Response ID [redacted]

Submitted to **Hearing Services Program Review - Consultation Paper**
Submitted on [redacted]

Overview

About you

Please check this box if you would you like your response to be confidential

I would like my response to be confidential:
No

What is your organisation? (please provide your name if you are an individual)

Name:
MQ Health Speech and Hearing Clinic, Macquarie University

How can we contact you?

Email:
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Which of the following best describes you or your organisation?

Service Provider

Introduction

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

Response to Topic

Response to 'objectives and scope' topic:
Explicit objectives would be a welcome addition to the program, as they could provide a clearer reference point for future decisions relating to the program.

Objectives should consider and reflect the evidence around hearing loss and the benefits of intervention for vulnerable populations. Furthermore, the objectives should represent the core and self-evident principles that characterise the program (such as equitable access) as well as the economic imperative for Government and other stakeholders to ensure the program is a viable and efficient vehicle for service delivery. Finally, to assist with monitoring impacts and compliance the objectives should , where possible, contain measurable and specific elements.

This will not be a simple task, broad consultation may be required. It is important to note that no single group, can represent all the voices of those Australians who the program services. The opportunity to contr bute here is welcome, yet the views and aspirations of vulnerable groups in the community may be under-represented if they do not have the means to contr bute to a process l ke this. Further research among program users (and elig ble non-users) may yield valuable insights.

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2. Which consumers should be eligibile for Program subsidies?

Response to Topic

Response to Topic:
There are two elements to this topic. The first includes factors relating to eligibility for services that address demographic, economic, or other social factors that impact an individual's ability to access private services. Once the additional funding for Hearing Australia is taken into account, the eligibility criteria do enable access to a number of Australians who would otherwise not be in a position to access services.

Areas where Government can play a role in assisting a broader range of Australians are not limited to the HSP. NDIS is part of this, but will be addressed separately in a later question. Investment from the Federal Government should lead to a demonstrable change in circumstance for the individuals, systems or stakeholders that are beneficiaries of this spend. Where the difference between a person being able to work or requiring support through the welfare system may be hearing services or assistive technology, are there ways to acknowledge this through direct funding or tax deductions? This type of assistance, even if it occurs outside of the HSP, would lead to measurable impacts and net economic benefits.

The second element is what services are eligible clients entitled to receive a subsidy for. The current model is biased towards basic hearing assessments and hearing aid fitting. Balance disorders, tinnitus, difficulties with hearing where devices are contraindicated or of limited benefit are some areas where HSP does not adequately allow clinics (with the requisite skills) to service clients under the program. The role of quality, holistic audiology services is disincentivised by the current funding model.

A funding model that is too simplistic may have the unintended consequence of eroding trust in hearing care as clinics are driven by commercial imperatives to provide the best service they can under the funding rules, which may neglect issues which were traditionally within the scope of practice for audiologists. Furthermore, clients should be able to visit a specialist site for services like vest bular testing without being encouraged to transfer away from their existing service provider. To avoid a complicated compliance system, a limited number of additional items of specialist audiological services could be considered. Clinic's would have to register to deliver these services and demonstrate, if and when required, the capability of their sites to meet HSP requirements.

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

Response to Topic

Response to Topic:
Good (and sub-optimal) outcomes are not necessarily a function of consumer pathways. The quality of clinical care and ways outcomes are measured are more significant. Our clinic regularly measures client outcomes and there appears to be little, if any, difference in the the benefit and satisfaction measured for private, NDIS or HSP clients. However, ambiguity (especially around the NDIS) does place unnecessary barriers in front of clients. It is worth noting that to deliver our best care to HSP and NDIS clients we are demonstrably worse-off financially, as device fitting is rewarded far more than the proper aftercare.

Regarding access to subsidy, HSP and CSO rules are clearer and more consistently applied than access to NDIS. Furthermore, the NDIS does not seem to assign subsidy based on financial capacity. The interpretation of legislation in determining NDIS funding as it relates to clinical need is also inconsistent. We have guided several clients through the NDIS application process. Many have significant loss but are not funded due to the unrealistically high levels of hearing loss being used as elig bility criteria. For specific device recommendations we are required to fill out forms which can be over 20 pages long to justify hearing aid recommendations. The basic levels of funding provided are less than HSP reimbursements and do not cover the equivalent costs that private clients would incur. The funding gap mean that NDIS participants may have to pay hundreds or thousands of dollars to receive a device that is the equivalent of a fully subsidised device under the HSP. In other words, NDIS does not cover the true cost of devices unless clinics use HSP pricing outside of the program, which has implications for the viability of delivering NDIS services. Copying HSP prices is not an optimal approach. The administrative cost of servicing NDIS clients is higher, there are less safeguards for clients, and other criteria (for example, replacement, refitting etc...) are also not provided. Granting HSP elig bility to NDIS participants, a practice which recently ceased, embedded those clients into a well-understood and more streamlined care pathway.

We understand it is not a simple task to respect the core principles of the NDIS and still find synergies with other programs, such as the HSP. Our clinic would be happy to provide further comment and work constructively with other stakeholders towards improving the system for elig ble people.

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4. Does the Program sufficiently support hearing loss prevention?

Response to Topic

Response to Topic:
Hearing loss prevention is an important area for National focus. Indeed, we believe a broader focus on hearing as a public health issue is required - whether the HSP is the best vehicle to deliver the desired impacts is less clear.

Undoubtedly there are public education and service delivery aspects to a public health campaign that may be relevant to the HSP. We welcome the recent budget announcements, and hope this funding is able to lead to measurable changes in how Australians work and enjoy sound safely. Furthermore, we welcome the announcement of funding for the development of the evidence base required to deliver greater benefits to vulnerable Australians. It is hoped that these different pieces of work are brought together and implemented through programs like the HSP.

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

Response to Topic

Response to Topic:
A broader diagnostic scope was discussed previously, and it is worth repeating that the program does not enable access to specialist services for tinnitus, balance disorders or other ear/auditory disorders.

The question of whether hearing technology is over-prescr bed is based on a false premise that audiometry reliable correlates with hearing aid use, benefit and satisfaction. There is clear and consistent evidence that this is not the case.In fact, self-reported hearing difficulties are the most consistent predictor of outcomes. Any changes to elig bility for devices should relegate audiometry to a secondary role, and the evidence required for hearing aid fitting should be a thorough

assessment of the client's self-reported need. The audiogram is the wrong tool for assessing readiness for and potential benefit from hearing devices in older adults. A full and thorough clinical history is one way that needs can be assessed. There are also many validated psychometric tools that measure hearing disability.

A mandatory co-contribution in some cases could help make ensure that the right clients are receiving subsidised devices. Currently, we perceive that the widespread belief HSP devices and services are "free" leads to more people receiving interventions that they do not want or need, not attempts by clinicians to fit people with lower degrees of measurable hearing loss. A person with a mild loss but a greater functional clinical need should not be disadvantaged because of the misappropriation of HSP resources in some other cases.

There is a potential mismatch in the understanding of what rehabilitation is and how often it is delivered. At our clinic we consider the fitting process incomplete if we do not discuss communication strategies, impacts of hearing loss and devices on relationships, work and social life and other areas of concern for clients. Claim data does not reflect the clinical time and skill employed in fitting a hearing aid, and how much of that is a process focused on embedding hearing aid use into a broader program aimed at increasing quality life by enhancing engagement and connection. We have preliminary data from our clinic which suggests that clients are more likely to use their hearing aids in challenging environments, and that they report greater benefit with lower degrees of hearing loss. These findings defy conventional wisdom and some existing research, supporting the idea that models of care that prioritise an assessment of readiness, motivation and functional hearing may deliver better outcomes.

Of course, we are not unaware that different clinics may interpret rehabilitation outcomes differently. Unfortunately audiology and audiometry are not optimally regulated. In this compliance and governance vacuum some less that ideal practices are a predictable by-product of current funding rules. Options may include making all consultations that achieve an outcome billable, shifting the focus from hearing aid subsidies, as well as changes to how providers are regulated.

Some of these measures may seem unpalatable to some stakeholders. Equally unpalatable would be the denial of access to valuable interventions for adults with significant functional difficulties due to the arbitrary use of audiograms as a surrogate for sound clinical judgement and supported choice for clients.

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

Response to Topic

Response to Topic:
Hearing aid technology is not radically different within or between manufacturers. There is very little independent evidence that shows repeatable and clear differences between basic and top-of-the-line technology, let alone two devices of the same tier. Nonetheless, there are some manufacturers who target specific segments and may represent better value for funders and clients. Where clinics benefit from relationships with certain manufacturers (or are indeed vertically integrated retail chains) this needs to be explicitly stated under current program rules.

Clients need more time with sufficiently skilled clinicians who can provide a wider range of services. If this is unrealistic given the current state of service provision, then it is difficult to immediately see how a large amount of independent clinical information can be distilled and delivered to the average HSP client. At our clinic we attempted a research project where we would recruit older clients for engagement on their smart phone - so that we could use apps, bots and videos to help bridge the health literacy gap that restricts informed choice. This was a distinctly unpopular study, with no clients choosing to participate after months of attempted recruitment. The feedback overwhelmingly was that clients valued the information but didn't want to receive it on their phone. They wanted it in their appointments. It would be interesting to re-assess this in a post-COVID world where telehealth has been normalised.

The future market may be easier to engage with online information, but currently there seems to be a neglig ble percentage of clients (at least at our clinic) who access information about the program through these more efficient channels.

Regarding the role of Hearing Australia and CSO funding, we would only support changes to CSO funding if there was strict regulation governing who could see vulnerable clients, especially children with aidable hearing loss. We value the current pathways for children we identify as having an aidable hearing loss. Hearing Australia's role in the private market reflects the history of Audiology in Australia, where for Commonwealth clinics were essentially the only provider previously. In this context their participation is not problematic, and without their network of clinics it is difficult to imagine who would service the needs of the thousands of vulnerable Australians they see.

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

Response to Topic

Response to Topic:
This question is best answered by clinics with larger telehealth programs, and most importantly, service recipients. Our experience has been that for reducing travel and face-to-face contact during a pandemic, telehealth has been useful. There is a growing body of evidence that outcomes can be enhanced by telehealth. As a single service provider we have not yet measured that, but we have enjoyed having the ability to maintain a certain level of engagement in an environment where this interaction has become more acceptable to clients and clinicians.

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

Response to Topic

Response to Topic:
Given we have a limited geographical region we service we will limit our comments to areas of our expertise. A key area for improvement would include funding of interpreters. Audiology is a discipline that focuses on communication as much as hearing. Making communication more access ble for CALD clients is important, and the subsidies paid for services and devices don't make this viable. As a University clinic we are able to leverage our translation and interpreting students, but what options exist for other clinics?

We deliver services to a range of communities via hearing screenings, from all over NSW and at times in the NT. Hearing Australia and the CSO program are a valuable resource that allow us to refer clients and families to a high quality local service. However, for diagnostic services there is a lack of public hospitals that have audiology services and this is an area that concerns us.

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

Response to Topic

Response to Topic:
The portal is a very useful tool. Changes to automatically correct claim value based on the service dates were very welcome. Deregulation of business and provider regulation, coupled with a clearer regulatory framework for clinical recommendations str ke a good balance. Innovations along the current continuum would be seen as positives from our perspective.

One pain point as a provider is the limited number of patient management systems that interface well with HSP. Streamlined portal claiming makes it more realistic for us to identify software that meets our clinical needs without having to consider HSP administration to the same degree. We would encourage an expansion of the number of systems that can interface with HSP, and recognise this has to come from the market, not the program. Alternatively, are there ways we can use the portal to streamline program administration in a centralised system that can easily share information with a wide range of practise management software, not just the limited number of audiology specific programs.

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

Response to Topic

Response to Topic:
This data is a potential source of information that could be very useful in informing public health initiatives referred to in the prevention question. De-identified data that combined demographic, social and health information could give us new insight into who does (and does not) access hearing services. Furthermore, it could assist in planning for thin markets. Although our clinic is not strictly for teaching or research, we are part of a network of people at our University engaged in Hearing, keenly aware of the opportunities and gaps in the current evidence base for clinical service planning. By working with Universities, the program would be assured that rigorous human ethics controls were in place and that outcomes of any research could be disseminated in the field. We would welcome the opportunity to work with this review, or with other relevant groups in the future.

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Would you like to provide additional information?

If you wish to upload an additional document in response to this consultation, please do so here. Please note that PDF or DOC formats are preferred. Additional documents can be submitted via email to hearing-review@health.gov.au

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