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Hearing Care Industry Association Submission

Hearing Services Program Review

11th December 2020

HCIA members vision is that hearing healthcare is accessible to everyone irrespective of where they live, their age or hearing care need.

HCIA members include Audika Australia, Bay Audio, National Hearing Care, Neurosensory, Sonova, Starkey Hearing Technologies and WS Audiology

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1. CONTEXT AND BACKGROUND

The Hearing Care Industry Association (HCIA) welcomes the opportunity to provide this submission in response to the Hearing Services Program (HSP) Review Consultation.

The HCIA strongly supports the initiative taken by the Hon Mark Coulton, Minister for Regional Health, Regional Communications and Local Government to initiate this review. For too long the HSP and HSP eligible Australians have been neglected. Hearing loss is an invisible and ironically silent health priority in Australia baring enormous social and economic cost.

In developing our response, the HCIA has enlisted subject matter expertise from each of our member businesses. We have focussed our response on constructively addressing the questions posed by the panel.

This has been approached in the context of a review focussed on the clinical needs and experiences of consumers, contemporary service delivery and eligibility criteria.

We have also considered that this review is taking place against the backdrop of an Australian context that is strongly influenced by the following important 'macro' factors:

a. Australia's increasingly diverse and ageing population, with longer life expectancy.

b. An increasing understanding of the correlation and risk modification relationship between hearing loss and impactful chronic health issues. The likelihood that early intervention for hearing loss may be protective in reducing the rate of cognitive decline is particularly relevant to how hearing services of the future are designed and funded.

c. Continually evolving advances in technology and service delivery, along with ongoing significant device-related innovation.

The HCIA strongly recommends drawing upon the experiences of their sector, their members global terms of reference and their daily front line experience with those to whom the program seeks to help and support.

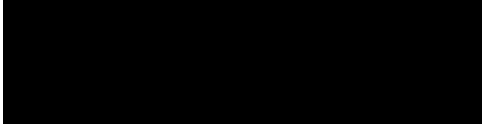
To that end HCIA recognises the significant opportunity this current review process presents to develop further and timely improvements and enhancements to the HSP - ensuring that the program is fit for purpose, improves access and consumer outcomes without adding unnecessary or costly regularity burden or through unintended consequence, diminishes what is already for those who are eligible, a responsive and agile health program.

We acknowledge the interim paper which was released by the HSP Review Panel on 4th December 2020. This interim paper has not been fully considered in our response, due to limited timing, however the HCIA is committing to continue to engage with the review panel over the coming months, working collaboratively and iteratively, to develop a stronger HSP for consumers, government and providers.

HCIA members wish to assure the panel that all our feedback is in good faith and with the primary objective of supporting the HSP in adopting and transforming its services to offer the best possible solution to those that need it.

We look forward to being a critical member of your stakeholder group and stand ready to support and contribute along with other members of the sector.

Executive Approval of this submission:



Ashley Wilson AM
Chair

Key Contact relating to this submission:

Part A:

2. ABOUT THE RESPONDENTS:

2.1 THE HCIA'S EXPERIENCE IN MANAGING AND DELIVERING HEARING CARE IN AUSTRALIA

The HCIA is the peak industry body representing hearing healthcare providers who deliver more than 70 per cent of the hearing services in Australia. For more than two decades HCIA has been a key partner of the health system in the provision and access to hearing health care. Our members connect with more than 50,000 consumers a month designing and delivering an end-to-end personalized care plan.

Our members are able to deliver this front-line care through their unparalleled geographic network reach. Offering consumers access to almost 700 hearing clinics plus enabling the same number of visiting clinics in GP rooms, pharmacies and allied health settings.

Our members daily efforts to those that are eligible is underpinned by the Hearing Services Administration Act 1997 which has experienced continued support under subsequent Governments. It is without comparison a world class system of hearing health care that others learn from and seek to emulate.

HCIA members are very proud to be a key partner in such a globally leading program.

HCIA members have a wealth of experience managing and supporting consumers (and their families) through no fault of their own find themselves with a life changing deficit. We would like to take this opportunity to share this experience with you – as it frames the context of our response to this consultation.

2.2 A CONSUMER'S EXPERIENCE

One consumers experience is never the same as another and managing hearing loss is not a method of averages but rather a management of exceptions. Hearing loss once experienced becomes a lifelong condition that does not get better but rather begins a journey of staged deterioration, constant review and ongoing management.

A consumer that has hearing loss – whether accepted and acted upon begins to navigate their life by a daily assessment of "am I able to function and engage with my key relationships", "do I feel safe and confident in my home", "do I feel capable and secure to connect and interact with activities and services outside my home environment".

Access and flexibility of care is critical to a consumer when faced with such an individual experience – care does not fit into a monthly cycle or even an annual calendar – instead it needs to fit into when a consumer (or their family) has a need for care and has the mindset to seek that care and actively engage in it.

Other health conditions are often obvious, present with pain or visible impairment – they can be treated and managed often in a finite process of interventions and rehabilitation – hearing loss is the silent and invisible exception.

HCIA members face these consumers every day and help them accept and navigate a pathway forward – we have many case studies that evidence the credible parts of the system but equally our members are aware of the consumers that fall between the gaps due to age, social stigma, financial hardship or geographic location.

It is equally important to accept that "the device" is not the cure but merely the enabler to a consumer's personalised plan of care – some consumers may need little rehabilitation and support whilst others need extensive time and ongoing interactions with their chosen provider to optimise their hearing health outcome. It is imperative that the consumer experience and pathway to hearing health benefit from this review and its intent to deliver consumer focused services and support.

3. The HCIA Key Recommendations for HSP Reform

Our members aim to deliver a detailed, constructive and evidence-based response to all the questions posed by the panel in this initial consultation. In that context and through the lens of the consumer following is a summary of our key recommendations for consideration.

3.1 PROGRAM OBJECTIVES AND SCOPE

RECOMMENDATION A:

The Government has an obligation to provide support to all Australians adversely affected by hearing loss and therefore the Government's objective should be **'to improve ALL hearing health in Australia'**.

RECOMMENDATION B:

The objectives and scope of the Government's flagship hearing-related program will have optimum relevance and impact if there is greater 'whole of Government' consistency across the different hearing health programs.

RECOMMENDATION C:

The overall management of the hearing health of all Australians should reside within the HSP.

RECOMMENDATION D:

The current HSP scope is narrow. Consistent with the broader objective of improving ALL hearing health in Australia, program access and subsequent eligibility criteria should be updated so that the **Program does not unnecessarily exclude certain categories of vulnerable people** who are at risk of being disadvantaged due to hearing loss.

3.2 CONSUMER JOURNEY ANALYSIS

RECOMMENDATION E:

The HCIA recommends the review invest in **consumer mapping analysis**, with full sector participation, identifying the different hearing health programs including the various eligibility and support services.

The HCIA members have rich consumer data and are extremely willing to participate and contribute to this analysis in order to design a program simplicity which enhances efficiency, accessibility and consumer outcomes, especially when a consumer may be eligible for more than one program.

The HCIA recommends that the insights from this analysis should form the basis for any future program enhancements and reforms including the development of program objectives and critical areas of data collection.

3.3 ACCESSING HEARING HEALTH CARE

RECOMMENDATION F:

The HCIA recommends that the HSP eligibility criteria and service design be changed to enable the following categories of people to access HSP services:

- residents of aged care homes or receiving in-home care
- Disadvantaged people from Culturally and Linguistically Diverse (CALD) backgrounds
- People in prison
- People experiencing homelessness; and
- Financially vulnerable and low-income earners (aged 26 - 64).

RECOMMENDATION G:

The HCIA recommends that the NDIS will be immediately improved with the following:

1. The creation of an online portal for consumers to access pre-approved services showing all relevant information, rather than via a planner, so that any barriers to hearing health care are minimised.

2. The adoption of the same clinical criteria as the HSP. The current clinical criteria for rehabilitation in the HSP provide proven comorbidity health benefit and compares very favourably to programs provided in other countries.

These two improvements will provide improved access and greater consistency of information between the HSP and NDIS for consumers.

3.4 PREVENTION OF HEARING LOSS AND PREVENTION OF THE IMPACTS OF UNMANAGED HEARING LOSS

RECOMMENDATION H:

The HCIA recommends that the HSP should focus on both the prevention of noise induced hearing loss and **also the compounding effects of hearing loss** for those who have already been diagnosed.

RECOMMENDATION I:

The HCIA recommends that **a standard screening protocol be developed for those >55 or 60 years**, and that this be communicated to primary healthcare providers.

RECOMMENDATION J:

The HCIA recommends that the **hearing assessments should be made available every year** to prevent downstream heath and societal impacts due to undiagnosed hearing loss.

3.5 HSP SERVICE LEVEL IMPROVEMENTS

RECOMMENDATION K:

The HCIA agree and endorses the Hearing Services Voucher being extended from 3 years to 5 years as this reduces the administration burden and red tape associated with reapplying for a new voucher at the current 3-year interval, however this endorsement is contingent on there being no detrimental impact to the HSP consumer in reduced services or to avail non-device wearers from ongoing hearing assessments.

A HSP eligible consumer with a 5-year voucher should receive funded devices and services for the full 5 years including annual reviews/assessments and the ability to receive new devices within the 5

years if they meet the refitting criteria. For HSP eligible customers that do not meet the 3FAHL for device fittings should receive funded annual hearing assessment so that their hearing health can be monitored and when appropriate early intervention is accessed.

RECOMMENDATION L:

The HCIA recommends that **consumers must not be disadvantaged under the proposed maintenance arrangements** in the first year after fitting. Device warranties do not provide for consumables and batteries. Consumers need to be able to keep their devices in good working order and will require maintenance outside of warranty conditions to achieve this outcome. The current maintenance system enables this to be achieved for consumers, therefore HCIA recommends that the current maintenance system is retained to avoid unintended consequences of any proposed changes that will bear out of pocket expenses for consumers.

RECOMMENDATION M:

The HCIA recommends that it is essential that the provision of **audiology programming services remain integrally linked to supply** of the hearing aid device to maintain clinical benefits to consumers.

RECOMMENDATION N:

The HCIA **support the continued adoption of telehealth** for those consumers for whom it is suitable as it has increased the range of options available to provide hearing health services to consumers.

3.6 CONSUMER CHOICE

RECOMMENDATION O:

HCIA members recommend that to maintain consumer's ability to make informed choices regarding their rehabilitation device/s, the current arrangements, which include their provider assisting them, should remain. It is recommended that the quote framework and associated paperwork for efficiency and timeliness only be applied to the devices which are to be fitted to the consumer.

RECOMMENDATION P:

The HCIA recommends that consumer choice of their hearing healthcare provider is paramount to the tenet of the HSP. Adults with more complex needs should not be disadvantaged, and therefore a **"Complex Consumer" category should be created** that is accessible to all accredited HSP providers.

3.7 THE ROLE OF THE GOVERNMENT PROVIDER

RECOMMENDATION Q:

The HCIA recommends that the CSO would provide greater consumer benefit to those that need it and meet the objective of the nature of a CSO if Hearing Australia are mandated to focus its extensive government funded resources into servicing CSO thin markets, especially indigenous hearing health, rather than concentrating in non – complex adult consumer. segments in urban and major regional areas which are already well serviced by HSP providers. Further, more effort should be placed on advertising the CSO program to consumers to expand its reach and impact to those it has been designed to service.

3.8 COLLABORATION WITH GOVERNMENT

RECOMMENDATION R:

The Department of Health (DoH) and its staff should be recognised for their agility in making changes to the HSP during COVID-19 to ensure consumer access and support. The HCIA supports recent

improvements to reduce administrative burden in the program and encourages further streamlining and simplification by the **establishment of an *industry consultative committee*** to work with government and the HSP to identify consumer outcome opportunities, program efficiencies and improvements as well as improving stakeholder consultation.

RECOMMENDATION S:

The HCIA recommends **sector consultation and early notification** of any proposed HSP changes are the two most critical factors to be considered in planning future program delivery changes. HCIA welcomes working with government to create and execute a HSP which delivers consumer, government and provider outcomes.

Part B: HCIA's Responses to the Discussion Issues

Question 1: What should be the objectives and scope of the Program?

Is there a need for clearer objectives for the Program?
In your view what should be included in any set of objectives?

1.1 Yes, the members of the HCIA support efforts to provide clearer and broader objectives for the HSP. It is important that the Program objectives be updated to recognise the significant impact of Australia's changing demographics, the relationship between hearing health and broader individual health and long-term wellbeing, and the impact of technological change and product innovation.

To that end, the Government has an obligation to provide support to all Australians adversely affected by hearing loss and therefore the Government's objective should be '*to improve all hearing health in Australia*'.

This is a broader concept than the currently narrow scope of the HSP relative to national need. The limited eligibility criteria for the assessment and rehabilitation support provided by the HSP does not meet the unmet consumer demand.

1.2 The following concepts of care and service are offered for consideration as partial updates to the objectives and scope of the Program:

a. Supporting the health, wellbeing and productivity of Australians who are (or are likely to be) impacted by hearing loss, through provision of high quality, person to person and family-centred hearing services.

b. Increasing awareness and education on the burden and impact of hearing loss in Australia if not acted upon through prevention and early intervention.

c. Cultivating a societal awareness that recognises and places a high value on hearing wellness.

d. Providing a sustainable framework of service provision delivering accessibility, flexibility, equity, consumer choice, early intervention, and prioritising rehabilitative outcomes.

1.3 Furthermore, the portfolio for general hearing health of Australians has never benefited from having a stable "home" within the bureaucracy. This should be captured in the HSP objectives – hearing health needs to find ownership through this program.

1.4 Importantly, we recommend that a program objective should capture the importance of consistency across the whole of Government to ensure that the scope of the Government's flagship hearing-related program will have optimum relevance and impact. Relevant examples of areas requiring further focus are:

a. Reforms to support services provided to in-home and residential aged care residents following the ongoing Royal Commission into Aged Care Quality and Safety (RCACQS).

b. The International Federation of Ageing (IFA), has recently developed its action plan for a '*Decade of Healthy Ageing 2020-30'* in support of the WHO's *Global Strategy on Ageing*

and Health. This strategy was endorsed by the 73rd World Health Assembly and in this strategy the IFA has stated[1]:

"*If people can experience these extra years of life in good health and if they live in a supportive environment, their ability to do the things they value will be little different from that of a younger person. If these added years are dominated by declines in physical and mental capacity, the implications for older people and for society are more negative."*

and

"Problems that matter for older people, such as pressure ulcers, chronic pain and difficulties with hearing, … are often overlooked by health professionals. In primary health care, the clinical focus still generally remains on detection and treatment of diseases; because these problems are not framed as diseases, health care providers may not be aware how to deal with them, and frequently lack guidance or training in recognizing and managing impairments and geriatric syndromes. This leads to older people disengaging from services, not adhering to treatment or not admitting themselves to primary health care clinics, based on the belief that there is no treatment available for their problems. …. New approaches and clinical intervention models need to be introduced at primary health care level, if the aim is to prevent care dependence and maintain intrinsic capacity."

Recommendation E

The HCIA recommends the review invest in ***consumer mapping analysis****, with full sector participation, identifying the different hearing health programs including the various eligibility and support services.*

The HCIA members have rich consumer data and are extremely willing to participate and contribute to this analysis in order to design a program simplicity which enhances efficiency, accessibility and consumer outcomes, especially when a consumer may be eligible for more than one program.

The HCIA recommends that the insights from this analysis should form the basis for any future program enhancements and reforms including the development of program objectives and critical areas of data collection.

Recommendation A

The Government has an obligation to provide support to all Australians adversely affected by hearing loss and therefore the Government's objective should be 'to improve ALL hearing health in Australia'.

Recommendation B

The objectives and scope of the Government's flagship hearing-related program will have optimum relevance and impact if there is greater 'whole of Government' consistency across the different hearing health programs.

Recommendation C

The overall management of the hearing health of all Australians should reside within the HSP.

[1] *Decade of Healthy Ageing 2020 – 2030*, Policy Document, IFA, p. 2 - 3

Recommendation D

The current HSP scope is narrow. Consistent with the broader objective of improving ALL hearing health in Australia, program access and subsequent eligibility criteria should be updated so that the Program does not unnecessarily exclude certain categories of vulnerable people who are at risk of being disadvantaged due to hearing loss.

Question 2: Which consumers should be eligible for Program subsidies?

What changes, if any, should be made to the categories of people who can access taxpayer funded hearing services and what are the likely overall benefits from broader access?

What changes, if any, should be made to the types of services that are offered under the Program and what would be the overall benefits?

2.1 Any Australian who is suffering life changing hearing loss and does not have sufficient private means to comprehensively access private care and management for that hearing loss should be eligible for Government assistance.

2.2 In that context consideration needs to be given to the best mechanism to increase the range of people eligible for hearing loss support in Australia, particularly those in the 26 – 64 age group. Notionally, we recognise that the two key options for the Government to consider in relation to adjusting eligibility criteria are to:

a. extend the HSP eligibility criteria; or

b. align the current clinical criteria for NDIS eligibility to make it consistent with the HSP clinical eligibility criteria. The NDIS criteria are currently different to the HSP voucher program and the 'Complex Adult criteria' in the HSP CSO program. We recommend the hearing loss threshold for NDIS funding should be re-aligned to the HSP Minimum Hearing Loss Threshold (MHLT).

2.3 HCIA's members believe that there should not be any discrimination in relation to clinical criteria for hearing ability between NDIS and HSP as the current inconsistency of clinical criteria has no logical basis.

2.4 Consumer access to hearing care needs to be simplified by the adoption of seamless and consistent assessment criteria, operating models and funding decisions between HSP and NDIS. HCIA strongly recommends that is a matter of priority for the review.

2.5 HCIA members fully support a broadening of HSP eligibility categories to include *vulnerable Australians who are at risk of long-term disadvantage due to hearing loss*. This includes people suffering hearing loss who are also:

a. residents of aged care homes or receiving in-home care;

b. Disadvantaged people from Culturally and Linguistically Diverse (CALD) backgrounds;

c. People in prison;

d. People experiencing homelessness; and

e. Financially vulnerable and low-income earners (aged 26 – 64).

2.6 Older Australians, whether they are residents of aged care homes or receiving in-home care, are an important category and require greater support from the HSP. Residents in aged care or in-home care with hearing loss have special and complex needs and comorbidities. Frequently, they cannot readily travel to another location for hearing care services and they require greater levels of support from the HSP than is currently offered.

2.7 There remains no program provision for the operational impact on providers who could be providing visiting services to those older Australians as there is no HSP funding for a domiciliary service. This has meant that for many years, those who are too frail or unwell to travel are dependent on hearing health services provided on a partly charitable basis at the discretion of providers. These visits can often involve up to one hour of unpaid return travel time per visit. Although home visit travel time can now be charged to consumers as a private service, this option financially impacts a consumer who in most cases can ill afford more out of pocket expenses and who should in fact be a priority for funded care and intervention.

2.8 In addition, in order to provide consumer and family-centred care to this group, carer involvement, device management and communication training are critical to outcomes that impact their health and social engagement. The provision of such services is often difficult to achieve in busy aged care facilities where carers are often not available at the time of the visit. Improvements should include the provision of hearing services that are designed for this population.

2.9 Almost all Australians of working age with hearing loss are currently ineligible for hearing health care under the HSP and most do not meet elevated NDIS eligibility criteria. For low income working age people, hearing loss leads to premature welfare dependency, a greater number of sick days from work and diminished capacity to work productively due to impaired ability and psychological stress and diminishing confidence. This situation perpetuates a low-income future and reduced quality of life. Their futures can be significantly improved with better hearing.

2.10 Extending HSP eligibility criteria to cover a further 13,523 financially vulnerable Australians aged 26-64 years would cost the Government $25.3 million annually but will create $311.7 million in productivity gains, essentially through increased employment.[2]

2.11 The correlation and risk modification relationship between hearing loss and chronic health issues is well established. HCIA supports updates to the HSP eligibility criteria to ensure earlier intervention and a 'whole of government' approach to HSP investment. The WHO has assessed the financial impacts associated with increased medical costs[3] and has concluded that: "*screening programs and early intervention of hearing loss through screening of newborns, school children, and adults over 50 years of age is found to be cost-effective."* Based on the available evidence and analysis, the WHO report made the following conclusions and recommendations:

- *"This initial analysis shows that unaddressed hearing loss poses substantial costs to the health-care system and to the economy as a whole.*
- *Current estimates show that most global healthcare and education costs linked to hearing loss are incurred in low- and middle-income countries.*
- *Public health interventions for prevention and early identification of hearing loss are cost-effective.*

[2] Hearing Care Industry Association, Report prepared with assistance from Deloitte Access Economics, Canberra, *Hearing for Life – The Value of Hearing Services for Vulnerable Australians,* March 2020, p. 28.
[3] *Global costs of unaddressed hearing loss and cost effectiveness of interventions*, WHO, p. 42

- *Provision of hearing devices is a cost-effective strategy, especially when used regularly and supported with rehabilitation services.*
- *Hearing loss must be addressed as a public health issue."*

2.12 The adoption of hearing aids in mid-life is the single biggest risk modifier for early onset dementia[4]. In 2017 the Lancet Commission Report (prepared by 24 international experts on dementia) identified untreated hearing loss in mid-life as not only one of nine modifiable risk factors for the disease, but the single most effective risk modifier. Dementia Australia reports that a five per cent reduction in the number of people with dementia over the age of 65 could lead to savings of $5.7 billion from 2016-25, and $120.4 billion by 2056. Dementia care currently costs Australia $14bn a year.

2.13 HCIA also recommends changes to the HSP eligibility criteria in the following areas:

a. Early Audiology Assessments: there is a need to strengthen the breadth of rehabilitative services and early intervention aspects of the Program and HCIA' recommends inclusion of audiology assessments as a routine allied health referral when preparing Enhanced Primary Care Plans, where relevant co-morbidities exist.

b. GP Awareness of Hearing co-morbidities: HCIA recommends the extension of HSP funding to promote GP awareness regarding hearing related co-morbidities (cardio-vascular disease, cognitive impairment, diabetes, depression, falls, social isolation).

e. CALD Services: current language access to the program is not equitable for this population, and family or phone-based interpreting is not ideal for these consumers due to their hearing status. Funding for video or in-person interpreter services should be available for people unable to communicate their needs and to fully interact with providers to allow informed decision-making.

Recommendation E

The HCIA recommends the review invest in ***consumer mapping analysis****, with full sector participation, identifying the different hearing health programs including the various eligibility and support services.*

The HCIA members have rich consumer data and are extremely willing to participate and contribute to this analysis in order to design a program simplicity which enhances efficiency, accessibility and consumer outcomes, especially when a consumer may be eligible for more than one program.

The HCIA recommends that the insights from this analysis should form the basis for any future program enhancements and reforms including the development of program objectives and critical areas of data collection.

Recommendation *A*

The Government has an obligation to provide support to all Australians adversely affected by hearing loss and therefore the Government's objective should be 'to improve ALL hearing health in Australia'.

Recommendation D

The current HSP scope is narrow. Consistent with the broader objective of improving ALL hearing health in Australia, program access and subsequent eligibility criteria should be updated so that the Program does not unnecessarily exclude certain categories of vulnerable people who are at risk of being disadvantaged due to hearing loss.

[4] *Dementia prevention, intervention and care*, The Lancet Commissions, The Lancet, Vol 390, 16 December 2017, p. 2673

Recommendation F

The HCIA recommends that the HSP eligibility criteria and service design be changed to enable the following categories of people to access HSP services:

- *residents of aged care homes or receiving in-home care*
- *Disadvantaged people from Culturally and Linguistically Diverse (CALD) backgrounds*
- *People in prison*
- *People experiencing homelessness; and*
- *Financially vulnerable and low-income earners (aged 26 - 64).*

Recommendation G

The HCIA recommends that the NDIS will be immediately improved with the following:

1. *The creation of an online portal for consumers to access pre-approved services showing all relevant information, rather than via a planner, so that any barriers to hearing health care are minimised.*

2. *The adoption of the same clinical criteria as the HSP. The current clinical criteria for rehabilitation in the HSP provide proven comorbidity health benefit and compares very favourably to programs provided in other countries.*

These two improvements will provide improved access and greater consistency of information between the HSP and NDIS for consumers.

Recommendation I

The HCIA recommends that a standard screening protocol be developed for those >55 or 60 years, and that this be communicated to primary healthcare providers.

Question 3: How well does this Program Interface with other schemes?

Do the interactions between consumer pathways through the hearing services schemes lead to good consumer outcomes?

Can they lead to people with similar hearing loss and similar financial capacity, for instance, to have different services and levels of subsidy?

Is there enough information about the scope and eligibility criteria of the various schemes?

What changes should be made to help consumers and improve equity?

3.1 The consumer pathways to hearing health are not clear nor are they easy to navigate. HCIA strongly recommends consumer mapping analysis, with full sector participation, identifying the different hearing health programs including the various eligibility and support services. This analysis has particular importance when a consumer may be eligible for more the one government program.

3.2 Due to this lack of clarity in relation to the consumer pathways for government funded hearing support very different consumer outcomes can occur, depending on which entry point is

selected by the consumer:

f. If entering via the HSP, consumers will generally be able to receive a hearing aid and the knowledge and after-care to maximise its benefit.

g. If entering via a GP or ENT specialist, up to 20% of people will walk away with untreated hearing loss.[5]

h. If entering via the NDIS, they are frequently advised on rather limiting interventions, such as Auslan (sign language) or lip reading.

i. If entering via Veterans' Services and State Worker's Compensation insurance agencies, the consumer is likely to be cost-shifted into the HSP and face out of pocket expenses.

3.3 In relation to the various funding programs that support consumers with hearing loss there is an opportunity to achieve greater alignment in relation to messages and information to consumers. This will minimise inconsistent advice being provided particularly when attempting to obtain information about how the various schemes intersect. It is not uncommon nor unreasonable to find staff from one program being less familiar with the operation of the other hearing-related programs. Information is power and ultimately a consumer should have access to clear and simple information to inform their decision and their choice or eligibility to their hearing healthcare.

3.4 HCIA members report examples of consumers with NDIS levels of disabling hearing loss experiencing inconsistent advice from the planners, which leads to inconsistent hearing care being approved and delivered. Some examples of consumer experiences are:

- Inconsistency in planner's approval/ rejection of rehabilitation programs.
- Being advised to "*shop online*" for hearing healthcare without any connection to an Australian accredited audiology professional.
- Being repeatedly redirected to one single provider – Hearing Australia (the Government provider) when their relationship and entry pathway was via a private provider.
- Being instructed to learn lip reading and sign language.

3.5 The NDIS will be immediately improved with the creation of an online portal for consumers to access pre-approved services showing all relevant information, rather than via a planner, so that any barriers to hearing health care are minimised. Further the clinical criteria should mirror the HSP, so that no consumer is disadvantaged due to age.

3.6 Further, consumer information needs to reflect that a NDIS participant has provider choice, particularly when self-managing.

3.7 A further example of inconsistent eligibility criteria within the HSP is in the case of consumers having severe to profound hearing loss and being required to receive a cochlear implant to meet their outcomes. These consumers are ineligible for any speech processor replacements/refits under the HSP. Conversely, if they had remained with conventional hearing aids, or their hearing loss is of a lower level, they would be eligible for hearing aid re-fits, approximately every 5 years. The irony is that those with the more severe hearing losses have less access to services under the current HSP.

[5] https://www.ehima.com/eurotrak/, e.g. see https://www.ehima.com/wp-content/uploads/2019/06/NewZealandTrak_2018.pdf, p. 23-25.

Recommendation E

*The HCIA recommends the review invest in **consumer mapping analysis**, with full sector participation, identifying the different hearing health programs including the various eligibility and support services.*

The HCIA members have rich consumer data and are extremely willing to participate and contribute to this analysis in order to design a program simplicity which enhances efficiency, accessibility and consumer outcomes, especially when a consumer may be eligible for more than one program.

The HCIA recommends that the insights from this analysis should form the basis for any future program enhancements and reforms including the development of program objectives and critical areas of data collection.

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The HCIA recommends that the NDIS will be immediately improved with the following:

1. *The creation of an online portal for consumers to access pre-approved services showing all relevant information, rather than via a planner, so that any barriers to hearing health care are minimised.*

2. *The adoption of the same clinical criteria as the HSP. The current clinical criteria for rehabilitation in the HSP provide proven comorbidity health benefit and compares very favourably to programs provided in other countries.*

These two improvements will provide improved access and greater consistency of information between the HSP and NDIS for consumers.

Question 4: Does the Program sufficiently support hearing loss prevention?

Should hearing loss prevention have a greater focus in the Program, and how could hearing loss prevention best be addressed?

4.1 Hearing loss prevention is an important public health responsibility and should be funded under an appropriately focussed government program. This is especially relevant given the emerging research correlating hearing loss and other health comorbidities.

4.2 HCIA recommend the review consider the WHO's '*Make Listening Safe*' campaign[6]. We also welcome hearing loss prevention strategies targeted at youth, whom the WHO has identified as being at greatest risk due to personal audio devices.

4.3 HCIA encourages the Panel to consider prevention not only in relation to noise induced hearing loss, *but also in relation to the prevention of the compounding effects of hearing loss* for those who have already been diagnosed. This would be consistent with the review's focus on consumer outcomes and ultimately relates to Program eligibility arrangements and clarity of access to appropriate hearing loss services.

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4.4 Beyond the HSP, serious investment in preventative effort could be directed to other government programs focussed on the workplace, public health, and lifestyle choices where there is potential for significant early impact.

4.5 Hearing loss prevention initiatives have generally been fragmented. Consideration should be given to achieving better consolidation and co-ordination between initiatives and the relative funding provided to such activities. Recent examples of initiatives are provided below and demonstrate the breadth of activity:

- The Government funded research into hearing loss prevention through the Hearing Loss Prevention Program, completed in 2017.
- Safe Work Australia's code of practice for "*Managing noise and preventing hearing loss at work.*
- Information on hearing loss is available on the Department's website through health direct.
- Government funding of the Hearing Co-operative Research Centre to develop the hearsmart.org website to promote hearing health and prevent noise-induced tinnitus and hearing loss.
- The October 2020 Budget, with funding for a national hearing awareness and prevention campaign.
- States and Territories also have responsibility for providing information on hearing loss to their respective residents.

4.6 HCIA are acutely aware that earlier intervention is needed before the decline of cognitive function. We therefore implore the review panel to recommend that a standard hearing screening protocol be developed for those >55 or 60 years, and that this be communicated to primary healthcare providers. We believe the focus for HSP should target early identification of adult-onset hearing loss, and reduction of whole person, family, health and economic impact of the sensory loss by strategies to enable early intervention.

4.7 Deafness Forum of Australia (DFA) previously undertook a promotional campaign called: "*Make it 10*", focussed on GPs. This campaign sought to raise awareness within the GP community so that they would add a hearing check to the current 9-step standard Primary Health checklist for older Australians. Ideally, undertaking this test could be added to Medicare, consistent with the '*Roadmap for Hearing Health*'[7].

4.8 There is currently no reference to hearing loss prevention in any clinical guidelines or outcomes requirement published by the HSP. This is a significant gap that should be addressed.

4.9 Importantly, HCIA believes that any improvements in support for hearing loss prevention initiatives should not be driven via diversion of resources and funding from the HSP's assessment and rehabilitation programs.

Assessment Frequency & Prevention:

4.10 Under the Voucher Scheme a full diagnostic hearing assessment of consumers may be undertaken every three years, however proposed changes in this year's Budget would result in **decreased access** to once every five years.

4.12 Whilst HCIA welcomes any relief to administrative burden these proposed changes may bring, it cannot be at the expense of consumer clinical outcomes. We are very concerned about the unintended consequences of these proposed changes on the consumer as it will undoubtedly

[7] *Roadmap for Hearing Health*, Hearing Health Sector Committee 2018 - 19

impact their access to assessment, diagnosis and sequential management of their hearing loss leading to the lack of prevention of downstream health and societal impacts.

4.13 HCIA can support an adjustment to the timing of the voucher on the following basis:

- That the Voucher Scheme changes include funding for an annual assessment for all HSP funded consumers in recognition of HCIA support for modifying re-fit criteria within the five-year period.
- This is offered with the caveat that no adjustments to the Scheme should adversely or knowingly be at the expense of a consumer's clinical outcomes
- It should be noted that the current annual review is only available to those who have been fitted with hearing aids.

Re-fitting Criteria:

4.14 Notwithstanding the technological advancements, refitting criteria needs to include some capacity for clinical judgement. For example: if the consumer is not able to use or benefit from their optimally adjusted current device due to significant changes in circumstances that are not included under the current six reasons, then clinical judgement should apply as to whether a refit is required.

If a trial of a more suitable device provides improved and measurable outcomes in a specified way (e.g., data logging shows increased usage) then this trial outcome should constitute a refit claim to be made.

Recommendation E

*The HCIA recommends the review invest in **consumer mapping analysis**, with full sector participation, identifying the different hearing health programs including the various eligibility and support services.*

The HCIA members have rich consumer data and are extremely willing to participate and contribute to this analysis in order to design a program simplicity which enhances efficiency, accessibility and consumer outcomes, especially when a consumer may be eligible for more than one program.

The HCIA recommends that the insights from this analysis should form the basis for any future program enhancements and reforms including the development of program objectives and critical areas of data collection.

Recommendation H

The HCIA recommends that the HSP should focus on both the prevention of noise induced hearing loss and also the compounding effects of hearing loss for those who have already been diagnosed.

Recommendation I

The HCIA recommends that a standard screening protocol be developed for those >55 or 60 years, and that this be communicated to primary healthcare providers.

Recommendation J

The HCIA recommends that the hearing assessments should be made available every year to prevent downstream heath and societal impacts due to undiagnosed hearing loss.

Recommendation K

The HCIA agree and endorses the Hearing Services Voucher being extended from 3 years to 5 years as this reduces the administration burden and red tape associated with reapplying for a new voucher at the current 3-year interval, however this endorsement is contingent on there being no detrimental impact to the HSP consumer in reduced services or to avail non-device wearers from ongoing hearing assessments.

A HSP eligible consumer with a 5-year voucher should receive funded devices and services for the full 5 years including annual reviews/assessments and the ability to receive new devices within the 5 years if they meet the refitting criteria. For HSP eligible customers that do not meet the 3FAHL for device fittings should receive funded annual hearing assessment so that their hearing health can be monitored and when appropriate early intervention is accessed.

Question 5: Are the Program's assessment services and rehabilitation activities meeting consumer needs?

What is the right mix and range of services that consumers would benefit from under the Program?

How could consumers, families and friends, workplaces and others in the community, as well as taxpayers, benefit from a rebalancing of services offered?

5.1 Overall, the HSP is recognised as providing significant benefits to consumers and compares very favourably with hearing loss programs provided in other countries. The HSP enables (1) comprehensive assessments, (2) the fitting of scheduled devices, (3) it enables consumers to have provider and device choice and to upgrade technology, (4) technology can be refitted if their clinical circumstances change and (5) there is a maintenance program to access services year-round to get full benefit from the device. Although the purchaser of these services is the Government, the program is structured around the needs of a consumer.

5.2 Under the HSP, the following aspects work well for consumers:

a. Hearing care is subsidised and provided by accredited clinicians and support staff who genuinely care about their consumers' hearing goals/outcomes.

b. It is not problematic to access the system if you are eligible. Various hurdles and roadblocks have been removed over the years and the introduction of the portal and removal of doctor referrals have resulted in significant life improvements for the consumers.

c. Consumer choice is fundamental to the HSP. There is the flexibility for consumers to choose their provider and choose their preferred device and to invest if they want additional benefits.

d. There is a competitive market of providers offering a range of devices and therefore the consumers benefit from this choice.

5.3 HCIA believes this review offers a timely opportunity to improve the service areas of the HSP which are not meeting current and future consumer needs including:

- Creating the opportunity for early intervention
- Address and overcome the social stigma associated with hearing loss

- Create extra/specific supports for nursing home and home bound consumers
- Increase complex consumers' choice of provider and desired pathway
- Review co-payments to ensure adequate consumer coverage
- Address funding and service inconstancies between implants and hearing aids
- Review and apply the most appropriate use of audiometric eligibility criteria

Creating the Opportunity for Early Intervention:

5.4 There is a real need to do more in Australia to create the opportunity for early hearing reviews. The current Australian model of regular eyesight testing by GPs and Ophthalmologists as part of Medicare is a good model for improved ageing health, leading to early review and intervention and lowering barriers to access.

Address and overcome the Stigma Issue:

5.5 The social stigma of a hearing aid remains prevalent in all ages of our population. Many people suffer with hearing loss for many years before they seek treatment. Accessing hearing health care remains a resistant and problematic psychological process for most people. Placing even the smallest barrier in the way of hearing health care will convince many people to not pursue a better outcome. This factor strongly supports the need for consumer acceptance barriers embedded within the HSP and the NDIS programs to be removed or reduced.

5.6 Audiology professionals are trained to recognise stigma and denial and HCIA frequently witnesses the reluctant consumer in the clinic being encouraged by their significant others to view the hearing aid not as the final chapter, but an opportunity to fully embrace the last decades of life connected, independent and happier.

5.7 According to HSP data, almost 700,000 people who are eligible for HSP support have had an initial assessment but many years later have still not taken the step to have a hearing aid fitted. This is a compelling and alarming statistic – one that is not paralleled in other conditions such as vision decline.

Specific Support for Residential Aged Care and CALD Consumers:

5.8 There is currently no provision in the HSP for extra or specific support for nursing home or CALD consumers. These services are more expensive to administer and often can extend to including the provision of an interpreter and/or home visit. Currently the program design offers no reimbursement for these additional services which leads to many providers being unable to support these vulnerable and growing populations. HCIA recommends that during the period of the current review, the panel consider the imminent findings of the Royal Commission in to Aged Care Quality and Safety (RCACQS) and update the HSP service to ensure that this unmet need is addressed appropriately.

Complex Consumers Cannot Choose Their Provider:

5.9 Current rehabilitation services for complex consumers can present a challenging pathway. Complex consumers are often not offered access to the provider of their choice, disregarding the established provider and consumer relationship. This can result in the consumers' needs not being met as they are forced to access care and services from the government provider.

If a consumer chose to design their care path outside of that prescribed pathway, they receive less funding even though the services provided are likely to be the same. This forced choice does not provide equity or access to those with complex needs. If this was coexisting in any other sector it would be viewed as channeling.

Implants v. Hearing Aids:

5.10 Under current HSP arrangements, implanted consumers receive less subsidized services than those HSP consumers using hearing aids. It is ironic that the most severely hearing-impaired consumers obtain a lower level of service through the program.

Limitations on the Use of Audiometric Eligibility Criteria:

5.11 The HSP assessment services are based on use of audiometric eligibility criteria. However, the WHO has noted that this method of measuring hearing loss and thus classifying eligibility for certain subsidies is not well supported by evidence.[8] The WHO states:

"*While audiometric descriptors may provide a useful summary of an individual's hearing thresholds, they should not be used as the sole determinant for the provision of hearing aids. The ability to detect pure tones using earphones in a quiet environment is not in itself a reliable indicator of hearing disability. Audiometric descriptors alone should not be used as the measure of difficulty experienced with communication in background noise, the primary complaint of individuals with hearing loss.*"

5.12 HCIA recommend that the WHO advice be adopted and the following additional MHLT exemptions should be added to the HSP eligibility criteria:

a. Measures to assess ability to understand speech in background noise should be considered as an additional exemption under criterion 1. In such cases binaural fitting should be funded unless there are clinical contra-indications.

b. Currently MHLT is strictly applied - even to those people with a significant and non-aid able hearing loss on the other ear and where a minimal loss in the better ear has a larger impact on hearing outcomes, especially in noisy environments. Providing the Wishes and Needs Tool (WANT) criteria are met, and audibility benefit is established, HCIA recommend that the program allow for a hearing device to be fitted in the better hearing ear, with or without a Contralateral Routing Of Signals (CROS) microphone in the poorer ear.

The Most Appropriate Audiometric Eligibility Levels:

5.13 The review Consultation Paper assumes that hearing aids for people with up to 40dB hearing loss deliver little benefit and the current HSP criteria of a three-frequency average hearing loss of greater than 23dB and up to 40dB results in unnecessary over servicing of consumers. ***HCIA is not aware of any research globally that supports this assumption and strongly disagrees with this exclusivity.***

5.14 HCIA understands the government's desire to have a purely quantitative approach for minimum threshold for amplification; however, the research clearly indicates that this approach is not possible or viable. In reviewing the research, HCIA has not found data which suggests that hearing loss thresholds are a reliable indicator of hearing aid outcomes, and to the contrary there is data which indicates that hearing loss thresholds is not a reliable indicator of outcomes, as summarised as follows:

1. (Bennett, 1989). 98 subjects with 3FA of <25dBHL, 85% considered that after 6 months of use, the hearing aids were a worthwhile investment.

2. (Roup & Noe, 2009). Subjects with normal or near normal hearing up to 2kHz achieved as much benefit from hearing aids as subjects who had an average hearing loss at 2KHz of 52 dB HL.

[8] https://www.who.int/pbd/deafness/hearing_impairment_grades/en/

3. (Stephens, et al., 1990). Hearing loss did not predict who wanted hearing aids when offered, and the group which were willing to trial hearing aids had greater reported disability than those who declined.

There is also some suggestion that the configuration of hearing loss (low frequency emphasis, high frequency emphasis, flat, ski slopes) may have some impacts on consequences, which cannot be measured via a frequency threshold average. As an example, (Bess, Lichtenstein, & Logan, 1991) disability seems to be more closely related to low frequency hearing loss thresholds than to high frequency hearing loss thresholds – however the 4FA only considers 1 low frequency threshold.

Many people with hearing loss also experience tinnitus. Even when a minimal hearing loss is measured, amplification is the recommended form of intervention, to assist in relieving the adverse effects of tinnitus, including the psychological effects (Searchfield, Kaur, & Martin , 2010).

Ultimately, degree of hearing loss is a very poor indicator of use or benefit from hearing aids.

5.15 Further, there is not (as referred to in the Consultation Paper) "*over-servicing of some consumers who may later decide to put aside their taxpayer subsidised device*" for the following reasons:

a. The Consultation Paper says: "*Eligibility for a hearing device with this level of hearing loss (>23dB and up to 40dB) is neither consistent with other programs in Australia such as the* (NDIS) *nor consistent with the internationally accepted definition of disabling hearing loss",* in reference to the WHO's definition of "*disabling hearing loss*" as greater than 40dB in the better ear in adults.[9]

b. Importantly, new 'Grades of hearing impairment as recommended by the Global Burden of Disease Expert Group on Hearing Loss', have been published, which replace the earlier 'WHO Grades of Hearing Impairment'. We understand that these new grades of hearing Impairment will be used in the WHO World Report on Hearing that will be launched on 3 March 2021.

c. The primary area of focus for the WHO is in addressing health issues in low-income countries,[10] where most of the world's hearing loss population live but where less than one per cent have access to hearing health care.[11] The use of the 40dB hearing loss limit by the WHO is appropriate for low-income countries due to both the dimension and scale of their issue and inform realistic local policy interventions. However, Australia is a high-income economy with much higher hearing aid adoption rates. It is also noteworthy that the WHO recommends that people with "mild" (WHO 26 - 40dB)[12] hearing loss benefit from hearing aids as noted below:

"Hard of hearing' refers to people with hearing loss ranging from mild to severe. People who are hard of hearing usually communicate through spoken language and can benefit from hearing aids, cochlear implants, and other assistive devices as well as captioning. People with more significant hearing losses may benefit from cochlear implants."[13]

d. If the audiometric eligibility levels were increased to the WHO definition of (from 23dB to 40dB, soon to be superseded), PwC has estimated that one third of currently eligible

[9] https://www.who.int/news-room/fact-sheets/detail/deafness-and-hearing-loss
[10] The WHO, Preferred profile for hearing-aid technology suitable for low- and middle-income countries, 2017: *Two thirds of those with severe-to-profound hearing loss live in developing countries The majority of individuals with disabling hearing loss live in low and middle-income countries (LMICs) and, for many of them, hearing aids are the key to rehabilitation.*
[11] Ibid. P.29
[12] The WHO, Grades of hearing impairment
[13] The WHO, Deafness and Hearing Loss Factsheet

Australians would be excluded from the HSP program.[14]. This decision would be directly contrary to the Terms of Reference and the key objectives of the review, to "*report on recommended improvements to program design that ensure the program remains consumer-focused, fit-for-purpose and sustainable*" and to "*focus on optimising program outcomes for consumers."* HCIA also believes this decision would result in worse outcomes for ageing Australians by delaying access and will be contrary to the intent of the WHO's action plan for a '*Decade of Healthy Ageing 2020-30'.*

e. Our concern in further delaying subsidised hearing health care is that it runs counter to established evidence and will compound rehabilitation challenges given that most people with hearing loss have already suffered for many years before seeking treatment. Research over the last 30 years has also provided overwhelming evidence that early intervention in hearing loss reduces serious associated comorbidities[15] as well as profound broader negative social and economic impacts.[16]

f. One of the most comprehensive hearing loss research reviews in the world noted:

"The available evidence concurs that hearing aids are effective at improving hearing-specific health related quality of life, general health-related quality of life and listening ability in adults with mild to moderate hearing loss. The evidence is compatible with the widespread provision of hearing aids as the first-line clinical management in those who seek help for hearing difficulties."[17]

g. An objective 2017 study by the University of Queensland School of Health and Rehabilitation Sciences of approximately 8,500 hearing aid users' data logging concluded:

"*Clinical populations with mild HI use HAs as frequently as those with a moderate HI. These findings support the recommendation of HAs for adults with milder degrees of HI."*[18]

h. Restricting access to subsidised hearing aids for people above 40dB 4FAHL hearing loss is also contrary to international clinical evidence and hearing loss consumer advocacy that hearing loss is best treated as early as possible. For example, the Deafness Forum of Australia and the Hearing CRC, as well as many other organisations, have made explicit statements on early intervention:

"The earlier a hearing loss is identified and remediated the better the outcome for the individual."[19]

"In terms of adults, it is widely estimated that the average time between someone identifying that they may be having difficulties with hearing, and actually visiting a professional is some 5-7 years. During this time, progressive hearing loss may result in progressive degeneration of the auditory systems abilities to process sound due to neural degeneration. Earlier detection and device fitting may reduce the degree of neural damage, and as such, may contribute to better outcomes from use of hearing aids and/or cochlear implants."[20]

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[14] PwC, Review of services and technology supply in the Hearing Services Program, Final report September 2017, p. 53 (ref: World Health Organisation, Deafness and hearing loss fact sheet, 2017)
[15] Still Waiting to be Heard, Report on the Inquiry into the Hearing Health and Wellbeing of Australia, P.18
[16] Shield B, Evaluation of the social and economic costs of hearing impairment – a report for Hear-it', 2006, and HCIA/Deloitte, Social and Economic Cost of Hearing Health in Australia, June 2017 updated March 2020
[17] UK Cochrane review, September 2017
[18] Timmer, Barbra H. B., Hickson, Louise, Launer, Stefan., *Hearing Aid Use and Mild Hearing Impairment: Learnings from Big Data, Journal of American Academy of Audiology*, January 2017
[19] *Deafness Forum of Australia, submission to the Hearing Health and Wellbeing of Australia Inquiry* P.13
[20] The Hearing CRC Ltd., *Submission to the Hearing Health and Wellbeing of Australia Inquiry*, P.11

i. In a call to action to mark World Hearing Day in 2018, Minister Wyatt acknowledged the role of Hearing Aids in addressing dementia, depression, emotional well-being, and the profound economic cost of hearing loss:

"*We know that staying connected through hearing is vital for our emotional wellbeing," said Minister Wyatt. "However, new international research now indicates deafness and the failure to use hearing aids can increase the risk of dementia by more than 20 per cent and, in men, markedly raise depression risk. "It also costs our community dearly, with the annual direct economic impact of poor hearing in Australia estimated at $15.9 billion."* [21]

The research Minister Wyatt referenced was presented to the European Parliament in February 2018.[22] The research was based on a 25-year study that concluded the failure to use hearing aids increased dementia risk by 21 per cent and, in men, increased the risk of depression by 43 per cent.

j. HCIA maintains that aided hearing loss avoids many of the secondary health burdens hearing loss creates. Ongoing reviews into the HSP have so far ignored and discounted the lived experience of those with hearing loss and instead focussed entirely on the economics of this disease. While the economic and social burden of hearing loss has been estimated in the past, the actual cost impost to specific areas of Commonwealth spending must be described before changes to the HSP impact more significantly in the form of cost-shifting from the HSP as an increasing total cost to the broader health system due to the other health burdens that untreated hearing loss creates.

k. HCIA does not recommend changing the current HSP MHLT criteria. HCIA also recommends the MHLT should continue to be based on 'each ear' not the 'better ear' and that restricting eligibility to the HSP further will lead to significant costs in other public health areas and greater suffering for pensioners and veterans. This is no different to the ophthalmic equivalent of a patient needing a different prescription for each lens of their glasses if both eyes do not have identical levels of vision impairment.

l. HCIA's members are also concerned about the administrative burden changing MHLT standards will place on clinicians having to manage two MHLT systems in parallel, potentially for decades - the revised MHLT of 40dB for new entrants into the HSP and the current MHLT for existing consumers.

Warranties & Year 1 Maintenance:

5.17 Providers welcome the removal of the HSP payment for maintenance of hearing devices that are covered by the minimum 12 months manufacturer's warranty and that the consumer co-payment is planned to remain. However, maintenance in the first 12 months generally is the provision of batteries, consumables and replacement of parts that are not covered under manufacturer warranty and device servicing. Therefore, consumers will be the ones that will bear the costs of these incidentals. This is an unintended consequence of these changes and HCIA strongly caution the panel to examine the co-payment to ensure adequate funding to cover battery, spare parts and consumables requirements for all devices for the full 12 month duration as well as in clinic servicing of the device.

[21] Minister Wyatt Media Release "*DEMENTIA, DEPRESSION WARNING MARKS WORLD HEARING DAY*" 02 March 2018

[22] Hélène Amieva, PhD, Camille Ouvrard, PhD, Céline Meillon, MSc, Laetitia Rullier, PhD, and Jean-François Dartigues, MD, PhD, Death, *Depression, Disability, and Dementia Associated With Self-reported Hearing Problems: A 25-Year Study*, J Gerontol A Biol Sci Med Sci, 2018, Vol. 00, No. 00, 1–7, 2018

Recommendation E

*The HCIA recommends the review invest in **consumer mapping analysis**, with full sector participation, identifying the different hearing health programs including the various eligibility and support services.*

The HCIA members have rich consumer data and are extremely willing to participate and contribute to this analysis in order to design a program simplicity which enhances efficiency, accessibility and consumer outcomes, especially when a consumer may be eligible for more than one program.

The HCIA recommends that the insights from this analysis should form the basis for any future program enhancements and reforms including the development of program objectives and critical areas of data collection.

Recommendation H

The HCIA recommends that the HSP should focus on both the prevention of noise induced hearing loss and also the compounding effects of hearing loss for those who have already been diagnosed.

Recommendation I

The HCIA recommends that a standard screening protocol be developed for those >55 or 60 years, and that this be communicated to primary healthcare providers.

Recommendation J

The HCIA recommends that the hearing assessments should be made available every year to prevent downstream heath and societal impacts due to undiagnosed hearing loss.

Recommendation K

The HCIA agree and endorses the Hearing Services Voucher being extended from 3 years to 5 years as this reduces the administration burden and red tape associated with reapplying for a new voucher at the current 3-year interval, however this endorsement is contingent on there being no detrimental impact to the HSP consumer in reduced services or to avail non-device wearers from ongoing hearing assessments.

A HSP eligible consumer with a 5-year voucher should receive funded devices and services for the full 5 years including annual reviews/assessments and the ability to receive new devices within the 5 years if they meet the refitting criteria. For HSP eligible customers that do not meet the 3FAHL for device fittings should receive funded annual hearing assessment so that their hearing health can be monitored and when appropriate early intervention is accessed.

Recommendation A

The Government has an obligation to provide support to all Australians adversely affected by hearing loss and therefore the Government's objective should be 'to improve ALL hearing health in Australia'.

Recommendation C

The overall management of the hearing health of all Australians should reside within the HSP.

Recommendation D

The current HSP scope is narrow. Consistent with the broader objective of improving ALL hearing health in Australia, program access and subsequent eligibility criteria should be updated so that the Program does not unnecessarily exclude certain categories of vulnerable people who are at risk of being disadvantaged due to hearing loss.

Recommendation F

The HCIA recommends that the HSP eligibility criteria and service design be changed to enable the following categories of people to access HSP services:

- *residents of aged care homes or receiving in-home care*
- *Disadvantaged people from Culturally and Linguistically Diverse (CALD) backgrounds*
- *People in prison*
- *People experiencing homelessness; and*
- *Financially vulnerable and low-income earners (aged 26 - 64).*

Recommendation L

The HCIA recommends that consumers must not be disadvantaged under the proposed maintenance arrangements in the first year after fitting. Device warranties do not provide for consumables and batteries. Consumers need to be able to keep their devices in good working order and will require maintenance outside of warranty conditions to achieve this outcome. The current maintenance system enables this to be achieved for consumers, therefore HCIA recommends that the current maintenance system is retained to avoid unintended consequences of any proposed changes that will bear out of pocket expenses for consumers.

Recommendation O

HCIA members recommend that to maintain consumer's ability to make informed choices regarding their rehabilitation device/s, the current arrangements, which include their provider assisting them, should remain. It is recommended that the quote framework and associated paperwork for efficiency and timeliness only be applied to the devices which are to be fitted to the consumer.

Recommendation P

The HCIA recommends that consumer choice of their hearing healthcare provider is paramount to the tenet of the HSP. Adults with more complex needs should not be disadvantaged, and therefore a "Complex Consumer" category should be created that is accessible to all accredited HSP providers.

Question 6: Is the Program supportive of consumer choice and control?

Do consumers receive sufficient information to make informed choices?

Do they have adequate control and flexibility over the hearing services that would be in their best interests? What changes, if any, should be made?

Should any changes be made to the CSO Scheme?

What should be the role of Hearing Australia, as a government service provider in providing hearing services?

6.1 The HSP Voucher Scheme enables consumers to choose both a preferred provider and their preferred hearing care solution. The hearing care services, and technologies marketplace is competitive and commercial. Organisations contest for consumers based on quality, standard of care, education and information provision, price and proximity.

Where there is low consumer concentration and a lack of trained and experienced workforce in some areas of Australia, consumer choice is adversely affected. This exacerbates the difficulties in encouraging people to undertake a hearing assessment.

The HCIA considers consumer choice to be a fundamental aspect of the Australian health system, and in turn of the HSP.

6.2 HCIA members take seriously their role in providing clear consumer information about the range of hearing aids that are clinically appropriate to each individual. In this way HCIA members partner with consumers to ensure they have adequate control and flexibility in managing their hearing aids. This is important as hearing aids are not a ‘fit and forget’ retail device, as is the case for reading glasses.

The hearing aid and the clinical service component cannot be separated. Hearing aids are personally programmed for each consumer via sophisticated software and require ongoing care, reprogramming and counselling by an audiologist as hearing health changes over time.

Consumer satisfaction and clinical efficiency are a paramount consideration for HCIA members. The commercial nature of the marketplace ensures providers assess that consumers are assured and confident with the functionality of their hearing care solution, and many members use transparent consumer feedback mechanisms to continually assess satisfaction levels. Hearing aids are a class II medical device as registered with the TGA, mis-fitting could produce serious detrimental clinical outcomes. This clearly sets hearing aids apart from an electronic retailer ‘headphone’ purchase.

6.3 **In Appendix 1** we have provided data extracted from Eurotrak: Surveys I EHIMA[23] showing that in the countries where the Hearing Aid Professional is separated from the consumer acquiring a hearing aid, the worst consumer satisfaction results are observed. For example, in Japan hearing aids can be purchased online without seeing an audiologist and not surprisingly Japan has the lowest consumer satisfaction experience.

[23] https://www.ehima.com/eurotrak/

A case study for consideration:

Switzerland is a very recent and relevant case study in commoditising the device and separating it from the hearing care and ongoing management:

In Switzerland in 2013 the government had concerns about the cost of hearing services in what was a highly protected market with very limited competition. The government reimbursement level at the time was comparatively high averaging €1800 per hearing aid. The government decided to completely open the market to reduce cost and then permitted any retail outlet to sell hearing aids, including supermarkets, with a two-tier reimbursement scheme.

Acquiring a hearing aid from a retail outlet meant the consumer had to pay 100% out of pocket. If the consumer instead acquired Hearing Aids via Audiologists, ENTs or Pharmacies they received a reimbursement of €700. If the Hearing Aid cost less than €700, the consumer pocketed the difference.

This resulted in Pharmacy businesses identifying a compelling business opportunity to sell sub €500 devices and the market was flooded with very low cost and very low-quality hearing aids.

Rather quickly Pharmacies realised that forecasted early profit margins were instantly eroded by consumers repeatedly coming back to the pharmacy wanting ongoing audiological adjustments, maintenance or simply to complain and demand a refund.

Pharmacies were only equipped to provide part of the solution. Very quickly the open retail device market collapsed but the consumer damage had already been done.

As a result of this regulatory market experiment the price of care did not reduce in fact the consumer impact on their own funds increased due to the need to access specialised Audiology services to get the actual help, they needed.

The price of hearing care for the consumer is now higher than it has ever been, the consumer uptake and access has been reduced and the associated benefits of good hearing health have significantly declined. The Swiss government has subsequently acknowledged this was a total policy failure driven by concerns of price rather than consumer need and well-being.

6.4 The Consultation Paper states, at page 11: "*Analysis of Program data indicates that 88 percent of providers who have fitted more than 5,000 consumers in the past three years have fitted more than 75 percent of their consumers with devices from a single manufacturer. This indicates that the provider's ownership and contractual relationships with suppliers may influence decisions about devices that are fitted through the Voucher Scheme. Some consumers may not be aware of the full range of listed devices that are available to them.*" We respectfully point out that the inferences drawn from this data are not correct because:

a. The critical aspect affecting the performance and suitability of the selected device is the programming undertaken by the audiologist to personalise the solution.

b. Better consumer outcomes are achieved when audiologists are extremely familiar with the workings of the technology and can adjust to suit the consumers' needs. Therefore, providers typically only train, support and service a limited range of devices which will suit most audiometric configurations and listening programs. Large ranges of devices often lead to poorer consumer outcomes, as it is the clinician, not the device, which achieves the desired outcome.

c. Consumers always have the choice under the HSP Voucher Scheme inside a competitive marketplace to visit to an alternative provider for an alternative option.

d. Some devices available in the market are suitable for a broad range of consumers, whereas others are more specialised in their features. Therefore, some devices are more popular with consumers than others. This fact is in no way a reflection on '*provider's*

ownership and contractual relationships with suppliers … influencing decisions about devices that are fitted through the Voucher Scheme'. Fortunately, the HSP maintains a broad schedule of approved devices, which means a suitable solution can be found for all consumers who are fully subsidised.

Hearing Australia & the CSO Scheme:

6.5 In relation to Hearing Australia as a government service provider of hearing services and its exclusive access to the CSO scheme, the HCIA's members provide the following insights:

a. Unlike the members of HCIA, who competitively supply services structured to support the Voucher Scheme, Hearing Australia benefits from the certainty of a guaranteed non-competitive revenue stream from the CSO Scheme and its exclusive right to provide those services to eligible consumers.

b. By the very nature of Hearing Australia's funding under the CSO Scheme – Hearing Australia is obligated to provide a critical role in the equity and access of hearing services to all Australians.

c. The support of a critical health infrastructure via a CSO scheme is not unique to hearing. The design and implementation of these schemes has been driven by the unique geographic challenges we face in Australia.

d. These schemes and those that are funded by them have a primary responsibility to provide services to locations that under normal commercial conditions are not viable. This must be Hearing Australia absolute priority.

This certainty, and the considerable annual funding base Hearing Australia receives from the Government, provides it with significant means to fulfil their obligations under the CSO.

e. In contrast, the members of the HCIA are entirely reliant on an open market driven by consumer satisfaction, experience and need. Their funding via the HSP is driven by their ability to compete via delivering on consumer choice with optimal outcomes to gain their share of the funded consumer market.

f. Against this backdrop, the market dynamic appears to be shifting– Hearing Australia's traditional base is broadening via increasingly aggressive efforts to provide services into the Voucher Scheme. Our members are concerned that a continuation of this trend and expansion by Hearing Australian into open markets will place at risk the CSO scheme given its important role in supporting vulnerable Australians.

Clarification of Hearing Australia's role:

6.6 The role of Hearing Australia is to support vulnerable Australians by servicing CSO thin markets. The HCIA is confident health outcomes could be improved in this area if Hearing Australia was directed to better focus its extensive government funded resources in as per their obligation rather than concentrating in urban and major regional areas which are already well serviced by HSP providers.[24]

6.7 There is confusion in the marketplace about the primary role of Hearing Australia. HCIA members educate consumers about this frequently. The CSO would be better serviced if Hearing Australia are required to focus its extensive government funded resources into servicing CSO thin markets, especially indigenous hearing health. The non – complex adult

[24] The most recent "Bus Tour" published on the Hearing Australia website shows visits to areas which are already heavily serviced by many established HSP hearing care providers. To argue that Hearing Australia's bus fleet tours into heavily serviced markets is a community awareness raising exercise, is disingenuous.

consumer segments are strongly serviced through the commercial competitive market. Alarmingly Hearing Australia is now advertising to private consumers deflecting Hearing Australia resource rom its fundamental role to support thin markets under the CSO.

This consumer confusion can be brought to life by this example. As of I July 2020, NDIS consumers in this category who are eligible for HSP vouchers no longer have a choice of provider and must be serviced by Hearing Australia. This does not appear to be designed in the consumers best interests.

Simplifying support avenues in hearing healthcare, especially for complex and higher risk consumers:

6.7 HCIA would like to see the review take a position in demystifying and simplifying the avenues of support available for all consumers in hearing healthcare. A critical recommendation of the HCIA is to map the consumer journey to understand and analyse the gaps in the current system between the CSO scheme, the NDIS and the HSP. HCIA members are rich in consumer data and research are would be very willing to contribute their time to assist with this analysis.

For complex consumers provision of clear hearing healthcare pathways is even more critical. HCIA would recommend the following:

a) Ensure CSO consumers who no longer eligible under HSP freedom of choice is critical as they embark on the next stage of their hearing care journey.

b) Enable adults with CSO funding to maintain a relationship with their longstanding provider. The current system requires a transfer to Hearing Australia to access the funding needed for additional technology options (which could be provided their current provider if that had access to the relevant funding).

c) Safeguard consumer choice to the competitive marketplace through equivalence across government programs. Under NDIS any provider can provide support for this group where their budget allows despite age or disability. On the other hand, if they are eligible for an HSP voucher, consumers with a similar level of hearing loss or communication disability as applies to NDIS can only receive above voucher services if they are seen by Hearing Australia

   This could be achieved through a new category could for any consumer with significant visual, dexterity, cognitive issues who requires more time to complete a successful rehabilitation program. Where individuals with severe/profound losses could continue to be streamed to Hearing Australia or continue to be seen by their provider of their choice where clinically appropriate.

d) Enable consumer choice when a consumer receives a cochlear implant. Currently batteries and maintenance for the implant can only be accessed through Hearing Australia, limiting consumer choice. Funding for bone anchored hearing systems is another area where consumer choice is limited to Hearing Australia. On the other hand, NDIS plans can incorporate cochlear implant and bone anchored hearing system device funding adding additional confusion as to where to refer these consumers.

Recommendation E

The HCIA recommends the review invest in ***consumer mapping analysis****, with full sector participation, identifying the different hearing health programs including the various eligibility and support services.*

The HCIA members have rich consumer data and are extremely willing to participate and contribute to this analysis in order to design a program simplicity which enhances efficiency, accessibility and consumer outcomes, especially when a consumer may be eligible for more than one program.

The HCIA recommends that the insights from this analysis should form the basis for any future program enhancements and reforms including the development of program objectives and critical areas of data collection.

Recommendation O

HCIA members recommend that to maintain consumer's ability to make informed choices regarding their rehabilitation device/s, the current arrangements, which include their provider assisting them, should remain. It is recommended that the quote framework and associated paperwork for efficiency and timeliness only be applied to the devices which are to be fitted to the consumer.

Recommendation P

The HCIA recommends that consumer choice of their hearing healthcare provider is paramount to the tenet of the HSP. Adults with more complex needs should not be disadvantaged, and therefore a "Complex Consumer" category should be created that is accessible to all accredited HSP providers.

Recommendation Q

The HCIA recommends that the CSO would provide greater consumer benefit to those that need it and meet the objective of the nature of a CSO if Hearing Australia are mandated to focus its extensive government funded resources into servicing CSO thin markets, especially indigenous hearing health, rather than concentrating in non – complex adult consumer. segments in urban and major regional areas which are already well serviced by HSP providers. Further, more effort should be placed on advertising the CSO program to consumers to expand its reach and impact to those it has been designed to service.

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

What are the advantages and challenges of having hearing appointments by telehealth?

Are there other technologies, or service delivery channels, that consumers could benefit from in the Program?

7.1 The HCIA supports the continued adoption of telehealth for consumers where telehealth is suitable.

Telehealth was fast-tracked during the COVID pandemic and telehealth benefits have now been tested and measured. Consumer comfort and satisfaction with telehealth has been evident wherever telehealth has been clinically appropriate. The majority of HSP consumers are elderly and during the pandemic were very reluctant to leave their homes, even to obtain medical care.

At the same time their communication needs to use a telephone, receive news updates and connect with family and friends was never more crucial.

The HCIA views telehealth as an alternative channel for consumers. Telehealth could enable immediate assessment and triage via agreed remote clinical processes and improve service provision for those with mobility issues and chronic co-morbidities. Telehealth would support remote service provision addressing the human resource challenge many providers have in staffing remote centres through remote service provision.

HCIA members would like to congratulate the DoH staff for their ability to make changes to the HSP very quickly as a result of the COVID-19 situation. This agility made a big difference to a number of hearing-impaired people.

7.2 Telehealth requires strict oversight. To ensure there are no negative impacts on consumer outcomes, program protocols and guidelines for routine telehealth post COVID are required. These should include candidacy, consent, privacy, and ongoing monitoring of outcomes, as well as prioritisation of consumer choice

7.3 HCIA members believe it is critical for the HSP to support any person experiencing hearing issues to access, whether via telehealth or otherwise, with a baseline hearing assessment from a qualified audiologist or audiometrist to triage their care and discuss options as applicable. Should any device categories be considered that are not based on a prescriptive algorithm, it should be on the basis that the consumer has choice and control over the device and has the benefit of clinical advice in this process, given a comprehensive rehabilitation program is more than device provision alone.

7.4 While telehealth has been a great development for remote service delivery, HCIA has general concerns about technology quality of testing and assessment and specific concerns about the potential separation of the hearing care professional conducting telehealth services from the provision of a hearing aid - fracturing an otherwise holistic care package. As part of the introduction of telehealth, is essential that a qualified audiologist continue to prescribe the device.

7.5 HCIA members generally recognise that there is a need for providers to provide convenient access to hearing health services to consumers. However, this is not a case of ‘one size fits all’. Consumer choice is an important consideration in delivery channel evolution. Hearing and communication outcomes are a paramount consideration for the HCIA. All future service delivery channels, including telehealth must carefully screen consumers for suitability. It is noted that many consumers <16 and >65 may not be as familiar and have regular use with technology. Face to face consumer management will remain important for this group.

7.6 HCIA encourages the government to consider a tele audiology model where the hearing care professional involved prescribes the hearing aid (where appropriate) and not a model where the hearing care professional provides advice on hearing aids obtained elsewhere. This aligns to the ISO21388 standard for Acoustics – Hearing Aid Fitting Management (HAFM) where selection, fitting, verification and follow up are part of a coherent package, The HCIA would therefore be very pleased to consult further with the Review in relation to this issue.

7.7 In relation to advances in hearing technologies, we note that:

a. The HSP does not provide any specific funding for HSP-eligible consumers where cochlear implant candidacy may need to be clinically explored prior to referral to an implant clinic.

b. There is currently no post-implant funding for refitting of an implant compatible device in the other ear (i.e. compatible with implant functioning and accessories), or adjustments to optimise the hearing device for a bimodal fitting.

Recommendation E

The HCIA recommends the review invest in ***consumer mapping analysis****, with full sector participation, identifying the different hearing health programs including the various eligibility and support services.*

The HCIA members have rich consumer data and are extremely willing to participate and contribute to this analysis in order to design a program simplicity which enhances efficiency, accessibility and consumer outcomes, especially when a consumer may be eligible for more than one program.

The HCIA recommends that the insights from this analysis should form the basis for any future program enhancements and reforms including the development of program objectives and critical areas of data collection.

Recommendation N

The HCIA support the continued adoption of telehealth for those consumers for whom it is suitable as it has increased the range of options available to provide hearing health services to consumers.

Question 8: Does the Program sufficiently support consumers in thin markets?

Are hearing services accessible to those who require them, irrespective of where they live or the size of the consumer group with particular needs?

Are the range and levels of government supports effective or are there further issues that need to be addressed?

8.1 The HCIA recognised the significant role Hearing Australia has in servicing the thin markets under the CSO Scheme.

8.2 Australia has one of the worst rates of indigenous hearing health in the world. Much more can be done to improve indigenous hearing health, and this was a key recommendation of the Roadmap for Hearing Health. Additional funding measures in the 2020/21 Federal budget were welcomed.

8.3 The 11 November 2020 edition of the Deafness Forum of Australia's (DFA), a very well-regarded sector newsletter 'One in Six' described in detail the challenges of indigenous hearing health and specifically in relation to employment outcomes[25]. The DFA noted: "*Looking at employment outcomes. People aged 18–64 years with a moderate, severe or profound hearing impairment had different labour force outcomes than people with no measured hearing impairment. For example: 37% were employed, compared with 57% with no impairment 60% were out of the labour force, almost double the proportion of those with no impairment (31%)".* The HCIA is aware that the One in Ten campaign also remains a priority for DFA.

8.4 The HCIA members emphasise to the Review Panel that the HSP's Voucher Scheme currently supports access to 52% of the hearing-impaired people in Australia and can also be considered to be a 'thin market'. More needs to be done to achieve the early intervention and the longer-term health benefits for the hidden category of the remaining 48% who are not receiving hearing

[25] ABS: National Aboriginal and Torres Strait Islander Health Survey 11/12/19], the Deafness Forum of Australia (DFA)

health care.

8.5 Within the context of this review, the HCIA believes the Government needs to consider, from a policy perspective, how much more it can – and wants to - cut from hearing health services, and why?

Does the Government want to make any such cuts without a complete understanding of the impacts, the eligibility criteria and perpetuate the inconsistencies we have highlighted, or does the Government want to make a real difference? The Government has a choice to make.

8.6 The significant correlation between hearing health and dementia is a 'whole of government issue' especially given the number of dementia patients projected in Australia. The needs of aged care residents, achievement of equity, the WHO's 'Healthy Ageing' initiative and its impact on Australia need to be carefully considered by the Government. If the Government decides to make funding or eligibility cuts to hearing health, the longer-term population health consequences need to be fully appreciated and fully accepted.

Recommendation E

*The HCIA recommends the review invest in **consumer mapping analysis**, with full sector participation, identifying the different hearing health programs including the various eligibility and support services.*

The HCIA members have rich consumer data and are extremely willing to participate and contribute to this analysis in order to design a program simplicity which enhances efficiency, accessibility and consumer outcomes, especially when a consumer may be eligible for more than one program.

The HCIA recommends that the insights from this analysis should form the basis for any future program enhancements and reforms including the development of program objectives and critical areas of data collection.

Recommendation A

The Government has an obligation to provide support to all Australians adversely affected by hearing loss and therefore the Government's objective should be 'to improve ALL hearing health in Australia'.

Recommendation B

The objectives and scope of the Government's flagship hearing-related program will have optimum relevance and impact if there is greater 'whole of Government' consistency across the different hearing health programs.

Recommendation C

The overall management of the hearing health of all Australians should reside within the HSP.

Recommendation D

The current HSP scope is narrow. Consistent with the broader objective of improving ALL hearing health in Australia, program access and subsequent eligibility criteria should be updated so that the Program does not unnecessarily exclude certain categories of vulnerable people who are at risk of being disadvantaged due to hearing loss.

Recommendation F

The HCIA recommends that the HSP eligibility criteria and service design be changed to enable the following categories of people to access HSP services:

- *residents of aged care homes or receiving in-home care*
- *Disadvantaged people from Culturally and Linguistically Diverse (CALD) backgrounds*
- *People in prison*
- *People experiencing homelessness; and*
- *Financially vulnerable and low-income earners (aged 26 - 64).*

Recommendation Q

The HCIA recommends that the CSO would provide greater consumer benefit to those that need it and meet the objective of the nature of a CSO if Hearing Australia are mandated to focus its extensive government funded resources into servicing CSO thin markets, especially indigenous hearing health, rather than concentrating in non – complex adult consumer. segments in urban and major regional areas which are already well serviced by HSP providers. Further, more effort should be placed on advertising the CSO program to consumers to expand its reach and impact to those it has been designed to service.

Recommendation I

The HCIA recommends that a standard screening protocol be developed for those >55 or 60 years, and that this be communicated to primary healthcare providers.

Question 9: Are there opportunities to improve the administration of the Program?

What is your experience with the administration of the Program, have improvements been well targeted and smoothly implemented, and how do you think the administration could be further improved?

9.1 HCIA's members would like to take this opportunity to compliment the Voucher Operations Team, and Compliance Support teams within HSP who provide outstanding service to support providers on a daily basis, well above all experiences with other government programs, such as the NDIS and Home Care Package.

9.2 Providers support any reduction in administrative burden and have appreciated the recent improvements - for example, elimination of medical clearance requirements and consumer signatures on claim forms. However, there are some administration issues providers would wish to raise:

a. Whilst fully appreciating the need for pricing transparency in the hearing care industry, the requirement to provide a detailed quote for devices which may or may not end up being provided to the consumer, and sometimes at no cost to them, has confused many consumers and disrupted focus from clinical care to discussing and explaining details and figures.

b. Providers would like to see this process reviewed to simplify exactly what is required on quotes to meet the basic requirements of the Legislative Instrument and remove the level

of detail as proposed on the 2019 Schedule of Service Items. Other methods of ensuring program consumers are aware of costs of fully subsidised options could be explored such as including this in a standard format provided to them when considering fitting options, requiring signatures only on detailed quotes related to the devices actually being fitted.

c. When new documents are released, there are sometimes subtle changes to wording that are not clearly identified in the accompanying information, which can change how the requirements are interpreted. An example of this was the proposed revision earlier this year to the Schedule of Service Items where many small changes to claiming requirements were seen but not actually identified. Providers request that all changes in wording to such documents are clearly identified so that providers can fully evaluate their impact and ensure compliance.

d. On occasion, conditions of claiming are changed without being brought to the attention of providers and this causes many difficulties. For example, on 1 October 2020 CSPN number 202012 (this is a message to all providers on HSP website) noted that an updated version of the Services Schedule would be available on the program website and portal. This did not seem to occur. However, on 1 November 2020, without any information being sent to providers, this new Schedule of Service Items was published on the HSP website and it contains other changes apart from the expected reserve gain requirement. Detailed review by a provider has found there is a new allowable review activity (930/940) i.e. now eight activities, whereas there used to be seven, being: “A review of consumer's expectations and appropriate use of communication tactics”.

9.3 The paperwork requiring consumer signatures is very time-consuming, can be redundant at times and, due to the number of forms needing signatures, can lead to providers being non-compliant, even when the consumer is very happy with the outcomes. For example, for one consumer, a provider needed written consent to check the portal, a signed Consumer Agreement, and a signed Maintenance Agreement. If the provider is missing one of those forms, they are non-compliant and the claim for a fitting must be recovered, regardless of whether the consumer is happily wearing his/her hearing aids or not.

9.4 The focus of the HSP has shifted away from consumer outcomes. An example of this is the strict refitting rules, despite the schedule of devices being updated. If a provider has a consumer who has a hearing aid replaced (typically due to a lost device) it is common right now to not be able to replace it with the same device. HSP has made it clear that the consumer must be fitted with mismatched technology until such time we can prove they have poor outcomes. In this time of synchronous hearing aids, which use different controls on each hearing aid to adjust both aids, 99% of consumers have poor outcomes because they either no longer have the flexibility of up and down volume changes as well as program changes, or they are asked to use two different remote controls.

9.5 During COVID there have been no requirements for a statutory declaration to be obtained for lost devices. This has significantly improved the ability of providers to replace devices in a timely way and ensure minimal impact on consumers, particularly for consumers who depend on carers. It is requested that this change remain as a permanent change to ease consumer burden.

9.6 In terms of NDIS, providers complete all paperwork required for NDIS consumers, and then the consumer is told to go to Hearing Australia once approval has been given. Why don’t NDIS consumers just get HSP programs? This change would help so many people who need help. The providers all know how to use the system and the processes are already set up, so it is so much easier for the consumer (and no NDIS paperwork).

9.6 The paperwork for NDIS funding requires simplification. The process typically takes hours to complete, and the decision takes many weeks to process. The NDIS staff always end up telling the consumers to go to Hearing Australia, even when the consumer is not HSP eligible and they are self-managed.

9.7 HCIA proposes that the HSP review recommends the establishment of an *industry consultative committee* to work with government and the HSP to identify consumer outcome opportunities, program efficiencies and improvements as well as improving stakeholder consultation. The Program would benefit from an Industry meeting every three - six months.

9.11 The HSP's 'home' location within the Government departments is an important issue. The HSP is constantly being tinkered with and then moved around within the DoH. This seems to de-prioritse a focus on HSP issues within the DoH and makes the HSP's interface with other departments problematic for the end user. The HCIA recognises the need to 'find a home for hearing health'.

Recommendation E

*The HCIA recommends the review invest in **consumer mapping analysis**, with full sector participation, identifying the different hearing health programs including the various eligibility and support services.*

The HCIA members have rich consumer data and are extremely willing to participate and contribute to this analysis in order to design a program simplicity which enhances efficiency, accessibility and consumer outcomes, especially when a consumer may be eligible for more than one program.

The HCIA recommends that the insights from this analysis should form the basis for any future program enhancements and reforms including the development of program objectives and critical areas of data collection.

Recommendation R

The DoH and its staff should be recognised for their agility in making changes to the HSP during COVID-19 to ensure consumer access and support. The HCIA supports recent improvements to reduce administrative burden in the program and encourages further streamlining and simplification by the establishment of an industry consultative committee to work with government and the HSP to identify consumer outcome opportunities, program efficiencies and improvements as well as improving stakeholder consultation.

Recommendation S

The HCIA recommends sector consultation and early notification of any proposed HSP changes are the two most critical factors to be considered in planning future program delivery changes. HCIA welcomes working with government to create and execute a HSP which delivers consumer, government and provider outcomes.

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

What data should be collected by the Program? Who should hold the data? What data should be published, and for what reasons?

Is there a need for more data about hearing and hearing loss in the wider community beyond the Hearing Services Program?

Other than the department, who or what government agencies should be able to access the data and for which purposes and with what consumer privacy protections?

10.1 HCIA members strongly recommend that the review engages in extensive consumer journey mapping and via that process and subsequent analysis the areas of ongoing critical data collection to develop accurate and timely consumer insights that inform program design and effectiveness will be plainly evident.

Recommendation E

*The HCIA recommends the review invest in **consumer mapping analysis**, with full sector participation, identifying the different hearing health programs including the various eligibility and support services.*

The HCIA members have rich consumer data and are extremely willing to participate and contribute to this analysis in order to design a program simplicity which enhances efficiency, accessibility and consumer outcomes, especially when a consumer may be eligible for more than one program.

The HCIA recommends that the insights from this analysis should form the basis for any future program enhancements and reforms including the development of program objectives and critical areas of data collection

Appendix 1: Consumer Satisfaction Rates in Twelve Countries Across Four Different Hearing Device Procurement Market Types

	State organized (tender)				Balanced markets, freedom of choice, recognized profession, reimbursement system						Fully private	Deregulated
	UK	NL	DK	NOR	IT	FR	DE	BE	CH	PL	ES	JAP
Adoption rate	47.6%	41.1%	53.0%	49.1%	29.50%	41.0%	36.9%	30.7%	41.4%	21.4%	36,5%*	14%
Overall satisfaction rate	74%	73%	71%	74%	81%	82%	76%	80%	81%	79%	78%	39%
Satisfaction rate for fully or partially reimbursed market	n/a	n/a**	n/a**	n/a**	86%	n/a	n/a**	n/a**	n/a	n/a	n/a	n/a
Usage rate (less than 1 hour use per day)	18%	15%	16%	22%	11%	14%	12%	13%	12%	17%	11%	23%
Non users (0 hour per day)	8%	5%	8%	7%	6%	7%	6%	5%	2%	9%	6%	7%
Satisfaction with current HA: . Professionalism of the dispenser	86%	n/d	85%	80%	86%	87%	87%	93%	90%	81%	86%	60%
Satisfaction with current HA: . Quality of service after purchase	81%	n/d	84%	74%	84%	86%	86%	91%	95%	80%	79%	64%
Percentage of hearing aids owners who declare that their hearing aids improve their quality of life	94%	93%	94%	93%	97%	97%	97%	95%	99%	94%	98%	84%
Percentage of hearing aids owners who declare that their hearing aids work better or as expected	85%	85%	85%	79%	88%	75%	82%	73%	80%	70%	82%	60%