HEARING SERVICES PROGRAM REVIEW

Submission from Deafness Forum of Australia

and its consumer representative advisory group

Contents

ABOUT DEAFNESS FORUM OF AUSTRALIA

Deafness Forum is the peak, national, not for profit organisation that represents one in six Australians who have a hearing issue, a chronic disorder of the ear, are deaf, and the families who support them.

Deafness Forum's objective is to provide timely and actionable advice to Government on strategic policy development and practice reform.

> "*Hearing impairment or deafness is a grossly underestimated public health problem in Australia, causing significant productivity loss to the nation. In addition, there must be a new focus on the prevention of avoidable hearing loss acquired from poor occupational health practices and other exposures to noise.*
>
> *There is a real need for national advocacy. It is Deafness Forum's role to provide informed and realistic advice to the Australian Government and the Opposition, to inform public policy to benefit the one in six Australians it represents."*
>
> *Hon John Howard OM AC, 25th Prime Minister of Australia, patron of Deafness Forum of Australia*

ABOUT THIS SUBMISSION

This submission is from the perspective of Deafness Forum's consumer constituents who are people with a lived experience of hearing loss and deafness.

ADVISORY GROUP MEMBERS

Aussie Deaf Kids (www.aussiedeafkids.org.au)

Aussie Deaf Kids provides online information and support to families of children with hearing loss across Australia. Founded in 2001, Aussie Deaf Kids is committed to providing parents with information that will assist them to make informed decisions about raising a child with hearing loss. Currently, over 3,000 Australian families are members of the Aussie Deaf Kids online support groups.

Deafness Council Western Australia Inc (www.deafnesscouncilwa.org.au)

The Deafness Council W.A. Inc was established in 1974. The Council is a co-ordinating body whose role is to facilitate the work of Deaf/Hard of Hearing individuals and agencies. The Council encourages relevant research and represents the needs and interests of the Deaf and Hard of Hearing to decision makers.

Hearing Matters Australia (www.hearingmattersaustralia.org)

Hearing Matters Australia (HMA) is dedicated to helping Australians with hearing loss whose primary method of communication is through speech. We provide information and support to people with hearing loss and their families, and we advocate on their behalf to all levels of government and the corporate sector. We are a voluntary, self-funded, not-for-profit organisation incorporated in New South Wales.

Parents of Deaf Children (www.podc.org.au)

Parents of Deaf Children (PODC), formerly Parent Council for Deaf Education, is a non-profit organisation, supporting families with babies, children and teenagers with hearing loss in NSW. The organisation offers a range of information, support and capacity building services for parents and carers, respecting the method or methods of communication that the family has chosen for their child.

Usher Kids Australia (www.usherkidsaustralia.com)

The mission of Usher Kids Australia is to enhance the lives of children with Usher syndrome and their families in Australia through information, collaboration and connection. Our purpose is to ensure the children diagnosed with Usher syndrome and their families have access to an informed, committed and caring community of clinicians, service providers, educators, researchers and peer support networks to allow them to thrive in their everyday endeavours.

HEARING SERVICES PROGRAM (HSP) REVIEW

A CONSUMER ORGANISATION PERSPECTIVE OF THE HSP

Consumer organisations are very supportive of the HSP as it makes a significant difference to people's lives.

The Voucher component of the HSP is valued for the important services it provides to older Australians on low income who experience hearing loss due to the ageing process. The Program addresses the impact of hearing loss on the social and emotional well-being of these clients.

The Community Service Obligations Program is recognised as being absolutely vital in addressing the needs of highly vulnerable client groups and those who need to receive specialised services. Parent groups in particular have felt this Program has been threatened by various reviews such as the potential sale of Hearing Australia and the introduction of the NDIS and want to again make it clear why this program is so important to them and why they value having Hearing Australia as the single, independent provider of services.

Families appreciate that

- the program allows for a family centred response, giving families time, information and support to allow them to make an informed decision for their baby or child
- children diagnosed with hearing loss, particularly infants diagnosed with hearing loss through newborn hearing screening programs, are given the highest priority for service over other client groups
- the child receives an individually tailored program to meet the needs of the child and the family, and to support the child to reach their full potential
- there are strong relationships between audiological services, educational services and other support services including referrers
- the service is provided by highly skilled clinicians
- the clinical programs are research based and supported by clinical protocols and there is a quality framework supporting the Program
- the programs are solely focussed on achieving the best outcome for the child and are not influenced by commercial practices such as sales targets or financial incentives
- services are equitable and not based on the family's ability to pay
- information and guidance are impartial and unbiased
- services are well located to minimise the need for travel

The expertise, technology, time and support that is provided by Hearing Australia under the CSO Program helps children reach their potential in educational attainment, employment and social engagement. Families are concerned that any changes to existing arrangements will put the outcomes for their child at risk.

The CSO Program is also provides critical services through its outreach program for Aboriginal and Torres Strait Islander children and eligible adults, and for its specialised services to adults with complex hearing rehabilitation needs.

SUMMARY OF RECOMMENDATIONS

1. PROGRAM OBJECTIVES

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.

The Program should aim to

- improve the quality of life of Program participants and improve their ability to participate socially, educationally and economically
- provide quality information, advice and support to clients, their family and significant others of Program participants
- provide general education and awareness of the causes and consequences of hearing loss and hearing loss prevention strategies
- foster quality and innovation in service delivery

2. PROGRAM ELIGIBILITY

VOUCHER PROGRAM

Existing groups should remain eligible for services under the Program.

Eligibility should be extended to broader group of people on low income including

- Commonwealth Seniors Health Card holders
- Health Care Card holders and Low Income Health Care Card holders who are not eligible for hearing support under the NDIS

CSO PROGRAM

Existing groups should remain eligible for services under the Program and the Program needs to be appropriately funded to ensure the quality of services is maintained and services remain accessible and equitable.

Eligibility should be extended to

- All frail elderly residents of aged care facilities regardless of income level
- People in the criminal justice system
- Children who are long term temporary residents and refugees

3. INTERFACE BETWEEN PROGRAMS

There needs to be improved advice and information for consumers, more streamlined access pathways and more communication between Programs regarding individual clients.

4. HEARING LOSS PREVENTION

The National Preventative Health Strategy that is currently under development needs to include a national strategy on hearing loss prevention.

The hearing loss prevention strategy should address

- Immunisation
- Early identification and intervention across the lifespan
- Prevention of otitis media in Aboriginal and Torres Strait Islander children
- Noise in the workplace
- Leisure noise

5. ASSESSMENT AND REHABILITATION ACTIVITIES

VOUCHER PROGRAM

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.

CSO PROGRAM

- Additional funding should be made available to allow Hearing Australia to provide initial assessment appointments to children without the need to have their hearing assessed elsewhere in the first instance, particularly Aboriginal and Torres Strait Islander children.
- Adults with cochlear implants should have access to speech processor upgrades and replacements under the Program.

6. CHOICE AND CONTROL

VOUCHER PROGRAM

Consumers need more information about the options available within a rehabilitation program so they understand there are more choices than a device fitting.

CSO PROGRAM

Hearing Australia should remain as the sole provider of services to children with hearing loss.

7. TECHNOLOGY DEVELOPMENTS

TELEHEALTH

Use of telehealth should not be implemented until there are standards in place regarding expertise, software and hardware capability. Telehealth is likely to improve access to professional support but the option of face to face appointments still needs to be available.

DEVICES

- The minimum specifications in the Deed of Standing Offer need to keep pace with improvements in technology
- Accessories that can be used with the person's primary device to improve connectivity to other devices such as mobile phones etc should be provided under the Program
- The HSP should provide a broader range of technology beyond hearing aids that assist with hearing and communication particularly for residents in aged care facilities
- The Program should not subsidise devices that are bought online without the involvement of a clinician in the process.

8. THIN MARKETS

- The HSP could do more to support people on low income by giving them access to the Program
- The Voucher Program could improve access to people from CALD backgrounds by covering the cost of interpreter services and providing information in other languages
- The CSO Program should continue to provide a safety net for groups that require specialised programs or are highly vulnerable or where the services are too costly to deliver for other providers

9. DATA

The Program should have appropriate measures in place to determine whether

- the objectives of the Program are being achieved
- quality standards are being met
- the groups that are targeted for assistance are accessing services
- expected client outcomes are being achieved
- level of client satisfaction with the services provided
- providers are complying with the contract requirements

VOUCHER PROGRAM

There needs to be more information on the outcomes for those who use the Program and also more about the profile of clients who are using the program to see if there are client groups eg CALD clients or clients from particular areas who are not accessing services.

CSO PROGRAM

- The development and implementation of a national database for newborn hearing screening would help to monitor the effectiveness of programs and to ensure that no children fall through the gaps between screening, diagnosis, hearing rehabilitation and early childhood early intervention programs.
- There needs to be more information published on the outcomes for children, including longer term outcomes such as level of educational attainment and employment
- Outcomes measures will need to access data from multiple domains such as Health, NDIS and Education

HEARING SERVICES PROGRAM REVIEW

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

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.

The Program should focus on the quality of life as it relates to the clients' hearing loss and how they manage their hearing loss in their daily lives. The device is one of the tools to rehabilitate communication. (Campos & Launer, 2020)

The Program should aim to

- improve the quality of life of Program participants and improve their ability to participate socially, educationally and economically
- provide quality information, advice and support to clients, their family and significant others of Program participants
- provide general education and awareness of the causes and consequences of hearing loss and hearing loss prevention strategies
- foster quality and innovation in service delivery

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2. Which consumers should be eligible for Program subsidies?

VOUCHER PROGRAM – Adults with non complex hearing needs

Existing groups should remain eligible for services under the Program.

These groups are:

- Pensioner Concession Card holders
- Department of Veterans' Affairs Gold Card holders
- Department of Veterans' Affairs Which Card holders with hearing specific conditions
- A dependant of a person in one of the above categories
- Members of the Australian Defence Force
- People referred by the Disability Employment Services (Disability Management Services) Program

Eligibility should be extended to a broader group of people on low income including:

a) Commonwealth Seniors Health Card holders

The prevalence of hearing loss increases with age (Wang et al., 2018) so it is critical to ensure that this segment of the population has appropriate access to hearing services so they can continue to engage in their normal lifestyle socially as well as through employment (paid or unpaid). Between 1968 and 1993 the Program was targeted to those on low income which was defined as being on a full Age Pension. Eligibility was extended to part pensioners in 1993. There are many self-funded retirees who do not have high levels of superannuation and because they do not receive any concessions on living expenses, struggle to fund the hearing services they need. The eligibility criteria needs to be reviewed so that it is targeted to the broader ageing population who need assistance with their hearing needs as they age, and who are not in a position to fund these services themselves. The Commonwealth Seniors Health Card identifies people of pension age who are on lower income. When the Commonwealth Seniors Health Card was established in 1993 it included eligibility for the HSP. This access was revoked in 1997 but in the current economic circumstances needs to be revisited as a threshold for entry to the HSP.

b) Health Care Card holders and Low Income Health Care Card holders

Health Care Card holders and Low Income Health Care Card holders who are not eligible for hearing supports under the NDIS should have access to government funded hearing services as a vulnerable group on low income. These people may be unemployed or in low paid employment. Access to hearing services could improve the person's opportunities for further education, employment or advancement within existing employment (Graydon, Waterworth, Miller & Gunasekera, 2019).

This was identified as a key action in the Roadmap for Hearing Health (Hearing Health Sector Committee, 2019, p. 17) *"Provide additional support for people on low incomes to access hearing health services, for those not eligible for the HSP or the NDIS".*

CSO PROGRAM – Children, eligible adults with complex hearing rehabilitation needs, certain Aboriginal and Torres Strait Islander people, and people requiring specialised supports or programs

Existing groups should remain eligible for services under the Program and the Program needs to be appropriately funded to ensure the quality of services is maintained and services remain accessible and equitable.

There groups include:

- Children under the age of 26 years
- People eligible for the Voucher Scheme who have complex hearing or communication needs or live in remote areas
- Aboriginal and Torres Strait Islander people over 50 years of age or participating in a Community Development Program

Eligibility (with associated funding) should be extended to:

a) ALL RESIDENTS IN AGED CARE FACILITIES

A new eligibility category should be created under the Community Service Obligations component of the HSP for all permanent residents of aged care facilities (ACF) regardless of income level for the following reasons.

1. Prevalence of hearing loss

There is a very high prevalence of hearing and communication impairment in older people living in ACFs, a significantly higher prevalence than is found in the wider elderly community. Research typically shows that hearing loss occurs in 80 to 90% of ACF residents compared to approximately 40 to 50% of older adults living in the community.

A recent Australian systematic review (Punch, Horstmanshof 2018) found that in many cases hearing loss in ACFs has been under-identified and unaddressed. The review also found a clear association between hearing loss and loneliness, reduced social engagement, and depression among residents.

2. Complex needs

The audiological management of residents in ACFs is more complex as the residents have other serious co-existing health conditions that complicate the hearing rehabilitation process. They are more likely to have more complex health conditions combined with hearing loss such as dementia, vision loss and physical impairments. Providing appropriate audiological care to clients with complex needs requires specialised knowledge and expertise which is available through the Community Service Obligations Program.

3. Support for residents

Residents in ACFs are generally highly dependent on staff for their personal care and management of health issues. They also rely on ACF staff to access hearing services and assist with any devices fitted. Evidence at the recent Aged Care Royal Commission indicates that staffing levels make it difficult for residents to be provided with support for basic needs let alone assistance with applying for hearing services or using the technology provided. Consequently, their hearing needs are often not addressed. The evidence from the family of one resident with significant hearing impairment showed that staff had no understanding of the importance of hearing aids for the resident or how to help that resident use the technology The evidence also showed that only 40% of residents had visitors which indicates how reliant the residents are on ACF staff to help them with their needs. It also indicates that very few residents have anyone else to advocate for them on their behalf. (Royal Commission transcripts 2019).

Staff in ACFs are not well equipped with the skills to work effectively with people with hearing loss or to help them manage any technology they may have. This leads to a level of frustration for staff as they do not have the skills to communicate effectively with people in

their care. Residents are left feeling anxious and are at risk if they are not understanding the questions or instructions from the staff. There is also a risk that staff could mistakenly believe that someone is uncommunicative due to other health issues such as dementia when in fact the person has an undiagnosed hearing loss. The model of care to provide hearing services to residents of ACFs needs to include a component of staff training to improve the skill level of staff in working with people with hearing loss as well as harnessing any volunteer programs that could support residents in managing their hearing needs and providing communication opportunities. The training needs to be extended to Aged Care Assessment Teams and also needs to be embedded in the certificate courses for aged care workers.

4. The environment

The physical and social environment in ACFs presents major challenges for residents in being able to participate in effective communication exchanges. The physical environment is problematic because of a lack of privacy, high reverberation levels and high levels of glare. Similarly, the social environment is restricted with residents having few opportunities to talk, few people to talk with, and limited topics of conversation and reasons to talk. Therefore, the environment needs to be reviewed and improved as part of the program to assist clients experiencing communication difficulties.

5. Appropriate model of service delivery for ACF

Standard audiological care, such as that provided under the Voucher Program consists of a hearing assessment and, usually, a hearing aid fitting. This isn't an appropriate model of care for residents in ACFs and leads to poor outcomes for clients. It is likely that many of the hearing aids fitted to these clients are lost or left in a drawer as it is often not the most effective way to address the hearing needs of this client group.

Based on research evidence (Looi et al 2004) the package of services for residents of aged care facilities needs to include:

- A broad range of assessment techniques that can be applied according to the client's abilities
- Consultation with facility staff and carers on the abilities and needs of the client
- Use of individual hearing and communication plans
- Use of assistive listening devices where indicated
- Use of hearing aids only in those circumstances where the client is experiencing hearing and communication difficulties, the need cannot be addressed appropriately through other means and the client is likely to cope with a hearing aid
- Advice to the aged care facility regarding possible changes to enhance communication in the environment eg visual displays, captioned TV, amplified telephones, acoustic shielding, changes to seating arrangements
- Education for staff, carers and family and friends that meets the needs of the target audience
- Identifying staff in the facility to co-ordinate services and support clients with their hearing care plans or setting up a volunteer program to support the service

- A means of evaluating outcomes eg qualitative reports from residents, staff, family, aged care facility management.

This model of care is currently provided to some extent under the Community Service Obligations component of the Hearing Services Program but it needs to be better funded and available to all residents, not just those who qualify for the Hearing Services Program.

The vulnerability of residents in ACFs was highlighted very starkly in the Aged Care Royal Commission report. The vulnerability of residents in ACFs is not related to the person's income level. Therefore, the hearing and communication needs of this entire group needs to be addressed through the Community Service Obligations Program not just those who meet the eligibility criteria for the HSP. There is precedence for this in that other vulnerable groups such as children with hearing loss and Aboriginal and Torres Strait Islander people aged over 50 years or those on Community Development Programs have been included in the eligibility criteria for the Community Service Obligations component of the Hearing Services Program without reference to income levels.

The interim report from the Aged Care Royal Commission shows that a significant level of investment that will be needed to improve the standard of care in ACFs. Directing some of this investment to addressing the hearing and communication needs of residents and upskilling ACF staff would improve the quality of life for residents and would assist staff to provide a better level of care. Delivering the program as a Community Service Obligations ensures services are delivered in the most cost-effective way. There are approximately 183,000 permanent residents living in ACFs and there are around 2,800 residential aged care facilities so it is a small, but highly vulnerable population whose hearing and communication needs are often neglected or poorly managed. Some of these clients are already eligible for and are receiving services under the Hearing Services Program but the resources may not be delivering the best outcome under current models of care. A model of care that is directed to the facility, the staff, as well as the individual has been shown to be more effective and could easily be provided under the Community Service Obligations Program. Residents would retain the right to continue to receive their hearing services through the Voucher Program if eligible, the NDIS if eligible, or as private clients if they wished to do so.

The Counsel Assisting the Royal Commission presented a series of recommendations to the Royal Commissioners which included:
Recommendation 18.1(b) - To ensure residential aged care includes a level of allied health care appropriate to each person's needs, the Australian Government and the Australian Aged Care Commission should, by no later than 1 July 2024 – require providers to enter into arrangements with each of the following professional groups to provide services as required to care recipients: optometrists; audiologists.

Currently this would involve multiple providers entering into arrangements to cover people requiring private audiology services, people who are eligible for the Voucher Program and people who are eligible for the CSO Program. The Hearing Services Program should take the

lead in addressing the recommendations from the Royal Commission in relation to the hearing needs of frail elderly residents in aged care facilities. Extending eligibility to the HSP for all frail elderly clients would streamline those arrangements and provide a more cost effective way of delivering the service with a model that will provide improved outcomes for clients.

The Roadmap for Hearing Health (Hearing Health Sector Committee, 2019, p. 15) has a key action to *"develop and implement a screening and intervention program for aged care".*

b) PEOPLE IN THE CRIMINAL JUSTICE SYSTEM

A study of auditory acuity using otoacoustic emission testing of 640 inmates from 26 correctional centres in NSW found prisoners had poor hearing than a normative Australian population sample (Murray, Le Page, Butler 2004). A study of Indigenous prisoners in Victoria found that 12% of prisoners had a hearing loss in at least one ear compared with 5% in an age matched Australian adult population. (Quinn, Rance 2009). One study at Darwin prison (Vanderpoll, Howard 2012) found 90 % of Indigenous prisoners had some degree of hearing loss.

The Australian Law Reform Commission report 'Pathways to Justice – Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples' 2018 p 65 states at para 2.41: "Hearing impairment among Aboriginal and Torres Strait Islanders is estimated to be extremely high---affecting between 80-95% of Aboriginal and Torres Strait Islander prisoners. This can result in communication difficulties when engaged with the criminal justice system, particularly when English is a second or third language".

The presence of hearing loss could impact on the person's ability to adequately hear in a courtroom, and could impact negatively on daily interactions in prison, and on the person's progress through a rehabilitation program.

As at 30 June 2020 there were 41,060 adult prisoners in Australia. Aboriginal and Torres Strait Islander prisoners accounted for over a quarter (29%) of the total Australian prisoner population. (Australian Bureau of Statistics 2020).

Australia's prison population is growing and it is ageing. Australia's prison population has grown by 47% over the past 10 years—from around 29,300 in 2009 to 43,000 in 2019. Over this period, the proportion of Australia's prison population who were aged 45 and over has increased—from 18% of the total prison population on 30 June 2009 to 22% at 30 June 2019. Prisoners aged 65 and over increased the most over the 10-year period to 2019, from 505 to 1,225 prisoners, up 143%. (Australian Institute of Health and Welfare 2018). The prevalence of hearing loss increases with age so there will be greater need for hearing services for adult prisoners.

A total of 5,694 young people aged 10 and over were under youth justice supervision on an average day in 2018–19 and 10,820 young people were supervised at some time during the year. More than 4 in 5 (84% or 4,767) young people under supervision on an average day were supervised in the community, and almost 1 in 5 (17% or 956) were in detention (some were supervised in both community and detention on the same day). Although only about 6% of young people aged 10–17 in Australia are Aboriginal or Torres Strait Islander, half (50%) of those under supervision on an average day in 2018–19 were Indigenous. Although most young people under supervision had come from cities and regional areas, those from geographically remote areas had the highest rates of supervision. On an average day in 2018–19, young people aged 10–17 who were from remote areas were 6 times as likely to be under supervision as those from major cities, while those from very remote areas were 9 times as likely. This reflects the higher proportions of Aboriginal and Torres Strait Islander people living in these areas. More than 1 in 3 young people (35%) under supervision on an average day in 2018–19 were from the lowest socioeconomic areas, compared with 6% from the highest socioeconomic areas. On average, Indigenous young people entered youth justice supervision at a younger age than non-Indigenous young people. About 2 in 5 (38%) Indigenous young people under supervision in 2018–19 were first supervised when aged 10–13, compared with about 1 in 7 (15%) non-Indigenous young people. (Australian Institute of Health and Welfare 2018–19)

While prison authorities have responsibility for the health and welfare of prisoners, there is limited understanding of the importance of screening for hearing loss, and the budget for health services is not usually sufficient to cover the cost of hearing devices. Several government inquiries have recommended action to address the hearing needs of prisoners yet no progress has been made. The Royal Commission into Aboriginal Deaths in Custody (1991) commented on the relationship between childhood ear disease, hearing loss and poor school performance, and their connection to involvement in the criminal justice system. The Senate Inquiry into Hearing Health in Australia (2010) noted the relationship between hearing loss, language impairment and criminal activity, and recommended that "hearing assessments be made available for people serving custodial sentences who have never been tested and that prisoners be encouraged to participate."

While in theory, the cost of providing hearing services to prisoners is a State responsibility, in practice it doesn't happen. Rather than continuing the argument as to who should pay, the Commonwealth needs to take action to provide a safety net by providing a targeted program to deliver the hearing services that are clearly needed but do not exist. The HSP is in an ideal position to address the hearing needs of this population. Access to appropriate hearing services would impact on the person's ability to engage in education and interact socially while in prison and is likely to help them engage with the community and with education and employment opportunities on release. It is important to address their hearing needs while they in prison as the chances of them accessing hearing services on release diminishes as they are unlikely to meet the criteria for free hearing services unless the eligibility for the HSP changes to include Health Care Card holders.

c) CHILDREN WHO ARE LONG TERM TEMPORARY RESIDENTS AND REFUGEES

Infants born in Australia to parents of temporary residents will have their hearing screened at birth but if they are found to have a hearing loss they cannot access the HSP for ongoing hearing services. Similarly, older children of people on working visas or student visas do not meet the eligibility criteria for the HSP. Those children with hearing loss should be able to have their hearing needs met so they do not fall behind with their speech and language development or with their education.

In Australia, rates of chronic suppurative otitis media (CSOM) and cholesteatoma in the adult refugee population are much higher than that documented in broader Australian population. Screening of newly arrived refugees and appropriate diagnosis and management is needed to minimise the burden of hearing loss. The presence of CSOM will make resettlement more challenging because of the resulting deafness and subsequent difficulty with language skills, socialising, education and employment. Learning English is a priority for all refugees and even mild hearing loss will impact on learning and correct pronunciation. (Benson & Mwanri, 2012).

Most people offered permanent settlement ultimately settle very successfully in Australia. However, on their arrival, refugees and asylum seekers may have:

- relatively poor health and complex health needs
- had limited or interrupted access to healthcare, particularly illness prevention and health promotion
- additional needs around access and care, due to language and cultural issues and stresses associated with resettlement, asylum and refugee experiences.

Addressing health issues at an early stage can help to promote health and wellbeing and optimise the chances of successful resettlement. Health and access to healthcare are also basic human rights.

New arrivals may be in relatively poor physical and mental health because of experiences of war, civil unrest and extended periods in refugee camps or countries of asylum. Many people will have been exposed to traumatic experiences, including torture. Refugees and asylum seekers may have had limited access to healthcare, and come from or through countries that struggle to meet basic healthcare needs. They may also have been ineligible for care in countries of asylum. Hearing health issues may be of particular concern to refugees and asylum seekers.

Refugees and asylum seekers face a range of disadvantages on arrival resulting from the interplay of language and cultural issues, the disruption associated with the refugee and resettlement experiences and adverse conditions in the community. Hearing health issues can compound these factors including:

- barriers to participation in employment and education
- limited connections with family and community
- stresses associated with adjusting to a new culture and country

- housing and financial insecurity
- social isolation and barriers associated with limited English
- varying access to Medicare and potential loss of direct access to Medicare if their bridging visa expires, as a result of administrative processing delays
- language barriers – 90 per cent of new entrants have no or very limited English (Department of Immigration and Border Protection 2014; Department of Health 2014)

Providing access to the HSP for refugees would allow their hearing needs to be met in the most cost effective way.

d) PROGRAMS FOR PEOPLE WITH TINNITUS

People with tinnitus may be offered a device to help relieve their tinnitus but the HSP does not fund tinnitus management programs except through some limited services offered under the CSO Program. People with severe tinnitus would benefit from additional support services from a clinician with expertise in tinnitus management to help them manage their tinnitus and this should be funded under the HSP.

e) TECHNOLOGY

The CSO Programs need to be appropriately funded so that it can provide not only the appropriate level of technology for the child's primary or secondary device but also fund accessories that improve listening and communication. Outcomes for children and young people in Australia are seen as leading the world as a result of our newborn hearing screening programs and early access to quality devices. If this gain is to be maintained, young people who are deaf or hard of hearing need to compete on a level playing field with their normal hearing peers in education and employment and need devices that will be compatible with changing mainstream technology (such as Bluetooth) at school and work. There is also evidence that accessing similar technology as their normal hearing peers has a positive benefit on building social capital and improving socio-emotional wellbeing. While some children can fund these devices through their NDIS plans not all children fitted with devices qualify for the NDIS.

f) HEARING ASSESSMENT SERVICES FOR CHILDREN UNDER 26 YEARS

While in theory children under the age of 26 years are able to access a hearing assessment under the CSO Program, in practice, policy decisions restrict access to children who have had a hearing assessment elsewhere and are known or at risk of having a hearing loss.

The difficulty is that there are few places to access hearing assessment services for children beyond the diagnostic services that are part of newborn hearing screening programs, particularly for children under 3 years and especially in rural and remote areas.

Newborn hearing screening will detect approximately half of the children who will be fitted with a hearing aid by the age of 5 years. Later onset hearing loss can occur due to accident or illness, progressive sensorineural hearing loss, mild or unilateral hearing loss that was either diagnosed at an early age, but which did not require assistance with hearing until school entry or not detected until school entry, and chronic conductive hearing loss due to otitis media. There are few services available where children can have the hearing assessed when parents have concerns about a later onset hearing loss.

Also, given the high rates of otitis media and associated hearing loss in Aboriginal and Torres Strait Islander children, it is critical that they be able to access a hearing assessment service that will lead to early identification and treatment services. If hearing issues can be addressed early in this population it is likely to lead to improved education and employment outcomes which can in turn reduce the likelihood of people entering the criminal justice system.

More funding is needed in the CSO Program to allow children to access the hearing assessment services they need and to provide a streamlined pathway between hearing screening provided in the community to a diagnostic assessment when there are concerns about a later onset hearing loss.

g) ELIGIBLE ADULTS WITH A COCHLEAR IMPLANT

Currently only children up to the age of 26 years are eligible to access a replacement or upgraded speech processor for their cochlear implant under the HSP. Adults who are eligible for the NDIS may have a new speech processor funded through that program. Adults with cochlear implants who are eligible for support through the Department of Veterans' Affairs can access to a replacement processor at no cost, but adults in receipt of an Age Pension cannot access a replacement speech processor under the HSP. It is difficult to understand why the Programs that are not means tested cover the cost of this high cost technology but the Program that is providing supports for adults on low income does not. This anomaly needs to be addressed and has been identified as an action item in the Roadmap for Hearing Health (Hearing Health Sector Committee, 2019, p. 17) "*Extend coverage of the HSP to include cochlear implant speech processors, including addressing the gap in support for people over 26 and particularly those over 65".*

3. How well does the Program interface with other schemes?

The streamlined referral pathway between the CSO Program, the NDIS and early childhood early intervention services for children aged 0-6 years is operating well and ensures that newborn babies, infants and young children diagnosed with hearing loss and their families are being supported appropriately with their hearing and communication needs. However, there is still a risk that children could fall through the gaps as there is no national database to track the child through the pathway from newborn hearing screening through to the

diagnostic assessment, referral to Hearing Australia, referral to the NDIS and referral to early intervention services.

Beyond that age group, 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.

Children and Young Adults

Some examples of the issues follow

a) There is inconsistency with the funding of technology to support children and young adults in their educational setting. Some of the technology is provided under the CSO Program and the family may be referred to the NDIS or education services for supplementary devices. Some NDIS planners are including goals that are education related in the participant's plan, whereas other participants are told that NDIS does not fund anything relating to education. There are differences with what is funded by State education services to support a child with a disability, and what is available through Catholic and independent school systems. The provision of equipment funded through state school systems may be linked to age rather than need which can be limiting for the individual. Some equipment might benefit the child at home as well as school so in these cases it is likely to fit within NDIS guidelines. Participants should not be left in a position where they are left without the technology support they need due to different interpretations of the funding arrangements for equipment used in educational settings. Care also needs to be taken to ensure that people are not accessing the same technology from multiple programs.

b) Some children with minimal or unilateral hearing loss are provided with a device. A recent consensus document on audiological management of unilateral hearing loss says "The Committee endorses consideration of these technologies in the context of the child's and family's needs and desires." However, some of these children would benefit more from educational support services than a device fitting. There can be issues in getting this type of support as in some cases the education support will only be provided to children with a device. Audiologists should not feel pressured to fit a device that is not clinically indicated in order for a child to access the educational support services they need. Families should also not feel pressured to fit a device in

this situation simply to access early educational support. The Joint Committee on Infant Hearing (JCIH) (AAP 2007) states that families of infants with any degree of bilateral or unilateral permanent hearing loss should be considered eligible for early intervention services and that services for infants with confirmed hearing loss should be provided by professionals who have expertise in hearing loss. Furthermore, the JCIH Supplement (AAP 2013) states that children identified with hearing loss of any degree, including those with unilateral or mild hearing loss, receive appropriate monitoring, and follow-up intervention services when appropriate. That is, early intervention is recommended but device fitting is on a case-by-case basis. (Bagatto et al 2019).

c) State and Territory governments are in theory responsible for providing hearing assessment services. In reality, few services exist especially for children under 3 years and particularly in rural and remote areas.

   Under the CSO Program children under 26 years of age are eligible for hearing assessment services. However, because of a policy restriction, it is only possible to access a free hearing assessment if the child has had their hearing assessed elsewhere and are known or at risk of having a hearing loss.

   This means that children who should have their hearing assessed are falling through the gaps leading to delays in getting the intervention services they need which may be medical or surgical treatment or a hearing rehabilitation program. This is particularly the case for Aboriginal and Torres Strait Islander children who have a high prevalence of ear disease and associated hearing loss but struggle to access the hearing assessment services they need.

d) Hearing Australia collaborates effectively with other programs in the delivery of the outreach program to Aboriginal and Torres Strait Islander clients to improve the timeliness of services. For example, in Queensland Hearing Australia works with the Deadly Ears Program to facilitate device fittings using teleaudiology.

Equity between programs

The NDIS makes it very clear that services and supports will be funded based on individual need. This can lead to people with similar conditions receiving very different funding levels. The risk is that the level of funding can be very dependent on the person's ability to advocate for their needs and the knowledge and training of the NDIS planner. We do not know whether this approach leads to equitable outcomes for NDIS participants. A study by the University of Melbourne into the NDIS from a service user perspective suggests that "insufficient attention is being paid to promoting equity of outcomes among service users with diverse needs and circumstances. Factors that are well-recognised in driving inequality – household income, education, residential location and household structure – remain

critical in filtering opportunities and capacities for service users and their carers to have choice and control in accessing services and resources under the NDIS". The study also found that "most of the participants accepted that the NDIS is a complex system. Many expressed concerns, however, that the views of people with disabilities, their families and carers were often overlooked in planning processes, that communication processes and messages in the NDIS were inconsistent, and that some people with disabilities were disadvantaged because they could not fully understand the system, its costs and its administrative requirements. Many described challenges accessing and understanding the huge volume of information surrounding the NDIS." (Warr, Dickinson, Olneyet. al. (2017)).

By contrast, the CSO Program attempts to ensure equity in the quality of services and technology available to its clients ensuring that no clients are left behind because they have not been in a position to advocate for their needs. This does not mean that everyone receives exactly the same services and devices. It is more about applying minimum standards and requirements that will lead to positive client outcomes while meeting the individual requirements of the client within the funding available.

The anomaly which sees the NDIS and the Department of Veterans' Affairs provide a replacement speech processor to an adult with a cochlear implant but this is not available to adults under the HSP has been highlighted earlier in the document.

4. Does the Program sufficiently support hearing loss prevention?

The support the Program has given to hearing loss prevention research has been useful to a point but no practical action seems to come from the research findings. The Program could make a greater contribution by developing a national strategy on hearing loss prevention and then funding the implementation of the strategy.

The strategy needs to address

- Immunisation
- Early identification and intervention across the lifespan
- Prevention of otitis media in Aboriginal and Torres Strait Islander children
- Noise in the workplace
- Leisure noise

The national strategy on hearing loss prevention should be a component of the National Preventative Health Strategy that is currently under development.

The strategy needs to be evidence based and requires leadership, commitment and funding to make it happen. There also needs to be measures in place to assess the effectiveness of the strategy. The Hearing Services Program is in an ideal position to provide the leadership by setting up an alliance of interest parties to progress the national strategy when it is developed.

Hearing loss prevention will be a major focus of the World Report on Hearing being launched by the World Health Organisations in March 2021 so it is timely for Australia to develop its own strategy and action plan.

Delivering hearing loss prevention campaigns has been identified as a priority in the Roadmap for Hearing Health (Hearing Health Sector Committee, 2019) and received funding in the 2020-21 Federal Budget. A key action in the Roadmap is to "*develop and implement a prevention focused campaign, using effective evidence-based strategies, that provide education on the importance of hearing health, including the potential impact of recreational and occupational noise, and knowledge of the potential impact of unaddressed ear infections, that is both broad-ranging and targeted at vulnerable populations using various formats*" (Hearing Health Sector Committee, 2019, p. 13).

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

VOUCHER PROGRAM

Clinicians are trained to deliver a broad range of services within a client's rehabilitation program. However, because of the way the fees are structured there is an over reliance on device fitting within a client's program. 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.

The Rehab Plus item is only available to clients who are fitted with a fully subsidised device for the first time and can only be claimed once per client. This item should be available to all clients including those with partially subsidised devices. It should be available for as many appointments as the client requires as it is likely to improve hearing aid usage and lead to better outcomes for the client.

The use of the Minimum Hearing Loss Threshold criteria to determine who can access a hearing device is not consistent with international practice. The fitting of a device and other hearing services should be based on the level of the client's functional impairment rather than a hearing threshold level. The HSP uses practitioners who are members of a professional organisation and are bound by a Code of Conduct. These clinicians should be trusted to use their clinical judgement to deliver appropriate services in consultation with their client. It should not be necessary to use this type of gateway for the provision of devices.

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

VOUCHER PROGRAM

Consumers need more information about the options available within a rehabilitation program. Many consumers assume that if they apply to have their hearing assessed then this will automatically lead to a device fitting. There are also a large number of consumers who believe that all of their hearing issues will be resolved with a device fitting. They are disappointed when this does not occur and some people abandon their devices because the device has not met the client's expectations. Consumers need to have a better understanding of the process and the options available to them. Consumer organisations could play an important role in that process e.g. in educating consumers on what is best practice in this area and the options available and the advantages and limitations of devices.

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. The different brands may have similar features but because they use different terminology to describe them 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. The HSP has some written information available on its website partially subsidised devices but this is not sufficient from a consumer perspective. 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. This arrangement would require funding on an ongoing basis.

From 1947 to 1992 Hearing Australia was the sole provider of services to all clients eligible under the Hearing Services Program so at that time there was no choice of provider. In 1993, when eligibility for the Program was extended to part pensioners, Hearing Australia contracted private providers to deliver services to adults with non complex needs while also continuing to provide services to children and adults. Based on the recommendations from a review by the Centre for International Economics into the efficiency and effectiveness of the Hearing Services Program in 1995 these arrangements changed in 1997 when the Voucher Program was introduced. The Voucher Program was set up so that Hearing Australia would no longer be both the purchaser/regulator and provider of hearing services. The Scheme was also to provide more choice and control for adults with non complex hearing needs by creating a competitive environment with a market ranging from large multinational vertically integrated companies to small single person businesses. Hearing Australia remained as the sole provider of services to clients under the Community Service Obligations Program as it was deemed that the Voucher Program could not meet the needs of these client groups. The Consultation Paper highlights the competition that is created by Hearing Australia having sites in regional areas. Hearing Australia would not be the only large provider that would compete with small private providers in regional and rural areas however it is often the only provider that delivers services to areas that are not profitable. 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. It is interesting to note that under the NDIS which was to offer choice and control, the number of active providers appears to be reducing over time. According to the COAG Disability Reform Council Quarterly Report the number of active providers in September 2019 was 13,434 and in September 2020 it was 9,150. This may be because of business mergers or providers may be dropping out due to the administrative burden and fee structure under the NDIS.

CSO PROGRAM

The CSO Program could be used to address the needs of vulnerable groups and those requiring specialised program who are not currently recognised in the eligibility criteria including all residents in aged care facilities and people in prison.

Additional funding should be made available to allow Hearing Australia to provide initial assessment appointments to children without the need to have their hearing assessed elsewhere in the first instance. This is particularly important for Aboriginal and Torres Strait Islander children who prefer to access services in a more culturally appropriate way in an environment where they feel safe, and children living in areas where there are no other services available due to the child's age or geographical location.

Hearing Australia should remain as the sole provider of services to children with hearing loss. Parent groups have been advocating for this position through the

- Investigation into the potential sale of Australian Hearing [redacted]
- NDIS Inquiries
- Senate Inquiry – Still waiting to be heard (2017)
- Ministers for Health and Social Services
- NDIS transition consultations when it was proposed that hearing services for children would be delivered through NDIS funding and become competitive

Families have previously been consulted on the issue. The results indicated that while parents understand the potential benefit of having a choice of provider, they believe it is far more important to preserve the existing benefits available through having the Government Provider as the sole provider of services to children and their families. Issues relating to expertise, unbiased information and advice, and trust were more valued by families than having a choice of provider. Families believe this will ensure the best outcome for their child. There is also concern that families who are very vulnerable at the time their child is diagnosed with hearing loss and know very little about hearing impairment are not in a position to make an informed choice about different providers. The current arrangements

provide a safety net for children and their families to ensure that the child's outcomes are not compromised.

Families are aware that their children benefit from the expertise and buying power of Hearing Australia in relation to devices. CSO clients, particularly children, often need very specific products to meet their needs. It takes time and expertise to: a) determine the specifications of the devices that will best meet the specific needs of the client, including issues relating to device features, safety, robustness, and functioning in areas of high humidity; b) source the product; c) assess its suitability; and d) negotiate the best price. CSO clients are aware that the purchasing power of Hearing Australia provides them with access to high level technology and access to improvements in technology when they become available (within the limits of the funding budget).

Families have confidence that their Hearing Australia audiologist will be appropriately skilled as they receive the training they need and see the volume of cases necessary to retain their skill. Once a professional has attained a certain skill, they need to apply these skills in the clinic on a regular basis in order to maintain their level of competency. This can be difficult to achieve in a small market such as the population of children with hearing loss. In 2019 there were 3,225 children under 26 years fitted with devices for the first time in Australia. Breaking this down further, there are approximately 400 infants under 12 months of age fitted for the first time (Hearing Australia, 2019). If these client groups were to receive services from a large number of practitioners, it would be difficult for the practitioner to maintain their skill level if they were to only see a small number of children each year or every few years. There is research evidence from the USA (McCreery, Bentler and Roush (2013)) that demonstrates that a significant number of hearing impaired children were not fitted optimally when they were seen by a clinician who did not see children regularly. Due to the small population of children with hearing loss, it is recommended that Hearing Australia remain as the sole provider of services to infants and children. Even as a single provider Hearing Australia had to nominate particular centres to manage referrals from newborn hearing screening programs in order to maintain expertise with a small number of clients.

Note: Hearing Matters Australia abstained from the discussion on the topic of paediatric services citing a lack of expertise in the demographic and its focus is on adult populations.

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

TELEHEALTH

Consumers are open to the use of more services being provided via telehealth options but this should not happen until there are standards in place regarding expertise, software and hardware capability. Telehealth is likely to improve access to professional support but the

option of face to face appointments still needs to be available. Ida Institute research found that consumers prefer a blended model of in-person and tele-health.

DEVICES

The minimum specifications in the Deed of Standing Offer for the Voucher Program need to keep pace with improvements in technology so that clients can be assured that they will always receive good quality devices that will meet their needs without the requirement for a co-payment to subsidise higher level technology.

Accessories that can be used with the person's primary device to improve connectivity to other devices such mobile phones etc should be provided under the Program.

The HSP should provide a broader range of technology beyond hearing aids that assist with hearing and communication particularly for residents in aged care facilities.

The Program should not subsidise devices that are bought online without the involvement of a clinician in the process. Clients are at risk of purchasing devices that are not appropriate which would mean they would not use them. Clients need information on the risks associated with online purchases.

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

The HSP could do more to support people on low income and those in residential aged care by giving them access to the Program. The Voucher Program could improve access to people from CALD backgrounds by covering the cost of interpreter services and providing information in other languages. (The cost of interpreters is covered under the CSO Program.) Clients need to be made aware that they have a right to an interpreter.

Providers would be more likely to provide services in a person's home where the person is unable to travel due to illness or frailty, or in rural areas if there was a loading paid which would then make the service more accessible. In the NDIS different fees apply based on the area where the person lives.

The CSO Program will always have an important role in providing a safety net with the government provider delivering services to those groups that require specialised programs or are highly vulnerable or where the services are too costly to deliver for other providers.

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

The removal of the requirement to have a GP approve the application to enter the Voucher Program has streamlined the application process making it more accessible for consumers.

The CSO Program is structured in such a way so that Hearing Australia assumes all of the responsibility for compliance with the administrative arrangements of the Program which reduces the burden on the client. The impact on the client is minimal. This is important as it

removes a potential barrier to people accessing the services they need particularly vulnerable groups.

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

The Program does not have sufficient data on the outcomes of the Program to inform decision making. Most of the data collected under the Voucher Program does not indicate whether the Program has met its objectives. The data that is published is mostly related to outputs eg Vouchers issued, devices fitted. There needs to be more information on the outcomes for those who use the Program and also more about the profile of clients who are using the program to see if there are client groups eg CALD clients or clients from particular areas who are not accessing services. Publishing this data and making de-identified data available to other research programs could be useful for research into issues such as hearing loss and dementia.

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

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

This was identified as a key action in the Roadmap for Hearing Health *"Enhance national data collection from the UNHS program and departments of education for longitudinal tracking and analysis" (*Hearing Health Sector Committee, *2019, p. 15).*

There needs to be more information published on the outcomes for children, including longer term outcomes such as level of educational attainment and employment. In order to effectively measure outcomes information needs to come from a range of sources including Health, Education and the NDIS. As Hearing Australia holds the baseline data on children fitted with devices it would be appropriate for it to collect a broader range of information and for its research arm the National Acoustic Laboratories (NAL) to analyse and publish the data. NAL could also be tasked with analysing and publishing deidentified outcomes data for the Voucher Program as well given its expertise in this area. The Australian Institute of Health and Welfare could also have a role in reporting on the outcomes of the Program for the various client groups. It already reports on hearing health outreach services for Aboriginal and Torres Strait Islander children in the Northern Territory.

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