IAA Response to Review Questions

1. **What should be the objectives and scope of the Program?**
   Rehabilitation of eligible Australians living with hearing loss and/or ear, hearing and listening associated conditions.

   Rehabilitation should mean optimising communication through a combination of counselling (of the individual with hearing loss and/or significant others), communication training (of the individual with hearing loss and/or significant others) and the use of technology matched to the needs, capabilities and environment of individuals with hearing loss. A shift in focus from device distribution to rehabilitation within the voucher scheme is expected. We urge the HSP to cover at least six sessions of aural rehabilitation per voucher, to be carried out by audiologists for all voucher holders with any auditory dysfunction, regardless of whether or not they also benefit from hearing device use, and not conditional of hearing devices being fitted.

   Some aspects of the program, such as paediatric care, were intended to transfer to the NDIS as of 1 July 2020. It is regrettable that this did not occur as planned as the integration of hearing care into overall management of associated disabilities is a far preferable model to the provision of hearing services in isolation, as per the Hearing Australia model, which was developed prior to Medicare and the NDIS, and ought to have been incorporated into other systems by now.

   We are pleased that hearing services for those 26 years of age and over did shift to the NDIS as of 1 July 2020 because NDIS participants have choice and control as to who their provider is. We anticipate further changes in future once transparency in standards for paediatric audiology is achieved, to bring hearing services in line with all other allied health and rehabilitative services. The Hearing Health Sector Alliance (HHSA - a self-appointed group that functions by invitation and a substantial joining fee) has been funded by the Department ofHealth to develop standards for paediatric audiology to be made available across the sector. The HHSA has allocated that funding to Audiology Australia and tasked them to develop standards for paediatric audiology to be publicly available. We look forward to those standards being readily available so that there can be no further barriers or objections to the transfer of hearing services for those 26 years and under to the NDIS.

   We support the transfer of hearing services to the NDIS for all those 65 years and under who are eligible is to allow patients to receive all services and devices from their audiologist of choice. We recognise that the NDIS does not cater for those 65 years of age and older who develop hearing needs. We believe that those (regardless of age) who are funded by the CSO managed by the HSP ought to have the same choice and control over who provides devices and services as those funded under the NDIS.

2. **Which consumers should be eligible for Program subsidies?**
   The voucher scheme should be open to Australian pensioners, veterans, first nations people and those on low income, living with hearing loss and or associated conditions.

   Community Service Obligation (CSO) funding should be available to all families, regardless of which provider they choose.

   CSO funding should be available to all eligible Australians and would ideally transfer to the NDIS for those 65 years and under. The transition of hearing services to the NDIS had been planned since 2013 when the NDIS discussions about hearing services first began. CSO funding was set to continue for those over 65 years with complex needs. The longstanding arrangement for CSO funding (for any ages for which it is applicable) to be allocated to only one provider (Hearing Australia) is outdated and denies choice and control to families.

   Industry is calling for hearing screening at around age 50 years, in line with other public health programs that screen for diseases that benefit from early intervention.

3. **How well does this Program interface with other schemes?**
The HSP is very poorly interfaced with other funding schemes.

HSP staff members do not understand the rules of the NDIS and vice versa. Local area co-ordinators and planners working with the NDIS regularly confuse Hearing Australia with the HSP, and direct NDIS applicants to Hearing Australia, even if they are not eligible for HSP funding (voucher or CSO).

The voucher scheme requires software that is outdated and is not compatible with claiming systems that allow for electronic claiming to Medicare. HSP contracted hearing services providers who are audiologists are also highly likely to be Medicare providers. Claiming software for the HSP has to function separately to other software programs that allow for claiming to Medicare. The software options for the HSP are dated and inflexible.

Contrasting working within Medicare and the HSP systems as audiologists highlights the punitive nature of the HSP voucher scheme. Contracting to hearing services providers who are businesses not necessarily healthcare professionals is one marked difference that appears to drive the punitive nature of the HSP voucher scheme for all providers. Another anomaly is that that clinical reports written by audiologists are not paid for under the HSP, but they are paid for under the NDIS, and that clinical notes belong to the Commonwealth and not to the clinician writing the notes.

4. **Does the Program sufficiently support hearing loss prevention?**
We recommend a shift to focus from prevention of hearing loss to prevention of the sequelae of untreated hearing loss (communication, cognitive and social difficulties and disorders).

Rehabilitation is the means to prevent of communication breakdown that affects relationships, cognition and capacity to work in and engage in society. To date the focus of the program has to the best of our knowledge, focussed on the prevention of noise induced hearing loss. Noise exposure is well catered for in industry, the military and other sectors at risk for noise induced hearing loss. In addition, Australian States and Territories have Workplace Health and Safety regulations and Codes of Practice for Hearing protection.

Hearing loss prevention being a federal government priority means that there is doubling up, unless there was a move towards adoption of a single national code of practice for hearing protection to replace the policies in place in all states and territories. Nonetheless, the HSP could contribute to hearing loss prevention by funding audiological counselling and noise protection equipment to those they fund via the voucher and CSO schemes.

The HSP should focus on rehabilitation as the means to prevent cognitive change, for which there is substantial evidence results in part from untreated hearing loss in older adults.

5. **Are the Program's assessment services and rehabilitation activities meeting consumer needs?**
One claimable hearing review per year and conditional rehabilitation related claims force a one size fits all model onto managing hearing loss even though the same hearing loss manifests in different ways across individuals. Individual tailored rehabilitation matched to assessment driven needs cannot have so few and such conditional claims to be effective.

If a patient experiences a change in hearing, the audiologist must conduct an audiological assessment to establish if there has, in fact been a measurable change in hearing threshold or auditory function. Best practice is to conduct a full audiological assessment to determine if hearing reported to have changed is due to conductive or sensorineural (or mixed) conditions to that the appropriate actions can be taken – such as referral to a medical specialist, further assessment of auditory processing, or further monitoring. Voucher holders assume this additional assessment will be funded under the Hearing Services Program. Voucher holders who have used up their assessment claim usually are evaluated by their audiologist at no charge, as the option to apply for a return voucher requires evidence of a change in hearing.

The rules do not allow for a reimbursement or claim for an assessment conducted prior to the return voucher issue date, so in order to claim and proceed with further eligible claims, a repeat reassessment has to be carried out, thus wasting valuable clinical time in a pointless exercise to satisfy an administrative rule that has no clinical value. Reassessment is to be allowed annually from 1 July 2021 for all voucher holders, which will offer some assistance, but will not change the fact that those needing a reassessment and a further appointment for an aid adjustment or further rehabilitation will still only have one claimable appointment per year, which will not be sufficient where significant changes to functioning have occurred – which is very common in the elderly – the demographic served by the HSP voucher scheme. Where hearing changes, counselling, adjustment of hearing aids and further advice on monitoring and communication are needed. Comprehensive audiological care requires at least two consultations to cover all the necessary aspects of a revised rehabilitation program.

The use of hearing devices issued within the voucher scheme has been shown to be less than optimal (Hogan, Donnelly, Ferguson, Boisvert, & Wu, 2020), and this means that the assessment services and rehabilitation are not working to identify which voucher holders are ready for intervention. Too many voucher holders are encouraged to obtain hearing devices even though they may not be motivated or supported to use them, as funding relies largely on device fitting. Too few voucher holders fitted with hearing aids by non-audiologists are referred to audiologists for individualised, assessment driven rehabilitation, that only audiologists are trained to provide. The device focus and claim system of the scheme is such that referrals by non-audiologists to audiologists hardly ever occurs within the voucher population.

Rehabilitation services funded by the HSP are conditional on either having no hearing device or a fully subsidised device. Some patients are motivated to purchase top up hearing aids, but they then are not allowed to access 680/681 claims for rehabilitation plus to provide additional support. The conditions attached to claiming rehabilitation services under the voucher scheme are not consistent with an individualised, assessment driven, tailored intervention program that should be delivered by an audiologist to all Australians funded by the HSP. The HSP requires separation of device fitting/follow-up/review appointments from rehabilitation appointments in order to claim for the rehabilitation program. This is an artificial separation. Voucher holders deemed "complex" are forced to change provider to Hearing Australia if they wish to access CSO funding. Similarly, children and young adults (26 years and under) are forced to attend only Hearing Australia if they are to benefit from public funding. CSO funding was historically provided to Hearing Australia so that clients with complex needs could receive extra services. Voucher holders s deemed "complex" are forced to change provider to Hearing Australia if they wish to make use of CSO funding. However, Hearing Australia offers limited rehabilitation services with most complex clients only being seen for one annual review. The CSO funding is being used in many cases to provide complex clients with higher level of technology, not extra audiological support, as was intended. RHearing Australia offers limited rehabilitation services and is mostly focussed on device supply. Most importantly, voucher holders deemed complex are forced to relocate from a provider who has supported their needs, sometimes for many years, to Hearing Australia which to them may be an unknown entity, just because their condition has become more complex. When relocating to Hearing Australia, the voucher holder with complex needs loses the benefits of choice, control and case continuity. Additionally, by relocating to Hearing Australia they face a limited choice of devices compared to the full range of devices available through independent practices, because Hearing Australia operates on a tender process with selected appointed device providers, thus not operating in the open market.

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

The program allows consumers who are voucher holders to choose their provider.
Whilst voucher holders can choose their provider, they cannot choose their intervention plan. Best audiological practice demands an individualised approach to hearing care and therapy, and yet, the current program is an outdated one-size fits all model of care with pre-defined numbers of claims that can only be made in a specific order, regardless of individual needs.

CSO funded consumers (children and adults) have to receive services at one provider only (Hearing Australia) or forgo funding.

Australians deemed most vulnerable have no choice or control over who their provider is. Many IAA members are regionally based and access to services for children and complex adults could easily be improved by allowing independent audiologists to provide services to those patients by introducing subsidies rather than block funding to one provider under the CSO arrangement. IAA members are vested in their communities, and already provide these same types of services to private patients with similar needs.

Choice and control for CSO (adult and paediatric patients) should be entrenched under the HSP.

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

The program focuses on device provision, despite research strongly supporting rehabilitation services that are not technology focussed. The program needs to pay audiologists to provide individualised, assessment driven, tailored rehabilitation, rather than the current approach of device distribution according to fixed model that is the same for all voucher holders.

During COVID 19, the HSP responded quickly to modify claiming criteria to accommodate remote / telehealth options. This rapid response was an indication that the scheme can be modernised relatively easily. We encourage further and permanent change to rely on professional autonomy rather than on pre-determined procedural checklists. However, we do urge caution regarding telehealth. Some manufacturers are very enthusiastic about telehealth options without providing evidence of efficacy, or patient confidence. Telehealth does not replicate in-house patient care, and whilst useful during pandemics, is not ideal and will not necessarily harbour excellent outcomes in the long term. Many HSP Voucher holders are elderly and not always technology-literate (with a number not owning mobile phones or computers). Those living in regional and remote areas may not have good internet access and may be disadvantaged during telehealth consultations, leading to reports to IAA members that they prefer and benefit far more from face to face consultations.

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

Geographically rural/remote areas: Funding is provided only to Hearing Australia to provide services in remote areas under the CSO agreement – yet many independent audiologists provide services permanent and regular visiting services in regional and remote areas, very often doing the work that Hearing Australia is funded to do (working with children with hearing loss, assisting adults deemed complex). CSO funding should be distributed to those who require it, allowing free choice of provider, and not be channelled only to one organization (Hearing Australia). CSO funded patients would then have regular access to providers and compliance is far more likely due to available follow up services and embedding of services in local communities.

Support type: (e.g. specialised supports with insufficient supply or low demand). The program does not sufficiently support independent audiologists to support those who are voucher holders who are also cochlear implant users, have auditory processing disorders, or other associated auditory or cognitive disorders common in the age group that most voucher holders fall into.

Voucher holders who have implantable hearing devices are typically have a regular independent audiologist who provides their implant mapping and care, under Medicare and/or private health insurance. However, implantable devices used by voucher holders can be maintained by the HSP under a very complicated system. Implanted devices are serviced (mapped) by an independent audiologist but implant consumables (batteries, cables, filters and repairs) for voucher holders are only obtained from Hearing Australia, whose audiologists do not map cochlear implants. Voucher holders who are implantees are caused unnecessary confusion about services, and face social and economic burden due to parallel agreements and additional travel to various providers. All implant related services could easily be provided

by independent audiologists if funding for maintenance was accessible outside of Hearing Australia.

Support for Aboriginal and Torres Strait Island participant: IAA members have local agreements with Indigenous not for profit (NFP) organizations to test children and community members. IAA members are locally embedded in their communities and are ideally placed to provide these services often in regional and remote areas under the CSO scheme. Under present arrangements they provide these services that government believes are funded through the CSO, for private fees or as pro bono work.

Support for Culturally and Linguistically Diverse (CALD) voucher and CSO recipients: Sign language interpreters are not included in the service provision for either voucher holders or CSO beneficiaries at Hearing Australia. NDIS offers language and community supports for participants, but the HSP does not offer this support at all. We note that older Deaf adults now have access to a funded interpreting service to access aged care services. In a significant omission, hearing services are not included in the list of services that can access the funded sign language interpreting services for elderly Australians. The lack of inclusion of hearing services into the sign language interpreting services available for older Australians within aged care is ironic. This omission is a clear example of the lack of understanding of the needs of those living with hearing loss. A basic consideration ought to be that the HSP supports sign language interpreting services for all voucher holders who are Deaf and their audiologists, with the HSP (at least) added to the services that can access funded sign language interpreting services.

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

CSO funding should be distributed based on need as a subsidy, not just allocated to one provider in block funding.

In the past, Hearing Australia was dedicated to providing publicly funded services primarily. Recently, they have changed their policies and advertise to attract private patients, offering prices of hearing devices that cannot be matched by the private sector due to their negotiated tender process that guarantees the government very low prices for devices. Given Hearing Australia's competitive approach in seeking to attract fee paying, private patients, their monopoly on CSO funding is no longer appropriate.

The HSP claiming system must be updated to allow audiologists to allow for use of the same practice management system for uploading claims to Medicare and the HSP.
The divide between contracted hearing services providers and practitioners within the HSP should be revised to match the Medicare rules whereby providers are practitioners.

Questions to the HSP by phone or email are often generically answered. For example, verbatim reading of the relevant rules from the written material already available to the provider. Typically no interpretation of these rules is provided, and yet the potential of punitive penalties applies if the provider does not correctly interpret these. Having access to a group or team of audiologists employed by the HSP, that are accessible, would be advantageous. Communication from the HSP is faceless, and without names. This leads providers to become disengaged and disillusioned with the system. The punitive focus of the HSP contributes to a lack of collaboration between the HSP and providers/practitioners.

The HSP collaborates with the self-regulating bodies that are deemed as a Professional Practitioner Bodies (PPB) on the basis of an ad hoc decision by the Minister of Health. The requirements to become a Professional Practitioner Body are tailored only to existing organizations with onerous requirements to monitor aspects of audiology training at universities, set standards for overseas qualified audiologists, and attend to complaints. We would like to see scope for recognition of other bodies as Professional Practitioner Bodies, such as IAA, that do not necessarily have to meet all the same criteria that the existing PPBs meet. It would seem that the list of criteria that was shared with IAA (when we requested this) was created post hoc, to match the activities of the existing PPBs, rather than being tailored to what is actually needed to be a PPB. For example, IAA could provide input to the HSP, provide training and counselling for its members and their staff, but would not have the

resources nor the desire to audit all university courses given that another organization already has full responsibility for that role. Self-regulating professions like audiology are at risk that those with the loudest voice are recognised as so called "peak bodies", ignoring the reality that peak bodies would normally represent organizations as well as individuals, and that any number of professional bodies can be formed at any point, and claim to represent the profession. A registration board overseen the Australian Health Practitioner Regulation Agency (AHPRA), would overcome this instability of self-regulation and would benefit the public in ensuring ongoing, overseen public protection. IAA's position on regulation has been widely distributed across government departments and has been raised in past inquiries.

The Hearing Health Sector Alliance (HHSA), an exclusive group only available for entry by fee and invitation, has presented itself to government as representing the whole sector, but there are many professional and consumer groups that are not part of that alliance. We encourage the HSP to publish the standards that guide who they take direction from, so that there can be ongoing transparency (not just during formal reviews or consultations) to reassure the public and the profession that decisions are made in a considered way from multiple perspectives.

The recently issued Regulation Impact Statement - Preventive Health – Ensuring a Sustainable Hearing Services Program (October 2020) is an example of misinformation and inaccuracies. Just one example "'Hearing aid technology has progressed dramatically since the establishment of the HSP … This illustrates the disconnect between consumers and their care, an inconvenience to them and an unnecessary expense to Government…. clients who had to go through the process and trouble of having a new device'" (Page 10). This statement is disrespectful to the entire hearing loss community – oversimplifying the impact of hearing loss and at the same denying an entire profession's skill base as an essential service to those living with hearing loss. The productivity commission and the subsequent decisions made to save money for government appear to be based on a belief that hearing devices (any device) can solve a hearing difficulty, that devices have a set lifespan that is independent of the progression of the individual person's needs, and that rehabilitation has no place. This is as far from person centred intervention as it is possible to be – yet this document is the justification of changes announced to the HSP effective 1 July 2021.

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

Decision making does not appear to be driven by data, but rather by the opinions of some. Layer upon layer of modifications over years appears to have obscured the original intent of many HSP rules. Intended outcomes may no longer be relevant to contemporary practice. For example, the removal of the 610 and 810 claims for Audiologists was based on the claim that these items were never meant to be used by audiologists. However, documents related to the Hearing Services Program back in 1997 clearly indicate in which circumstances these items could be used by audiologists. The removal of this item means that audiologists are providing advanced diagnostic site of lesion assessments pro bono in most cases, thus propping up and cross subsidising the HSP voucher scheme.

Ongoing and unexplained requirements to use tools (eg the WANT) with no evidence base (whilst at the same time calling for evidence-based interventions in the guidelines for providers) is a prime example of not using data to drive decisions. Persistence with the device distribution model rather than a person-centred audiological rehabilitation model, is another.

We encourage decisions to be informed by audiological science. Economic reasons should be related to cost effectiveness, not just cost saving, as appears to be the case for recently announced changes to the voucher scheme, to be effective 1 July 2021. The focus of the scheme should be on healthcare provision and audiologic rehabilitation, not device sales.

In summary, we see scope for the scheme to become rehabilitation focussed, address inequities in the CSO funding, reconsider maintenance and relocations item numbers, update the claim system to allow for use of modern practice management systems, providers to lodge claims, recognise the professional role of audiologists in working with individuals and families regardless of age or degree of difficulty, and pay audiologists appropriately for the services they deliver.

Attachment 1- Aural Rehabilitation

Rehabilitation is included in the list of hearing services (see Clause 5 (definitions), the Instrument). However, rehabilitation (claim item 670) can only be claimed if hearing aids have not been fitted. The rehabilitation program is expected to be delivered for $207.95. The amount suggests a single appointment, with no funding for a communication needs assessment, planning of an individualised therapy plan, series of appointments to achieve short term and long-term goals, or follow up. If the rehabilitation item is claimed, the voucher holder is not eligible to receive hearing aids. There is no gap fee allowed on services offered on the voucher, making the rehabilitation provision a very grey area as it would be impossible to provide a full rehabilitation program (excluding the fitting of a hearing device) for the fee paid. This item is rarely claimed.
Rehab plus (claim items 680 and 681) can be claimed for vouchers holders fitted with fully subsidised devices only.

The introduction of annual reviews for all voucher holders from July 2021 will assist in monitoring voucher holders and providing ongoing support, but will not cover the cost of a tailored, individual therapy program that may be needed.

Revision to the existing device focus of the voucher scheme is warranted. As shown below, and specifically addressed by Hogan et al. (2020), the voucher scheme provides access to devices, but does not reflect published literature that the provision of hearing devices must occur alongside the provision of counselling and communication training. This notion is not new, and nor is it untested. Traditional (now classic) rehabilitation models developed almost half a century ago demonstrated the need for public health models of multiple aspects of intervention to be provided in parallel before improved outcomes could be expected (Getty & Hetu, 1991; Hetu & Getty, 1991; Hetu, Lalonde, & Getty, 1987). Recent evidence as shown below supports a return to those models of care and indicates clearly that developments in hearing device technology have not negated the need for rehabilitation.

We provide a detailed explanation below of what constitutes rehabilitation based on common misunderstandings that hearing device provision constitutes rehabilitation. In doing so we draw on a recent presentation prepared for IAA by Prof Sophia Kramer, Department of Otolaryngology, Amsterdam Public Health Research Institute.

Two people with exactly the same audiogram commonly may have completely different patterns of complaints associated with their hearing loss. Whereas one person may still be completely happy to be fully engaged in social life, the other may feel continuously tired, avoid social gatherings and become isolated. Extensive research has shown that variation in patient complaints cannot be explained by peripheral hearing alone (see for example Füllgrabe, Moore, and Stone (2015)). As these and other published sources explain, variation in patient complaints cannot be explained by hearing sensitivity as reflected in the hearing thresholds shown on an audiogram or other tests of hearing sensitivity, but instead results from a complexity of auditory and nonauditory factors.

Auditory factors contributing to the impact of hearing loss fall into the domain of auditory processing such as spectral and temporal resolution which means the interaction between signals arriving at each ear and processed by the brain. This interaction and the ability of the brain to separate wanted from unwanted sound are factors that determine hearing and communication breakdown. Advanced diagnostic testing of auditory processing is usually undertaken by audiologists when factors in the case history suggest this is needed, where case history reporting does not match test results, where results between tests are inconsistent, or where progress from a basic intervention program is less than expected. Advanced diagnostic audiological assessment

and subsequent adjustment of an intervention plan to include extensive training and or adjustment to disordered communication is not factored into the existing HSP voucher scheme.

Voucher holders either have to cover the cost of this type of intervention themselves, audiologists have to offer this work pro bono, or audiological interventions are foregone. Although there is no direct study that examines the relationship between advanced audiological procedures and outcomes, Hogan et al. (2020) report that 24 % of voucher holders fitted with hearing aids admit to not using their devices regularly. As a group, voucher holders are typically aged over 75 years of age, when auditory processing can be expected to be degraded due to age, as well as to having lived with progressive loss of hearing sensitivity due to age and/or other noxious factors such as noise, ototoxicity, and due to accumulating co-morbidities. Identifying underlying auditory processing abilities can be essential to setting realistic expectations in any rehabilitation program, and is very likely for those who are in the 65 + age bracket.

Non-auditory factors (cognition and linguistic processing) play a significant role in hearing and determining the effects of hearing loss on individuals. Nonauditory factors are sometimes described as brain factors or top-down processing. Theoretical models that explain the role of the brain in listening include the Ease of Language Understanding Model (ELU) (Rönnberg, Holmer, & Rudner, 2019; Rönnberg et al., 2013). The ELU model is widely cited in audiology literature. The model demonstrates how speech signals are degraded by background noise or reverberation; or distorted by speaker variables (such as accent, word choice, language, topic changes, fluency, voice loudness) or listener variable (hearing, cognitive or linguistic ability).
Degraded speech signals compromise bottom-up processing so reliance shifts to top-down processing – making listening effortful and tiring. At least five cognitive functions are involved in daily life listening behaviours need support in the course of a hearing rehabilitation program:

Speed of information processing is extensively studied in many laboratories across the world. Time compressed speech presented to listeners consistently shows that as speech speed increases, understanding decreases, in particular in older listeners as a result of generalised cognitive slowing. Older people who also have a hearing loss have the difficulty with speed of information processing compounded by the loss (Gordon-Salant & Fitzgibbons, 1993; Lin, Thorpe, Gordon-Salant, & Ferrucci, 2011)
Rehabilitation provides support for the brains of older listeners older people, by training communication partners to change the rate of information, and the speed of their speech. Effective rehabilitation requires goal setting, training and carry over into real life. Providing a list of hearing tactics that includes to slow down the rate of speech <u>does not</u> constitute a rehabilitation program unless there is monitoring of the effectiveness of the strategy, and further training, modification and review as required.

Linguistic context is well documented as a determiner of communication effectiveness (for example Benichov, Cox, Tun, & Wingfield, 2012) who demonstrated the where no context is available, the effect of hearing loss is greatest, and that effect diminishes progressively with increased availability of contextual cues. Given sufficient context, people with hearing loss act like normally hearing peers, even when signal to noise ratios are very poor, demonstrating that what is needed is support the brain of listeners with hearing loss by providing adequate context.

Inhibition of irrelevant information means the ability to switch attention. Actively inhibiting unwanted sounds when listening to one person is an executive function. This ability is not directly measured in audiological assessment, but can be assessed indirectly by applying different types of competing or masking sounds and measuring discrimination ability to show that the type of competing noise that is most interfering is other people talking, or informational maskers, that making listening more effortful (Ng, Rudner, Lunner, Pedersen, & Rönnberg, 2013).

A common hearing tactic provided to those with hearing loss is to reduce background noise., but a comprehensive rehabilitation program involves training in identifying what sounds are most interfering, and developing strategies that suit that individual's circumstance – which may be to remove the source of the noise, remove the person from the noise, or avoid communication in a particular environment if the noise source cannot be modified , to avoid raised listening effort that results in exhaustion and leads to avoidance of social circumstances if not adequately addressed.

Working memory & linguistic closure applied to listening is usually predicted from reading test results. A high level of overlap occurs between the scores of individuals tested on visual memory and linguistic closure and ability to discriminate speech in noise, providing further evidence of cognition as a determiner of hearing and communication ability (Zekveld, Deijen, Goverts, & Kramer, 2007; Zekveld, Kramer, & Festen, 2011).
The undeniable role of cognition in hearing calls for a shift away from only focussing on the peripheral hearing system and hearing device provision as the primary (often only) form of intervention, toa focus on the whole auditory and cognitive system that does not separate brain function from ear function. Consistent with this is the shift in audiology away from consultations that focus on choosing a hearing device, to a focus on function and communication needs assessment (Spoor, 2020). Evolving research on the role of the brain in hearing clearly shows the revival of communication strategies training, not simply providing a list of strategies that the public has probably been provided with through various organizations, but a tailored, assessment driven rehabilitation program that is monitored and review for outcomes.

Laplante-Lévesque, Hickson, and Worrall (2010) identified that the primary intervention for Australians with hearing loss is the provision of devices, yet fewer than half of all participants in their study selected hearing devices as their first intervention when given a choice between devices, communication training, self-help information or no intervention. This result is consistent with reports across the world (regardless of funding model) that the uptake of devices is less than 50% of those with hearing loss (Valente & Amlani, 2017). Of note is that almost one in five participants opted for communication training as their first option, in contrast to popular perception that the public are not willing to engage with communication training.

Adult acquired hearing loss is a long-term condition that requires lifelong management. Even those who use hearing devices continue to experience activity limitations or participation restrictions that remain without effective self-efficacy. Hearing aid fitting combined with a self-management support program results in less hearing handicap, better quality of life, improved verbal communication over the short term, and results in slightly more hearing aid benefit over the long term (Preminger & Rothpletz, 2016). Of importance is that rehabilitation does require guidance and monitoring of outcomes by audiologists in order to ensure tailored programs and effectiveness – in particular for older individuals coping with declining abilities and common co-morbidities (Tye-Murray, 2018).

Providing hearing devices to all those with hearing loss as the first (and/or only) intervention is poor use of public funds, as we can fully expect that less than half of those individuals will make regular and routine use of those devices. The current voucher scheme allows for a choice between a series of counselling and communication training sessions and a hearing device, which, given that a voucher will only be issued once every 5 years from July 2021, is an unfair choice. Those who opt for fully subsidised devices are entitled to two "Rehab Plus" appointments after the fitting of the hearing aid. The restrictive rules of the voucher scheme are not grounded in clinical or demonstrated need, but on an attempt to provide the same services to each person with a hearing loss, and to insist on a sequence of consultation types within time frames are unlikely to suit any particular individual, but are based on averages or for the convenience of funders, rather than being driven by patient need.

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Attachment 2 – Working with the HSP

1. Relocations
2. Minimum Hearing Loss Thresholds and the WANT
3. Community Service Obligations and the HSP
4. Fees, Charges and Records
5. Claiming

The Hearing Services Program (Voucher) Instrument 2019 is referred to below as "the Instrument"). Fees are referenced to the 2020 – 2021 Schedule of Fees. The contract referred to is the current contract

1. Relocations

HSP Rules

Voucher holders can relocate between contracted hearing service providers (Clause 35 of the Instrument).
Relocations require the new provider to gain permission in writing from the voucher holder and then lodge the relocation on the HSP portal.
The new provider can put in a claim for maintenance if the voucher holder already has hearing aids ($241.50 for binaural fittings).
There is no claim for assessments if the first provider has already claimed for an initial assessment. The expectation is that records provided by the old provider will be sufficient for the new provider to provide further audiological advice.

Impact of the HSP Rules

IAA members report that they attract many more relocations of voucher holders to their clinics than relocate away. The right of voucher holders to choose their own provider is an important aspect of the scheme. However, relocations to clinics are costly for the new provider. The relocation maintenance claims 711 and 722 of $119 and $241 respectively do not cover the full cost of providing a review and maintenance of devices to a relocating voucher holder. The *average* cost to the clinic (i.e. costs not covered by the HSP) is estimated to be $300.00 per relocated voucher holder. Costs are made up of unclaimable assessments, time interviewing the patient to understand their concerns and reason or relocation, provision of batteries and other hearing aid consumables, and repairs for devices that are out of warranty at the time of relocation particularly given that Hearing Australia only off the minimum warrant of 12 months. Costs can be much higher than the average, with the clinic itself having to pay any shortfall.

Relocations to independent providers sometimes creates a highly competitive environment whereby voucher holders are enticed to relocate back to their original providers with offers and deals. The reason for the competition is not the immediate benefit to the original provider, but the prospect of claiming over again when a new voucher is issued, and the voucher holder is again eligible for a subsidy for new hearing devices.

"Shopping around for the best deal" is encouraged by the Australian Competition and Consumer Commission (ACCC) in regards to hearing aids (see https://www.accc.gov.au/consumers/health-home-travel/hearing-aids). However, the HSP, who shares the ACCC recommendations with voucher holders, does not pay for second opinions and does not discuss the impact of quality of service or expertise of the audiologist as important to decision making, focussing only on price. Some of the ACCC recommendations are based on assumptions that services like hearing assessments are sales tactics and ought to be offered for free and that results from screening are adequate for audiological diagnosis and are transferrable between clinics. Relocations are a form of second opinion for HSP voucher

holders. Relocations to independent practices occur typically because of dissatisfaction with the service or product the voucher holder has received elsewhere. Many voucher holders who relocate have no claims available on their voucher for services necessary to solve the difficulties experienced by the voucher holder. The new provider must either charge the voucher holder (unclear in the documentation as to whether this is allowable – see below), offer services for free, or not provide necessary services leaving the voucher holder with poor satisfaction. The last option would very rarely be taken by audiologists who would be seeking to assist the public and maintain their professional reputation within their local communities.

Examples of working with HSP voucher holder relocations

“Voucher holder's ENT (specialist doctor) encouraged him to see us for 2nd opinion re hearing aids and voucher holder requested to relocate. File had not arrived prior to appointment (requested 9 days before) so we had to do full assessment (asymmetrical loss, poor discrimination in one ear). 800 and 830 had been claimed by previous provider so we couldn't claim (not even a 940!). Both aids were faulty so had to be sent for repair - both aids out of warranty so repair cost to us was around $330, plus we had to make a second appointment to check REM and adjust. After repair and REM evaluation we decided to try moulds instead of domes, so we had to pay for moulds ($70) and then get voucher holder back to fit them. So - 3 x appointments which we could have charged a private voucher holder up to $200 each for, + $400 in repairs and parts so far - $1000+ worth of service for a relocated MTN fee of $253.58”.

“Often 940 (review appointment) has been done by previous provider, but voucher holder is unhappy, and 2-3 appointments are required”

“If someone relocates, it is often because they were fitted with the wrong hearing aid for their needs by the first provider. They might need a mould made up to help retention of the device, this cost comes out of our battery and maintenance. The voucher holder is often only been fitted with a device within 12 months and don’t know how to use the device. But we can’t claim annual review because it’s not been 12 months yet.”

“Main thing is about broken aids and repairing. You have to have an initial appointment with them and then multiple appts to fix. However, I don't want to trap patients into having to stay with a provider - I'd hate to see the HSP impose a time limit for changing (providers) on patients”.

“Relocating voucher holders who have been previously fitted will oftentimes not have any claimable appointments available. This means that to provide any care is at a cost to the business”

“We are associated with an ENT clinic, so voucher holders often come that route and it is not always clear (or appropriate to decide) if they will be HSP voucher holder (new or relocated) until we see them. There is always a delay in receiving relocated files that means delays for the voucher holder and extra appointments needed. More info available directly through the portal would be good. Also - The info on the portal about previous providers is not helpful - it would be good if there was an email address and phone and fax number listed so we could make contact with providers more easily to obtain information”

“Previous provider gets paid for assessment, but voucher holder needs to be reassessed due to relocation. Most voucher holders relocating to us are uncomfortable with sales pressure from the major chains. They attend their first hearing assessment that was initiated from a cold call from a multinational company. The voucher holder often feels pressured to go to these appointments and then further pressure to purchase top ups and aren't offered the free to voucher holder aids. We had a circumstance where a voucher holder relocated to us from a multinational company and the voucher holder was then hounded via phone and email to reconsider and go back to them and purchase the expensive aids. In this instance where a voucher holder feels so put off by their previous provider and they come to us looking for assistance and we do a reassessment and reassure them that they don't need to spend that kind of money to get hearing aids. Sometimes the voucher holder is still wary and doesn't want to get aids anymore as they have been scarred by the previous provider. We don't get any compensation for the reassessment and if the voucher holder decides not to go ahead with aids then we don't get anything at all. We had a relocation where the voucher holder had just been fitted before she moved to the area. So, she wasn't due for anything when she came in and transferred. She was having problems with her moulds. We took new impressions and then fitted her with new moulds. Her aids also needed adjusting. No claim was able to be done for 2 appointments.”

“Patient relocates with broken hearing aids, only a year old but out of warranty (Hearing Australia only offer 12-month warranty). Had to repair both aids ($400) and see them for a check and a reprogram (2 hours of time-audiology alone)”

"Having to do complete reassessment as voucher holder is often dissatisfied with previous results/hearing solution. Time and cost factor especially considering that new software may have to be learnt for another brand of aid".

"Voucher holder has relocated. The voucher is current, but the assessment has been claimed. Voucher holder feels hearing has deteriorated and is not hearing well with aids. Hearing needs to be reassessed. REM shows aids are under-amplifying and require servicing. Voucher holder's hearing aids are outside of the warranty period and the repair costs are more than the annual maintenance HSP payment."

"Cost to clinic, time and material subsidized, spare parts for aids, courier cost sending aids for warranty repairs"

"Because they are coming to us for a second opinion, we have to do a reassessment which isn't claimable as the previous provider has put their claim in. Often the voucher holders are coming to us with a pair of hearing aids that they haven't had the correct support in using so we have to book them in for a rehabilitation appointment. Not claimable."

"Voucher holders files are not always transferred in the timely manner. Especially from large organisations such as national hearing care or Australian Hearing. Voucher holders are often phoned and harassed by the previous provider to find out why they relocated. Making the voucher holder feel guilty for changing providers even though they get more personal service at an independent clinic."

2. Minimum Hearing Loss Thresholds and the WANT

HSP Rules

Minimum hearing loss thresholds are required for voucher holders to be eligible to receive aids. The threshold information is based on a pure tone audiogram, the most basic hearing test. If hearing thresholds are better than the minimum threshold, the clinician needs to administer a particular assessment tool, which requires the patient to independently answer questions that are scored. Minimum scores are required for eligibility for hearing aids to be recognised. The assessment tool (Wishes and Needs Tool, abbreviated WANT) must be signed by the voucher holder and kept on file (Clause 47, the Instrument).

Impact of the HSP Rule

Minimal hearing loss is a measure against average hearing. An individual who had hearing at the extreme range of normal (e.g. a pure tone thresholds of 0 dBHL) could have a 25 dB hearing loss (a very noticeable hearing loss) but when compared to the average would indicate only a mild change or minimal hearing loss. Without historical, longitudinal records for each individual, the audiologist uses the case history and a combination of test results to establish the hearing status of the individual. For some, tinnitus or auditory processing difficulties associated with neurological disorders or aging may indicate that low gain hearing aids would be beneficial – even though hearing thresholds may be in the minimal hearing loss thresholds, based on averages. Where a voucher holder does not meet the minimum hearing loss requirement based on their audiometric thresholds (basic pure tone hearing test), the HSP requires their Wishes and Needs Tool (WANT), a paper questionnaire that is scored, to kept on file as evidence of the voucher holder's motivation to use hearing aids. From a clinical perspective, the fitting of hearing aids to those with minimal hearing loss involves a very complex decision based on the individual's case history, presence of associated conditions such as tinnitus, their cognitive ability, and communication needs. Asking the individual themselves ought not to be the only definitive answer. If an individual was honest, most would say they did not *want* hearing aids, particularly not before they had been trialled and adjusted to. Most people would not *want* acquired hearing loss and so do not want hearing aids. This does not mean that they don't *need* hearing aids, or that the introduction of hearing aids is not a suitable intervention for them. However, for an individual who is not an audiologist to determine their own need for hearing aids is fraught with the possibility of error.

Evidence to support the use of the Wishes and Needs Tool was sought from the Office of Hearing Services by AAAPP in 2011. In 2012, we wrote in a submission to OHS that: *We request again that the research basis of this tool be made available on the OHS website. Currently the OHS website contains only the following reference to the WANT: "Dillon, Denis, Byrne, Oration (2008), presented at Audiology Australia Conference, Canberra, 2008 identified*

that voucher holders who were motivated were more likely to be successful hearing aid wearers. In a 2005 survey of voucher holders, analysis of voucher holder answers to two questions correlated highly with device fitting outcomes. Information about voucher holders' readiness to accept hearing aids gives valuable information about fitting candidacy". Reference to a published peer reviewed paper providing evidence that the WANT provides adequate information in light of the extensive evidence available related to the complexity of clinical decision making must be made available before the WANT can be enforced as a tool to be used for all voucher holders.

To date, no evidence has been produced, with various responses from the department's staff over the years including: "Do you really want us to produce evidence?" "the evidence is confidential", "the research was carried out in-house". When IAA staff member Louise Collingridge asked Harvey Dillon to explain how he developed the WANT, he said that he had thought it out informally, but had not tested it out. Dillon makes scant reference to the WANT in the second edition of the textbook he authored entitled "Hearing Aids" (Dillon, 2012 2nd Ed). The WANT is listed and briefly described in a textbox titled "Determining motivation to obtain help". This textbox lists and briefly describes six tools (WANT, HASP, ALHQ, SPHA and HARQ) as potentially providing "insights into a patient's attitude towards wearing hearing aids (page 259). There is no explanation of the evidence base to support the design or use of the tool. As shown in the example below, hearing aids are fitted to private patients with minimal hearing losses (including by Hearing Australia), placing a burden on the voucher holder as well as any providers they relocate to.

Ridgway, Hickson, and Lind (2015) report using the WANT (amongst other assessment tools) in an investigation of motivation amongst hearing aid users found no correlation between WANT scores and motivation. There are no other studies that we are aware of that report on the WANT. Yet, five years after the only publication refencing the WANT, and one that found no correlation with motivation, the WANT remains mandatory with significant consequences for hearing services providers who do not have a record of the WANT on file for voucher holders with minimal hearing loss who were fitted with hearing aids.

Consequences for hearing services providers who do not have the WANT documented on file can be devastating. In one case, a former member of IAA specialised in tinnitus and had a number of cases specifically referred to the practice. The WANT was introduced, but was not on file for a number of cases, so that even though the voucher holders had been successfully treated for tinnitus with hearing aids, the money paid by to the provider by OHS had to be returned. The cost was crippling, and the clinic shut down.

IAA members would be very pleased to comply with requirements to fully assess and report on motivation, provided that the use of specific measures are at the discretion of the professional conducting the assessment – which might be case history information, specifically selected communication profiles or surveys, or observation.

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Examples of the effect of the MHLT / WANT rule

"Hearing Australia fitted a patient with a minimal hearing loss with headphones (ALD) and sold them private hearing aids. The patient relocated to us several years ago. claims for maintenance of relocated private purchased aids paid for years and then this year rejected."

3. Community Service Obligations (CSO) and the HSP

HSP Rules

V*oucher holders who meet certain criteria (related to degree of hearing loss and other associated difficulties) can be deemed "complex", and if so, must be informed that they have the option to change providers to Hearing Australia, the only provider funded to delivery so-called "specialist hearing services" under the CSO agreement.*

Eligible Australians aged 26 years and under are deemed declared services for which only Hearing Australia is funded under the CSO agreement.

Voucher holders who have implanted hearing devices can only receive funding for maintenance of their implanted devices from Hearing Australia under the CSO agreement.

No CSO funding is available for any eligible person to receive services at any other provider (as per the HSP website) placing an burden on consumers to either risk changing providers, or bear the cost of specialist hearing services not covered by their voucher.

Impact of the HSP Rule

Specialist hearing services are provided to all Australians at the provider of their choice, except if they are voucher holders under the HSP. Independent audiologists provide specialist hearing services funded by Medicare, private health funds, the NDIS and private fees – yet their own voucher patients have to be sent to Hearing Australia.

Up until a few years ago, Hearing Australia was funded under the CSO for hearing services but did not undertake private work. Passing on so-called complex voucher holder to the CSO scheme seemed a somewhat equitable arrangement, albeit one that removed choice and control from CSO funded patients. Significant developments have taken place prompt us to call for a subsidy scheme available to CSO patients to allow them to choose their own provider to replace the CSO agreement with Hearing Australia. The following underlie our call for a subsidy to replace the existing agreement with Hearing Australia:

1. **Hearing Australia now competes with the private secto**r.
   Infants and children are recruited by Hearing Australia through advertising to the public. Diagnostic hearing assessments – previously carried out only by state hospitals and independent audiology clinics are offered at Hearing Australia for a fee that must come out the pocket of families. Hearing Australia charges for each assessment and refunds money paid only if children are found to have a permanent sensorineural hearing loss. Note that children with conductive hearing loss or normal hearing pay for the assessment out of the family pocket. Only those with permanent hearing loss are eligible for CSO funding. Families whose children do not have permanent hearing loss are out of pocket. Those families have been misled as they may have had access to Medicare funding for a hearing assessment, may have accessed a state funded service, or sought an audiologist who offered paediatric services for less than the $99.00 currently charged at Hearing Australia.

   Hearing aids sales to the fee-paying public are advertised at record low prices by Hearing Australia. Hearing Australia negotiates a government tender for the supply of their hearing aids. Their volume of orders and guaranteed purchase from one supplier ensures very low wholesale prices for hearing aids. Hearing Australia is able to offer services and devices at prices that are impossible for independent audiologists to match. The message sent by Hearing Australia to the public is that the cost of hearing devices and audiology services is excessive in the private sector. Yet, Hearing Australia can only offer very low prices because of their privileged position that perhaps only the hearing services owned or associated with hearing aid suppliers and manufacturers could match. According to the latest Hearing Australia annual report, the agency generated $13 million in profit, even

after extremely high salaries for managers that are comparable to salaries paid to large corporations. These profits can only be driven by very large margins in device sales so that even though their prices are very cheap, the wholesale price they pay for devices must be much lower. Hearing Australia information to voucher holders is that the HSP covers $1500 for the cost of hearing devices, when in fact that is the cost provided for the audiology services combined with the cost of devices.

2. Implantable hearing devices are supplied in the private sector but maintained under CSO arrangements

Teams of Ear Nose and Throat specialists and audiologists in the private sector provide implantable hearing devices that are funded by Medicare and private health funds. Many implantees have a combination of hearing aids and implantable devices. Voucher holders who have cochlear implants can only receive maintenance for their implants from Hearing Australia. This means that many have to have either two maintenance contracts (at double the expense to them). Hearing Australia uses this arrangement as an opportunity to encourage voucher holders to relocate to them, where they can benefit from future hearing device fittings and maintenance fees. When voucher holders relocate to Hearing Australia, they still have to return to the implant team for implant mapping and rehabilitation. This arrangement is not person centred. The system appears to be based on some administrative decision that is regularly exploited by Hearing Australia to encourage voucher holders to relocate. A far more patient friendly arrangement would be for the patient to access the CSO funding available to them through the provider of their choice.

3. Voucher holder with complex needs – choice and control

Choice and control are key elements of contemporary healthcare – including audiology. The CSO arrangements operate in stark contrast, whereby to receive funding, voucher holders with complex needs can only receive CSO funding through a single provider, Hearing Australia. Yet, audiologists are already providing services to complex adults who are self-funded or funded via an Aged Care package or private health fund. There can thus be no argument that independent audiologists are not sufficiently skilled to provide specialist services. Many voucher holders opt to remain on the voucher scheme so that they can stay with their provider even though they are informed of the funding available through the CSO program. They may need to use family resources to pay for additional necessary services. As the CSO is intended to ensure services are available to a vulnerable sector of the population, it would appear to be failing in its current form in that it is not meeting the needs of the people it was designed to help.

4. The division of hearing services between the NDIS and the HSP

Some hearing related services are funded by the NDIS, which allows for choice and control by consumers, and others are funded under the CSO banner only through Hearing Australia. Directives to change provider to Hearing Australia are often given by NDIS staff, who confuse the HSP with Hearing Australia. Directives to unnecessarily change provider are very disruptive to the service provision. NDIS participants are sent from one provider with whom they may have longstanding relationship, to Hearing Australia where they may not even be eligible to receive services. Importantly, some families *want* to access services through NDIS rather than through the HSP. Options for families who do not wish to attend Hearing Australia (such as due to appointment availability, consultation quotas, lack of technology choice, more comprehensive services offered by a local independent, or awareness of more experienced professional services in their community) are required to pay private fees, placing them at a financial disadvantage compared to those who accept the services and technologies offered at Hearing Australia.

Examples of the impact of the CSO MOA with Hearing Australia

"Trying to provide a holistic service to voucher holders where we are seeing them outside the HSP as well - eg we have a number of voucher holders with implants in one ear and HSP aids in the other. We need to try and keep documentation separate. We can give them parts for their aids but not their implants. We provide a specialist service for some very complex implant voucher holders that extends to cover their hearing aids and overall (holistic) rehabilitation (that Hearing Australia does NOT provide), yet we aren't eligible to access CSO funding for these voucher holders. There is also no funding for interpreters for HSP voucher holders or for home visits for HSP voucher holders - providing these services is costly to our business."

"The system is biased toward Hearing Australia and big companies (Specsavers). Little clinics have no voice."

"Voucher holders get fitted with cochlear implants at my clinic and they have to pay battery and maintenance twice! Once to Hearing Australia and the other to my clinic. They are forced to go to a Hearing Australia clinic even if they don't want to in order to get updated processors. They are then tricked into signing over to Hearing Australia who can't adjust their cochlear implant, and don't pair the hearing aid up to the cochlear implant and therefore the voucher holder is confused and comes back to my clinic to fix up the hearing aid and the implant! We should be able to access funding for table microphones if the voucher holder has a cochlear implant and needs more support. Especially when they don't get the support from the local Hearing Australia clinic and in regional NSW where they can't drive over 1 hr to get to that clinic. Voucher holders who are Indigenous Australian people get better devices from Hearing Australia due to monopoly of funding but have to wait for over 6 months for an appointment with them. Therefore, if they see my clinic, I can help them but not with the same level of technology. It's unfair to the voucher holder, forcing them to go to another provider if they are happy with my services and feel like they are betraying my clinic for having no choice but to transfer. NDIS have told some planners in my region that the voucher holders would get better help for hearing aids from Hearing Australia than private practices. This is unfair of NDIS. Trying to get hearing aids approved on NDIS is a mind field. Unless the voucher holder is proactive, they can't get the hearing aid they need on NDIS approved."

"Patients at our clinic are referred to us for Cochlear Implant assessment via their ENT. They undergo assessment, surgery, switch on and mapping. And then after this, I have to direct them to my competitor to get their batteries and spare parts. It is dis-jointed care which confuses the pathway of the patient. Furthermore, despite me sending them to Hearing Australia with a letter for a parallel agreement, Hearing Australia still tries to relocate the patient. To top it all off, most patients can't order their cochlear implant batteries or parts online, leaving us to do the ordering for them on the HA website. It's an awful, confusing system for the patient. And, it is a typical abuse of market power from Hearing Australia".

4. Fees, Charges and Records

HSP Rules

Maintenance fees are currently incorporated into the initial fitting (claims 630, 640 and 760). When this has already been claimed and a voucher holder relocates, the new provider can claim relocated maintenance (claims 711 and 722). From July 2021, maintenance will not be paid for the first 12 months of device use. Maintenance fees will change to per device and will be paid quarterly, rather than monthly.

Services or devices cannot be provided to a voucher holder for a fee if the same or a substantially similar service or device is available to the voucher holder (as per Clause 49, the Instrument). Voucher holders must be informed of all fees, including when there are $0 costs in the case of fully subsidised hearing aids. Private fees and notes related to private services are expected to be kept for voucher holders, and a report on private services issued in the case of relocations (Clause 11 of the Contract).

Records are the property of the Commonwealth and have to be passed on to providers in the case of relocations.

Impact of the HSP Rule

Changes to the payment of maintenance contracts by the HSP from 1 July 2021 are designed to save costs for government. As discussed above, relocations cost the new provider on average $300.00. Maintenance costs are to be cut out of the initial fitting fee. That fee covers the clinical time and materials required to take impressions for earmolds, scan / send impressions via courier to manufactures, complete order forms, set up quotes and invoices, check and program hearing aids, carry out real ear measures or other functional measures of hearing aid benefit, explain adjustment and use of devices, provide follow up appointments to review settings and establish what further rehabilitation is needed to achieve goals and evaluate progress. A number of Bluetooth hearing devices are now available as fully subsidised devices. Assisting clients to pair hearing aids with their Bluetooth devices and practicing and teaching them how to use this technology is an added part of device fitting that was not the case even a few years ago. Currently Claim 640 pays $576 which is expected to cover all of this work AND maintenance of the device for 12 months. From 1 July 2021, if $206.33 (the current annual maintenance) is subtracted from the claim, audiologists will be required to carry out all of the above functions for just $369.67. This is clearly below the cost of service delivery. As the true cost of fitting a device will not be covered by the voucher, a very grey area is whether these costs can be passed on to voucher holders. If not, then this policy will simply drive up the cost of private hearing aid costs and encourage more fitting of partially subsidised devices so that costs can be covered. Additionally, the voucher life is to be extended to 5 years from 1 July 2021, including for current vouchers. These changes are acknowledged to require new business plans from contracted hearing services providers – but the Office of Best Practice Regulation that recommended the changes to the voucher have not taken the implications of their recommendations into account, or do not care that voucher holders and private patients will be increasingly out of pocket in order for clinics to cover the cost of what has to date been taxpayer funded.

Top up fees for hearing devices have always been allowed under the HSP voucher scheme, with no regulation of the charges for devices of the maintenance packages offered. Yet, the charging of gap fees for services has always been refused by the HSP. Very recently, the HSP allowed fees to be charged to voucher holders but with the provision that the service is not available on the voucher. This is a very grey area, and many audiologists are concerned that if they charge fees to recover their costs, that they will be audited and penalised for doing so. Some have sought clarification from the HSP and received personal communication that appears to sanction the charging of fees. Those clinics are more confident that on audit, they would not be penalised, but the information is not made clear on publicly available documentation. We believe that this scheme should be made absolutely clear and that fees for all and any services offered on any date on which a claim to the HSP was not made, should be chargeable to the voucher holder.

The HSP has said that to cover this rule, a patient could be directed to an audiologist who is not a contracted hearing services provider for additional services – which is not helpful advice as case continuity (i.e. the same audiologist treating the patient over time) is best practice, and patient centred.

Ownership of records by the Commonwealth is an anomaly that denies audiology is an allied health profession in its own right, separate from the device industry. Clinical notes are distinct from reports. Medical professionals and allied healthcare practitioners use reports to communicate with one another. Their clinical notes remain their own property and are used to record and plan consultations. This does not deny privacy legislation that allows patients to have access to all clinical notes should they request them. However, that clinical notes are the property of the Commonwealth, and not the clinician, to be passed between providers is a throwback to Australian Hearing (as it was then known and is still officially referred to in government documentation) being the only agency to work with publicly funded patients requiring hearing services (i.e. pre 1997).

Examples of the impact of the rules regarding fees and charges of the HSP

“Patient fitted with aids, sudden hearing loss, seen for assessment and hearing aid changes. You have to test first before you can apply for a new voucher. Reshell aids. New moulds- impressions Managing devices Aid adjustments before the 12 months. Writing reports (NDIS pays for this). Calling GPs and ENTs Nursing home visits, ALD set up in home”

“Not being autonomous, not being able to see complex patients (patients have no choice!!!)” -

“We subsidise the HSP voucher scheme regularly by supply our older voucher holder's access to rechargeable hearing aids. These are not available as a free to voucher holder device on the scheme therefore we provide the first level top up device with a recharging unit at no cost to the voucher holder. We have provided a number of our voucher holders with multiple counselling and rehabilitation appointments outside the voucher scheme to ensure they are successful in using their hearing aids.”

“Unpaid/underpaid appointments/ and time needed to service voucher holders taking away from other possible paid services”

“Not being paid adequately for the ongoing appointments require to ensure successful hearing aid use and good hearing outcomes, especially when there are regular changes in hearing. e/g fluctuating conductive hearing loss and Meniere’s patients. Applying for a new voucher when the voucher holder has type B tymps isn't an option and is not realistic when the hearing changes every month. The cost of running my clinic is $240 per hour, and only one audiologist. $110 for one review appointment which takes 45 mins is sorely inadequate to cover the costs of providing good Audiological care to voucher holders.”

Not being autonomous, not being able to see complex patients (patients have no choice!!!) - Staff worry about punitive audits over brilliant patient care. - The system is biased toward Hearing Australia and big companies (Specsavers). Little clinics have no voice. - Lack of regulation around commissions and incentives. - No one to talk to clinically. Questions posed via email are generically answered leaving me to have to waste more time or give up.

“Some voucher holders require ongoing appointments and assistance which is not covered by HSP (i.e. voucher holder with wax management issues, voucher holders with middle ear conditions, voucher holders with sudden hearing loss, voucher holder's with fluctuating hearing loss, voucher holders undergoing medical treatment which requires hearing to be monitored, voucher holders who need ongoing assistance with the management of aids).”

5. Claiming

HSP Rules

Although Medicare and the HSP fall under the Department of Health, they require different claiming systems. The claiming system used by the HSP is not compatible with Medicare claims, forcing the doubling up on practice management systems for audiologists who operate within both Medicare and the HSP.

Claims are only allowable when conditions are met. Claims that are rejected may be so because of an omission on the electronic claim.

Claims that are paid that are later deemed by the HSP to have not met criteria have to paid back by the provider, even though the services and devices have been provided to the voucher holder.

Impact of the HSP Rule

The HSP system requires so many checks against nonclinical issues that most audiology practices employ at least as many administrative staff as clinical staff to carry out HSP work. Some contracted Hearing Services Providers have a very high ratio of administration staff to audiologists. Those clinics have high numbers of HSP consultations. Smaller clinics (sole traders) tend not to have as many support staff, but some clinics have three administration staff for one audiologist.

Fees paid by the HSP are not sufficient to cover the cost of employing multiple staff members, rent, insurance, equipment and other costs of service delivery – although the hourly rate ought to cover the professional time of the clinician. As a result, when services are provided without a claim available, responsible business planning requires an alternative source of income to cover that cost. In many audiology practices, the more ready source of income is the private sale (or top up in the case of HSP voucher holders) of hearing devices. The fact that the HSP at best covers only some costs associated with service delivery means that businesses need alternative sources of income.

Most audiologists work with multiple funding bodies, the largest of which are Medicare and the HSP. The HSP claiming system requires clinics to choose one of just four stand-alone claiming software systems that are compatible with HSP system. None of the systems that can be chosen from allows for the interaction between practice management and claims records and this means that audiologists have to work with multiple practice management systems – often for the same patients – to claim to Medicare and the HSP (frequently the same patients) and the NDIS.

The HSP system is so inflexible that a highly successful software company that produces practice software for allied health attempted to integrate the HSP claiming system as an option, but had to abandon the attempt because the HSP was uncooperative and their system was very outdated.

Examples of the impact of the claiming system of the HSP

““Patient relocated from SpecSavers. They have proprietary software. I contacted the HSP, who directed me to a person in Specsavers for a copy of the software. The person at Specsavers put me off and would not confirm in writing if the software had any spyware embedded in it, and would not offer training, replacement fees and charges of any kind. It’s really not okay to have a supplier with their own hearing aids, it restricts patient choice and increases market power. Some companies are acting like cartels in my opinion, where companies team up together to exclude small businesses and limit competition. This process slows down their ability to get care. It was really difficult and we still don’t have a resolution.

” Patients can't book online because we are stuck with an outdated software program for claiming. - Meeting all the paperwork requirements. “

“Staff worry about punitive audits over brilliant patient care. - Lack of regulation around commissions and incentives. - No one to talk to clinically. Questions posed via email are generically answered leaving me to have to waste more time or give up.”

“Paperwork, record keeping, complexity and amount of work required. Complexity of billing, missing applicable item codes that could be billed. Administrative staff needing to spend an inordinate amount of time managing voucher holder files, using claim system and following up maintenance fees etc.”

“HSP and Centrelink don't always match - example when someone passes away, they remain on the HSP. The one size doesn't fit all appointments/claims. Some voucher holders have the standard assessment, fitting, follow up and annual review. Other voucher holders are more challenging and require extra appointments that aren't claimable but still need to be done. Rehabilitation outside the scheme is appropriate to compensate our services.”