care Card holders aged 26 to Age Pension eligibility age:** between \$17.05 million and \$27.06 million per year
- **all Aboriginal and Torres Strait Islander adults:** between \$21.34 million and \$33.91 million per year
- **permanent residents in aged care homes:** between \$9.23 million and \$12.90 million per year.

These changes would be the biggest source of expenditure increases.

Another potentially significant increase in public expenditure would arise from expanding the scope and numbers of hearing devices which are fully subsidised and including a greater range of other hearing and non-hearing technologies.

Other less significant expenditure increases are expected to arise from the removal of various barriers which currently inhibit eligible people from accessing services, as proposed in **Chapters 4 and 5**. The *Roadmap for Hearing Health* awareness campaign is another example where there may be an increase in the uptake of Hearing Services Program services as older people take the opportunity to have their hearing assessed and, if they are eligible, access services to address any hearing loss issues.

Each initiative will also bring significant private and public benefits, although not necessarily directly offsetting Australian Government expenditure. Investment in communication and rehabilitation services, however, is an example of a reform which would not only generate a flow of benefits to the people with hearing loss, their communication network, workplaces and broader community but also reduce expenditure – in this case on the fitting and supply of devices which are subsequently discarded or under-utilised.

## Impact on legislative regime

The Expert Panel recognises that major and many minor reforms to the Hearing Services Program will require legislative changes to the Act and the *Hearing Services Program (Voucher) Instrument 2019* and potentially the *Australian Hearing Services (Declared Hearing Services) Determination 2019*. Depending on the scale of changes required, sufficient time will be required not only to consult with stakeholders in the development of the detailed proposals and have the matters addressed by parliament but also to implement the new arrangements in a manner that would allow the Department of Health, providers and software vendors to amend policy documentation, processes and systems and to inform people with hearing loss of any changes to the available care and support.

## Recommendations

### Recommendation 19: A national data service

The Australian, state and territory governments should implement a national digital database of hearing screening of infants and children, recognising that the responsibility for universal newborn hearing screening and screening at any other age such as prior to starting school, lies with state and territory governments. This initiative could act as a precursor to the development of a broader national hearing health data service.

### Recommendation 20: Program monitoring and evaluation

- 20(a) The Australian Government should develop and invest in a Hearing Services Program monitoring and evaluation framework that supports the monitoring of the program's achievement of its objectives in terms of both client outcomes and program-level outcomes.
- 20(b) The Australian Government should report on the performance of the program in 2 years, drawing on improved data availability and measurement tools, and commission an independent evaluation within a further 5 years.

# Chapter 7

## Hearing health and hearing loss research

### KEY POINTS

- The 2019 *Roadmap for Hearing Health* (the Roadmap) and various parliamentary inquiries have provided suggestions for future research.
- The Australian Government is supporting the Roadmap research recommendations through its \$7.3 million investment in research that will improve evidence to support better hearing outcomes. This research may include, but will not be limited to:
  - determining if population-based screening is appropriate and identifying intervention options
  - identifying suitable methods to accurately measure the prevalence and severity of hearing loss in the Australian community
  - assessing the incidence of balance disorders.
- Other current research gaps include:
  - evaluation of the benefit and cost-effectiveness of interventions and hearing devices for managing hearing loss
  - the relationship between risky behaviours and noise-induced hearing loss and the design of effective hearing health and hearing loss prevention campaigns
  - the relationship between ageing and hearing loss
  - the patterns of comorbidity associated with hearing loss
  - prevention of hearing loss caused by ototoxic substances
  - measurement and mitigation of health, social and economic effects of hearing loss.
- Research on hearing health and hearing loss can be improved through the following approaches:
  - adopting a more strategic approach to planning for research, including the development of a research strategy and a regular updating of research topic priorities through broad consultation with all stakeholders
  - developing co-designed service delivery models, with the relevant groups of people also being involved in the conduct of the research and its analysis and in the dissemination of research findings
  - developing client and program outcome measures and evaluation tools
  - funding meaningful longitudinal studies.

As part of its remit, the Hearing Services Program supports research and prevention activities in relation to hearing health and hearing loss. Therefore, the Expert Panel considers the research component of the program as being within the terms of reference for this review.

Over the past 2 decades, there has been research on hearing health interventions, technological advances in hearing devices and several parliamentary inquiries or reviews with recommendations on how to prevent hearing loss and improve Australia's assistance to people with hearing loss.<sup>(46)</sup> Research has made an important contribution to these improvements.

The parliamentary inquiry *Still waiting to be Heard ... Report on the Inquiry into the Hearing Health and Wellbeing of Australia (Still Waiting to be Heard)* highlighted several key areas for hearing research including:

- longitudinal research on adults undergoing treatment for hearing impairment
- Aboriginal and Torres Strait Islander hearing health issues
- prioritisation on balance disorders and treatments
- genetic stem cell based treatments for hearing impairment.<sup>(46)</sup>

The 2019 Roadmap outlined numerous opportunities for research across its 6 domains, with input from a broad range of stakeholders across the sector.<sup>(4)</sup> However, despite a growing international research effort on hearing loss and hearing devices, critical knowledge gaps still exist in hearing health.

The remainder of this chapter is divided into 2 parts:

- Existing research priorities: what research is happening now?
- Research gaps: what opportunities are there to improve the hearing health evidence base?

## Existing research priorities: what research is being undertaken?

### National Acoustic Laboratories

The National Acoustic Laboratories (NAL) is the research arm of Hearing Australia. Research undertaken by NAL is governed by the *Australian Hearing Services Act 1991*. Section 8 of this Act outlines the scope of research to be undertaken including assessment of hearing, hearing devices and fitting procedures, hearing rehabilitation, hearing loss preventions, the effects of noise on the community, the design and development of hearing services and the development of standards in relation to noise levels in the community.

NAL is funded under a memorandum of agreement (MOA) with the Department of Health for research and development activities that contribute to the development of improved policies and service delivery and to better identify the needs of the community in relation to hearing loss. It also coordinates research and development projects with other parties and conducts commercially funded research.

Approximately \$4.5 million is paid annually to Hearing Australia under the MOA for baseline administration and research funding. In the 2019–20 financial year, this was increased to \$10.7 million to cover additional research projects on the costs of maintaining cochlear speech processors and the eligibility criteria for the Hearing Services Program.



Hearing Australia's 2019–20 annual report highlighted NAL's research activities for that reporting period as follows:

- 6 of the 17 projects initiated in the 2019–20 financial year were focused on the hearing health of Aboriginal and Torres Strait Islander peoples
- the start of Wave 3 of the Longitudinal Outcomes for Children with Hearing Impairment (LOCHI) project that runs for 5 years, tracking the benefit of early intervention with hearing devices and cochlear implants for language ability to age 16 years
- the completion of a behavioural insight project to help clients make better decisions about hearing health
- work on several projects involving the development of teleaudiology tools and assessment of teleaudiology service outcomes
- a report to the Department of Health on the state of hearing health care in Australia and recommendations for a hearing awareness campaign.(192)

### **National Acoustic Laboratories' research on hearing loss in Aboriginal and Torres Strait Islander peoples**

Examples of some recent research on hearing loss and the prevention of hearing loss in Aboriginal and Torres Strait Islander peoples are described below:

- developing and validating screening tools that can be used by primary health workers and early educators for detecting and identifying potential hearing and communication difficulties in Aboriginal and Torres Strait Islander children – the Parent-evaluated Listening & Understanding Measure (PLUM) and Hear and Talk Scale (HATS) for Aboriginal and Torres Strait Islander children aged from birth to 5 years
- investigating hearing loss and spatial processing disorder (defined as no measurable hearing loss but diminished ability to use location cues for listening in noise) in Aboriginal and Torres Strait Islander young people in youth justice centres and any associations these findings have with self-reported hearing difficulties and general ear and hearing health
- developing an evidence base on the current knowledge about the effectiveness of early intervention and the effect of the timing of intervention on outcomes of young children with chronic otitis media and associated hearing problems, with a special interest in Aboriginal and Torres Strait Islander children.

### **The Longitudinal Outcomes of Children with Hearing Impairment Study (LOCHI) Study (193)**

NAL is overseeing the Longitudinal Outcomes of Children with Hearing Impairment (LOCHI) Study - a population-based longitudinal study that prospectively evaluates the development of a cohort of about 450 Australian children with hearing loss as they grow up. It commenced in 2005 and was the first study of its type in the world to provide evidence of the lifelong benefits of early treatment of hearing impairment with cochlear implants or hearing devices.

The Australian Government has, to date, invested about \$10 million into the study.

The LOCHI Study is unique in its inclusion of children whose hearing loss was diagnosed through either Universal Newborn Hearing Screening or standard care; and all of whom access the same post-diagnostic services provided by the national audiological service provider, Hearing Australia. The consistency of audiological services means that their results can be fairly compared, regardless of when and where their hearing loss was discovered.

The 3 study phases address the following research questions:

- Does Universal Newborn Hearing Screening and early intervention improve the outcomes of children with hearing loss at a population level?
- What factors influence the outcomes of children with hearing loss?
- Can early performance predict later outcomes of children with hearing loss?

Phases 1 and 2 of the study were supported by the United States National Institutes of Health and the HEARing Cooperative Research Centre (CRC). The Australian Government funding for the HEARing CRC ceased on 30 June 2019.

LOCHI Phase 3 will measure outcomes for the study cohort after they turn 16 years of age. By continuing to track the development of the children, the LOCHI Study will provide evidence on the long-term effectiveness of early intervention and the cost-effectiveness of Universal Newborn Hearing Screening and early intervention for improving outcomes of children with hearing loss. The research represents the longest span of a person's life ever measured for this kind of study.

The Expert Panel supports the government continuing to fund this important project so that the benefits of the Universal Newborn Hearing Screening system can be evaluated across a person's lifetime.

## National Health and Medical Research Council

The National Health and Medical Research Council (NHMRC) provides funding for research through a competitive, investigator-initiated grant system, with a transparent peer-review process to determine how funding is allocated. It also oversees Targeted Calls for Research – one-off grant opportunities designed to stimulate research or build research capacity in a particular area of health and medical science. Research funding made available through the NHMRC is governed by the *National Health and Medical Research Council Act 1992*.

## The Medical Research Future Fund

The Medical Research Future Fund (MRFF) is an ongoing research fund set up by the Australian Government in 2015. While hearing health is not listed as a specific priority in the MRFF strategy for 2020–2022, it is relevant to other priorities that have initiatives underway, including:

- Aboriginal and Torres Strait Islander health - for example, the Indigenous Health Research Fund, investing in Indigenous-led research tackling health issues facing Aboriginal and Torres Strait Islander peoples
- Ageing and aged care - for example, the Dementia, Ageing and Aged Care Mission aims to support older Australians to maintain their health and quality of life as they age, live independently for longer, and access quality care when they need it
- Primary care - for example, the Primary Health Care Research initiative will increase Australia's evidence base in primary health care through research to improve service delivery and patient outcomes
- Comparing the value of different health interventions - for example, the Clinical Trials Activity and Clinician Researchers initiatives
- Testing public health interventions to reduce chronic disease - for example, the Preventive and Public Health Research initiative
- Digital health tools and supporting Australian biomedical and medical device development.

## Roadmap for Hearing Health research initiative

The Australian Government is supporting the Roadmap research recommendations through its \$7.3 million investment in research that will improve evidence for treatment, service delivery and the prevention of hearing loss. It will be led by the NHMRC and seeks to improve the lives of Australians at risk of, or impacted by, hearing loss as well as enhancing the hearing sector's capacity to deliver improved hearing outcomes.

At the time of finalising this report, the research will include:

- determining if population-based screening is appropriate and identifying intervention options
- identifying suitable methods to accurately measure the prevalence and severity of hearing loss in the Australian community
- researching the incidence of balance disorders.

Stakeholder consultation to inform this Roadmap research activity revealed the following options to enhance current research:

- encouraging a national strategy to integrate ear health checks in the first years of life
- developing therapeutic treatments for hearing loss to improve outcomes for hearing loss patients who use devices to assist hearing
- undertaking hearing health surveys to inform key issues, including developing a national database on hearing loss, facilitating standardised national reporting of hearing loss and supporting the current national set of key performance indicators for Aboriginal and Torres Strait Islander ear and hearing health
- funding research on hearing loss prevention
- evaluating strategies for the prevention of otitis media in Aboriginal and Torres Strait Islander children.

The Expert Panel notes that several academics in Australia are also engaged in conducting research on hearing loss and related matters and that many hearing health clinicians undertake research in their clinics aimed at improving the lives of Australians living with hearing loss. The Expert Panel wishes to acknowledge the contribution that all researchers have made to this review, either directly or through having published papers and provided reports. The Expert Panel has drawn on these to inform the development or refinement of recommendations.

## Research gaps: opportunities to improve the hearing health evidence base

The Department of Health's website on hearing health research states that gaps in the evidence base include, but are not limited to:

- accurate, descriptive and predictive models of hearing loss incidence, prevalence and impacts
- an understanding of the relationship between ageing and hearing loss
- an understanding of the stigma associated with hearing loss and mental health and wellbeing
- an understanding of patterns of comorbidity associated with hearing loss
- investigating the relationship between ototoxic substances and hearing impairment and the implications for preventing hearing loss
- an understanding of the relationship between risky behaviours and noise-induced hearing loss

- and the design of effective hearing health and hearing loss prevention campaigns
- a mechanism to effectively measure and mitigate health, social and economic effects of hearing loss
- an evaluation of benefit, satisfaction and cost-effectiveness of interventions and hearing devices for hearing loss.(194)

Other evidence, including submissions to this review, identified several opportunities for improving the evidence base that will augment the above activities currently underway. They are examined in the following sections.

## Development of a research strategy

The research output in this field over the last 2 decades has occurred in a somewhat ad hoc manner, at the instigation of individual hearing health researchers and in response to sector and parliamentary driven reports and inquiries. At the same time, the technology embedded in hearing devices has made significant advances and the understanding of client-focused hearing health care has expanded to encompass all aspects of a person's life.

The Department of Health is well placed as the funder of the Hearing Services Program, and with its MOA with Hearing Australia, to develop and ensure a more strategic approach to identifying research priorities and activities and to map the milestones to a specified time period.

The Expert Panel considers that there is a need to develop and publish a research strategy in consultation with hearing services stakeholders. Such a consultation would include client/carer representation and could:

- expand on the research ideas provided in this report
- advise on prioritising them
- advise on a time frame for refreshing and reviewing the strategy.

A guiding principle for the research strategy should be that research is co-designed with relevant population cohorts and that those groups of people should be involved in the conduct of the research, its analysis and the dissemination of research findings.

## Research on hearing loss prevention

The Hearing Health Sector Alliance recommended that a national strategy on hearing loss prevention be developed and its implementation funded. It could be a component of the National Preventative Health Strategy that is currently being developed by the Department of Health.(195) This broader strategy is being guided by an expert steering committee composed of experts from across the public health, research, health promotion, medical, allied health and nursing fields.

In 2007–08 the Australian Government, through the Hearing Services Program, funded a 4-year prevention research program in response to a 2006 Access Economics report. Funded projects included research on prevention of hearing loss for children, including specific projects addressing prevention of hearing loss in Aboriginal and Torres Strait Islander children, and prevention of work-related hearing loss.(196)

Hearing Australia is currently drafting a new national strategy to reduce preventable hearing loss, acknowledging that some 30–40% of hearing loss is preventable and that certain high-risk communities, especially Aboriginal and Torres Strait Islander children and workers in high-risk industries, suffer unacceptable levels of avoidable hearing loss.

The Expert Panel understands that the Department of Health is working in collaboration with Hearing Australia on this strategy and its implementation.

## Research on models of service delivery

Research is needed on models of service delivery to identify evidence-based approaches for improving clients' communication capacity, including through the effective and efficient delivery of rehabilitation services and the supply, fitting and support in the use of hearing devices.

Several submissions recommended a model of service delivery which differed from the current focus on supplying and fitting hearing devices. This alternative would incorporate a management or care program to meet the communication, education and psychosocial needs of a person with hearing loss at any stage of their hearing care journey. Some submissions also referred to the need to support the clinical needs of people with hearing loss who do not want a hearing device. (24,26,72,78) There also may be an opportunity to pilot a more aural rehabilitative service delivery model for this cohort, with practitioners to include trained counsellors. As noted in **Chapter 4**, Soundfair submitted a proposal to the review which would entail a pilot study of a service delivery model based on a whole-person, person-centred hearing services. Possible research topics could include an examination of how a more psychosocial or holistic health model of hearing health care could deliver improved health outcomes; and an assessment of the economic benefit of such a model.

As mentioned earlier in the report, there is also a need for services to be delivered in a culturally safe and respectful manner for Aboriginal and Torres Strait Islander peoples and for people from culturally diverse backgrounds. The Expert Panel proposes that all research on improving hearing health outcomes for these groups should be co-designed with those groups and that they should be involved in the conduct of the research, its analysis and in the dissemination of the research findings. Study designs should be based on a culturally appropriate and sustainable partnership which continues for the duration of the research and beyond.

Translational research that supports mainstream services to be responsive to the needs of local communities is also important – regardless of whether that community is mainly comprised of Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds or people with other needs, such as those who are homeless, suffering a debilitating addiction or have poor mental health. Funding could be sourced through a MRFF grant (which has both primary care and Aboriginal and Torres Strait Islander health grants) or through NHMRC funded targeted research.

Researchers and research organisations, including tertiary institutions, private research bodies, NAL and the Australian Institute of Health and Welfare (AIHW), should have access to Hearing Services Program data, subject to the necessary privacy provisions.(26,73) In accordance with NHMRC principles there are several approaches that could provide guidance on how the Department of Health, as the custodian of these data, could ensure that data access by researchers is managed appropriately.(197)

## Examples of other potential research questions

**Chapter 6** highlighted the lack of adequate data on client outcomes and program outcomes and the need for improved outcome measurement. Australia needs to have a set of standardised measures which can be used and reported against across the country to further enable improved data collection and, in turn, improved program evaluation.

The Expert Panel notes the value of longitudinal studies, given they are a rich source of data and information about the impact of hearing impairment and hearing loss on a person's life, and the life of those around them. The 2017 parliamentary inquiry recommended that the Hearing Services Program and NAL prioritise funding for research to focus, among other things, on 'longitudinal research on the experiences of adults undergoing treatment for hearing impairment'.<sup>(46)</sup> Submissions to the consultation on the Expert Panel's draft report referred to the importance of the Children with Unilateral Hearing Loss (CUHL) NAL study, which aims to determine the effectiveness of early hearing device fitting for improving outcomes of these children and the factors influencing language and psychosocial outcomes.

Research which identifies the extent of any thin markets in hearing services can inform policy-making aimed at improving accessibility to services.<sup>(165)</sup> The examination of fundamental research questions such as 'What are the barriers and facilitators to improving access to services in areas of thin markets?' may go part way to developing a greater understanding of this issue. In this respect the Royal Flying Doctor Service (RFDS) reported a research opportunity to explore how it could use its assets to effectively and efficiently deliver further services, including hearing services, on behalf of the Australian Government to areas where small populations across large geographic areas make it unviable for permanent local services to exist.<sup>(198)</sup>

## Recommendations

### Recommendation 21: Research strategy

- 21(a) The Australian Government should develop a Research Strategy in consultation with hearing services stakeholders and publish it on the Hearing Services Program website. A guiding principle should be that research is co-designed with relevant population cohorts and that those groups are involved in the conduct of the research, its analysis and the dissemination of the research findings.
- 21(b) Research funded directly through the Hearing Services Program should be aligned with this broader research strategy. Research priorities should be advised through consultation but should include the removal of barriers to accessing the program's services and facilitating the cultural appropriateness of service delivery.

### Recommendation 22: Longitudinal studies

The Australian Government should support meaningful longitudinal studies that align with the research strategy, noting the rich data that such studies provide about the life course of hearing loss.

In this respect, the Australian Government should continue to fund the National Acoustic Laboratories to extend the conduct of the Longitudinal Outcomes of Children with Hearing Impairment (LOCHI) Study.

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# APPENDIX A

## HISTORY OF REVIEWS RELATED TO THE HEARING SERVICES PROGRAM AND HEARING HEALTH

Date	Organisation	Title	Synopsis of report
February 2006	Access Economics	Listen hear!: The economic impact and cost of hearing loss in Australia: A report.(1)	Quantified the impact of hearing loss on the Australian population. Further research was recommended for a number of hearing loss related issues.
April 2006	Attorney-General's Department	Work-related noise induced hearing loss in Australia, April 2006. (199)	Identified that over a million employees in Australia may be exposed to hazardous levels of noise at work (in the absence of hearing protection) and reported the average cost of a noise-induced deafness claim. The 2001-02 calculated cost to the economy was \$31 million. The report identified the main industries of concern, as well as the prevention and audit activities undertaken in Australia to reduce work-related noise-induced hearing loss.
May 2010	Senate Community Affairs References Committee Inquiry into Hearing Health in Australia	Hear us: Inquiry into Hearing Health in Australia.(200)	<p>The committee undertook an inquiry that received 184 public submissions and heard evidence on 9 occasions at cities across Australia. The final report made 34 recommendations for action by both the Australian Government and state governments. The Australian Government supported most the recommendations that were subject to federal control.</p> <p>Key topics: Causes of hearing loss, costs of hearing loss, impact of hearing loss on people and community, adequacy of access to services, adequacy of research, adequacy of education and awareness programs, hearing issues in Aboriginal and Torres Strait Islander communities.</p>

Date	Organisation	Title	Synopsis of report
December 2012	MP Consulting	Review of the efficiency and effectiveness of the regulatory framework for hearing services. (201)	The review found that the existing framework is complex, burdensome and overly prescriptive, with over 100 ongoing obligations imposed on service providers along with 30 discrete prohibitions. Twenty-three submissions supported the need to streamline and simplify the regulatory framework.
May 2014	The Australian National Audit Office (ANAO)	Delivery of the Hearing Community Service Obligations.(202)	ANAO examined the effectiveness of the Department of Health's and Australian Hearing's administration of the Community Service Obligations (CSO) program for hearing services. The ANAO found that there is scope for the Department of Health to develop a methodology, in consultation with Australian Hearing, to enable reporting of service targets funded by a 2011-12 Budget measure; and other outcomes for the CSO.
March 2017	Australian Competition & Consumer Commission (ACCC)	Issues around the sale of hearing aids.(93)	This reported on issues involved in the sale of hearing aids. The ACCC surveyed consumers and industry about the nature and extent of consumer protections in the hearing clinic industry. Three key issues were identified: sales may be driven by commissions and other incentives rather than consumer need cost and performance of hearing aids treatment of vulnerable customers. The ACCC indicated concerns about business practices in the hearing services industry. Focus was on the sales-based arrangements for clinicians. The ACCC requested that the hearing industry review incentive programs and performance measures to ensure no conflict of interest.
June 2017	Siggins Miller Consultants	Examination of Australian Government Indigenous ear and hearing health initiatives.(203)	This report examined the systems, processes and effectiveness of the 6 Australian Government Indigenous ear and hearing initiatives, including the demand for services and unmet need. The consultants sought stakeholder advice about how the investments could be strengthened or improved. There were 31 recommendations, with the conclusion that, despite significant government investment, there was scant evidence of improved health outcomes and the burden of disease was not declining significantly.

Date	Organisation	Title	Synopsis of report
September 2017	PricewaterhouseCoopers (PwC)	Review of services and technology supply in the Hearing Services Program.(92)	<p>The review findings and recommendations supported a whole-of-government approach to the provision of hearing services and assistive hearing technology (AHT).</p> <p>The review identified 12 major findings for the current service delivery model: more can be done to focus on client outcomes</p> <p>the current Minimum Hearing Loss Threshold and measures do not align with international definitions</p> <p>the current level of funding for services contributes to a higher prevalence of cross-subsidisation</p> <p>a greater focus on rehabilitation and support is needed</p> <p>the flexibility of the service pathway needs to be improved</p> <p>there is a need to improve the quality of information made available to clients</p> <p>minimum specifications are fundamental to ensuring access to high-quality AHT</p> <p>effectiveness of AHT schedules could be improved</p> <p>access and types of Alternate Listening Devices (ALDs) available under the voucher stream should be broadened</p> <p>validity of the partially subsidised schedule and its role in the perceived upselling of AHT</p> <p>most government subsidised hearing services are limited to clients who acquire AHT through the voucher stream</p> <p>NDIS uncertainty around the implementation and impact.</p> <p>The review identified a series of recommendations for the voucher stream based on these findings.</p>

Date	Organisation	Title	Synopsis of report
September 2017	House of Representatives Standing Committee on Health, Aged Care and Sport	Still waiting to be heard ... Report on the Inquiry into the Hearing Health and Wellbeing of Australia.(46)	<p>The committee reviewed the current state of hearing health in Australia, including looking at: the prevalence of hearing impairment in Australia and the costs imposed both on individuals and on the broader Australian community</p> <p>the state of hearing health within at-risk population groups - in particular, the impacts of otitis media infections among Aboriginal and Torres Strait Islander children; and also issues related to access of services and treatment for people from culturally and linguistically diverse backgrounds, people living in rural and regional areas, and older Australians</p> <p>programs to encourage Australians, particularly young Australians, to take action to protect their hearing and to increase awareness of the benefits of seeking treatment for hearing loss</p> <p>sales practices within the hearing device clinic industry, including the payment of commissions and incentives to clinicians to encourage the sale of hearing devices</p> <p>the introduction of the National Disability Insurance Scheme (NDIS) and the impact this will have on the delivery of hearing services.</p> <p>The committee made 22 recommendations.</p>
September 2017	The Joint Standing Committee on the National Disability Insurance Scheme (NDIS)	Interim report of the Joint Standing Committee on the NDIS on the provision of hearing services under the NDIS.(204)	<p>The terms of reference for the inquiry were to examine the provision of hearing services under the NDIS, with particular reference to:</p> <ul style="list-style-type: none"> <li>eligibility criteria for determining access to, and service needs of, deaf and hearing impaired people under the NDIS</li> <li>delays in receiving services particularly early intervention services; adequacy of funding in NDIS</li> <li>accessibility of hearing services (rural and remote areas)</li> <li>the principle of choice of hearing service provider</li> <li>liaison with key stakeholders in the design of NDIS hearing services, particularly in the development of reference packages</li> <li>investment in research and innovation in hearing services</li> <li>any other related matters.</li> </ul> <p>The committee made 6 recommendations in the final report, released on 21 June 2018.</p>

Date	Organisation	Title	Synopsis of report
June 2018	The Joint Standing Committee on the NDIS	Final report of the Joint Standing Committee on the NDIS on the provision of hearing services under the NDIS.(205)	<p>The committee made 3 recommendations to address fundamental issues within the NDIS in relation to the provision of hearing services:</p> <ul style="list-style-type: none"> <li>that National Disability Insurance Agency (NDIA) contract Australian Hearing as the national early childhood early intervention partner for families of deaf and hard of hearing children</li> <li>that NDIA reintroduce transdisciplinary package quotes from specialist service providers for children who are deaf and hard of hearing and require access to early intervention services</li> <li>that the Australian Government put in place arrangements similar to Canadian model to ensure a child-first approach to the delivery of services for children with hearing loss.</li> </ul>
April 2019	House of Representatives Standing Committee on Health, Aged Care and Sport, Australian Parliament	Inquiry into the 2017–18 annual reports of the Department of Health and Australian Hearing.(46)	<p>The committee examined the government's progress relating to its previous recommendations and the most up-to-date hearing health policy and programs more broadly.</p> <p>The committee recommended 7 changes:</p> <ul style="list-style-type: none"> <li>reiterate recommendations of the Still Waiting to be Heard report 2017</li> <li>Australian Hearing remain the sole provider of hearing services for children aged from 0 to 6 years</li> <li>COAG establish mandatory hearing screening program for children in their first year of school using Sound Scouts</li> <li>the Australian Government develop, implement and make public its plan for the Community Service Obligations (CSO) program with the rollout of the NDIS on 1 July 2020</li> <li>the Department of Health consider development of a pilot hearing screening program for Australians accessing the aged care system</li> <li>the Australian Government commission research into the possible causes of balance disorders and potential treatment options</li> <li>the <i>Roadmap for Hearing Health</i> embed a clear allocation of responsibilities between jurisdictions; timelines for implementation of key actions; and funding allocations.</li> </ul> <p>The Australian Government is currently responding to this inquiry.</p>











Date	Organisation	Title	Synopsis of report
May 2019	Australian Government Competitive Neutrality Complaints Office, Productivity Commission (AGCNCO)	Australian Hearing Investigation No 16.(206)	<p>AGCNCO received two complaints that alleged Australian Hearing engaged in anti-competitive behaviour in the voucher services market, with market advantages over competitors as a result of government ownership. AGCNCO reported two items were outside of the competitive neutrality policy. Most other complaints were unsubstantiated except for Australian Hearing's advantage as a result of the workers compensation regulation.</p> <p>AGCNCO reported government provided a minor competitive advantage to Australian Hearing as a result of undue promotion on government websites and in Ministerial media releases.</p> <p>The Department of Human Services and the Department of Health have no record of a Ministerial direction limiting Australian Hearing's commercial activities in the private hearing services market. There is no record in the Federal Register of Legislation of such a ministerial direction. Therefore, Australian Hearing's legislation does not preclude it from operating in the private market.</p>

# APPENDIX B

## HEARING DEVICES AVAILABLE THROUGH THE HEARING SERVICES PROGRAM

Hearing devices come in a range of sizes, shapes and styles. The following is a description of the types of fully subsidised hearing aid devices available through the Hearing Services Program.

Figure 11: Hearing devices

 	<b>Behind-the-ear (BTE)</b> The hearing aid sits toward the top of the outer ear (behind the ear) and is attached by a tube to an ear mould sitting inside the bowl of the outer ear and into the ear canal. Sound travels from the hearing aid, through the ear mould and into the ear canal. These hearing aids are discreet and are easy to clean and maintain.
 	<b>High-powered BTE</b> These hearing aids are more powerful for people who have a severe to profound hearing loss. They are often larger than other BTE hearing aids, as they require a larger battery.
 	<b>Open fit BTE</b> These hearing aids have a specially designed earpiece with very thin tubing which directs sound from the hearing aid into the ear canal. This type of hearing aid is useful for people who have good hearing for low pitch sounds or who cannot wear an ear mould.
 	<b>In-the-canal (ITC) and in-the-ear (ITE)</b> The main part of these hearing aids sits in the bowl of the outer ear, with a portion extending into the ear canal to direct the sound into the ear. ITE hearing aids are more powerful than ITC hearing aids and are slightly larger
 	<b>Completely in the canal (CIC)</b> These are small and sit deeply in the ear canal. Due to their size, they may have less variety of features or power than the other styles of hearing aids. They are not suitable for all levels of hearing loss and may not be suitable for people with very narrow or 'bendy' ear canals or those who have difficulty using their hands. Like ITC or ITE hearing aids, CIC hearing aids are more vulnerable to damage from wax and the conditions of the ear canal.

Source: Images – Audiology Australia, Source Descriptors – Hearing Services Program

# APPENDIX C

## BETTER PRACTICE LEGISLATION – LEGISLATIVE AND REGULATORY CHANGES SINCE 2019

As well as the 2019 decision to replace 5 pieces of subordinate legislation with one consolidated instrument for the voucher stream, other administrative changes made over the past 2 years include simplifying the application processes to make the Hearing Services Program more accessible to clients; and changes to the service provider contract for the voucher stream. Hearing Australia observed:

*Overall, the changes to the Service Provider Contract relating to administrative procedures have been well received.(74)*

Other regulatory improvements were also implemented, including:

- removing the requirement for medical referral certification, which was identified as a barrier to timely access to hearing services
- improving client education and support for informed decision-making, including improved quote and maintenance agreement requirements
- simplifying the service provider contract and making the contract in perpetuity unless terminated, thus reducing the regulatory burden of contract renewals
- removing the requirement for clients to sign claim forms.

There was a mixed reaction to these changes from stakeholders involved with this review, with several stakeholders raising concerns about the lack of consultation with the sector. The Hearing Health Sector Committee referred to these concerns as it drafted the *Roadmap for Hearing Health in 2019* and in the committee's final document, captured as a Roadmap guiding principle that:

*future changes and improvements are co-designed with those directly impacted, including consumers, providers, and other relevant stakeholders.(4)*

Further work is underway to consolidate and simplify multiple program-level documents, including program standards, Schedule of Service Items and Fees, claiming conditions and evidence requirements. These initiatives are supported by key stakeholders including providers, Practitioner Professional Bodies and industry groups.(75)



# APPENDIX D

## PROGRAM ADMINISTRATION – DETAILS

### Administration of the voucher stream

#### Voucher issuing

The *Hearing Services Administration Act 1997* stipulates requirements for the establishment of a system to support the issuing of vouchers to eligible persons to receive hearing services. The Act further allows for rules to be established about the duration and replacement of vouchers. The *Hearing Services Program (Voucher) Instrument 2019* (Voucher Instrument) documents the legislated voucher rules as required by the Act, which establish that:

- clients, or their contracted service provider (on behalf of their clients) can apply for a voucher on an approved form with the required information supplied
- the voucher can be issued to an eligible person if the form was properly completed and has been approved by the Department of Health via the Hearing Services Online portal
- vouchers are for a set period, which is currently 3 years. However, from 1 July 2021 the period will be 5 years
- the issuing of a voucher entitles the voucher holder to receive available hearing services.

Information about eligibility and recommendations from this review about eligibility are discussed in **Chapter 3**.

There is no requirement for one of the above groups to have any identified hearing issues or functional challenges resulting from hearing loss before obtaining a voucher. The issuing of a voucher entitles the client to obtain an assessment through the Hearing Services Program to then determine the appropriate rehabilitation plan for the client, including if they need hearing devices.

#### Provider accreditation

Hearing providers who wish to deliver and claim for services for Hearing Services Program clients must be accredited in accordance with the Accreditation Scheme as required by the Act and the Voucher Instrument. To become accredited with the Hearing Services Program, providers must apply to the Department of Health on the approved form demonstrating how they comply with the conditions of accreditation, including capacity to comply with the Rules of Conduct. If accredited, the provider enters into a service provider contract with the Department of Health.(155)

As of 1 March 2021, there were 298 contracted service providers accredited to deliver hearing services under the Hearing Services Program. The number can fluctuate month by month; however, is usually around 300. Providers are currently operating at over 3,000 sites across Australia, with a mix of permanent and visiting site locations; however, there is no clear definition of what are deemed to be permanent or visiting sites. Providers are classified as large, medium, small and micro, depending on the revenue received from the Hearing Services Program each year. A breakdown on how many vouchers were issued for new clients over the last 3 years by provider is outlined in Table 16.(37)

**TABLE 16:** Number of new client vouchers issued by provider type from 2017 to 2020

Provider size by Hearing Services Program revenue	Number of new client vouchers
Large providers (>\$2 million per year)	282,980
Medium providers (\$200,000 to \$2 million per year)	47,763
Small providers (\$50,000 to \$200,000 per year)	7,113
Micro providers (<\$50,000 per year)	943
<b>Total</b>	<b>338,799</b>

Source: Department of Health, Hearing Services Program data and statistics (internal).

In 2019 the Hearing Services Program reviewed its accreditation processes and released a streamlined, more risk-focused accreditation process. This has reduced the time taken and cost to submit accreditation forms. A 2020 review of these processes has shown a reduction in the time it has taken providers from their first submission to a complete application, reducing the time from 42 days for the paper-based system to 13 days for the online semi-automated form.(207) Prior to the 2019 legislation changes, providers were also not able to transfer their accreditation to a new entity. Amendments have enabled easier and timelier processing.

Accredited and contracted service providers have a range of regulatory obligations regarding practitioners, record keeping and insurance as described below.

## Practitioners

Unlike other allied health professions, audiology is not a profession regulated through the Australian Health Practitioners Regulation Agency (AHPRA). The legislative framework underpinning the Hearing Services Program has established minimum standards for providers and qualified practitioners who deliver services to program clients, including requirements for Practitioner Professional Body (PPB) membership for audiologists and audiometrists. PPBs have developed a code of conduct and scope of practice, and over the past 10 years the sector has evolved substantially to ensure appropriate regulation of the delivery of services. In 2015 the then Council of Australian Governments (COAG) Health Council (208) released a National Code of Conduct for unregulated health care workers. This code has since been adopted and tailored for use by the PPBs, and all contracted providers with the Hearing Services Program must ensure staff are delivering services in accordance with the PPB scope of practice and code of conduct.

Audiology Australia, the largest PPB, has obtained accreditation with the National Alliance of Self-Regulating Health Professionals (NASRHP).

Requirements for PPB status has been long established in program legislation:

- a PPB must be an Australian body that is formally constituted for the interests of the professions of audiology or audiometry or both
- membership is based on appropriate industry recognised professional qualifications
- the PPB supervises and enforces a code of ethics and requires members to participate in continuing professional development.

Three PPBs are recognised by the Hearing Services Program as meeting the legislative requirements: Audiology Australia Limited (AudA) for audiologists, Australian College of Audiology (ACAud) for audiologists and audiometrists, and Hearing Aid Audiology Society of Australia (HAASA) for audiometrists. Any hearing practitioner must receive a qualified practitioner

(QP) number before delivering and claiming for services through the Hearing Services Program. This number is separate from the practitioner's assigned Medicare practitioner numbers.

The Voucher Instrument requires all services to be delivered by a QP, except maintenance services. Some rehabilitation services can be delivered by groups with the skills to do so; however, these must be supervised by a QP and can only be claimed for from a contracted service provider. The current legislative framework and Accreditation Scheme only provide for contracted service providers to be funded to deliver program services.

## Record keeping

The records created by providers for Hearing Services Program clients are covered by the *National Archives Act 1983* and the National Archives Authority (NAA) (2011/00396196). Under this NAA, Class 47469 stipulates that all clinical and client records maintained by contracted service providers have minimum periods of disposal. To meet this obligation, the service provider contract deems that client records are Commonwealth Records, making the Australian Government the owner of all client records.

The relevant National Records Authority (NRA) stipulates that clinical and client records are subject to the NRA and its disposal requirements. The Department of Health is unaware of any other Australian Government program that has client records listed under the NRA.

When a client relocates or a provider closes, the client record must be transferred to the new provider or returned to the Australian Government for custody. Status as a Commonwealth Record requires providers to have in place processes to meet the obligations of both the National Archives and other record-keeping requirements such as privacy and tax legislation. Removal of the NAA stipulation and Commonwealth Record status would allow for the reduction in administration for providers and the Hearing Services Program.

Record-keeping requirements to substantiate services and claiming were identified as onerous by some providers and industry groups. Independent Audiologists Australia also noted that, while the National Disability Insurance Scheme has service items for the preparation of clinical notes, the Hearing Services Program (deeming client records as Commonwealth Records) does not cover the costs of time for record keeping.<sup>(75)</sup>

## Hearing Services Online portal

In 2015 the Hearing Services Program launched the Hearing Services Online (HSO) portal, which enabled real-time eligibility checking and voucher issuing. It also enables providers to access and manage provider and client information and process manual claiming. The HSO portal has made significant improvements in the time taken to access hearing services and has given providers greater access to manage their own information, reducing the time to receive a voucher from 6 weeks to real time in almost all cases.

Prior to 2019 the claiming was split across Department of Human Services (97% of claims) and the HSO portal (3%). All claims are now submitted via the HSO portal and the payments are processed by Services Australia (formerly the Department of Human Services).

The HSO portal is used alongside other patient management systems that providers are required to manage for the Hearing Services Program and their general service delivery. These include Medicare claiming systems, HICAPs (health insurance claiming system) and specific patient records management systems. The HSO portal acts as a data repository, including some data on over 1.4 million program clients; however, it is used mainly to support administration of the Hearing Services Program.

## Other provider obligations

In addition to practitioner and record-keeping requirements, contracted service providers are responsible for the ensuring compliance with a range of other legislative and contractual requirements, including insurances, ambient noise and equipment calibration standards, hearing device supply arrangements, and claiming.

## Program compliance

The *Hearing Services Administration Act 1997* and the Voucher Instrument provide a high-level framework for the management of compliance monitoring for the voucher stream, including for voucher issuing, accreditation, practitioners, provider compliance, and recoveries. For the voucher stream, the Hearing Services Program currently monitors compliance with a small team of compliance officers and as part of other existing personnel roles such as complaints and accreditation. Table 17 provides the main compliance activities.

**TABLE 17:** Compliance activities under the Hearing Services Program

Compliance activity	Explanation
Voucher issuing	Government-to-government eligibility checking occurs between Services Australia and the Department of Veterans' Affairs prior to issuing a voucher to a client. Eligibility checking occurs each time a client applies for a new voucher. Manual processes are in place to check eligibility for current serving members and National Disability Insurance Scheme and Disability Employment Service participants.
Accreditation	Service providers who wish to deliver services to program clients must be accredited in accordance with the <i>Hearing Services Administration Act 1997</i> and the <i>Hearing Services Program (Voucher) Instrument 2019</i> . The Hearing Services Program has recently revised the administration of accreditation by streamlining and semi-automating the accreditation application process.
Practitioners	The Practitioner Professional Bodies memorandum of understanding sets out information sharing, reporting and compliance arrangements for practitioners, including the issuing of qualified practitioner (QP) numbers. If a practitioner does not have a QP number, it is the obligation of the provider to request a QP number through the Hearing Services Online portal and the providers must check qualifications and maintain practitioner links and details on an ongoing basis.
Services Schedule	<p>The services available to clients are prescribed by legislation and the Schedule of Service Items and Fees (Services Schedule). The <i>Hearing Services Administration Act 1997</i> (33) specifies that the issuing of a voucher for a specified period entitles the person to one or more specified hearing services. The services may be subject to particular conditions outlined within the legislation, service provider contract, and Schedule of Service Items and Fees, including program standards.</p> <p>The Hearing Services Program's compliance monitoring activities are routinely audited by the Australian National Audit Office and have been subject to 2 internal Department of Health audits.</p>

Compliance activity	Explanation
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Provider compliance	<p>Provider compliance is managed in accordance with the Compliance Monitoring and Support Framework.(209) The Hearing Services Program takes a risk-based proportionate response to monitoring compliance underpinned by provider education and awareness raising.</p> <p>The framework details the range of supports in place to support provider compliance, including provider factsheets, notices, communication materials and website content. To support providers to review their policies and processes, providers complete an annual self-assessment.</p> <p>The framework outlines that provider compliance monitoring is focused on 4 key risk areas:</p> <ol style="list-style-type: none"><li>1. client safety and wellbeing</li><li>2. management of public funds</li><li>3. program integrity</li><li>4. protection of client records and personal information.</li></ol> <p>In addition to the prevention education and support provided, the Hearing Services Program monitors compliance utilising a risk-based approach. It uses risk signals such as claiming data analysis, complaints and tip-offs, previous audit history and so on. Three tiers of compliance monitoring may be implemented, from claims reviews and limited scope audits to full provider audits, depending on the scale of risk identified. Compliance actions taken as a result of noncompliance depend on the seriousness of the noncompliance and the willingness and the capacity of the provider to comply. Potential compliance actions are outlined in the compliance pyramid available in the framework.</p>
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## Hearing device supply arrangements

Hearing devices supplied through the Hearing Services Program must be purchased from an Appointed Supplier (manufacturers and suppliers), who is contracted with the Department of Health and commits to meet the minimum specifications and other conditions including warranty and returns. The Deed of Standing Offer (172) which sets out these supply arrangements has not been comprehensively reviewed or updated since 2012. Where required, hearing devices supplied through the Hearing Services Program must also be registered with the Therapeutic Goods Administration's Australia Register of Therapeutic Goods. Private hearing devices can be brought onto the Hearing Services Program for maintenance purposes as long as the hearing device is listed on a Schedule of Approved Devices.

## Hearing device supply arrangements disclosure

The 2017 Standing Committee Inquiry into Hearing Health (46) recommended the Hearing Services Program ban all commissions and equivalent sales practices. While this was not implemented, the Hearing Services Program further expanded the requirement for providers to disclose to clients if they had a 'preferred supply relationship arrangement' in place. The Hearing Services Program also strengthened the consumer information required to be provided to clients to assist clients make informed decisions about the Hearing Services Program, including hearing device quotes and maintenance agreement information.

## Minimum specifications

The Deed of Standing Offer outlines the minimum hearing device specifications for each Device Schedule and separately for ear moulds and non-standard devices.

## Hearing device schedules

If hearing devices meet the minimum specifications referred to above, they can be listed on either the fully or partially subsidised Device Schedule. Listing of hearing devices is managed by appointed suppliers who have a deed with the Department of Health and is completed online through the HSO portal. Fully and partially subsidised hearing devices have separate minimum specifications. Device Schedules are maintained in real time - that is, they are updated when suppliers make changes, add or delist hearing devices from the schedules.

As of 1 March 2021 there were 235 hearing devices listed on the fully subsidised Device Schedule and 1,934 hearing devices listed on the partially subsidised Device Schedule.<sup>(37)</sup> A range of hearing devices available through the Hearing Services Program are categorised as behind-the-ear (BTE), completely (CIC) or in-the-canal (ITC), in-the-ear (ITE) or non-standard devices. The Schedule of Items and Fees, which is indexed annually, sets the fees for hearing devices based on these categories.

# Administration of the Community Service Obligations stream

The Community Services Obligations (CSO) stream is administered under a memorandum of understanding (MOU) (previously a memorandum of agreement) between the Department of Health and Australian Hearing Services Pty Ltd trading as Hearing Australia. Funding is allocated through the Portfolio Budget Statements to the Department of Health and is then paid quarterly upfront to Hearing Australia.

The MOU outlines the governance arrangements for the delivery of the CSO stream in accordance with the *Hearing Services Administration Act 1997*, as well as the *Australian Hearing Services (Declared Hearing Services) Determination 2019*.

Joint coordination meetings are held between the Department of Health, Hearing Australia and Services Australia on a quarterly basis. Hearing Australia provides quarterly financial and activity reporting, including the populations covered and services provided.

# APPENDIX E

## STAKEHOLDERS WHO CONTRIBUTED TO THE REVIEW OF THE HEARING SERVICES PROGRAM

Stakeholder name	Contribution to the review of the Hearing Services Program					
	Met with the Expert Panel prior to drafting of consultation paper	Provided a written submission to the consultation paper	Met with the Expert Panel regarding the consultation paper	More information provided to the Department of Health to inform the review	Attended a virtual information session on draft report	Provided a written submission to the draft report
Individuals and consumer, advocacy, community and education groups						
NH (individual)		•				
PL (individual)		•				
ANON 1 (individual)		•				
Dennis Leembruggen (individual)		•				
Bert Hoebee (individual)		•				•
Frank Tidswell (distributor)		•			•	•
Dubbo and District Parent Support Group ('Hear our Heart Ear Bus Project')		•				
Air Force Association		•				
TPI Federation (Australian Federation of Totally & Permanently Incapacitated Ex-Servicemen & Women)	•	•			•	•
Royal Flying Doctor Service (RFDS)		•				
Australian Small Business & Family Enterprises Ombudsman (ASBFEO)		•			•	•



Contribution to the review of the Hearing Services Program						
Stakeholder name	Met with the Expert Panel prior to drafting of consultation paper	Provided a written submission to the consultation paper	Met with the Expert Panel regarding the consultation paper	More information provided to the Department of Health to inform the review	Attended a virtual information session on draft report	Provided a written submission to the draft report
Deafness Forum of Australia Consumer Advocacy Group (Deafness Forum)	•	•	•		•	•
Better Hearing Australia	•					
Soundfair	•	•	•		•	•
First Voice		•	•			•
Australasian Newborn Hearing Association (ANHA)		•				
NextSense (formerly known as Royal Institute for Deaf and Blind Children)		•				
National Aboriginal Community Controlled Health Organisation (NACCHO)		•			•	•
Hearing Matters Australia					•	•
CICADA Australia Inc						•
UsherKids Australia Ltd					•	
Can Do Group					•	
Aussie Deaf Kids					•	
<b>Service providers</b>						
Neil and Sue Clutterbuck		•				
Stay Tuned Hearing		•				
Hearing Australia	•	•	•		•	•
MK (also an audiologist)		•				
Odio Tech		•				
MQ Health Speech and Hearing Clinic – Macquarie University		•				

Contribution to the review of the Hearing Services Program						
Stakeholder name	Met with the Expert Panel prior to drafting of consultation paper	Provided a written submission to the consultation paper	Met with the Expert Panel regarding the consultation paper	More information provided to the Department of Health to inform the review	Attended a virtual information session on draft report	Provided a written submission to the draft report
Telethon Speech and Hearing		•			•	
Audika Australia		•	•		•	•
Specsavers		•			•	•
Connect Hearing					•	•
Amplifon					•	•
Neurosensory					•	•
Hearing Check					•	•
ANON 2					•	•
ANON 3						•
Attune Hearing					•	
Bloom Hearing					•	
ReSound					•	
Sonova					•	
Hearing Power					•	
<b>Practitioners</b>						
Derek Moule		•				
<b>Professional bodies</b>						
Independent Audiologists (IAA)	•	•	•	•	•	•
Audiology Australia	•	•	•		•	•
Australian College of Audiology	•	•	•		•	•
Australian Society of Rehabilitation Consultants (ASORC)		•			•	•

Contribution to the review of the Hearing Services Program						
Stakeholder name	Met with the Expert Panel prior to drafting of consultation paper	Provided a written submission to the consultation paper	Met with the Expert Panel regarding the consultation paper	More information provided to the Department of Health to inform the review	Attended a virtual information session on draft report	Provided a written submission to the draft report
<b>Industry representative bodies</b>						
Hearing Business Alliance (HBA)	•	•	•	•	•	•
Hearing Care Industry Association (HCIA)	•	•	•		•	•
Hearing Aid Audiology Society of Australia (HAASA)	•					
Hearing Health Sector Alliance (HHSA)	•	•	•		•	•
<b>Manufacturers</b>						
Hearing Aid Manufacturers and Distributors Association of Australia (HAMADAA)	•	•	•	•		•
Sivantos		•				
Cochlear Australia	•	•			•	•
Med-El						•
Oticon Hearing Aids					•	
<b>Academics/research</b>						
Professor Louise Hickson (University of Queensland)	•	•	•	•	•	
Honorary Professor Anthony Hogan PhD (Faculty of Health Sciences, University of Sydney)	•			•		
National Acoustics Laboratories (NAL)				•		•
<b>Government bodies</b>						
Department Veterans' Affairs	•	•	•		•	•
New Zealand Ministry of Health				•		
<b>Other</b>						
Astute Advocacy					•	
Due Diligence Australia					•	

# APPENDIX F

## ABBREVIATIONS USED IN THIS REPORT

Abbreviation	Definition
ACAud	Australian College of Audiology
ACCHOs	Aboriginal Community Controlled Health Organisations
AIHW	Australian Institute for Health and Welfare
ALD	Assistive Listening Device
AudA	Audiology Australia
BTE	Behind-the-ear
CALD	Culturally and linguistically diverse
CDEP	Community Development Employment Projects
CDP	Community Development Program
CHERE	Centre for Health Economics Research and Evaluation, University of Technology Sydney
COSI	Client Orientated Scale of Improvement
CSO	Community Service Obligations
DVA	Department of Veterans' Affairs
ENT	Ear nose and throat
FAHL	Frequency Average Hearing Loss
HAASA	Hearing Aid Audiology Society of Australia
HBA	Hearing Business Alliance
HCIA	Hearing Care Industry Association
HHSA	Hearing Health Sector Alliance
HRO	Hearing Rehabilitation Outcomes
HSO	Hearing Services Online (the HSO portal)
HSP	Hearing Services Program
ITC	In-the-canal device
ITE	In-the-ear device
LOCHI	Longitudinal Outcomes of Children with Hearing Impairment
MHLT	Minimum Hearing Loss Threshold
NACCHO	National Aboriginal Community Controlled Health Organisation
NAL	National Acoustic Laboratories
NDIS	National Disability Insurance Scheme
NHMRC	National Health and Medical Research Council
PPB	Practitioner Professional Body
QP	Qualified practitioner
RFDS	Royal Flying Doctor Service
WANT	Wishes and Needs Tool

# APPENDIX G

## GLOSSARY OF TERMS USED IN THIS REPORT AND BY THE SECTOR

### Accreditation

Accreditation is the process used by the Australian Government Hearing Services Program to assess and approve a provider of hearing services. Being accredited means that the provider has been found to meet the requirements necessary as set out in the Hearing Services Providers Accreditation Scheme 1997 to deliver hearing services to clients of the Hearing Services Program.

### Accreditation Scheme

The Accreditation Scheme sets out the requirements for applicants and empowers the Minister for Health to make decisions to accredit hearing services providers.

### Aged care homes

An aged care home is a special-purpose facility which provides accommodation and other types of support, including assistance with day-to-day living, intensive forms of care, and assistance towards independent living, to frail and aged residents. They are accredited by the Aged Care Standards and Accreditation Agency Ltd.

### Air conduction

Air conduction tests evaluate the sensitivity of the entire hearing system. Earphones are placed over the ears or inserted into the ear canal. The hearing practitioner presents single frequency ('pure') tones produced by a calibrated audiometer. The softest sounds heard by the client at each pitch are recorded as the thresholds.

### Assistive listening device

Assisted listening devices (ALDs) are devices which assist someone with a hearing loss to hear and understand what is being said more clearly. ALDs commonly include headphones and microphones. ALDs are sometimes referred to as assistive listening devices.

### Assessment

An assessment is the test undertaken by a hearing practitioner to determine if a client has a hearing loss and the type of loss.

### Audiogram

An audiogram is a graph which plots hearing loss. Hearing thresholds are graphed to show how close a client's hearing is to the 'normal' range. An audiogram helps to determine the level of hearing loss and identify the location of the hearing problem. The audiogram is split into 2 sections: frequency (range of hearing) and intensity (or loudness).

## **Audiologist**

Audiologists are university graduated allied health professionals with postgraduate qualifications in audiology or equivalent training. Audiologists have expertise in non-medical areas of hearing services, including complex hearing assessment and rehabilitation of hearing impairment.

## **Audiology Australia Limited**

Audiologists are represented professionally by Audiology Australia Limited. Audiology Australia Limited is a Practitioner Professional Body under the Hearing Services Program. It was previously known as the Audiological Society of Australia (ASA).

## **Audiometrist**

Audiometrists have completed a diploma course in hearing aid prescription and evaluation.

## **Audit**

An audit is a systematic, independent and documented process of obtaining and evaluating audit evidence to determine whether specified criteria are met. An audit enables the program to check whether a hearing services provider has the systems, processes and governance arrangements in place to meet the requirements of the program.

## **Audit and compliance framework**

The audit and compliance framework describes the Department of Health's risk-based approach to audit and compliance. The framework provides a plan for monitoring and encouraging compliance from hearing services providers in delivering hearing services to clients.

## **Australian College of Audiology**

Audiometrists and some audiologists are represented professionally by the Australian College of Audiology (ACAud). ACAud is a Practitioner Professional Body under the Hearing Services Program.

## **Australian Hearing Specialist Program for Indigenous Australians**

The Australian Hearing Specialist Program for Indigenous Australians (AHSPiA) is Australian Hearing's outreach service. It is delivered in a culturally sensitive way in localities that encourage Aboriginal and Torres Strait Islander people to use hearing services. The services are designed to meet the audiological needs that arise in Aboriginal and Torres Strait Islander communities, caused by the high prevalence of otitis media and its associated hearing loss.

## **Behind the ear**

Behind-the-ear (BTE) is a type of hearing device where the main part of the device, including the electronics and battery, sits in a case behind the ear.

## **Bilateral CROS**

Bilateral CROS (BiCROS) is a type of hearing device which allows sounds to arrive at either ear with the strongest ear processing the sound.

## **Binaural fitting**

A binaural fitting is when a hearing device is fitted in both ears.

## **Bone Anchored Hearing Aid**

A Bone Anchored Hearing Aid (BAHA) is a surgically implantable system for the treatment of hearing loss. This device allows sound to be conducted through the bone rather than the middle ear – a process known as direct bone conduction.

## **Bone conduction**

Bone conduction testing uses a small bone-conduction vibrator which is placed on the mastoid bone behind the ear. Sound is transmitted through the bones of the skull to the inner ear, bypassing the outer and middle ear. A difference between air and bone conduction thresholds indicates a hearing loss caused by a problem with the outer or middle ear.

## **Client**

A client is a person who is eligible for the Hearing Services Program as a voucher holder or eligible for the Community Service Obligations component.

## **Client rights and responsibilities**

The rights and responsibilities of a client under the Hearing Services Program.

## **Clinical hearing services**

Clinical hearing services include a hearing assessment, device fitting and evaluation, training and advice.

## **Cochlear implant**

A cochlear implant is a surgically implanted device which enables a person to experience sounds by sending electrical signals to the nerve endings in the inner ear (the cochlear).

## **Community Service Obligations**

The Community Service Obligations (CSO) enable Australian Hearing to provide specialist hearing services to people who are Australian citizens or permanent residents and are younger than 26 years; Aboriginal and Torres Strait Islander people who are over 50 years; Aboriginal and Torres Strait Islander participants in the Remote Jobs and Communities Program (now known as the Community Development Program); Aboriginal and Torres Strait Islander participants in the Community Development Employment Projects program, who received hearing services before 30 June 2013; a client who meets voucher stream eligibility and has a profound hearing loss or hearing loss and severe communication impairment; or a client who meets voucher stream eligibility and lives in a listed remote area of Australia.

Australian Hearing is the sole provider of CSO services. This information is general advice only.

## **Complaint**

A complaint is an expression of dissatisfaction with any aspect of the Hearing Services Program. Please refer to the OHS Complaints Policy.

## **Client with complex or specialised needs (specialist hearing services)**

A client with complex or specialised needs is a client who has severe to profound bilateral hearing loss or whose communication is limited due to significant physical, intellectual, mental, emotional or social disability. These clients are entitled to receive specialist hearing services through Community Service Obligations. They were previously referred to as 'complex clients'.

### **Confidential information**

Confidential information means facts or knowledge that are not publicly available, are by their nature confidential, or are designated by the Australian Government as confidential.

### **Contracted service provider**

A contracted service provider is a hearing services provider who has been accredited and contracted to provide services to clients of the Hearing Services Program voucher stream.

### **Contracted service provider notice**

A contracted service provider notice is email and web-based information provided to hearing services providers containing announcements and updates relating to the Hearing Services Program. (They were previously known as ‘SPAs’.)

### **CROS aid**

CROS aids are hearing aids where one aid contains a microphone and the other the amplifier and receiver. CROS aids can be used by people who have one good hearing ear and one ear where the loss is so great that a hearing aid will provide no benefit. Essentially, a CROS aid is a hearing device with a microphone on one side carrying sound from that side of the head to the other side.

### **Date of services**

In relation to any particular aspect of the services, date of services means that date as defined in the Schedule of Service Items and Fees.

### **Deaf (and hearing impaired)**

A deaf or hearing impaired person is a person who cannot hear. When referring to a deaf person – it is accepted in the community that we use ‘deaf’ and if referring to deaf people in general – we use ‘deaf’. For additional information on this topic, see National Association for the Deaf website.

### **Department of Health**

The Department of Health is the Australian Government department responsible for the Australian Government’s priorities for health. The Hearing Services Program operates within the department.

### **Dependant**

To be eligible as a dependant under the Hearing Services Program a person must be 21 years of age or above and the spouse or de facto spouse of an eligible person or a person who is between the age of 21 and 24 inclusive (under 25); receiving full-time education at a school, college or university; not receiving a disability support pension; and wholly or substantially dependent on the eligible person or the spouse or de facto spouse of an eligible person.

### **Eligibility criteria for refitting**

Eligibility criteria that must be met in order for a client to be refitted with a new hearing device.

### **Entity**

Entity means an individual, or a body corporate, or a partnership, or an authority of the Commonwealth, a state or a territory, or a department of the Australian Government, or a state or a territory.



### **Expert Panel**

The Expert Panel was established in July 2020 to lead the Independent Review of the Hearing Services Program. Members are Professor Michael Woods and Dr Zena Burgess, with secretariat services provided by the Department of Health.

### **Fully subsidised device schedule**

All fully subsidised hearing devices are listed in the Main Schedule of Approved Devices.

### **Fully subsidised device**

Fully subsidised devices are approved by the Hearing Services Program and available to eligible clients.

### **Hearing Australia**

Hearing Australia (HA) is a hearing services provider under the Hearing Services Program. HA is a statutory authority (government owned) that reports to the Minister for Human Services and provides services to clients eligible under the Community Service Obligations component of the program. It is also referred to as Australian Hearing.

### **Hearing Aid Audiometrist Society of Australia**

Audiometrists are represented professionally by the Hearing Aid Audiometrist Society of Australia (HAASA). HAASA is a Practitioner Professional Body under the Hearing Services Program.

### **Hearing Care Industry Association**

The Hearing Care Industry Association (HCIA) provides input to Hearing Services on policy and administrative matters that impact upon its corporate membership and the hearing industry.

### **Hearing device**

Hearing devices are those that are listed in the Schedule of Approved Devices for the program. They are also known as approved devices. Goods for purposes in connection with hearing rehabilitation, including the ear mould and any other attachments necessary for the operation of the device. Also known as an approved hearing device.

### **Hearing loss**

There are 3 types of hearing loss: conductive hearing loss (when sounds are blocked from reaching the hearing nerve); sensorineural hearing loss (when sounds can reach the hearing nerve but are not sent to the brain); and mixed hearing loss (a combination of conductive and sensorineural hearing loss).

### **Hearing Loss Prevention Program (HLPP)**

The Hearing Loss Prevention Program (HLPP) funds research that contributes to the development of improved policies and service delivery and/or enables the Department of Health to better identify the needs of the community in relation to hearing loss.

### **Hearing practitioner**

A hearing practitioner is a person who has been engaged by a contracted service provider to provide hearing services to clients of the Hearing Services Program. A hearing practitioner may be an audiologist or audiometrist.

### **Hearing rehabilitation outcomes**

The hearing rehabilitation outcomes (HRO) document the results intended to be achieved by practitioners in providing services to clients.

### **Hearing services**

Hearing services may include assessment of hearing loss and hearing rehabilitation.

### **Hearing Services Online portal**

The Hearing Services Online (HSO) portal and website were developed by the Department of Health to support the administration of the voucher component of the Australian Government Hearing Services Program. The HSO portal is based in the web environment and improves access to the program for clients and providers. Clients can use the HSO portal to confirm eligibility for the program, submit an application for a hearing services voucher, and view the hearing services provider directory in a searchable map.

### **Hearing Services Program**

The Hearing Services Program is administered in the Department of Health. The program provides access to hearing services to eligible people.

### **Hearing services provider**

A contracted hearing services provider has been accredited and contracted by the Department of Health to deliver services to clients of the Hearing Services Program.

### **In-the-canal device**

An in-the-canal device is a hearing device that sits inside the ear canal.

### **In-the-ear device**

An in-the-ear device is a hearing device that sits inside the ear.

### **Maintenance service**

Maintenance services for a hearing device includes supply of batteries, servicing and repairs. They include any of the following services for a hearing device to ensure it operates effectively, giving advice to a client about the use or servicing of a hearing device, or providing and replacing hearing device batteries.

### **Manual claim**

A manual claim is an online or paper claim for services lodged by a contracted service provider. Manual claims are processed by Hearing Services.

### **Medical practitioner**

A medical practitioner is a person who, under the law of a state or territory, is a legally qualified medical practitioner.

### **Minimum Hearing Loss Threshold**

The Minimum Hearing Loss Threshold (MHLT) for fitting a hearing device to a client under the Hearing Services Program is a 3 Frequency Average Hearing Loss of more than 23 decibels.

### **Monaural fitting**

A monaural fitting is when a hearing device is fitted in one ear only.

### **National Disability Insurance Scheme**

The National Disability Insurance Scheme (NDIS) funds individualised support for eligible people with disability.

### **Non-routine client**

A non-routine client is a client found to have one or more of the following audiometric presentations:

- an air bone gap of 20dB or greater at 500 Hz, 1 kHz or 2 kHz
- speech discrimination poorer than expected given HTLs
- evidence of fluctuation in audiometric thresholds.

### **New voucher**

A new voucher is issued to clients who have been found eligible for the Hearing Services Program who have not previously received services under the program.

### **Partially subsidised device**

Partially subsidised devices are ones approved by the Hearing Services Program. Partially subsidised devices have additional features.

### **Partially subsidised device schedule**

A partially subsidised advice schedule is a list of all partially subsidised devices currently available through the Hearing Services Program.

### **Permanent site**

A permanent site is a location or facility operated by a hearing services provider where hearing services are provided on an ongoing basis.

### **Practitioner Professional Body**

A Practitioner Professional Body (PPB) is an Australian body which meets all of the following criteria:

- the body is formally constituted for the purpose of representing the interests of the professions of audiology or audiometry
- membership of the body is based on appropriate industry-recognised professional qualifications for audiometrists or audiologists
- the body supervises and enforces a code of ethics for the professions of audiology or audiometry and the body requires members to continue their professional development.

### **Provisional audiologist**

A provisional audiologist is a person who is in an approved membership category of a Practitioner Professional Body for provisional audiologists.

Provisional audiologists must be supervised by a qualified practitioner when providing hearing services to eligible clients.

### **Provisional audiometrist**

A provisional audiometrist is a person who is in an approved membership category of a Practitioner Professional Body for provisional audiometrists.

Provisional audiometrists must be supervised by a qualified practitioner when providing hearing services to eligible clients.

### **Qualified practitioner**

A qualified practitioner is a qualified hearing services practitioner (audiologist or audiometrist).

### **Qualified practitioner (audiologist)**

A qualified practitioner (audiologist) is a person who is in an approved membership category of a Practitioner Professional Body for qualified practitioners (audiologist).

### **Qualified practitioner (audiometrist)**

A qualified practitioner (audiometrist) is a person who is in an approved membership category of a Practitioner Professional Body for qualified practitioners (audiometrist).

### **Qualified practitioner number**

A qualified practitioner (QP) number is the unique number allocated to a qualified practitioner by the Minister for Health under rule 25 of the Rules of Conduct of the Australian Government Hearing Services Program.

### **Records**

Records are any information, data or documents about clients maintained by a hearing services provider.

### **Rehabilitation Plus (Rehab Plus)**

The Rehab Plus service offered under the Hearing Services Program provides clients with additional support in managing their hearing loss through group sessions and individual appointments. Rehab Plus Group Services means support and assistance provided in a group setting to clients who have been fitted for the first time with a fully subsidised hearing device under the voucher system to maximise their communication abilities and to better manage their hearing loss.

### **Relocation**

A relocation is when a client moves from one hearing services provider to another within the Hearing Services Program.

### **Replacement (device)**

A replacement is the fitting of a new hearing device when an existing device has been lost or damaged beyond repair or become obsolete.

### **Return voucher**

A return voucher is a voucher issued to a client who has previously received services under the Hearing Services Program.

### **Roadmap for Hearing Health**

The *Roadmap for Hearing Health* was released by the Australian Government in February 2019. It was created to improve the lives of the millions of Australians affected by hearing loss.

## Rules of Conduct

The Hearing Services ROC 2012 outlines the requirements and standards that hearing service providers must adhere to when providing services to eligible voucher holders under the Hearing Services Program.

## Schedule of Approved Devices

The Schedule for Approved Devices lists all approved hearing devices under the Hearing Services Program.

## Schedule of Items and Fees

The Schedule of Fees lists the fee paid by the Hearing Services Program to hearing services providers for each service item and hearing device category.

The Schedule of Service Items lists each service item with a description and conditions for claiming.

## Screening test

A screening test is a partial hearing test to determine if a person may require further audiological assessment.

## Self-Assessment Tool

Hearing services providers are required to complete and submit an annual Self-Assessment Tool (SAT). The SAT assists hearing services providers to check if they have systems in place to meet the requirements of the Hearing Services Program.

## Service provider contract

The service provider contract sets out the terms and conditions under which a hearing services provider must deliver the Hearing Services Program.

## Service Provider Number

Contracted service providers who are accredited with the Hearing Services Program are issued an individual identification number at the start of their contract.

## Teleaudiology

Teleaudiology involves the utilisation of telehealth to provide audiology services.

## Voucher

A voucher is a digital authority issued by the Department of Health to eligible clients of the Hearing Services Program enabling them to have their hearing tested and devices reviewed. From 1 July 2021 all new vouchers issued will be valid for 5 years. For clients with a voucher which has an expiry date after 30 June 2021, their voucher will automatically be extended by a further 2 years.

## Voucher details

Voucher details include the date of issue the service or services for which the voucher has been issued; the date by which the voucher must be first presented to a hearing services provider for a hearing assessment; the name of the voucher holder; and any other relevant matters.

### **Voucher stream**

A voucher stream is the voucher component of the Hearing Services Program.

### **Wishes and Needs Tool**

The Wishes and Needs Tool (WANT) is a legislated client self-report instrument for evaluating a client's attitude and motivation level for the fitting of a hearing device.

### **Young adults**

In the context of the Hearing Services Program, young adults are those aged from 21 to 26 who are eligible for hearing services through the Community Service Obligations component of the program.

### **Young Australians**

In the context of the Hearing Services Program, young Australians are those aged under 21 who are eligible for hearing services through the Community Service Obligations component of the program.





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