



Australian Government
Department of Health



Hearing Services Program Review

Review of the Hearing Services Program

Draft Report

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ACKNOWLEDGEMENT OF COUNTRY

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

A note on the use of data in this Report

Data extracted for this report comes from the Hearing Services Online (HSO) administrative database. Although every effort has been made to ensure the data is accurate at the time of data extraction, there is no time limit on claims and record changes due to recoveries, so there may be slight differences between the data included in this report and previously published statistics.

Modelling and forecasting of demand for hearing services are based on a variety of source datasets and should be treated as estimates only. This information is included to illustrate the potential expected costs and should not be used as the definitive figure for any change for government policy as they do not include the expected costs for the Department of Health and industry stakeholders.

RECOMMENDATIONS OF THE REVIEW OF THE HEARING SERVICES PROGRAM

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

Chapter 2 – Objectives of the Hearing Services Program

1. Defining new Objectives for the Hearing Services Program –

1(a) The Australian Government should define the objectives of the Hearing Services Program to guide: the expectations of those with hearing loss, the Department's administration of the Program, the delivery of services by providers, the participation of other stakeholders in the Program, and the measurement and assessment of client outcomes. The Australian Government should also establish a regular assessment of Program outcomes to ensure the accountability of all participants.

1(b) The Australian Government should undertake community consultation on the following draft objectives before committing to a final set of Program Objectives and to subsequently enshrining them in legislation:

A. The Program's objectives for eligible people with hearing loss are that they:

A1 have equitable access to prescribed services which comprise hearing assessment and hearing rehabilitation, hearing aid devices and other support. Specifically, that eligible people:

- (i) have equitable access to support irrespective of their location or personal attributes and circumstances; and
- (ii) be provided with support which is culturally safe and appropriate to them;

A2 are able to exercise informed choice about, and control how to live with hearing loss, including:

- (i) how to address their communication needs and maximise social inclusion through social activity, economic participation, and in physical and cultural pursuits to the fullest extent possible; and
- (ii) how they can be engaged in the planning, assessment, selection and delivery of the services offered to them; and

A3 are able to exercise informed choice about, and control the selection of, their service provider and have clear and independent processes for resolving any complaints.

B The Program's objectives for service providers under Hearing Services Program are that they:

B1 always act in the best interests of the eligible clients who have chosen them;

B2 demonstrate that they meet Program contract requirements such as key performance indicators; and

B3 provide culturally appropriate services that respond to the needs of people with hearing loss in their local area.

C The objectives for Qualified Practitioners (QPs)/health professionals are that they:

C1 abide by all current Practitioner Professional Bodies (PPBs) Codes of Conduct and meet all professional standards and/or competencies.

D The Program's objectives for the Government and the Hearing Services Program administrators are that:

D1 when defining the subsidised set of prescribed services, categories of eligibility, hearing loss thresholds and criteria for service provider accreditation, it has regard to:

(i) supporting the communication needs of people with hearing loss and their social inclusion through social activity, economic participation, and physical and cultural pursuits; and

(ii) the benefits to families and other persons with whom people with hearing loss communicate;

(iii) the broader benefits of employability, participation in society, social cohesion and economic growth; and

(iv) the quantum and sustainability of costs to, and opportunities forgone by, current and future taxpayers;

D2 it ensures that the services, hearing aid devices and other technologies made available to people with hearing loss through the Hearing Services Program are regularly reviewed and modified to reflect best practice, and to ensure that people with hearing loss do not experience harm arising from poor quality services or supports;

D3 it raises community awareness of the issues that affect the social and economic participation of people with hearing loss, and facilitate their greater community inclusion; and

D4 it supports the collection of data associated with hearing loss in Australia and the outcomes achieved by hearing services programs, and invests in research, to:

(i) facilitate innovation, continuous improvement and contemporary best practice in improving hearing health, preventing hearing loss and supporting people with hearing loss

(ii) inform the future direction of hearing services programs.

Chapter 3 – Eligibility requirements for support under the Hearing Services Program

2. Extension of eligibility to additional priority populations

2(a) The Australian Government should expand the categories of eligible people under the Voucher stream of the Hearing Service Program to include all Low Income Health Care Card holders.

2(b) The Australian Government should expand the categories of eligible people under the Voucher and Community Service Obligation (CSO) streams of the Hearing Service Program to include

all Aboriginal and/or Torres Strait Islander people (noting that some choose to enter the Program through Voucher eligibility criteria pathways. Clients choose only one stream).

3. Clearer delineation and support for Voucher stream and CSO stream clients

3(a) The Australian Government should replace the term 'Voucher stream' with a term such as 'National Hearing Support stream' to modernise the Program terminology and better reflect the purpose of the stream.

3(b) The Australian Government should improve clarity for eligibility to the National Hearing Support and CSO streams by including in the definition of eligible clients for the National Hearing Support stream those clients who have special needs, namely adults with complex hearing needs and adults with cochlear/bone anchored implants. The Australian Government should then remove these categories of adults from the definition of eligible clients for the CSO stream.

3(c) The Australian Government should implement a system of audits to ensure Providers are appropriately claiming for clients who have special needs, namely adults with complex hearing needs, adults with cochlear/bone anchored implants and clients without specialised or complex hearing support needs.

3(d) The Australian Government should require all Providers to demonstrate that they have the capacity, skills and cultural awareness capabilities to support clients with specialist hearing support needs, such as adults with complex hearing needs and adults with cochlear/bone anchored implants, and encourage Practitioner Professional Bodies (PPB) to develop appropriate training for clinicians to deliver these specialised hearing services.

4. Making better use of Medicare

The Australian Government, through its management of Medicare, should include within the funded item 'Health assessment for people aged 75 years and older' a full diagnostic hearing assessment where considered warranted by the patient and the GP.

Chapter 4 – Clinical need and client experience within the Hearing Services Program

5. Engagement with consumer groups

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

6. Client decision-making support

6(a) The Australian Government should develop a range of illustrative client pathways on the website that clearly show the options for clients who are eligible for hearing services in the Voucher stream and the CSO stream. These should be reviewed at an appropriate time period following

implementation to assess their usefulness. Specific pathways should be developed for clients who might benefit from targeted wayfinding information, including:

- children and young people under 21 receiving services via Hearing Australia;
- Aboriginal and/or Torres Strait Islander clients seeking hearing services;
- clients living in rural and remote areas;
- clients from culturally and linguistically diverse backgrounds;
- clients with complex hearing or specialist needs; and
- adults with cochlear/bone anchored implants.

6(b) The Australian Government, following consultation with stakeholders, should incorporate a set of linked Decision Aid Tools in the Program's website to assist prospective clients to make more informed choices before committing to join the Program. This should be reviewed within two years of implementation to assess its effectiveness and advise on improvements.

6(c) Following a review of the effectiveness of the set of linked Decision Aid Tools on the Hearing Services Program website, the Australian Government should consider including them in the Hearing Assessment process, with the data to be stored in the client's clinical file and made available to the clients.

7. Availability of translation, interpreting and Auslan services

The Australian Government should ensure that audiologists are made aware of the AUSLAN services available under the NDIS and the NABS programs and how to access these services. (The Panel recognises that a separate Australian Government process is underway to include audiologists and audiometrists as 'approved groups and individuals' with the national Translation and Interpreting Service.)

8. Delivering rehabilitation and support services

8(a) The Australian Government should undertake a review of the current Schedule of Fees to assess whether:

- there is an unintended bias in profit margins which favours the supply and fitting of hearing aid devices ahead of providing rehabilitation services, and undertake any necessary rebalancing of the fees; and
- the complexity of the current Schedule of Fees can be simplified from the current 55 items to under 20 service items to more clearly capture these rehabilitation interventions.

8(b) The Australian Government should amend the scope of the Hearing Services Program to require service providers to offer a more holistic assessment of clients' needs and broader range of interventions to better address those needs. This would include:

- holistic assessment of clients' needs;
- rehabilitation alternatives prior to offering the option of being supplied and fitted with a hearing aid device; and
- rehabilitation services as part of providing a device; and
- psychosocial support alongside hearing assistance; and
- assessment and management plans better suited to diverse clients.

8(c) The Australian Government should consider developing and implementing a pilot to test the feasibility of the provision of independent rehabilitation services delivered by counsellors who can provide the necessary psychosocial support for clients, including clients with diverse needs.

9. Assessment of hearing loss

The Australian Government should redefine a hearing assessment to be a comprehensive process that involves an individual's communication and psychosocial needs and should be guided by the National Acoustics Laboratory (NAL) Report to be released in 2021 in redefining the minimum hearing loss thresholds and other communication and psychosocial needs criteria (also referred to as 'eligibility criteria' by NAL).

10. Improving access for Aboriginal and Torres Strait Islander people

10(a) The Australian Government should work with key Aboriginal and/or Torres Strait Islander stakeholders to co-develop alternative models of hearing service delivery that are culturally safe and accessible to increase the proportion of eligible Aboriginal and/or Torres Strait Islander people with hearing loss taking part in the Health Services Program.

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

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

11. Improving access for people from culturally and linguistically diverse (CALD) backgrounds

The Australian Government should develop a data base and undertake analysis of shortfalls in engagement with, and outcomes from, the Health Services Program for culturally and linguistically diverse populations. The Australian Government should undertake a co-design approach to working with peak bodies representing these groups to address any identified issues impacting on access for eligible clients to the Hearing Services Program.

12. Improve access for Regional, rural and remote communities

12(a) The Australian Government should maintain Hearing Australia's role as sole provider of CSO services, recognising the critical role that its service plays in maintaining access to hearing health care for eligible people living in regional, rural and remote areas and the likelihood that increased competition would exacerbate service availability for people with hearing loss who live in thin markets.

12(b) The Expert Panel recognises the ongoing challenges for regional, rural and remote communities in accessing hearing health services and references its previous advice to the Australian Government regarding the changes to Hearing Services Program Voucher stream, this being:

The Australian Government should undertake further analysis and consultation with the sector and community on the following policy approaches:

- 1. Provide a loading on service items delivered in rural and remote regions (MM 3-7)*
- 2. Provide a loading on service items delivered by small and medium service providers*
- 3. Expand teleaudiology services available through the Program*

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

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

13. Improve access for residents of Aged Care Homes

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

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

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

Chapter 5 – Service delivery of the Hearing Services Program

14. Supply and client choice

The Australian Government should enable improved consumer choice by:

- (i) amending the Deed to require providers to publish (as a minimum, on their website in an easily accessible manner) the price and features of the devices they supply under the Program;
- (ii) undertaking a detailed feasibility study into the impacts on clients, providers and manufacturers of deleting partially subsidised devices from the Program; and
- (iii) convening a stakeholder working group, including consumer representation, to advise on new minimum specifications and other supply and technology issues.

15. Broadening the scope of technology

15(a) The Australian Government should continue its support of flexible service modalities such as tele-audiology and other technologies such as improving Bluetooth technologies as they are discovered and implemented, subject to evaluations of the benefits and costs of those modalities and the level of confidence and comfort felt by clients that their needs are being met.

15(b) The Australian Government should conduct a review of the benefits and costs of current Hearing Services Program technologies and pricing to inform changes to the Services Schedule, so that updated technologies can be available to all clients into the future

Chapter 6 – Program design of the Hearing Services Program

16. A national data service

The Australian, State and Territory Governments should commission a feasibility study into the development of a national digital database of hearing screening of infants and children, recognising that the responsibility for universal newborn hearing screening and screening at any other age such as prior to starting school, lies with State and Territory Governments.

17. Program monitoring and evaluation

17(a) The Australian Government should develop and invest in a Data Plan for the Hearing Services Program that aims to support the monitoring of the Program's achievements of its objectives (as described in Chapter 2). The Data Plan should address:

- improving client clinical outcome measurement (hearing and non-hearing);
- qualitative and quantitative program outcome measurement, including client satisfaction measures;
- better use of the Hearing Service Portal to capture and analyse data; and
- ensuring clients can access their audiological records and assessment reports.

17(b) The Australian Government should undertake an internal Preliminary evaluation of the Program in two years, drawing on the improved data availability and measurement tools and a major external evaluation in five years.

Chapter 7 – Hearing health and hearing loss research

18. Research strategy

18(a) The Australian Government should develop a Research Strategy in consultation with hearing services stakeholders and publish it on the Hearing Service Program website. A guiding principle should be to ensure co –design with each relevant population cohort, with research priorities to include the removal of barriers to access to services and to facilitate the cultural appropriateness of service delivery

18(b) Research funded through the National Acoustics Laboratory also needs to have a more strategic approach, aligning with this broader Research Strategy.

19. *The Longitudinal Outcomes of Children with Hearing Impairment Study*

The Australian Government should continue to fund the National Acoustics Laboratory to conduct the Longitudinal Outcomes of Children with Hearing Impairment (LOCHI) Study.

EXECUTIVE SUMMARY

The Review into the Hearing Services Program

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

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

The deliberations of the Expert Panel have been informed by policy papers and previous reviews, inquiries and audits of the Hearing Services Program, and national and international research. The Panel has sought submissions from, and consulted with, stakeholder groups comprising industry (including service providers and hearing aid device manufacturers), consumer advocates and clients, professional associations and academics.

Interim Advice to Government

On 6 October 2020, the Australian Government announced changes to the Hearing Services Program Voucher Stream in the Federal Budget. The changes related to the Voucher period, the 12 month warranty period maintenance payment and the timing of the maintenance payments. The Minister requested that the Expert Panel provide Interim Advice to the Government on the impact of the implementation of these changes to the Hearing Services Program. This advice was provided to the Minister in the report *Hearing Services Review Interim Advice to Government – Implementation of Hearing Services Program Changes (Interim Advice)* on 25 February 2021 and, where applicable, the conclusions from that report are included in this Review report.

Previous reviews

There have been several previous reviews of all or part of the Hearing Services Program. Of note is the relatively recent *Review of Services and Technology Supply in the Hearing Services Program* undertaken by PricewaterhouseCoopers (PwC) and completed in 2017. The Expert Panel has independently drawn its own conclusions and developed recommendations, but nonetheless notes the consistency of some of its recommendations with those contained in the PwC report.

Program objectives

The enabling legislation for the Hearing Services Program provides no statement of purpose of the Program or its specific objectives. This lack of clarity is in contrast to the legislation establishing Aged Care and the NDIS.

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

While the high level statements of objectives of the Program that are contained in other documentation provide a generalised framework for the Program and its funding streams, the actual implementation is characterised by an over-emphasis on providers supplying and fitting clients with hearing aid devices.

This Review has proposed a set of potential objectives as a starting point for consultation with relevant stakeholders, including people with hearing loss, their advocates and the general community. The suggested objectives are directed to eligible people with hearing loss, service providers, qualified practitioners and Program administrators.

An associated recommendation is that the term 'Voucher stream' be changed to move away from the idea that the Program's purpose is to deliver an entitlement to a publicly subsidised hearing aid device instead of more broadly helping people with hearing loss to be supported in their communication and psychosocial needs. The Expert Panel envisages stakeholder consultation on this, but suggests a term such as 'National Hearing Support (NHS) stream' replace the current 'Voucher stream' to better reflect its purpose and function. The Expert Panel proposes that the Community Service Obligation (CSO) stream retain its title.

Eligibility for the Program

To access publicly subsidised services through the Hearing Services Program, a person needs to be in a category of eligible people as specified under clause 5 of the Hearing Services Administration Act 1997. The next step for eligible Voucher clients is to receive one full hearing assessment and be offered a hearing aid device per ear if their hearing loss is above the Minimum Hearing Loss Threshold (MHLT) of 23 decibels. The Voucher also covers the maintenance and repair services for their hearing aid device as well as an annual review of their hearing loss and any adjustment of their device. Clients are also covered for a hearing aid replacement if the device is lost or damaged beyond repair.

Voucher clients whose level of hearing impairment is assessed as being below the MHLT are not eligible for a subsidised device and following their hearing assessment can receive up to two rehabilitation sessions until their next Voucher.

Australians who are currently in eligible categories for the Voucher stream in the Hearing Services Program include: those holding Pensioner Concession Cards (PCC); Department of Veterans' Affairs Gold Card holders and some White card holders, and their dependents; current permanent and full-

time reservist members of the Australian Defence Force (ADF), and those referred by the Disability Employment Services (Disability Management Services) Program.

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

The Expert Panel recommends that the eligibility definitions for the Voucher stream be amended to include adults with complex hearing needs and adults with cochlear/bone anchored implants rather than having them included under the CSO stream. This would give people in these groups a wider choice of providers. There would be no change to the scope of services available to meet their special needs. Hearing Australia would continue to be a provider of these services (for which it was the sole provider under the CSO stream), as it is a registered provider under the Voucher stream.

The Expert Panel examined the various public and private benefits and costs of extending the categories of eligibility for the Hearing Services Program to groups of people with hearing loss who are currently not eligible. Following analysis, two groups identified as having high priority net benefits are Low Income Health Care Card holders and all Aboriginal and Torres Strait Islander people (irrespective of their age). The Expert Panel also noted the opportunity to improve access to assessment for older Australians by including a full diagnostic hearing assessment in the funded MBS item 'Health assessment for people aged 75 years and older' if it is considered warranted by the patient and their GP. In all cases, this might require additional skills development for hearing service providers to effectively support these groups.

The client experience

The Expert Panel notes the importance of client choice and control as an underpinning principle of all health care and advises that to the extent possible, people with hearing loss should be able to make choices about the hearing health services they receive and the providers of those services, and have control over how those services are provided. This has been a recurring theme in earlier reviews and Parliamentary inquiries. Choice is based on knowledge and understanding of available options and the consequences of choosing them, and requires that people have timely and reliable information in an easily understood format prior to them making those decisions.

This does not necessarily occur at the moment for clients of the Hearing Services Program and the Expert Panel identified several ways in which consumers' access to information could be improved, including by the use of Decision Aids. The Program website could be upgraded to make it easier to navigate and to include more information to support consumer decision making, including by developing a range of illustrative client service pathways.

A particular priority for the Expert Panel has been to seek input from consumers and organisations who represent consumer interest. Consumer organisations are very supportive of the Hearing Services Program and believe it makes a significant difference to people's lives. Similarly, families generally do not want to see changes to existing arrangements where Hearing Australia is the sole

CSO provider, with some expressing concern that any changes may put the outcomes for their child at risk. Consequentially, recognising that issue-driven consumer engagement currently takes place, the Expert Panel recommends that the Department of Health establish a hearing services consumer consultation forum with relevant consumers and representative organisations. Such a forum would facilitate information exchange, to seek advice on improving the equitable, effective, efficient and sustainable functioning of the Hearing Services Program and associated hearing activities, and to explore ways to increase the opportunities for consumer advocacy groups and organisations to assist people with hearing loss.

The Expert Panel found that while hearing impairment, hearing care help-seeking and hearing health care provision are complex and multifactorial, current interventions by providers under the Program to address client hearing impairment are strongly focused on the supply and fitting of hearing aid devices. A review of the current Schedule of Fees is needed to assess whether there is an unintended bias in profit margins which favours hearing aid devices ahead of providing rehabilitation services. Such a review may point to the benefits of rebalancing the fees.

A commonly expressed concern is that there is minimal use of additional rehabilitation services as part of the overall package of hearing health care made available to clients, despite stakeholder support for this approach. Evidence suggests that positive outcomes from the use of hearing aid devices depends on client readiness, motivation and support, not solely on the level of hearing loss. Accordingly, the lack of separately provided rehabilitation is a deficit in the current service provision models.

The Expert Panel also noted, however, that it is difficult to obtain a full picture of the uptake of rehabilitation options within the Program as this component of care is often included in other services such as fittings and maintenance items. The Expert Panel considers that the scope of the Hearing Service Program should be more clearly defined in terms of offering a more holistic assessment and broader range of interventions that better suit clients' needs. The scope should include a specific requirement for the delivery of rehabilitation and support as a separate service at several stages within the overall support available to all clients. The Expert Panel recommends that these issues be examined and supports a review of the Schedule of Service Items and Fees. The Panel has also explored the option of conducting a pilot trial if rehabilitation services being delivered independently from providers of hearing aid devices and other hearing supports.

A related issue is that under the Hearing Services Program (Voucher stream) the assessment of hearing loss is evaluated primarily using pure tone audiometry. Recent evidence, including from the World Health Organisation, indicates that this should not be the sole option for understanding the holistic needs of people with hearing loss or the indicator of choice of intervention(s), whether that be the supply and fitting of hearing aid devices or other support. The Expert Panel recommends that hearing assessment should be redefined to be a comprehensive process that includes an individual's communication and psychosocial needs – of which pure tone audiometry is only one part. It further considers that any amendment to the current Minimum Hearing Loss Threshold should be deferred until the completion of current research by the National Acoustics Laboratory on this matter.

The positive client experience of the Program described above is tempered by the evidence that over 60% of people who are currently eligible for its services are not engaged with the Program. In

particular, there is significant under-representation of some eligible populations who face specific barriers to accessing those services.

It is a matter of concern, considering the increased risk and incidence of ear health problems amongst Aboriginal and Torres Strait Islander people that they are underrepresented in the CSO stream and find it difficult to access culturally appropriate hearing services across the entire Hearing Services Program. The Panel has recommended a co-design approach to developing culturally safe, and accessible hearing health services for Aboriginal and Torres Strait Islander people – one that maximises opportunities for collaboration with the Aboriginal community controlled health sector.

The Panel found that there are other high priority populations who experience additional challenges in accessing hearing health services and who should have those barriers addressed with a view to improving access to the Program. These include people from culturally and linguistically diverse backgrounds, people living in regional, rural and remote communities, older people in general and residents of aged care homes specifically. Acknowledging the work currently being undertaken through the *2019 Roadmap for Hearing Health* to address access for these groups, the Expert Panel has endorsed those initiatives, including enhancement of sector workforce capacity. Again, a co-design approach is recommended, especially for culturally and linguistically diverse communities.

Service provision

Client choice of a service provider can affect how and what services the client is offered (education and counselling and/or a hearing aid device), the quality of services they receive, and even likely determine the range and brands of hearing aid devices they are offered. However, service provider decisions about services provided and which hearing device aid devices are offered can be shaped by corporate concerns such as vertical integration with hearing aid device manufacturers rather than by the comprehensive communication and psychosocial needs of clients based on the principle of informed choice and control over their management of hearing loss.

The Expert Panel considers there is a need for increased transparency and accessibility of information to consumers across all aspects of the Program, including on the range, features and pricing of hearing aid devices, to support consumer choice. A related issue is that having fully and partially subsidised hearing aid devices may be creating a perverse incentive for service providers to market partially subsidised hearing aid devices in place of suitable full subsidised devices. The Panel has recommended actions to improve consumer choice including updating the client rights and responsibilities information to form a Client Charter, giving clients access to their service history and to available services via a client module in the Hearing Services Portal, and expanding the range and frequency of services available through the Program, including the existing rehabilitation and client review services.

The Expert Panel acknowledges that the COVID-19 pandemic has had an impact on the face-to-face delivery of services through the Hearing Services Program. Changes to the Program have included the relaxation of rules to enable the use of tele-audiology for some clinical appointments, allowing verbal client consent for services and the provision of hearing services at temporary business sites and home visits. It is likely that some of these changes will become 'business as usual' for the delivery of clinical services. More generally, continual technological advances in hearing health care

are shaping consumer demand and the service provider offerings to clients. However the Program schedule may not be keeping pace with these advances. The Panel heard that more flexible modalities for service delivery will be welcomed by some clients, such as tele-audiology and settings based service delivery models, including in residential aged care settings, but that the alternative modalities are not well suited to all services nor do they meet the needs of all clients.

The Expert Panel recommends there should be a review of the current Program technologies and pricing to inform changes to the Services Schedule, so that updated technologies can be available to clients into the future.

Program administration

The majority of stakeholders who responded to the *Hearing Services Program Review Consultation Paper* suggested amendments to the current service delivery model rather than broader reform. Nevertheless the Expert Panel considers there are opportunities to implement changes to the current administration of the Program to ensure program objectives are being met, that the service providers, workforce and suppliers are appropriately regulated, that the Program demonstrates value for money and that it has the flexibility to adapt to emerging trends. This might include a name change from Voucher stream to something like the 'National Hearing Support stream' (NHS), or a similar term which more accurately reflects the purpose and processes of the rehabilitation and support that should be provided.

Wayfinding for consumers often begins at the Hearing Services Program website. In line with the overriding principle of informed consumer choice and control, the Expert Panel recommends the development of a range of illustrative client pathways, accessible on the website, which clearly show the options for clients who are eligible for hearing services. This concept should be further developed to direct clients to various service options through the relevant entry points for registration. The options should particularly address the needs of children and young people, Aboriginal and/or Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, people living in rural and remote locations and adults with complex hearing needs, as well as the broader community of people with hearing loss. The illustrative pathways should also assist people who are not eligible for the publicly funded subsidies under the Program but who are seeking help with managing their hearing loss. The Expert Panel considers that further stakeholder engagement during public consultation on the draft report will help consider optimum pathways.

In similar manner to the current lack of legislated Hearing Services Program objectives, there are no clearly described client clinical outcomes or standardised client outcome measures for service providers and no defined Program level outcomes or associated measures; or processes in place to monitor and evaluate these. Available data collections are inadequate for this task. Stakeholder feedback supports a greater investment in measuring client hearing and non-hearing outcomes to help track client progress and to monitor the effectiveness and efficiency of the Program. The Expert Panel recommends the Australian Government develop and invest in a Data Plan which would enable the measurement of performance against Program objectives. The Plan would address the abovementioned deficiencies and make better use of the Hearing Services Portal to capture and analyse data.

There is a complex legislative, contractual and program policy framework underpinning the delivery of services through the Hearing Services Program. While positive steps have been made in simplifying the regulatory framework for the Program, there is agreement that further work is needed. In addition, hearing aid device supply arrangements have not been comprehensively reviewed for almost ten years, may not be demonstrating value for money, and require early attention.

Research

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

The Expert Panel has identified further research opportunities including researching service delivery models, clinical and program outcomes and their measurement tools, and program evaluation research. Importantly though, what is missing is a strategic approach to considering and planning for research. The Panel considers it critical that a Research Strategy is developed in consultation with stakeholders and then published on the Program website. Guiding principles should be to ensure co-design with the relevant population cohort, with research priorities to include the removal of barriers to access to services and to facilitate the cultural appropriateness of service delivery. Research funded through the National Acoustics Laboratory also needs to have a more strategic approach, aligning with this broader Research Strategy.

Hearing Australia is currently developing a hearing loss prevention National Strategy, and the Expert Panel recommends the Department continue to work in collaboration with Hearing Australia on its implementation. Furthermore, recognising the long term value of the Longitudinal Outcomes of Children with Hearing Impairment (LOCHI) study, the Expert Panel recommends the Australian Government continue to fund the National Acoustics Laboratory to complete this study.

Implementation of the outcomes of this Review

The Expert Panel estimates that the expected annual cost increases of the Program arising from the recommendations of this report would be as outlined below.

For expanding eligibility to low income earners, the Expert Panel estimates an expenditure increase of \$5,153,700 to \$8,269,600 p.a. from the 2021/22 financial year to the 2024/25 financial year. By the 2024/25 financial year, the annual nominal increase in expenditure would represent a 0.3 per cent increase from 2019/20.

For expanding eligibility to Aboriginal and/or Torres Strait Islander people aged 25-49 years the Expert Panel estimates an expenditure increase of \$21,341.9 to \$33,907.9 p.a. from the 2021/22 financial year to the 2024/25 financial year. By the 2024/25 financial year the annual nominal increase in expenditure would represent a 1.22 per cent increase from 2019/20.

These above changes would be the biggest source of cost increases. Other less significant expenditure increases are expected to arise from the removal of various barriers which currently inhibit people from accessing services. Program expenditure savings may arise, however, such as

where a greater investment in rehabilitation services is more than offset by savings in the fitting and supply of devices which are subsequently discarded or underutilised. Further there would again be flow on benefits to the people with hearing loss, their communication network, workplaces and broader community.

Some of the recommendations from this Review would be relatively simple to implement. However, the Expert Panel acknowledges that others, as has been the case with prior reviews, are more complex and in some cases involve changes to existing legislation and/or collaboration with other jurisdictions. Many recommendations which are likely to have a significant impact on consumers, the professional workforce and industry would require time and negotiation to implement successfully. Nevertheless, it is the view of the Panel that these challenges are part of the opportunity for change, and can be addressed through a well-constructed reform implementation plan.

CHAPTER 1 – INTRODUCTION

Hearing loss prevalence in Australia

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

Types of hearing loss

Hearing loss levels can be characterised on a spectrum, with *mild hearing loss* usually meaning there are some minor hearing difficulties in some situations. *Profound hearing loss* means the person cannot hear any sounds without an amplification device such as a hearing aid device or cochlear implant.

Hearing loss can be categorised as either “acquired” meaning it occurs due to age, a disease process or injury; or “congenital” meaning it occurred or was identified at birth. Under each of these categories, hearing loss can occur when there is a problem:

- in the inner ear or with the auditory nerve (sensorineural) which is most often associated with ageing or noise-induced damage;
- in the outer or middle ear (conductive) such as through a blockage in the outer ear or poor functioning of the middle ear bones; or
- with sound travelling through both the middle ear and the inner ear (mixed hearing loss).

Hearing loss can also occur as a consequence of a number of medical conditions including *Otitis Media* (an inflammation of the middle ear); *Meniere's Disease* (an inner ear disorder that can affect both hearing and balance); Central Auditory Processing Disorder (a central nervous system disorder that disrupts the processing of sound); and *Tinnitus* (where a person experiences a ringing or similar sound in the ears).

Preventing hearing loss

Hearing loss is an irreversible health condition and prevention is the most effective way to reduce the future incidence of hearing loss and tinnitus. Unnecessary exposure to noise is a major cause of approximately one third of adult onset hearing loss.

Early identification of hearing loss, when followed by timely and appropriate management, can effectively reduce the impact of that hearing loss on a person's ability to live their life and fully engage with family, friends and their community. Neonatal and infant hearing screening programs are an effective strategy for early intervention in cases of congenital and early onset hearing loss.(3) Hearing rehabilitation services and interventions (such as

providing communication strategies and/or hearing aid devices) may be necessary where hearing loss has progressed.

The impacts of hearing loss

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

A child with hearing loss will have difficulty developing speech and language. They may also have behavioural issues. This can have a detrimental effect on the child's education (poor performance and attendance) which may then lead to poorer long-term socio-economic outcomes.

An adult with hearing loss may have difficulties with communication, life-long learning and fully functioning in social and work settings. Their ability to earn an income may be reduced and they may experience or perceive stigmatisation. Hearing loss can affect a person's mental wellbeing and overall quality of life. There is some evidence indicating a higher risk of cognitive decline or dementia in people with hearing loss.(4,5)

In a March 2020 paper, the Hearing Care Industry Association, with assistance from Deloitte Access Economics, estimated that the financial costs of hearing loss in FY 2019/20 in Australia were as high as \$20.0 billion. They indicated that this comprised:

- health system costs of approximately \$1.0 billion;
- productivity losses of \$16.2 billion;
- informal care costs of \$174.7 million;
- deadweight losses of \$1.9 billion; and
- other financial costs of \$683.4 million.(6)

Introduction to the Hearing Services Program

Context of the Hearing Services Program within the health sector

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

...provides for assessment of hearing impairment and rehabilitation programs for non-medical problems. Rehabilitation usually consists of fitting a hearing aid or aids and assisting clients to fully utilise the aids and develop other techniques to improve their capacity for communication. Treatment for medical conditions that impair

hearing are outside the scope of the program and training for signing and speech reading are not provided...(7)

For those outside the eligible population, there are a range of ways to access hearing health care, including through private providers and government programs as detailed below.

- State and Territory governments are significant providers of primary, secondary and tertiary hearing health care. They are responsible for hearing health across the health, justice, education, workplace noise and hearing health workforce domains. Examples of where services are provided include hospitals, health centres, community care, schools and prisons. Clinicians include audiologists, audiometrists and Ear Nose and Throat (ENT) specialists.
- Private primary care services include clinical audiology and audiometry and ear health care (e.g. wax removal). Some of these are supported by Medicare where referred by a GP or ENT.(8) (Other general health assessment checks funded through Medicare such as those that focus on chronic disease, eye health and oral health do not include ear and hearing checks).
- ENT services are provided through private (Medicare supported) and State and Territory health services (i.e. public hospitals).
- Some private health insurers offer audiology services and hearing aid devices under their extras products.
- The National Disability Insurance Scheme (NDIS) supports people with disability in Australia, including those with profound hearing loss. It is available to:
 - children under seven years of age, for whom it funds additional supports such as early childhood intervention or other assistive technology that is not funded under the Hearing Services Program; and
 - those over seven years of age, for whom it funds reasonable and necessary hearing supports that are not available through the Hearing Services Program. (9)

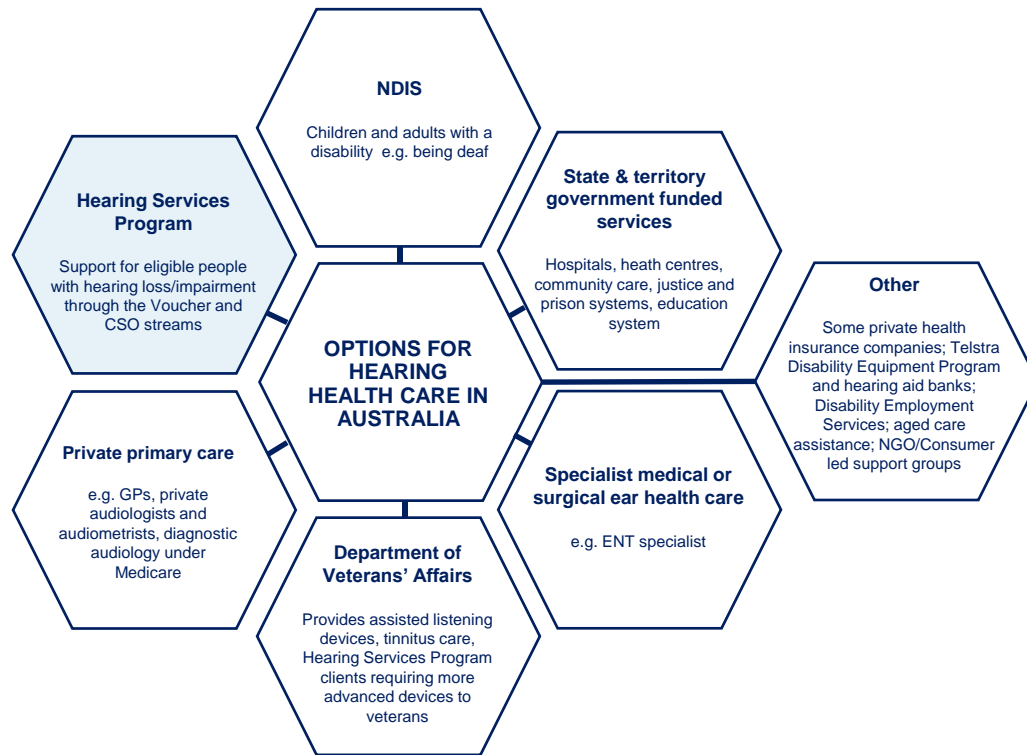
(People with hearing loss can access the NDIS and the Hearing Services Program at the same time, however they cannot get the same supports from both programs at the same time).

- Department of Veterans' Affairs (DVA) provides additional hearing supports for eligible veterans for assistive listening devices and tinnitus care, if assessed by an ENT or audiologist. If a provider has identified that an eligible DVA client's needs cannot be met by the Hearing Services Program, DVA may be able to fund additional supports (i.e. DVA Gold and DVA White Card holders (hearing specific conditions)).
- People who are ineligible for the Hearing Services Program and are unable to afford hearing care may be able to have a hearing aid device fitted at a reduced cost through a hearing aid bank run by volunteers. Hearing aid banks are available in most states and territories. Hearing aid banks recondition donated hearing aids and distribute the hearing aid devices according to their eligibility criteria.

- The Telstra Disability Equipment Program offers assistance to people whose hearing loss affects their ability to use a standard telephone handset.(10)

Figure 1 depicts the different ways Australians can seek hearing health care, showing that the Hearing Services Program is a small but critical element of the hearing health system.

Figure 1: Avenues for accessing hearing health care in Australia



The Hearing Services Program was established by the *Hearing Services Administration Act 1997* to provide access to high quality hearing services and devices.(11) The Program also funds research on strategies to prevent hearing loss or lessen its impact.

The two streams of the Hearing Services Program

Program services are delivered through two streams:

- The **Voucher** stream delivers subsidised hearing services to holders of an Australian Government concession card, specifically:
 - Pensioner Concession Card holders (Includes Aged Pension, Carer Payment, Jobseeker recipients - if partially able to work or single with a dependent child, Disability Support Pension, Parenting Payment if single, Youth Allowance if single, looking for work and caring for dependents. Excludes Seniors Health Card holders);
 - members of the Australian Defence Force;
 - people referred by the Disability Employment Services Program; or

- DVA Gold Card holders or White Card holders (where the card is issued for hearing loss).

The Voucher stream services are delivered by approximately 300 contracted private providers and Hearing Australia (a statutory authority established under the Australian Hearing Services Act 1991).

- The **Community Service Obligations (CSO)** stream delivers subsidised hearing services to disadvantaged population cohorts: all children and young adults up to the age of 26 years; adults with specialist hearing needs; and Aboriginal and/or Torres Strait Islander people over the age of 50 or who live in a remote location or participated in a particular work scheme such as the Community Development Program.(12) Hearing Australia is the exclusive provider of hearing services to CSO clients.

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

Total Hearing Services Program expenditure

The Hearing Services Program is demand-driven within the eligibility criteria (meaning that there is no monetary cap on how much Government funding is contributed to the program as long as eligibility is met by each client). In FY 2019/20, the Program provided 1,607,286 services to 821,726 clients with mild or greater level of hearing loss (primarily through the Voucher stream) at a cost of \$542,2million. **Table 1** provides a summary of costs).(13) A more detailed breakdown of services and costs for eligible Voucher and CSO categories is set out in **Chapter 3**. Research activity under the Program is examined in **Chapter 7**.

Table 1: Breakdown of Hearing Services Program costs for FY 2019/20

Active clients by eligibility	Number	Expenditure
Voucher stream	751,052	\$451,791,000
CSO stream (14)	70,674	\$79,864,000
TOTAL	821,726	\$542,227,000

Source: Department of Health Annual Report 2019-20(13), Hearing Australia CSO Quarterly Report 2019-20(14).

Implementation of certain initiatives from the Australian Government Roadmap for Hearing Health

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

From October 2020, the Government is investing \$21.2 million over five years to implement key initiatives from the *Roadmap for Hearing Health* (the *Roadmap*).⁽³⁾ This investment aims to increase public awareness of hearing health, generate scientific evidence through research, and support vulnerable Australians who are most likely to need hearing loss support.

The *Roadmap* package comprises:

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

The impact of disasters on the delivery of health care programs

Australia has always experienced natural disasters such as floods, bushfires and, at times, earthquakes – usually at a local or regional level. We have also experienced pandemics in the past, such as the Spanish influenza, Avian Influenza and H1N1. The last two years have seen a ‘perfect storm’ of virtually all these natural disasters and the CoVID-19 pandemic, with resultant impacts on service delivery across a range of services. Some impacts have been regionalised, while others have been felt at state or national level. The extended time frame and range for the CoVID-19 pandemic has changed the rules in terms of how health care providers provide services, including increased opportunities for remote models of practice⁽¹⁵⁾ but also the potential for service disruption with very little notice due to public health responses to local outbreaks.

More severe and prolonged weather events and further pandemics have been predicted to occur in the future.⁽¹⁶⁾ This may well be the ‘new normal’, and raises important questions about how to build adaptation and flexibility into program planning to enable a ‘business as usual’ approach to disaster preparation, response and recovery rather than a response to each individual adverse event.

Context and conduct of the Review of the Hearing Services Program

This current Review is the first major review of the Hearing Services Program as a whole since it was established in 1997. Over the ensuing two decades, the hearing health sector has grown in scope and scale. Developments in hearing technology and changes to retail service delivery mean that people accessing hearing health care services (herein referred to as clients) have more choice than ever in both service delivery options and hearing aid devices. In addition, a greater focus on early detection and intervention, particularly amongst vulnerable client groups, as well as the ageing of Australia’s population, is expected to continue to increase the demand for hearing services.

Despite these developments, the current arrangements for delivery of hearing services through the Hearing Services Program have remained largely unchanged since its establishment in 1997. There have been several more limited reviews of the Program, including those conducted by Access Economics (2006); the Australian Competition and Consumer Commission (2017); and PricewaterhouseCoopers Australia (2017). These and other reviews are described in **Appendix A**.

Terms of Reference of the Review of the Hearing Services Program

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

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

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

The Review has included consideration of, but was not limited to:

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

The Review identifies opportunities to:

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

The Expert Panel of the Review of the Hearing Services Program

The Expert Panel was established in July 2020 and has met regularly since. Membership consists of:

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

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

Conduct of the Review of the Hearing Services Program

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

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

Hearing Services Program Review Consultation Paper

The *Hearing Services Program Review Consultation Paper*(17) was released on 30 October 2020 to prompt discussion on key areas that could inform the Program's modernisation. Submissions were sought from interested stakeholders up until 4 December 2020. These submissions were considered by the Expert Panel and where requested (by either the stakeholder or the Expert Panel) virtual one-on-one discussions took place with the stakeholder. The Consultation Paper asked ten questions of stakeholders:

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

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

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

On 6 October 2020, the Australian Government announced changes to the Hearing Services Program Voucher Stream in the Federal Budget. The changes related to the Voucher period, the 12 month warranty period maintenance payment and the timing of the maintenance payments

The Minister requested that the Expert Panel provide Interim Advice to the Government on the impact of the implementation of these changes to the Hearing Services Program. On 4 December 2020, the Expert Panel released their *Hearing Services Review Interim Advice to Government – Implementation of Hearing Services Program Changes (Interim Advice)*(18) seeking any feedback from stakeholders by 18 January 2021. Following consideration of the stakeholder responses, the Expert Panel provided their *Final Interim Advice* to the Minister on 25 February 2021.

Consultation on the Review of the Hearing Services Program Draft Report

This Draft Report sets out the Expert Panel's proposed advice to the Australian Government on future Hearing Services Program settings to support hearing-impaired Australians and to ensure appropriate access to Program services. The Draft Report is open for consultation from late May to 24 June 2021 and interested parties will be invited to attend a virtual information session and provide a written submission in response to the Draft Report and its recommendations.

Following consultation, the Final Report of the Review of the Hearing Services Program Expert Panel will be provided to the Minister in July 2021.

Structure of this Draft Report

The remaining chapters of this Draft Report are set out as follows:

Chapter 2 – Defining the objectives of the Hearing Services Program

Chapter 3 – Eligibility requirements for support under the program

Chapter 4 – Improving the client experience and assessing need for support

Chapter 5 – Delivery of services

Chapter 6 – Program design and administration

Chapter 7 – Hearing health and hearing loss research

APPENDICES

- A. History of reviews related to the hearing services program and broader hearing health
- B. Hearing aid devices available through the hearing services program
- C. Better practice regulation – legislative and regulatory changes since 2019
- D. Program administration
- E. Stakeholders who contributed to the Review of the Hearing Services Program
- F. Abbreviations used in this report
- G. Glossary of terms used in this report

CHAPTER 2 – DEFINING THE OBJECTIVES OF THE HEARING SERVICES PROGRAM

Key Points

- The enabling legislation for the Hearing Services Program provides no statement of purpose for the program or specific objectives. This lack of clarity is in contrast to the legislation establishing Aged Care and the NDIS.
- While high level statements of objectives of the Program which are contained in other documentation provide a generalised framework for the Program and its funding streams, the actual implementation is characterised by an over-emphasis on the supply and fitting of hearing aid devices.
- There is a need to explicitly define the objectives of the Hearing Services Program to guide its future reform, emphasise the centrality of client outcomes, choice and control, provide clarity and direction for its administration, ensure alignment with contemporary service delivery, and to facilitate accountability through the measurement of outcomes.
- A set of more defined Program objectives is presented in this chapter for further consultation.

Current Objectives of the Hearing Services Program

The enabling legislation for the Hearing Services Program provides no guidance on its objectives. The *Hearing Services Administration Act 1997* sets out the categories of eligible persons under the Voucher stream and associated prescribed services but does not identify the objectives of that stream of public funding. Similarly, the *Australian Hearing Services Act 1991* provides for the delivery of declared services to CSO clients by Hearing Australia, as well as the conduct of research, but does not define the objectives.

Some statements relating to the objectives of the current Program can be found in several key documents. The Department of Health website summarises the main objective of the Hearing Services Program as:

...to work towards reducing the incidence and consequences of avoidable hearing loss in the Australian community by providing access to high quality hearing services and devices.(11)

The Portfolio Budget Statements for the Department of Health also refers to the conduct of research in its reporting of the Hearing Services Program objective:

Provide hearing services and a range of fully and partially subsidised hearing devices to eligible Australians to help manage their hearing loss and improve engagement with the community. Continue support for hearing research, with a focus on ways to reduce the impact of hearing loss and the incidence and consequence of avoidable hearing loss.(19)

In essence the Hearing Services Program currently has three broad activities which have the following aims:

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

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

Effective and measurable program objectives are the foundation of any program evaluation. The Australian National Audit Office reports that good performance management is underpinned by clear objectives and states that *'performance information is clearly linked to the objectives and intended results of programs and activities, and enables a ready assessment of program performance in terms of effectiveness, efficiency, and service quality'*.(20)

The Hearing Service Program has not undergone any formal evaluation since its inception in 1997. This Review has identified that the objectives are poorly defined and do not support contemporary service delivery. A 2018 Department of Health Program Assurance review identified a need for improved program governance documentation, including a program logic, governance structures, roles and responsibilities and overall program risk management.(21) This was supported by the 2020 internal report which also identified that a lack of clear program objectives was hampering achievement of program outcomes.(22)

The Review provides an opportunity to improve how the Hearing Services Program objectives are defined and described, and used into the future for program administration and evaluation.

Improving the Objectives of the Hearing Services Program

The Expert Panel received submissions advocating for the Hearing Services Program's objectives to be more explicit and to set out how the Program aims to reduce the impact of hearing loss. The line of argument from many stakeholders was that the Departments' administration of the Hearing Services Program and the providers' delivery of publicly funded services is too hearing aid "device focused". Instead, the Program's objectives should more clearly articulate the improved outcomes which could come with greater provision of rehabilitation and psychosocial support.

Submissions to this Review included some insight into what the improved objectives should encompass. For example the Deafness Forum of Australia identified that:

Consumers need more information about the options available within a rehabilitation program so they understand there are more choices than a device fitting...The Program should aim to...provide quality information, advice and support to clients, their family and significant others of Program participants...(23)

Audiology Australia noted that:

Hearing loss affects a person's ability to communicate, and consequently can negatively impact a person's psychological well-being...the Program's scope should expand its current focus on communication training to also include provision of psychosocial support to all Australians under the Program who require it.(24)

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

The Program Objectives should include:...hearing loss prevention strategies that: address workplace and leisure noise...(25)

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

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

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

...self-determination is the foundation for designing and implementing culturally-appropriate services to close the gap between Aboriginal and Torres Strait Islander people and non-Aboriginal people.(3)

A comparison with more recently developed social service programs, such as Aged Care and the NDIS, illustrates the need to define the purpose of the Hearing Services Program in the enabling legislation to ensure that the objectives are presented in a clear, consistent and concise manner that allows for the equitable, effective, efficient and sustainable administration of the program and the measurement of outcomes. In doing so it would be adopting the better practice approaches contained in other social services legislation. For instance, Section 2-1 of the Aged Care Act 1997 includes objectives that cover such matters as:

- promoting a high quality of care and accommodation for the recipients of aged care services;
- encouraging diverse, flexible and responsive aged care services that meet recipient's needs;
- protecting the health and well-being of the recipients of aged care services; and

- ensuring that aged care services are targeted towards, and accessible by, the people with the greatest needs.(26)

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

...(c) support the independence and social and economic participation of people with disability; and

(d) provide reasonable and necessary supports, including early intervention supports, for participants in the National Disability Insurance Scheme launch; and

(e) enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports; and

(f) facilitate the development of a nationally consistent approach to the access to, and the planning and funding of, supports for people with disability; and

(g) promote the provision of high quality and innovative supports that enable people with disability to maximise independent lifestyles and full inclusion in the mainstream community; and

(h) raise community awareness of the issues that affect the social and economic participation of people with disability, and facilitate greater community inclusion of people with disability...(27)

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

Accordingly, the Expert Panel proposes the following recommended objectives for the Hearing Services Program for consideration and feedback prior to finalising its report.

Recommendations

1. Defining new Objectives for the Hearing Services Program –

1(a) The Australian Government should define the objectives of the Hearing Services Program to guide: the expectations of those with hearing loss, the Department’s administration of the Program, the delivery of services by providers, the participation of other stakeholders in the Program, and the measurement and assessment of client outcomes. The Australian Government should also establish a regular assessment of Program outcomes to ensure the accountability of all participants.

1(b) The Australian Government should undertake community consultation on the following draft objectives before committing to a final set of Program Objectives and to subsequently enshrining them in legislation:

A. The Program's objectives for eligible people with hearing loss are that they:

A1 have equitable access to prescribed services which comprise hearing assessment and hearing rehabilitation, hearing aid devices and other support. Specifically, that eligible people:

- (i) have equitable access to support irrespective of their location or personal attributes and circumstances; and
- (ii) be provided with support which is culturally safe and appropriate to them;

A2 are able to exercise informed choice about, and control how to live with hearing loss, including:

- (i) how to address their communication needs and maximise social inclusion through social activity, economic participation and in physical, and cultural pursuits to the fullest extent possible; and
- (ii) how they can be engaged in the planning, assessment, selection and delivery of the services offered to them; and

A3 are able to exercise informed choice about, and control the selection of, their service provider and have clear and independent processes for resolving any complaints.

B The Program's objectives for service providers under Hearing Services Program are that they:

B1 always act in the best interests of the eligible clients who have chosen them;

B2 demonstrate that they meet Program contract requirements such as key performance indicators; and

B3 provide culturally appropriate services that respond to the needs of people with hearing loss in their local area.

C The objectives for Qualified Practitioners (QPs)/health professionals are that they:

C1 abide by all current Practitioner Professional Bodies (PPBs) Codes of Conduct and meet all professional standards and/or competencies.

D The Program's objectives for the Government and the Hearing Services Program administrators are that:

D1 when defining the subsidised set of prescribed services, categories of eligibility, hearing loss thresholds and criteria for service provider accreditation, it has regard to:

- (i) supporting the communication needs of people with hearing loss and their social inclusion through social activity, economic participation, and physical and cultural pursuits; and
- (ii) the benefits to families and other persons with whom people with hearing loss communicate;

(iii) the broader benefits of employability, participation in society, social cohesion and economic growth; and

(iv) the quantum and sustainability of costs to, and opportunities forgone by, current and future taxpayers;

D2 it ensures that the services, hearing aid devices and other technologies made available to people with hearing loss through the Hearing Services Program are regularly reviewed and modified to reflect best practice, and to ensure that people with hearing loss do not experience harm arising from poor quality services or supports;

D3 it raises community awareness of the issues that affect the social and economic participation of people with hearing loss, and facilitate their greater community inclusion; and

D4 it supports the collection of data associated with hearing loss in Australia and the outcomes achieved by hearing services programs, and invests in research, to:

(i) facilitate innovation, continuous improvement and contemporary best practice in improving hearing health, preventing hearing loss and supporting people with hearing loss

(ii) inform the future direction of hearing services programs.

CHAPTER 3 – ELIGIBILITY REQUIREMENTS FOR SUPPORT UNDER THE PROGRAM

Key Points

- In FY 2019/20, it was estimated that 3.9 million Australians lived with hearing loss. In this same year 2.1 million of these people with mild or greater levels of hearing loss fulfilled the eligibility criteria for the Hearing Services Program – while noting that only 39% of currently eligible people participated in the Program.
- There are several groups of non-eligible people who experience a higher prevalence of hearing loss or who require financial support and who would benefit from access to publicly subsidised hearing services through the Hearing Services Program. The Expert Panel examined the various public and private benefits and costs of extending eligibility to each of those groups of people.
- People with hearing loss who are at most need of priority inclusion in the Program are those who hold a Low Income Health Care Card and all Aboriginal and/or Torres Strait Islander people (irrespective of their age).
- There is an opportunity to expand the availability of full diagnostic assessments under the Program through the Medicare Item ‘Health Assessment for people aged 75years and older’.

The Expert Panel was requested by the Minister to investigate how the Hearing Services Program services are currently delivered and to advise how to improve access to hearing services for low-income earners, vulnerable Australians including Aboriginal and/or Torres Strait islander people, those over 65 years of age, and those living in regional, rural and remote areas.

To address these Terms of Reference, the Expert Panel has had to examine two separate, but related, issues:

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

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

On the other hand, overcoming the barriers to access experienced by those who are already eligible are largely matters of improving program design, funding, service delivery and administration, as well as overcoming market failures. As such, these issues provide rationales for funding either clients or providers to overcome these barriers as well as for regulation and direct intervention by

government (such as by delivering services through Hearing Australia, information campaigns and the like).

This chapter addresses the issue of the scope of eligibility. The second issue – overcoming barriers to access by those who are eligible – is addressed in chapter 4 (the client experience) and chapter 5 (service delivery).

Distinguishing between eligibility and participation in the Hearing Services Program

Table 2 notes that hearing loss is estimated to be experienced by 3.9 million people (FY 2019/20), according to Deloitte Access Economics (2020).⁽⁶⁾ Prevalence modelling indicates that during FY 2019/20 a total of 2.1 million people with hearing loss were eligible for subsidised hearing services under the Hearing Services Program. However, as the table below shows, only around 822,000 were active in FY 2019/20, representing a participation rate of only 39% of currently eligible persons with hearing loss.

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

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

Sources and Notes:

¹ HCIA and Deloitte Access Economics, March 2020 https://www.hcia.com.au/hcia-wp/wp-content/uploads/2020/02/Hearing_for_Life.pdf

² Estimated prevalence of persons with mild hearing loss or greater based on Davis UK study.

³ Voucher clients who were eligible and had a current Voucher and were classified as eligible in the HSO system.

⁴ Voucher clients who had at least one service in the financial year.

⁵ CSO clients who had at least one service in the financial year.

⁶ Estimated private hearing aid clients based on statement by Professor Harvey Dillon, Director, National Acoustic Laboratories, Australian Hearing, Official Committee Hansard, Canberra, 3 March 2017, pp 19-20.

Current eligibility requirements of the Hearing Services Program

As noted in the Introduction of this Report, the Hearing Services Program is split into two streams: the Voucher stream and the Community Services Obligation (CSO) stream, each with their own eligibility requirements as set out below. The eligibility requirements for both streams of the Hearing Services Program are set out in the *Hearing Services Administration Act 1997*.⁽²⁸⁾

Voucher stream

Eligibility for the Voucher stream of the Hearing Services Program includes Australian citizens or permanent residents 21 years or older who are a:

- Pensioner Concession Card holder (this does not include Seniors Health Card holders), including those receiving:
 - An Age Pension (age requirement of 66 years and six months as of 1 July 2021);
 - A Carer Payment (an income support payment if an individual gives constant care to someone who has a severe disability, illness, or an adult who is frail aged);
 - A Disability Support Pension;
 - A JobSeeker Payment (if partially able to work or single with a dependent child) or Youth Allowance and are single, caring for a dependent child and looking for work. This does not include those who receive a Jobseeker payment who are single or a couple with/without dependent children;
 - Parenting Payment (single).(29)
- Department of Veterans' Affairs Gold Card holder;
- Department of Veterans' Affairs White Card holder (with hearing specific conditions);
- dependent of a person in one of the above categories;
- member of the Australian Defence Force including a current member of the:
 - Permanent Navy, the Regular Army or the Permanent Air Force; or
 - Reserves who is rendering continuous full-time service; and/or
- referred by the Disability Employment Services (Disability Management Services) Program.

Voucher services are provided by accredited service providers throughout Australia, including by Hearing Australia.

Eligible Voucher holders receive one full hearing assessment and one hearing aid per ear if the client's hearing loss is above the Minimum Hearing Loss Threshold (MHLT) of 24 decibels. The Voucher also covers the maintenance and repair services for their hearing aid as well as an annual review of their hearing loss and suitability of their hearing aid. Clients are also covered for a hearing aid replacement if they are lost or damaged beyond repair.

Voucher clients whose level of hearing impairment is assessed as being below the MHLT are not eligible for a subsidized device and following their hearing assessment can receive up to two rehabilitation sessions until their next Voucher.

Community Service Obligations (CSO) stream

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

- are eligible for the Voucher stream of the Hearing Services Program but who have complex hearing or communications needs or lives in a remote area;
- identify as an Aboriginal and/or Torres Strait Islander person and are:
 - over 50 years of age; or

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

Hearing Australia is the sole provider of CSO services.

Cross over in eligibility across the Voucher and CSO streams

There is some cross over of eligibility within the two streams of the Hearing Services Program and this has been known to cause confusion and administrative burden, particularly for service providers. These circumstances are outlined below.

Adults with complex hearing needs

The Glossary on the Hearing Services Program website states:

A complex client is a client who has severe to profound bilateral hearing loss or whose communication is limited due to significant physical, intellectual, mental, emotional or social disability. Complex clients are entitled to receive specialist hearing services through Community Service Obligations.(30)

Adults with complex hearing needs have the choice to receive support through Hearing Australia using either the Voucher Stream or CSO supports, or both, if they require it. Currently they represent 40 per cent of the CSO client base.(31) However, confusion lies in the fact that all adults with complex hearing needs must be eligible for (but not necessarily holding) a Voucher before they can access CSO supports.

Referral of Voucher clients to CSO

Service providers are required to notify their client that they can receive additional supports through the CSO stream of the Hearing Services Program if and when their hearing needs become complex.

The client can choose to move across to the CSO stream or remain with their current provider.

Section 50 of the *Hearing Services Program (Voucher) Instrument 2019* (Cth) states that:

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

- (a) notify the Department that a voucher-holder who is eligible for specialist hearing services is requesting hearing services; and*
- (b) explain to the voucher-holder the specialist hearing services that may be available to him or her from AHS; and*
- (c) allow at least 10 business days from the time at which the explanation under (1)(b) was provided before contacting the voucher-holder to ask whether he or she has decided whether to receive specialist services from AHS; and*

- (d) not provide further hearing services to the voucher-holder until the person advises the contracted service provider that he or she has made an informed decision not to receive specialist services from AHS; and*
- (e) retain evidence on the voucher-holder's record of the advice given to the voucher-holder and the voucher-holder's decision.(32)*

The Expert Panel highlights that there is a contradiction in the communication around how clients with complex hearing needs should be supported through the Hearing Services Program. The Panel considers that that this can be clarified by expanding the eligibility definitions for the Voucher stream to specifically include clients with special needs, namely adults with complex hearing needs, and adults with Cochlear/bone anchored implants rather than having them included under the CSO stream. This would give people in these groups a wider choice of providers. There would be no change to the scope of services available to meet their special needs. Hearing Australia would continue to be a provider of these services (for which it was the sole provider under the CSO stream), as it is a registered provider under the Voucher stream.

Young people receiving CSO services who turn 26 years old

The CSO stream is available for young people under 26, however those aged 21-25 years are able to choose to receive services through the Voucher stream instead (if they meet the required eligibility criteria). From age 26 years onwards access to CSO services ends unless the client meets other CSO eligibility criteria.

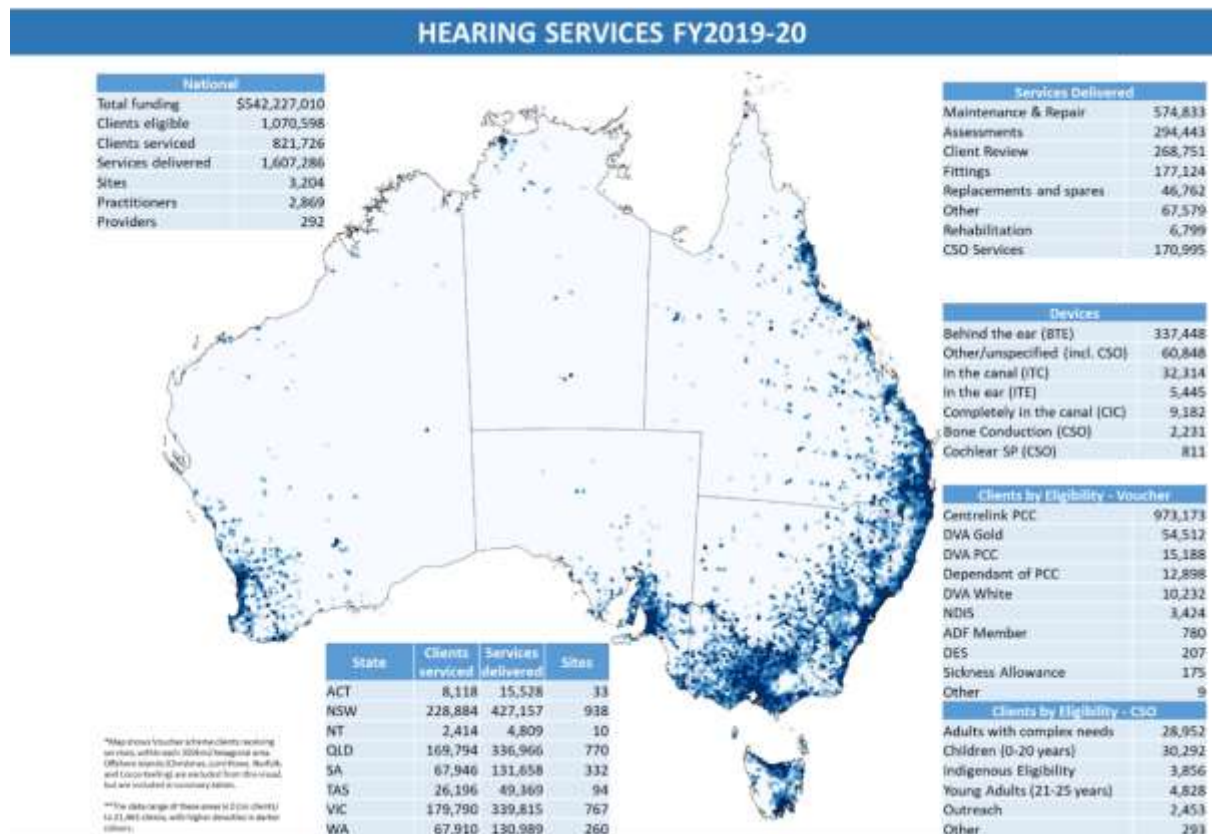
A profile of eligible people who are accessing the Hearing Services Program

In FY 2019/20, the Hearing Services Program provided 1,602,188 services to 821,726 clients (with over around 751,000 of these clients receiving services through the Voucher stream and around 71,000 through the CSO).(31)

There are 2.1 million estimated eligible Australians with mild or greater hearing loss. Of those 751,052 (35.4%) are active clients in the Voucher stream and 70,674 (3.3%) in the CSO stream based on in 2019/20 data. However of the 1,070,598 registered clients in the Voucher stream, only 829,000 have a mild or greater level of hearing loss, as access to specific government benefits is the eligibility requirement for the Voucher stream.

The map below (**Figure 2**) shows the distribution of hearing services delivered through the Hearing Services Program in FY 2019/20. As expected, the distribution broadly follows that of the population overall, with a slight bias to areas that have an older population (retirement and rural areas) and a higher CSO presence in some rural and remote areas.

Figure 2: Distribution of hearing services delivered through the Hearing Services Program FY 2019/20



Source: Department of Health – *Hearing Services Program Data and Statistics (Internal)*.

Details based on the two streams of the Program are outlined below. **Table 3** provides a breakdown of clients under each stream of the Hearing Services Program by eligibility criteria and shows that 82% of all Voucher stream clients are those who hold a Pensioner Concession Card, but they account for a slightly smaller proportion of expenditure (three quarters). In the CSO stream, children under 21 years of age and adults with complex or specialist hearing needs account for similar proportion of CSO client numbers (about 3.5 per cent), but the children under 21 years of age represent almost double the expenditure (6.9 per cent) compared to the adults with complex hearing needs (3.55 per cent). This is a result of children and young adults being eligible to receive Cochlear implant speech processor replacements and requiring more hearing services than adults with complex hearing needs.

Table 3: Count of active clients by Hearing Services Program stream eligibility criteria in FY 2019/20

Eligibility criteria	Active clients	Percentage of grand total of clients	Expenditure excluding GST (\$,000s)	Percentage of grand total expenditure
Voucher stream				
Centrelink Pensioner Concession Card (PCC) ¹	675,068	82.15%	\$404,604.7	74.62%
DVA Gold Health Repatriation Card	45,247	5.51%	\$28,191.5	5.20%
DVA Pensioner Concession Card	11,542	1.40%	\$6,737.5	1.24%
DVA White Health Repatriation Card (for Hearing Loss)	7,900	≤ 1%	\$5,272.7	≤ 1%
Dependant of a concession card holder	8,183	≤ 1%	\$4,809.0	≤ 1%
National Disability Insurance Scheme (NDIS)	2,345	≤ 1%	\$1,650.7	≤ 1%
Member of the Australian Defence Force	414	≤ 1%	\$297.1	≤ 1%
Disability Employment Services (DES)	212	≤ 1%	\$132.5	≤ 1%
Centrelink Sickness Allowance	136	≤ 1%	\$90.2	≤ 1%
Other	5	≤ 1%	\$4.8	≤ 1%
Total (Voucher)	751,052	91.40%	\$451,790.6	83.32%
CSO stream				
Children (under 21 years old) ²	26,185	3.19%	\$36,935.6	6.90%
Indigenous Children (under 21 years old) ²	4,107	≤ 1%		
Young Adults (21 to under 26 years old)	4,828	≤ 1%	\$4,398.0	≤ 1%
Complex Adults (clients with specialist needs) ³	28,952	3.52%	\$18,982.6	3.55%
Extended Indigenous Eligibility	6,309	≤ 1%	\$6,496.8	1.21%
CSO Remote – Other	293	≤ 1%	-	-
Other expenditure – Cochlear implant upgrades and repairs and maintenance ⁴	-	-	\$9,734.2	1.82%
Other expenditure – Outreach ⁴	-	-	\$3,316.9	≤ 1%
Total (CSO)	70,674	8.60%	\$79,864.1	14.92%
National Acoustics Laboratory			\$10,572.3	1.95%
Grand Total⁵	821,726	100%	\$542,227.0	100%

Source: Department of Health – Hearing Services Program Data and Statistics (Internal).

¹ as previously defined earlier in this chapter

² Children seen includes children that did not go on to a fitting nor needed further hearing health care (i.e. discharged), hence this number being higher than the number of Aided Young Australians

³ Expenditure for Complex Adults includes \$12.296m funding from the Voucher Scheme.

⁴ Other expenditure is used to refer to costs associated across the CSO stream in clients already counted under an eligibility criterion.

⁵ Total expenditure will not match the Department of Health Annual Report due to differences in the CSO expenditure.

Identifying gaps in the Hearing Services Program eligibility criteria

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

The Hearing Services Program (HSP) should ensure that vulnerable groups, those requiring specialised programs to address their hearing needs, and people on low income have access to high quality hearing services at no cost or minimal cost.(23)

The range of suggested categories of people who should be eligible for publicly subsidised hearing services included:

- all people living on a low income (where they are also not eligible for the NDIS), including:
 - people of working age who are unemployed or in low paid employment (including those receiving Jobseeker);
 - adults aged 65 and over with hearing loss who are on a low income, unemployed or retired (including self-funded retirees on low income);
 - adults holding one of the numerous health care cards or concession cards generally provided to those experiencing some form of economic disadvantage; and
 - Low Income Health Care Card holders.
- all Aboriginal and/or Torres Strait Islander people (not just those who live in remote communities or who are over 50 years of age);(33)
- Commonwealth Seniors Health Card holders;
- tinnitus sufferers;(34)
- adults over 65 years with a cochlear implant; and
- people in the criminal justice system.

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

- the *Roadmap for Hearing Health* – in particular Priority 8 “*additional support for people on low incomes is made available to access hearing health services*”(3);
- the *Parliamentary Inquiry Still Waiting to be Heard – Report on the Inquiry into the Hearing Health and Wellbeing of Australia*, which made recommendations to improve access to hearing services for Aboriginal and/or Torres Strait Islander people and which also heard from stakeholders who called for the expansion of the Voucher stream to holders of the Commonwealth Seniors Health Card;(35)
- HCIA’s *Hearing for Life* report which identified the benefits of expanding hearing services to Australians of working age who are on low incomes or who are unemployed;(6) and

- Access Economics 2006 report which investigated the financial impacts of hearing loss on the Australian economy.(1)

Expert Panel's assessment of extending the categories of eligibility

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

Low income earners

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

Hearing loss can have a long-lasting impact on the academic outcomes of an individual...those with hearing loss have reduced school performance, slower progression through the academic system, a greater risk of dropping out of school, and lower likelihood of applying for higher education, compared with their hearing peers... Students with hearing loss often demonstrate a lack of career-planning and decision-making which are required for success in the workplace. Overall, adults with hearing loss have increased odds of unemployment or underemployment...often earn lower wages and retire earlier than their hearing peers.(36)

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

Among people in the labour force with hearing loss and communication difficulties, nearly two out of three report that their disability restricts their employment, most notably in their type of work or with difficulties in changing jobs or securing preferred jobs.(37)

This summation is supported by a 2017 report prepared by Deloitte Access Economics for the Hearing Care Industry Association (HCIA) that calculated that untreated hearing loss resulted in \$12.8 billion in productivity losses per year (amounting to approximately \$3,566 per person with hearing loss), of which the majority was associated with reduced workforce participation of people with hearing loss (including absenteeism and reduced productivity at work).(6)

There is little empirical evidence of the impact of increased access to hearing health care and use of hearing aid devices among Australians of working age. However, international evidence from the United Kingdom, where hearing aids are free of charge to all citizens who need them under the National Health Service, suggests that unemployment of those with hearing loss is reduced when

they have access to hearing services.(38) Further a 2010 study of 40,000 households in the United States found that:

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

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

There was a strong relationship between degree of hearing loss and unemployment for unaided subjects. Those with severe hearing loss had unemployment rates (15.6%), double that of the normal-hearing population (7.8%) and nearly double that of their aided peers (8.3%).(39)

The Expert Panel recognises that access to the Hearing Services Program would provide opportunities for low income earners and those who are unemployed to improve their work prospects by gaining employment, working more hours or undertaking more complex/skilled work; and/or undertake vocational or higher education. It also recognises that the Disability Employment Service (DES), which provides supports for people who are at risk of losing their jobs or are unemployed, refers people to the program if hearing loss is considered a factor.

The Expert Panel proposes using the Low Income Health Care Card as the basis for eligibility under the broad category of “low income earners and the unemployed”. The Australian Government through Services Australia assesses the eligibility of Low Income Health Care Card holders through the use of an annual income test (including incomes from paid employment, rental income, payments from the Australian Government etc.).

Table 4: *Income test threshold for the Low Income Health Care Card*

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

Source: Services Australia

Extending eligibility to this cohort of Australians would also support Recommendation 11 of the *Still Waiting to be Heard* Parliamentary Inquiry, which stated that the Hearing Services Program should:

...be extended to provide hearing services to hearing impaired Australians aged 26 to 65 years on low incomes or who are unemployed and qualify for lower income support...(35)

While the recommendation of the *Still Waiting to be Heard* Parliamentary Inquiry stipulated that this population group should have access to the CSO stream of the Hearing Services Program, that would be a decision for Government to make based on need and cost.

Taking the above evidence into consideration, along with data on the prevalence of mild and greater hearing loss, **Table 5** provides an indicative estimate of the additional number of clients who have mild or greater hearing loss and the annual cost per year over the 2019/20 year to the Hearing Services Program by extending eligibility of the Voucher stream to low income earners who hold a Low Income Health Care Card.

By 2024/25 there would be an estimated additional 8,154 clients, increasing the Voucher stream expenditure by nearly \$8.3 million per annum. The total additional spend over the four years would be about \$25.54 million.

The current government eligibility requirements for the Low Income Health Care Card enables singles and couples on the Job Seeker allowance and Seniors Health Care Card holders to apply for access to this benefit. They automatically gain access to a Health Care Card so there is no current incentive for them to apply for the Low Income Health Care Card. Allowing eligibility for the Hearing Services Program may provide this incentive. The Expert Panel is undertaking further analysis of the potential impact of this option on Low Income Health Care Card recipients and the consequent increase in the numbers of clients and expenditure.

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

	Financial year increase on FY 2019/20			
	2021/22	2022/23	2023/24	2024/25
Expected increase in number of clients	4,173	4,300	6,183	8,154
Total expected nominal increase in cost (\$'000s)	\$5,153.7	\$5,386.6	\$6,729.5	\$8,269.6
Expected annual compound growth increase (%) compared to FY 2019/20	0.9%	0.47%	0.33%	0.31%

Source: Department of Health – Hearing Services Program Data and Statistics (Internal).

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

Aboriginal and/or Torres Strait Islander people

Hearing loss is a significant problem for Aboriginal and Torres Strait Islander people and, as the World Health Organisation reports, their children experience some of the highest rates of ear disease and associated hearing loss in the world.(40) The National Aboriginal Community Controlled Health Organisation (NACCHO) stated:

Hearing health for our Aboriginal and Torres Strait Islander communities should be a national priority, as defects in hearing can lead to lifelong issues in education, employment, and health. There are currently inadequate services to deal with the demand of ear and hearing health problems among Aboriginal and Torres Strait Islander communities and wait times can be years to access much needed treatment.(33)

In 2018–19, the *National Aboriginal and Torres Strait Islander Health Survey* (NATSIHS) reported on data from a voluntary hearing test, which indicated more than four in 10 (43% or 290,400) people

aged seven years and over had a hearing impairment in at least one ear at the time of interview. Of these:

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

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

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

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

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

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

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

In examining the latter issue of expanding the eligibility criteria in this chapter, there are an estimated 164,408 Aboriginal and Torres Strait Islander people with mild or greater hearing loss between the ages of 25 to 49 years, essentially encompassing the group who are not explicitly covered by the current eligibility criteria for that group of people.

Some will be eligible through other criteria, including those who have a Pensioner Concession Card or eligible DVA card or who receive services as complex adults. While data is not complete, it is estimated that this would marginally reduce the numbers of Aboriginal and/or Torres Strait Islander people with hearing loss who are not covered under the current eligibility criteria to 130,433. Should the government accept the proposal that people with hearing loss who have a Low income Health Care Card, this would further marginally reduce the numbers of this group who are not covered to 129,880.

The question then arises as to the rationale for providing subsidies for Aboriginal and/or Torres Strait Islander people who are not supported under other existing or proposed eligibility criteria. The *Still Waiting to be Heard* Parliamentary Inquiry highlighted that hearing loss and impairment among Aboriginal and/or Torres Strait Islander people had a significant impact on their ability to remain in education; increased their interactions with the criminal justice system; and increased their likelihood of experiencing isolation as they are unlikely to use Auslan or a signing system recognised outside of their own country.(35)

These factors, along with recognition of the long and historic disadvantage experienced by Aboriginal and/or Torres Strait Islander people, supports the expansion of the Hearing Services Program to include all people who identify as Aboriginal and/or Torres Strait Islander, regardless of other eligibility criteria.

Table 6 provides an indicative estimate of the expected increase in number of clients and the annual cost per year to the Hearing Services Program over four years to the 2019/20 financial year by extending eligibility to all people who identify as Aboriginal and/or Torres Strait Islander and who would meet the hearing loss criteria. The total additional spend over the four years would be about \$105.1 million.

Table 6: *Indicative financial implications to extending access to the Hearing Services Program to Aboriginal and/or Torres Strait Islander people aged 25-49 years with hearing loss (based on costings associated with the Voucher stream)*

	Financial year increase on FY 2019/20			
	2021/22	2022/23	2023/24	2024/25
Expected increase in number of clients	17,279	17,735	25,427	33,461
Total expected nominal increase in cost (\$'000s)	\$21,341.9	\$22,219.0	\$27,661.8	\$33,907.9
Expected annual compound growth increase (%) compared to FY 2019/20	3.74%	1.95%	1.35%	1.25%

Source: Department of Health – Hearing Services Program Data and Statistics (Internal).

Assumptions: These estimates have been modelled using ABS Aboriginal and/or Torres Strait Islander population projections. Assumptions have been made that the behavioural characteristics of the modelled population will match the current Pensioner Concession Card population and their level of hearing loss will match the measured prevalence rate in the ABS 2018-19 National Aboriginal and Torres Strait Islander Health Survey. The cost of service provision assumes that they will receive their hearing services in the Voucher Stream and their rate of returning for services will match the existing Voucher population. This takes into account that not all of the above 129,880 people would seek to access services.

Commonwealth Seniors Health Card holders

Although hearing loss is more prevalent in people aged 60 and older, the Hearing Services Program is generally only accessible to older people who hold a Pensioner Concession Card or Department of Veterans' Affairs Gold or White Card or are a member of the Defence Force or who are eligible under the CSO stream. This means that many older Australians are potentially missing out on and/or are avoiding seeking professional hearing care which may be due to the costs associated with paying for care privately, although motivation, accessibility and other factors also play a part.(42)

There are other programs within Australia's social services systems where older people receive subsidised services as a consequence of their age more than their inability to financially access the services they need. The debates inevitably centre on the balance of public and private benefits, equity of access, and capacity and sustainability to pay. A particular example is a Medicare item for people aged 75 years and older which allows them to access a health assessment. That assessment may also consider their social isolation, oral health, nutrition and need for community services but does not specifically require the GP to assess a person's level of hearing.(43)

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

The Australian Government through Services Australia manages the eligibility for the Commonwealth Seniors Health Card which includes being of Age Pension age(44); living in Australia (with citizenship or permanent visa); not be receiving a DVA or Australian Government payment; and meeting an income test (**Table 7**)

Table 7: *Income test threshold for the Commonwealth Seniors Health Card*

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

Source: Services Australia

The Commonwealth Seniors Health Card was introduced in 1994, to give low income retirees (people who are not pensioners but who have the same or lower income as age pensioners) access to similar Commonwealth concessions as holders of the Pensioner Concession Card. This included access to concessional prescription medicines under the Pharmaceutical Benefits Scheme (PBS), certain free basic dental services and free hearing aids and hearing services through the Hearing Services Program. However, in 1997, the Australian Government removed Commonwealth Health

Care Card holders from being eligible for the Hearing Services Program as part of a general Government policy change to focus on the most vulnerable Australians accessing Government Services.(45)

In examining the options for extending eligibility, it is important to note that the range of health benefits available to this group is quite limited. Specifically, they include only a discount on medicines under the Pharmaceutical Benefits Scheme, ability to be bulk billed by a GP provided the GP agrees, limited Medicare claiming for audiological assessments where referred by a GP or ENT, and a refund for medical costs when they reach the [Medicare Safety Net](#). Some States and Territories also lower some health costs and these may include ambulance, dental and eye care.

One option would be to include this group of people directly into the Voucher stream of the Hearing Services Program. As **Table 8** shows, however, this would see over 235,000 people with mild or greater hearing loss join the Hearing Services Program with an estimated additional spend of \$265.85 million over four years. Additionally, this level of subsidy would be out of keeping with the benefits received for other health care for Commonwealth Seniors Health Card holders.

Table 8: Option 1: Indicative financial implications to extending access to the Hearing Services Program to Commonwealth Seniors Health Card holders (based on costings associated with the Voucher stream)

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

Source: Department of Health – Hearing Services Program Data and Statistics (Internal).

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

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

...help identify any risk factors exhibited by an elderly patient that may require further health management. In addition to assessing a person’s health status, a health assessment is used to identify a broad range of factors that influence a person’s physical, psychological and social functioning.(43)

Such an approach is consistent with the Expert Panel’s proposed objective A1 (which addresses issues of cultural safety, equity and appropriateness of services) and objective D1 (which addresses

individual, community and economic benefits from the Program) for hearing services as outlined in **Chapter 2**.

Currently the Department of Health's suggested form for the 75+ health assessment provides as one of the '*Optional Components as relevant to the patient*' a section to report on the results of '*Assess hearing*'.(46) However, this is not mandatory and does not equate to a full diagnostic hearing assessment. Many people aged 75 or older will already have received a full diagnostic hearing assessment as part of their participation in the Hearing Services Program. Many others who are eligible but are not active participants could also receive such an assessment if it was warranted, but do not, perhaps in part due to the separation of the hearing industry from general practice and other healthcare, and an assumption by GPs and consumers that hearing loss is a normal part of ageing.(47,48)

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

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

Tinnitus sufferers

Tinnitus is a medical condition which, while it can be a cause of hearing loss, can be treated medically as a stand-alone condition through the use of tinnitus inhibitors and other types of rehabilitation and therefore does not warrant the provision of all services under the Hearing Services Program. This is noting that, while tinnitus cannot be the sole reason to provide hearing aid devices under the Hearing Services Program, there is already a provision under the Program that allows for fitting where it can be shown to address both mild hearing loss and reduce severe or constant tinnitus that significantly affects quality of life. Documented evidence must show that aiding the client has had successful outcomes for both their hearing loss and tinnitus relief.(49)

Adults over 65 years with a cochlear implant

The Expert Panel is advised that the Department of Health has contracted the National Acoustics Laboratory (NAL) to conduct an evaluation of the clinical- and cost- effectiveness of upgrading cochlear implant sound processors through the Hearing Services Program. Any recommendation on this matter should await the completion of the evaluation.(50)

People in the criminal justice system

The provision of health services (including hearing health) to prisoners is the responsibility of the State and Territory Governments and therefore is outside the scope of this Review. From the perspective of the Hearing Services Program, people who are already Voucher Stream clients at the time of incarceration, are entitled to receive the services available on their voucher for the remaining period of that voucher. If the prisoner has lost their eligibility as they are now incarcerated, they will not be able to receive a new voucher when their existing voucher expires and until they become eligible again. CSO clients do not lose eligibility for the CSO stream as result of incarceration. Access to services from prison, however, will be dependent on jurisdiction health services to prisoners, local prison arrangements, geography locations and qualifications and skills of prison health service personnel. For example, it is likely that only prisoners who can access day release would be able to use their voucher services with a service provider.

The Expert Panel also supports the following Key Actions of the *Roadmap for Hearing Health* that hope to increase the identification of hearing loss among those in incarceration:

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

State and Territory prison health services implement routine hearing screening of at least high-risk people, including Aboriginal and Torres Strait Islander prisoners, and referral to further services as appropriate to their hearing health needs and period of incarceration.(3)

Conclusion

The Expert Panel considers there is strong evidence that there are a number of population groups which currently sit outside the eligibility criteria, who would benefit from access to support under the Hearing Services Program. The following two populations have particularly compelling claims to become eligible categories of people under the Program given their higher prevalence of hearing loss and/or requirement for financial support:

- Low Income Health Care Card holders and
- Aboriginal and/or Torres Strait Islander people.

In addition, the Expert Panel considers that the health assessment for people aged 75 and older could be a useful prompt for a full diagnostic hearing assessment as a vehicle for identifying one of the important factors that can influence a person's physical, psychological and social functioning.

Modelling based on the current access rate and costs of the Voucher stream indicates that expanding eligibility to Low Income Health Care Card holders and Aboriginal and/or Torres Strait Islander people with mild or greater hearing loss would see an increase of 116,710 clients at a cost of approximately \$130.7m (or a compound growth increase of 1.51%) over a four year period.

The Expert Panel notes the additional capacity, skills and cultural awareness capabilities that might be required of providers when delivering services to these population groups and suggests that additional training for providers might be necessary to support delivery of specialised services to adults with complex hearing needs.

Recommendations

2. Extension of eligibility to additional priority populations

2(a) The Australian Government should expand the categories of eligible people under the Voucher stream of the Hearing Service Program to include all Low Income Health Care Card holders.

2(b) The Australian Government should expand the categories of eligible people under the Voucher and Community Service Obligation (CSO) streams of the Hearing Service Program to include all Aboriginal and/or Torres Strait Islander people (noting that some choose to enter the Program through Voucher eligibility criteria pathways. Clients choose only one stream).

3. Clearer delineation and support for Voucher stream and CSO stream clients

3(a) The Australian Government should replace the term 'Voucher stream' with a term such as 'National Hearing Support stream' to modernise the Program terminology and better reflect the purpose of the stream.

3(b) The Australian Government should improve clarity for eligibility to the National Hearing Support and CSO streams by including in the definition of eligible clients for the National Hearing Support stream those clients who have special needs, namely adults with complex hearing needs and adults with cochlear/bone anchored implants. The Australian Government should then remove these categories of adults from the definition of eligible clients for the CSO stream.

3(c) The Australian Government should implement a system of audits to ensure Providers are appropriately claiming for clients who have special needs, namely adults with complex hearing needs, adults with cochlear/bone anchored implants and clients without specialised or complex hearing support needs.

3(d) The Australian Government should require all Providers to demonstrate that they have the capacity, skills and cultural awareness capabilities to support clients with specialist hearing support needs, such as adults with complex hearing needs and adults with cochlear/bone anchored implants, and encourage Practitioner Professional Bodies (PPB) to develop appropriate training for clinicians to deliver these specialised hearing services.

4. Making better use of Medicare

The Australian Government, through its management of Medicare, should include within the funded item 'Health assessment for people aged 75 years and older' a full diagnostic hearing assessment where considered warranted by the patient and the GP.

CHAPTER 4 – IMPROVING THE CLIENT EXPERIENCE AND ASSESSING NEED FOR SUPPORT

Key Points

- Consumer organisations are supportive of the Hearing Services Program and its history of making a significant difference to people’s lives. This includes Hearing Australia’s delivery of CSO services. Consumer input is currently sought on the operation of the Program, but this could be enhanced through a formalised process.
- There is consensus from providers and clients that clients should be given greater ability and resources to make informed choices about their service provider and the services they receive and have control over how those services are delivered.
- Positive outcomes from the wearing of hearing aid devices depends on client motivation and support, more so than on their level of hearing loss. Delayed use of hearing aid devices is often the result of actual or perceived stigma of wearing a hearing aid device and poor client ‘readiness’.
- Hearing impairment is complex, and the Hearing Services Program relies solely on the clinician’s assessment of the client’s clinical need to determine if the client’s hearing care needs are being fully identified and comprehensively addressed.
- Clinical need is evaluated primarily using pure tone audiometry assessment of hearing loss. Recent evidence indicates that this should not be the sole assessment option or the indicator of choice of intervention(s) such as hearing aid devices.
- Provider services are strongly focused on the supply and fitting of hearing aid devices. There is a need for a review of the current Schedule of Fees to assess whether there is an unintended bias in profit margins which favours hearing aid devices ahead of providing rehabilitation services. Such a review may point to the benefits of rebalancing the fees.
- While there is limited information on rehabilitation available, due to the current bundling of fees, there appears to be minimal delivery of separate rehabilitation services to clients. There is a need to review the Schedule of Service Items and Fees to improve transparency of service delivery, as well as to improve the holistic assessment of client needs and delivery of rehabilitation and support services. A pilot of an independent rehabilitation services may be warranted.
- There are high priority diverse populations who experience additional challenges in receiving the care and treatment they require for hearing loss. As only 39% of eligible people with mild or greater hearing loss actively participate in the Hearing Services Program, the barriers to access should be addressed.
- Aboriginal and Torres Strait Islander people are underrepresented in the CSO stream. One barrier is the difficulty in accessing culturally appropriate hearing services across the entire Hearing Services Program. A second barrier is the low numbers of trained Aboriginal and Torres Strait people in the trained workforce delivering hearing health services.
- Barriers to accessing the services available through the Hearing Services Program are also experienced by people from culturally and linguistically diverse backgrounds, those who live in rural and remote areas and those who receive aged care. There is a range of initiatives that could reduce those barriers.

At the start of chapter 3 the point was made that in terms of increasing access to the Hearing Services Program by people with hearing loss, there were two separate, but related, issues. The first, as dealt with in that chapter, was to broaden the scope of categories of eligible people to the Program.

The second is to address barriers facing people who are eligible, but who do not access the available hearing services. Some of these barriers arise from their personal (or anticipated) experiences in accessing program services, as examined in this chapter. Other barriers, while inter-related, are more to do with issues of service delivery and are dealt with in **Chapter 5**.

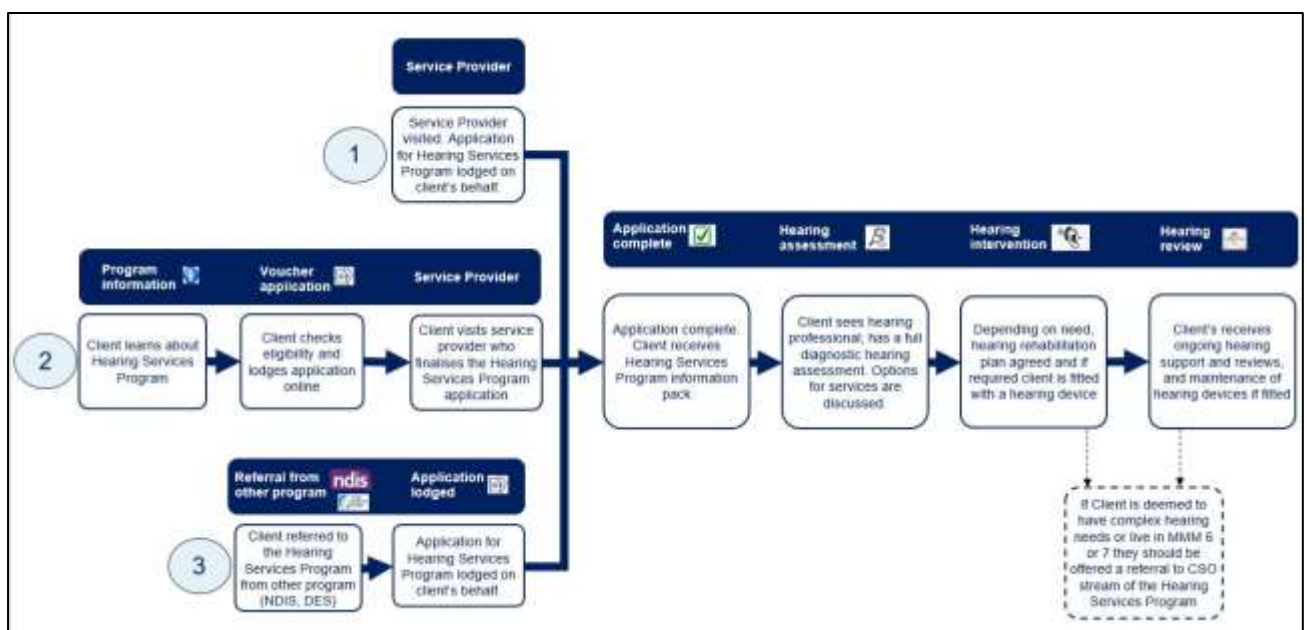
The experiences of people living with hearing loss when they are contemplating and preparing to access support services, and the subsequent experiences of those who do progress to being clients, play a very important role in determining whether the benefits of those services are equitably, effectively,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

Given that of the 39% of eligible people with mild or greater hearing loss who participate in the Program (see **Table 2** in **Chapter 3**) not all of them are being provided with the full range of services that could assist with their communication difficulties, there is considerable scope to reduce the current burden of disease of hearing loss. Importantly, even greater gains can be achieved by also addressing the concerns and barriers facing the two thirds of those with hearing loss who do not receive care.

The client journey

Before looking more closely at the assessment of need and client experiences of the Hearing Services Program, it is useful to reflect on the typical client journey through the Program. **Figure 3** provides a visual representation of the journey through the Voucher stream and **Figure 4** through the pathway for the CSO stream.

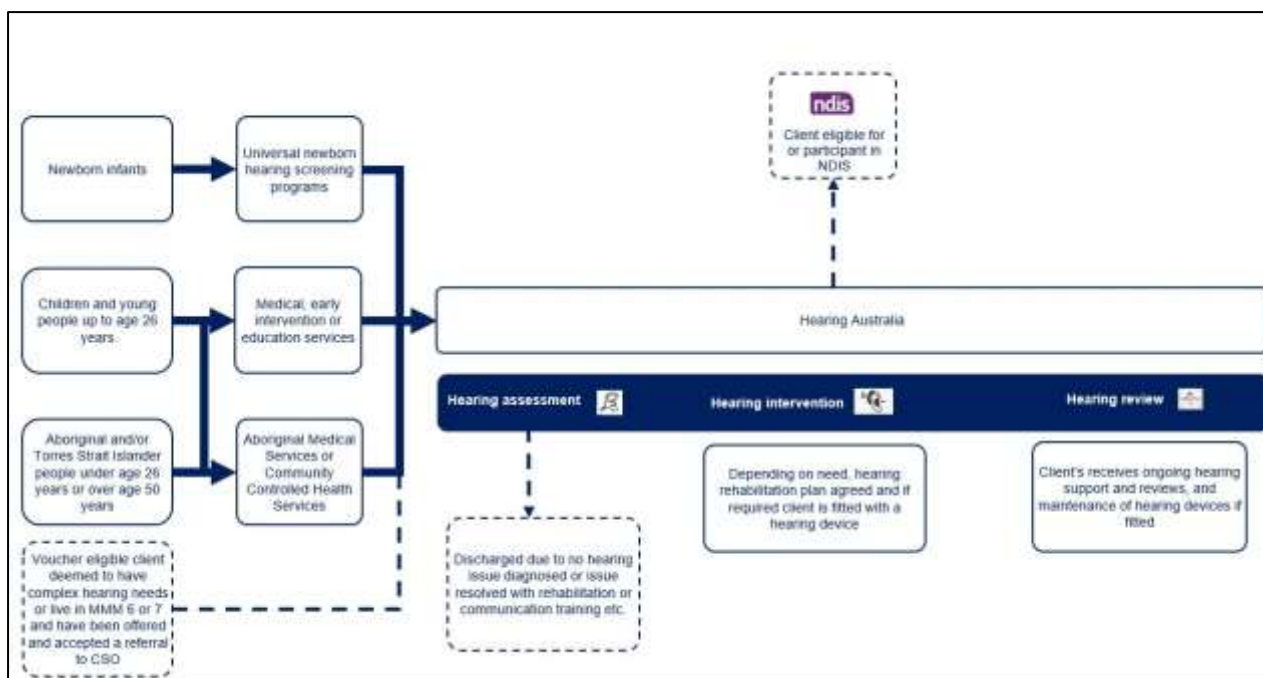
Figure 3: Client Journey in the Hearing Services Program (Voucher stream)



As set out above, there are three main pathways a person with hearing loss can follow to receive publicly funded support under the Voucher stream. They can either:

- visit a hearing health clinician, who is an approved provider. This often involves a hearing screening. The clinician informs their client whether they are eligible to access the Program, and lodges an application for a Voucher on their client’s behalf (90 percent);
- learn about the Program (e.g. from a friend) and check eligibility. They lodge an application for a Voucher online; or
- are a person who is already receiving services from another program such as NDIS or the Disability Employment Service (DES), and is referred to the Voucher stream of the Program.

Figure 4: Client Journey in the Hearing Services Program (CSO stream)



For access to the CSO stream:

- newborns are referred to the service once diagnosed as having a hearing loss through the Universal Newborn Hearing Screen, or other similar neonatal service;
- children and young people (up to age 26 years) are referred through medical, early intervention or education services;
- Aboriginal and Torres Strait Islander people under 26 and over 50 years of age are referred through their provider (mainstream health and medical services or through an Aboriginal Medical Service or Community Controlled health service); and

- clients who are Voucher and CSO eligible can access the CSO stream through the Voucher stream or directly with the CSO stream.

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

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

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

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

Numerous submissions to the Review reported that clients of the Hearing Services Program express overall satisfaction with the hearing care they receive across both streams of the Program.(23,24,51–58) Of note, many of these submissions were from organisations that have clients' interests as a part of their core role, or have conducted client surveys as part of their role [for example the Deafness Forum of Australia; First Voice; the Royal Institute for Deaf and Blind Children (now called Nextsense); and Hearing Australia]. However, as will be explored in these next two chapters, neither the client experiences nor the service delivery live up to best practice in facilitating choice and control.

While Australia's PPB Codes of Conduct and Scope of Practice include elements of client centred care, there is no formal definition of Patient Centred Care for the profession of Audiology(59). In contrast, the UK's National Institute for Health and Care Excellence (NICE) published clinical guidance in 2018, in which it advised that audiological assessments should include:

1. the person's hearing and communication needs at home, at work or in education, and in social situations;
2. any psychosocial difficulties related to hearing; and
3. the person's expectations and motivations with respect to their hearing loss and the listening and communication strategies available to them.(60)

The NICE guidelines propose that hearing aid devices be offered to adults 'whose hearing loss affects their ability to communicate and hear, including awareness of warning sounds and the environment, and appreciation of music', rather than to those who meet a minimum hearing threshold. This approach is based on individual need, with the best outcomes for the client at the forefront.

Similarly, though in the broader health context, the Australian Commission on Safety and Quality in HealthCare defines patient-centred care as an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families.(61) The Commission states that the key dimensions of patient-centred care

include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of carers and family, and access to care.

This aligns with one of the Guiding Principles of the *Roadmap for Hearing Health*:

...That services are delivered in a person- and family-centric way — and ensure that individuals and their families can effectively exercise choice and control.(3)

The current Hearing Services Program could be characterised as having a foundation of consumer sovereignty – consumers can choose to have their hearing screened and clinically assessed and can say yes or no to a hearing aid device (and to subsequently using it). Many submissions reported, however, that there are serious shortcomings in the Program’s design and operation, as described below.

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

The Program, however, could enhance consumer choice and control. Consumers would benefit, for example, from more information about rehabilitation options available within the Program to support better informed choices. Consumer organisations could play an important role in disseminating this information. Providers, with appropriate reimbursement of their time, could spend more time with their clients explaining options and, if a hearing device is selected, how to maximise communication outcomes.(25)

In support of this view, numerous submissions commented that the Hearing Services Program focuses too much on technological solutions, and that too often the intervention is a prescription for a hearing aid device.(23,24,51–58) Failure to be offered a range of rehabilitation options means that many clients find that their only decision is whether or not to accept a hearing aid device. Other care options are often only provided after a device has been declined. This is more driven by the business model of the provider than by the limitations in the program

Additionally, Hearing Services Program funding does not allow for independent support, such as through a case co-ordinator or case planner,(3,62) and the client often makes decisions that are not underpinned by comprehensive information.(25,51,52,62,63) Rehabilitation service items are able to be delivered by consumer and Non-Government Organisations but are currently required to be coordinated and claimed for by the provider. Each provider decides how those services are run and how the client is informed of this option.

The Expert Panel has undertaken its review of the Program through the lens of person-centred care and the centrality of client choice and control in accordance with its proposed objectives for the Program.

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

Overcoming barriers to addressing hearing impairment/loss

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

It is well established that a large proportion of people who have a hearing impairment choose not to seek help or have hearing aids.(64,65) Others delay seeking help and, as most age-related hearing loss happens gradually, it can take an average of about nine years for a person to move from a stage of contemplation to action.(66)

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

- other priorities including health problems, disabilities or caring responsibilities;
- a previous experience with hearing professionals or attempt at wearing hearing aids which had been unsuccessful;
- only losing their hearing in one ear, or being able to manage;
- not seeing themselves as someone with hearing loss or a hearing aid; and/or
- denial of any sign of the ageing process, including hearing loss.(67)

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

...very few wait until their vision problems are so bad they lose their driving licence, or can no longer read. On average, people with hearing loss (and their families) endure the consequences of deteriorating communication for at least 10 years before seeking help.(62)

Initially the biggest challenge is at the contemplation stage, including helping people accept that they do have hearing loss and improving their level of readiness to receive help. Contemplation will usually only occur if there are impacts or signs, such as concerns raised by family members or self-perceived indicators of hearing loss.(68) Support to move from contemplation to action can include helping people become more informed about their options, for example through community education and in pre-appointment screening as well as in appointments to improve psychological readiness and motivation for receiving support and using a hearing aid device. Managing expectations and overcoming scepticism about the benefits of receiving care and support are other factors – research shows that a large proportion of those who don't seek care believe that hearing aid devices don't work.(39)

Overcoming the stigma associated with hearing loss

For many, overcoming any actual or perceived stigma associated with their hearing loss is also a seminal early step.(69) Southall et al. found there can be a perceived association of hearing loss

with old age as well as with incompetence, cognitive impairment and social impairment.(70) Other research results similarly point to:

...the pervasiveness of perceived stigma associated with hearing loss and use of hearing aids and their close association with ageism and perceptions of disability.(71)

The 2019 *Roadmap for Hearing Health* refers to the stigma of hearing loss, calling it the 'hidden or invisible disability', where people with hearing loss are viewed as being cognitively impaired, less able, or they are simply ignored. The *Roadmap* aims to eliminate this stigma by helping people who recognise that they or a family member may have a hearing loss know how to get help and be encouraged to quickly do so.(3)

Improving availability of information to facilitate choice and control

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

Hearing Australia noted that:

Consumer choice is driven by transparency and unfortunately there is incomplete information about eligibility, providers, services and devices – all the necessary building blocks to place the choice and control into the hands of users.(54)

This view is supported by the Deafness Forum which stated:

The HSP has some written information available on its website (about) partially subsidised devices but this is not sufficient from a consumer perspective.(23)

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

The PwC *Review of services and technology supply in the Hearing Services Program* (2017) concluded that clients have minimal access to vital information that could improve the quality of their decision making and that more was needed to educate clients and increase client health literacy.(72) This view was validated by the 2017 Australian Competition and Consumer Commission (ACCC) inquiry into the hearing sector. The ACCC Report and the Parliamentary Review *Still Waiting to be Heard* identified contributing factors as being the vertical integration (ownership or control of clinics by manufacturers or distributors) and lack of disclosure to consumers of sales incentives. (35,73)

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

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

It is clear from the research that choices provided to clients are typically not offered in a way that facilitates shared decision making (a central tenet of person- and family-centred care) and information that is provided focuses on the device alone and does not include communication education or counselling.(58)

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

The Hearing Health Sector Alliance, which includes consumer representation, suggested providing transparency about what is available to clients to enable them, together with their provider, to make better informed decisions about their options(25). Audiology Australia suggested simplifying and ‘unbundling’ the model of claiming under the Hearing Services Program where the cost of devices and audiology services are itemised and separated out. The organisation argued that this could help improve transparency (particularly of the Voucher stream) and enable clients to better understand where the expenses lie. In many cases this is with the device.(24)

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

Improving the Hearing Services Program website

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

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

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

My Aged Care website (www.myagedcare.gov.au)(74) is an example of consumer-focused information that aims to instil confidence in consumers needing critical services. The information on this website maps the journey from the initial decision to explore aged care, details eligibility and

assessment criteria, links potential consumers to providers and helps them manage their services through an online account.

The *My Aged Care* website has undergone several enhancements since it was first introduced in 2013. The Report of the Aged Care Royal Commission, released in February 2021, called for more accessible and usable information on aged care to be included on the website in Recommendation 27:

The Australian Government should continue to enhance My Aged Care to ensure it is the Government's official source of consistent, accessible, inclusive, reliable and useful information about the aged care system and aged care providers.(75)

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

The Hearing Services Program website, Hearing Services Online (HSO) is the primary communication channel for information relating to the Program, for professionals and clients as well as hosting the HSO portal. The Expert Panel considers the current Program website is in need of a significant renovation to provide clearer and more informative guidance to those people experiencing hearing loss and to their family, friends, workplaces and others. Greater transparency about providers, the services they actually deliver and their links with manufacturers should also be included.

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

The Expert Panel considers there is value to people with hearing loss for the Department to develop a range of illustrative client pathways on the website that clearly show the options for clients who are eligible for hearing services in the Voucher stream and the CSO stream. The pathways would direct the client into various service options, depending on need and have links to appropriate services or information. The website should also improve its guidance to people who are not eligible for the HSP but who are seeking assistance with managing their hearing loss.

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

Engaging with consumer organisations

There are several organisations which provide a consumer voice about hearing health. They offer support and education for children, adults and families, and some have a stronger advocacy role. Deafness Forum of Australia is a peak national body that represents the interests of all Australians

with hearing loss, and includes smaller and more specific consumer groups. It has a mission to make hearing health and wellbeing a national priority in Australia(76) and is an active member of the Hearing Health Sector Alliance.

The Alliance argued that there are strong benefits in improving collaborations with consumer groups to assist with developing and disseminating client information. The Deafness Forum considered that consumer organisations can play a more active role in supporting consumers. For instance, in relation to the selection of a hearing aid device, it stated:

Understanding the range of devices available under the Voucher Program is overwhelming for a client's perspective. Consumers are generally more interested in how the device can help them rather than the brand name of the device... it is difficult for consumers to compare devices. Consumers also need to make decisions on whether the fully subsidised devices will be adequate for their needs or whether they should invest in higher level technology... Consumer organisations or an independent help line could help provide clarity for those clients who want to consult with someone else before making a decision.(23)

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

...offer effective counselling and support for families at the various stages of their child's life to support choices that impact on their development... [and]

...support families of children with a permanent hearing loss minimise the time between a child's diagnosis and uptake of the required support and services; ensuring access for all Australian children with hearing loss to the best possible supports.(77)

The Expert Panel agrees that there is scope for more formalised consultation between the Hearing Services Program administration and consumer groups to enable the latter to be of greater value to people with hearing loss as they navigate the Program and the hearing services sector more generally. A hearing services consumer consultation forum could be established with consumers and representative organisations to facilitate information exchange, to seek advice on improving the equitable, effective, efficient and sustainable functioning of the Program and associated hearing activities. Indeed, there would be scope for consumer groups to be considered as suppliers for some services such as rehabilitation and support with the groups to be funded as (non-audiologist/Audiometrist) providers through the program.

Using decision aids for hearing health care

Providing clients with a pre-assessment decision aid to help them understand the signs of their hearing impairment can assist them make more informed choices. A 2016 study by Pryce et al identified that:

Decision making occurs before meeting with an audiologist and preferences and values shape the decision to seek clinical help. The way in which the individual decides to seek help is an important context for the decision making that occurs during clinical appointments...

Participants all described a gradual process of evaluating signs and symptoms before seeking help and a gradual evaluation of hearing behaviour as atypical.(78)

Ottawa Hospital Research Institute defines decision aids as:

...tools that help people become involved in decision making by making explicit the decisions that need to be made, providing information about the options and outcomes, and by clarifying personal values. They are designed to complement, rather than replace, counselling from a health practitioner.(79)

Decision aids summarise intervention options and the expected outcomes of each option according to recent scientific literature, and they can be presented in a simple visual format which adheres to health literacy principles. According to Hargraves et al., such aids should address the six elements of shared decision making: situation diagnosis, choice awareness, option clarification, discussion of harms and benefits, patient preferences deliberation, and making the decision.(80) Hickson argues that this contrasts with the current practice in audiology, which remains hearing aid device focussed.(58)

Laplante-Levesque et al (2012) offered 153 adults with untreated hearing loss options for treatment using Decision Aids. They found that only 43% obtained hearing aids, using this approach, while 18% completed communication programs and 39% decided to take no action.(81) An international systematic review of over 100 research studies found that when people use decision aids, they improve their knowledge of the options and feel better informed and clearer about what matters most to them.(82) The Australian Commission on Safety and Quality in Health Care also has guidance on the use of decision aids, with the aim of encouraging a more client centred service delivery.(83)

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

Option 1 would incorporate a decision aid tool in the Program's website to enable prospective clients to test their motivation to address their hearing impairment before they commit to join the program.

The benefits of this option are that it could provide an objective process for anyone with a hearing loss to consider their motivations to joining the HSP for their hearing impairment, which may be of particular help to those experiencing hearing loss who are not currently accessing the Hearing Services Program. If the information is then able to be linked to a future client's registration, then it could also be passed onto their hearing service provider. The cost of including a decision aid tool on the website would be minimal as it would be limited to the cost of development, user-testing and certification prior to being put into production.

Option 2 would require the inclusion of a decision aid tool in the Hearing Assessment process, with the data stored in the client's clinical file. This would require clinicians to receive additional professional training on how to incorporate a decision aid tool to assist with a client's psychosocial wellbeing.

The benefits of this second option would include greater transparency of decision making, displaying the options for treatment more openly for clients and involving them more in this step of their care. Evidence suggest there would be no adverse effects on health outcomes or satisfaction.(82)

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

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

Availability of translation, interpreting and Auslan services

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

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

Providing understandable and accessible health information can improve people's knowledge, understanding and recall about their health and care. It can also increase their feelings of empowerment, improve their ability to cope, increase satisfaction, support shared decision making and contribute to improved health literacy, so that people can be partners in their health care. (84)

The Hearing Services Program does not currently fund translation, interpreting or Auslan services, despite recommendations from *The Roadmap for Hearing Health* and previous hearing sector inquiries.(3,35) While the national Translating and Interpreting Service (TIS) provides free services to non-English speaking Australian citizens and permanent residents when they communicate with 'approved groups and individuals', audiologists and audiometrists have not been declared as approved groups or individuals. There remains an ongoing challenge where practitioners are relying on family members or carers for interpretation, and this is likely to impact quality of information flows.

Unlike the National Disability Insurance Scheme (NDIS), the Hearing Services Program does not fund interpreting and translation services.(85) Auslan services are available to Deaf, deafblind and hard of hearing people of all ages through numerous avenues. There are also a number of Commonwealth funded programs currently available and described below.

The NDIS funds interpreting and translation services for all Deaf people eligible for the scheme (children and adults under 65).

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

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

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

The Expert Panel considers that free and equitable access to interpreters and translation services for all clients of the Program is very important, and advises that the Program should ensure that audiologists are aware of the AUSLAN services available under the NDIS and the NABS program and know how to access these services. The Panel recognises that a separate Australian Government process is underway at the time of writing this report that aims to include audiologists and audiometrists as 'approved groups and individuals' with TIS.

Enhancing the delivery of rehabilitation and support services

Feedback on the Hearing Service Program Review Consultation Paper referred to the opportunity to use a less technology-focused approach in two phases of clients' hearing health care:

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

This is consistent with the UK's National Institute for Health and Care Excellence advice in its 2018 guidelines, that hearing care encompass:

...the person's hearing and communication needs at home, at work or in education, and in social situations; any psychosocial difficulties related to hearing; and the person's expectations and motivations with respect to their hearing loss and the listening and communication strategies available to them.(60)

The role of rehabilitation

Professional organisations and service providers claim that they strongly support rehabilitation services. Some providers and professionals argue that they are limited by time and funding in providing more, and more effective, rehabilitation support.

Audiology Australia commented that clients often experience psychosocial distress due to communication breakdown caused by hearing loss. This professional organisation believes that its members are well placed to provide support and intervention, and that the Program's 'Rehab Plus' code should be expanded to include support and training for not just communication, but also for emotional and psychosocial support and social skills training for people with and without hearing aid devices or assistive listening devices and at various stages of life.(24) Bennett et al. (2020) argued that time and funding are two key barriers preventing Australian audiologists from providing emotional support to clients, including referrals to mental health professionals.(86)

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

These services do not and cannot replace devices; they are a critical adjunct to using a device and can help build comfort and confidence in users. Rehabilitation services provide helpful strategies to manage hearing loss but do not meaningfully delay the need for a device for someone meeting the loss criteria for the HSP.(74)

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

Other rehabilitation services are often under claimed due to confusion around the claiming requirements and some providers are actually providing the services as part of their clinical practice but not claiming. There is also the limitation that rehabilitation services following hearing aid device fittings can only be claimed for those fitted with fully subsidised hearing aid devices and not partially subsidised. This makes no sense from an end-user perspective as the need for rehabilitation services is not determined by the financial contribution of the individual.(87)

Another submission to the Review by N. and S. Clutterbucks noted the 'commercial' challenges for Providers to provide and fit devices as well as deliver related rehabilitation services, and how this affects client communication outcomes:

There is a tendency to focus on fitting the device, rather than supporting the effective use of the device to minimise communication problems. This latter service takes time when responding to the individual needs of the client, but providers report that such time is not compensated in the current funding model. Attempts at correcting this by enhancements of the Program such as "Rehab Plus" have not had good take up because there is no focus on rewarding successful outcomes.(62)

People with hearing loss come to service providers with significantly different need, reflecting their unique circumstances, and yet a lack of rehabilitation options being offered to clients means that

many find that their only decision is about accepting or refusing hearing aid devices. Dr Caitlin Barr's research (for Soundfair) observed over 60 consultations across Australia and found that all consumers who were diagnosed with any level of hearing loss or tinnitus were recommended hearing aid devices and that in just eight per cent of cases was an alternative offered. Other care options were only provided after a device was declined.(52) This is neither informed client choice nor control.

In the current model of service provision, rehabilitation should be provided as part of the device fitting process. But the available evidence suggests that service providers are failing to deliver these beneficial services to clients. Clients who have received their first fitting with either a fully-subsidised hearing device or an assistive listening device, are able to receive one rehabilitation plus program after their fitting and follow-up services. However, only 6,449 (3.6%) services were claimed for rehabilitation plus out of 177,124 clients who received a hearing device fitting in FY 2019/20. New clients can also access rehabilitation if they have not been fitted with a hearing device, to help them receive training and learn strategies that will help them manage their hearing loss. However, in FY 2019/20 only 357 (0.3%) of the 121, 143 new clients received this service.(31)

In addition, Program data show that client review services which are also rehabilitation focused and are available annually are seriously underutilised (only approximately 30 % of clients receive a client review service in a given year).(31)

Specsavers observed that measuring and publishing client-focused rehabilitation outcomes should considerably improve the range of services provided, thereby improving those outcomes and supporting those people around the individual who are also affected by the person's hearing difficulties.(87) The PwC review (2017) found that 75% of respondents to its study considered that the current rehabilitation services did not provide clients with appropriate support.(72)

A recent study by Hogan et al (2020) found that a device-centric approach to hearing health care is only effective in approximately half the clients accessing these services. A cost benefit analysis was conducted as part of the study, focussing on clients who previously had rarely or never used their hearing aids. It identified that the provision of additional rehabilitation services (at a cost of \$750 per client) prior to device fitting resulted in expected savings between \$27.1m to \$108.8m per financial year compared to the current service delivery model.(88)

Adults with cochlear implants are also reportedly receiving care that is not specific to their needs. Cochlear, in its submission mentioned that while originally designed with hearing aid device user needs in mind, the remuneration settings underestimate the support required to help cochlear implant candidates navigate a complex health system. The settings also present 'disincentives' to address the needs of clients who may be eligible for implants. The result is that most providers treat cochlear implant counselling with similar resources to a hearing aid device fitting, which results in inconsistent adoption of the standard of care.(57)

Audiology Australia noted that frail, elderly clients, whose dementia makes their hearing care more complex, are a client cohort that also deserve greater support.(24) Using standardised testing that involves cognition complicates the assessment process, and may detract from an accurate diagnosis and management plan.

Simplifying the Schedule of Service Items and Fees and making it more client-centred

In addition to potentially expanding the types of services that should be available to program clients to enhance choice and control, there is also support for specifically and independently listing items in the Services Schedule to support more tailored rehabilitation plans for clients.(55)

The current Schedule of Service Items and Fees includes over 50 separate service items and six categories for hearing devices. Fitting services such as device fitting, follow-up, rehabilitation and maintenance are currently bundled together in the one 'Fitting' item. Many service items focus on monaural (one) and binaural (two) hearing devices. Historically, this has meant that it is difficult to unpack what services a client receives, and the Program does not capture data on the elements of hearing care provided.

Simplifying the Schedule of Service Items and Fees, by de-bundling services and reducing the number of separate service items will reduce the regulatory burden and confusion for providers in managing claiming and better enable identification of which hearing services are received by clients. These simplified items could include, for example: Assessment, Fitting, Follow-up, Rehabilitation, Maintenance, Hearing Device and Client Review.

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

Several submissions indicated that the Schedule of Fees could be reviewed and simplified so that it can better support good clinical practice and provide appropriate payment for assessment and rehabilitation services as well as hearing aid devices. As Audiology Australia noted, this would:

- assess client 'readiness' for any intervention;
- offer improvements to practical issues such as communication, hearing aid device utilisation and work practices, with a view to improving quality of life, instead of the Hearing Services Program being input driven (e.g. focusing on number of episodes of care, numbers of hearing aid devices prescribed);
- encourage use of shared decision making tools such as decision aids; and
- provide a broad range of services that aim for better client outcomes and that better reflect and recognise the broad range of assessment and rehabilitation options that audiologists can provide in accordance with the audiology profession's Scope of Practice.(24)

The Department of Veterans Affairs agrees, proposing the following:

It is suggested that rehabilitation and education regarding the management of hearing loss needs an increased focus going forward. Improving and streamlining, simplifying the funding and claiming structure would allow practitioners greater autonomy when managing individual rehabilitation programs, which then reduces the program's focus on purely technological solutions and supports a more holistic and veteran-centric service.(51)

The Deafness Forum expressed similar views:

The fee schedule needs to be reviewed so that it supports good clinical practice and provides appropriate payment for assessment and rehabilitation services as well as devices. This will result in consumers receiving a broader range of services which is likely to lead to improved device utilisation and better client outcomes.(23)

Feedback from this review and other reviews and inquiries has identified scope for changes to the way fees are set.

A review of the way services are funded was one of the recommendations of the PwC Review. The recommendation was “supported by benchmarking of the FY 2016-17 schedule prices for services in the Voucher stream against the private market and other government programs, which indicates that the current fees are low for a range of key services.(24)

Organisations representing audiologists noted the significant differences in fee structures between the Voucher stream and other programs. For example, they noted that an assessment service with the NDIS pays \$193.99 while the Voucher stream pays \$143.90, and Medicare pays lower rates for assessment services. Independent Audiologists of Australia noted that the NDIS takes into account remote and very remote service delivery with higher fee support.(55) The organisation also noted that while clients can be charged top-up fees for hearing aid devices there was no capacity to allow for gap fees for other program funded services.

The Expert Panel sees value in undertaking a review of the current Schedule of Fees to assess whether there is an unintended bias in profit margins which favours the supply and fitting of hearing aid devices ahead of providing more holistic rehabilitative and support interventions and undertake any necessary rebalancing of the fees. This would be accompanied by removal of the current restrictions around the use of rehabilitation services in the current service delivery model so that all Program clients, where appropriate, would receive rehabilitation and psychosocial support services before and after they are fitted with hearing devices.

Rebalancing the incentive for providers to deliver more rehabilitation services and expanding eligibility for those services would provide significant personal benefits for many people with hearing loss. There are also broader societal and productivity benefits. Deloitte Access Economics, in *The Social and Economic Cost of Hearing Loss in Australia* reported that almost 50% of the economic cost of hearing loss is due to its psychosocial impacts.(89)

Based on the current schedule of fees and services and numbers of clients and the following assumptions about hours of service delivered, the maximum cost of pre-fitting rehabilitation would be \$24.9m per annum (1 hour x \$207.95 per hour x 120,000 new clients). The maximum cost of provision of post fitting rehabilitation services would be \$52.2m (2 hours x \$147.35 per hour x 177,124 fitting services in FY 2019/20).

Exploring an alternative model of independent provision of rehabilitation services.

In New Zealand, the Ministry of Health has established an aural rehabilitation services for all citizens which is independent of hearing services providers. Life Unlimited, which operates the service stated in their submission to the Parliamentary Hearing Health and Wellbeing inquiry that:

The New Zealand hearing therapy service model offers a social rather than a medical model of intervention that is community-based, independent (not aligned to any one provider of audiology services and having no financial interest in the selling of hearing aids), and accessible (free to users and nationally spread). (90)

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

The aural rehabilitation service does not include skilled audiological or otological interventions, social support, counselling or other services that can be provided elsewhere in the community.(91) All citizens are eligible to receive support. In FY 2019/20, some 3,700 New Zealanders received 4,900 services at a cost of \$2.5 million. There is no published research that evaluates the effectiveness of the aural rehabilitation services. There would be scope with legislation and system changes to allow NGOs and consumer groups in Australia to be funded for delivering rehabilitation services to program clients.

Along similar lines, the Expert Panel was provided with a proposal for a pilot study to examine a service delivery model described as 'whole-person, person-centred hearing service' (52) Soundfair advise that this approach is based on considerable consumer consultation and the latest evidence. It proposes two stages: the first to analyse the cost of delivering non-device rehabilitation programs and analyse similar funding models found in Australia and internationally; and the second to pilot the model over a two-year period across a metropolitan and a rural site. It is possible that the pilot outcomes could provide economic modelling of the true cost and effectiveness of hearing service interventions which could be used as the basis of provider benchmarking for quality improvement purposes.

The main aim is to enhance rehabilitation so that it moves beyond rehabilitation purely in relation to hearing device use to include a focus on psychosocial support for clients as part of a holistic approach to improve their health and wellbeing. This greater delivery of rehabilitation would assist people with hearing loss to address their communication needs and maximise social inclusion through social activity, economic participation, and in physical and cultural pursuits to the fullest extent possible (proposed objective A2). There would be an additional benefit from providing the aural rehabilitation services independently of Hearing Service Providers to reduce any real or perceived conflict of interest for the clinician. Clients would also be more informed about their hearing impairment and this may contribute to a better hearing outcome.

Recent studies by Van Leeuwen et al, however, show that allied health professionals may lack the skills, resources and support to integrate psychosocial support services into their daily clinical practices, including in audiology(92). This provides further justification for the incorporation of psychosocial interventions training into audiology programs, and continued professional development opportunities for audiologists currently working in the field.

The Expert Panel considers there is value in examining the feasibility of establishing independent rehabilitation services which would be delivered by counsellors who would act within clearly defined scopes of service to deliver psychosocial support for clients, including clients with diverse needs. Hearing service providers could subcontract out rehabilitation services to external parties. The existing framework could support this approach, though system changes would be required. The timing of when the rehabilitation services were provided would depend on the service delivery model.

If this approach were considered to potentially have net benefits, it could be assessed through a trial pilot. To illustrate, the cost of providing aural rehabilitation counselling for one hour per new client is \$22.3m per annum (\$186 per hour x 120,000 new Voucher clients in FY 2019/20). The cost of establishing a new rehabilitation hearing service has not been estimated at this stage.

Assessment of hearing loss

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

The Program sets Voucher criteria around the minimum level of hearing loss that a vouchered person needs to have in order for them to be eligible to receive a fitting of a hearing aid device to the ear being tested. This is the Minimum Hearing Loss Threshold (MHLT). There are exemptions under the Program for clients whose hearing loss is below the MHLT, but the presumption (though not necessarily the fact) is that these clients would be provided with a rehabilitation service (communication training and strategies to manage their hearing loss) rather than be fitted with a hearing aid device.(49)

The PwC review (2017) found that the current Minimum Hearing Loss Threshold (MHLT), and practices for measuring it, do not align to international definitions. It does not align with the World Health Organisation's (WHO's) definition of disabling hearing loss (measured on 4 FAHL), nor does it adopt the most common form of Frequency Average Hearing Loss measurement used by practitioners (4 FAHL consisting of measurements at 0.5, 1, 2, and 4 kHz).(72)

The PwC review also noted that State based workers' compensation schemes adopt different stances on measuring eligibility due to hearing loss. For example, the State Insurance Regulatory

Authority (SIRA) New South Wales (NSW) evaluates impairment through binaural hearing impairment evaluations as defined by the National Acoustic Laboratories (NAL).(72)

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

It was consistently reported to the Expert Panel that use of the MHLT as the sole tool for discerning a client's eligibility for the Program has limitations and research indicates that the use of pure tone audiometry tests alone does not fully measure the impact of hearing impairment.(93) First and foremost, hearing loss is complex and relying on a threshold set by pure tone audiometry may not be ideal for measuring hearing health. In addition, the MHLT only refers to the fitting of hearing aid devices and does not specifically reference the use of other interventions such as communications training or fitting an alternative listening device that may benefit a client.

The United Kingdom National Institute for Clinical Excellence proposes, instead of relying on an audiogram alone, that the ability to communicate should be the prime criteria for assessment:

Offer hearing aids to adults whose hearing loss affects their ability to communicate and hear.(60)

In parallel with this Review, the National Acoustic Laboratories (NAL) is carrying out a project on *Defining Eligibility for the Hearing Services Program* which will aim to develop a robust, evidence-based, and clinically practicable method of determining which older adults should be fitted with hearing aid devices. It is likely that this project will be delivered in July 2021 and will be considered by the Government in line with the final version of this Report. According to the NAL website:

The current criteria of hearing sensitivity for assessing who should be fit with hearing aid devices is a poor predictor of hearing aid use and benefit, therefore the audiogram alone is unlikely to be the best measure to identify who should get hearing aids in terms of patient benefit. Instead, eligibility criteria that includes other measures such as self-reported hearing disability, readiness to wear hearing aids, expectations, and individual needs has the potential to better identify those who would benefit from and use hearing aids in the [Hearing Services Program], and thereby improve hearing outcomes from the program. (94)

The Expert Panel has been advised of a range of options to change the current MHLT in various ways. However it considers that the better approach to this issue is to await the completion of the NAL Report rather than invest further consideration and analysis of amending the MHLT at this stage. More importantly, the Expert Panel considers that hearing assessment should be redefined to be a comprehensive process that includes an individual's communication and psychosocial needs.

Improving client satisfaction and outcomes in the CSO stream

Whilst the Review Terms of Reference focussed on the Voucher stream, numerous submissions commented on and made suggestions for improvements that could be made to the CSO stream. The Expert Panel has opted to include this feedback in the Report.

Under current Program arrangements, children have their hearing tested in a health clinic, hospital (newborn screening) or private clinic to establish a diagnosis of a hearing loss before being able to access amplification and rehabilitation services provided by the sole provider – Hearing Australia. The Deafness Forum noted that this creates a fragmented service delivery, particularly for Aboriginal and/or Torres Strait Islander children, and queried the possibility of being able to access Hearing Australia in the first instance as a way of creating less friction in the system.(23)

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

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

Whilst several professional organisations felt individual practitioners and other providers should also be able to offer services to CSO clients, there was overwhelming support for Hearing Australia maintaining CSO services for children and young people. Deafness Forum of Australia’s Consumer Advisory Group, First Voice and the Australian Newborn Hearing Association all expressed satisfaction with the agency.(23,53,77,95) The Royal Institute for Deaf and Blind Children expressed this in the following terms:

There is no doubt that children who engage with Hearing Australia under the terms and provisions of the HSP are offered an excellent assessment service and generally gain access to appropriate amplification using strong evidence-based strategies for fitting of devices. Indeed, the Longitudinal Outcomes of Children with Hearing Impairment (LOCHI) study has established the efficacy of the device fitting procedures used by Hearing Australia for all paediatric HSP clients relative to other internationally acknowledged strategies.(53)

The Deafness Forum advised that families were concerned that any changes to existing arrangements would put the outcomes for their child at risk. Parent groups in particular have felt the Program has been threatened by various reviews and initiatives such as the potential sale of Hearing Australia and the introduction of the NDIS, and wanted to emphasise that the Program is important to them and that they value having Hearing Australia as the single, independent provider of services.(23)

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

Family support service

As noted earlier, First Voice advised that families could be better supported in making choices for their hearing impaired children through a 'National Hearing Loss Family Support Service', which could improve access for all eligible children and minimise the period between diagnosis and access to support and services.(77)

Clearer 'service pathway'

The Deafness Forum of Australia argued that CSO clients and their families could benefit from a guided pathway from hearing assessment and device fitting services under the Program to engagement with early intervention or other providers under the terms of the NDIS or education sectors.(23) Currently this exists for those children identified in early childhood, but not beyond that age.

Improved screening

First Voice, in its role as a peak body that comprises numerous organisations that focus on early intervention for children with hearing loss, recommended the Program include screening for 4-7 year olds to make sure these young children do not 'fall through the cracks' before formally starting school.(77)

Funding for initial hearing assessment

First Voice argued that additional funding is needed to allow Hearing Australia to provide initial assessment appointments, particularly for Aboriginal and/or Torres Strait Islander children.(77) Currently, all infants and children have their hearing assessed elsewhere in the first instance so as to establish a diagnosis of a hearing loss before being eligible to access the Program. Allowing the initial and subsequent services to be delivered by the same provider would improve continuity of care for the infant and family.

Overcoming inequitable access to hearing services

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

This section of the chapter focusses on the following groups of people and their experiences with receiving care and support for their hearing loss: Aboriginal and Torres Strait Islander people; people from culturally and linguistically diverse (CALD) backgrounds; people living in rural and remote areas; and residents of Aged Care Homes.

Improved access for Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people under 26 and over 50 years of age, or who are voucher eligible, or are current Community Development Program participants (including some previous CDEP participants) are automatically eligible to receive services under the CSO component of the Hearing Services Program.(96) Voucher eligible Aboriginal and Torres Strait Islander people who have specialist hearing needs or reside in Modified Monash Model (MMM) areas 6 or 7 are also

eligible for additional services through the CSO component. If the person is voucher eligible, they can receive voucher services with any contracted service provider in the Voucher stream. CSO funded services are only available through Hearing Australia.

Table 9: Hearing Services Program Aboriginal and/or Torres Strait Islander clients by Program stream and age group in FY 2019/20 (97)

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

Source: Department of Health

As **Table 9** (above) shows, services to Aboriginal and Torres Strait Islander people are predominantly delivered by Hearing Australia through the CSO. This pattern of delivery applies not only to regional, rural and remote areas but also to those people living in metropolitan Australia (see **Table 10** below).

Table 10: Hearing Services Program Aboriginal and/or Torres Strait Islander clients by Program stream and MMM area in in FY 2019/20 (97)

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

Source: Department of Health.

The estimated number of Aboriginal and Torres Strait Islander people who are eligible for the Hearing Services Program is estimated to be 653,080 persons (FY 2019/20). Of this population about

230,713 are estimated to have mild or greater hearing loss. However, based on prevalence data and the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), it is estimated that only 5 percent of the Aboriginal and/or Torres Strait Islander people who are currently eligible for the Program as a whole are actually accessing services under the Program, predominantly through the CSO stream.

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

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

Many Aboriginal and/or Torres Strait Islander families report waiting years to access services for their children.(98) This can be due to factors such as the remoteness, affordability and lack of cultural safety.(99,100)

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

... future changes and improvements are co-designed with those directly impacted, including consumers, providers, and other relevant stakeholders.(3)

Culturally safe health care can improve engagement with health care and the quality of care received, which in turn can improve health outcomes for Aboriginal and/or Torres Strait Islander people and those from culturally diverse backgrounds.(13,100) However the current access rate for the CSO Scheme delivery of hearing services to Aboriginal and Torres Strait Islanders (at 5% of those eligible for the service) is very low.

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

Families and service providers know what is needed to increase uptake of services. Factors cited include: being welcoming and safe for families; working to develop trust; engaging regularly with the community; being visible at community initiatives; seeking community input; employing Aboriginal staff, which increases cultural safety; ensuring staff undertake cultural competency training; increasing coordination/co-location of services in-community; locating services where families go, in places accessible by public transport.(100)

The National Agreement on Closing the Gap aims to improve the way governments work with Aboriginal and Torres Strait Islander communities and people, including ensuring service delivery is

based on their needs, cultures and relationship to country. (101) The National Aboriginal Community Control Health Organisation (NACCHO) advises:

Aboriginal and Torres Strait Islander people continue to feel misunderstood by mainstream providers especially if those providers have very little training or knowledge of the ways that disability or chronic conditions intersects with different cultural experiences. Often service provision forms have a 'tick box' for Aboriginal and/or Torres Strait Islander people or disability, not both.(33)

There are 143 Aboriginal Community Controlled Health Organisations (ACCHOs) around Australia that deliver comprehensive primary health care to Aboriginal and/or Torres Strait Islander people through approximately 700 facilities. NACCHO highlighted in their submission to the Review that:

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

And that:

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

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

The Expert Panel considers there are opportunities for the Australian Government to work with NACCHO and Hearing Australia to develop alternative models of hearing service delivery for Aboriginal and Torres Strait Islanders that are culturally safe and accessible and could increase the proportion of eligible Aboriginal and/or Torres Strait Islander people taking part in the Program. Depending on the outcome of this co-design approach, options might include one or more of the following:

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

- reviewing the content and appearance of the Program website for cultural appropriateness and ease of navigation for Aboriginal and/or Torres Strait Islander people.

People from culturally and linguistically diverse (CALD) backgrounds

People from culturally and linguistically diverse backgrounds are disproportionately affected by the social determinants of health including access to health care, education, employment, income, safe housing, and food.(102) Individual/family/community issues impacting on access to culturally appropriate health care for people from culturally and linguistically diverse backgrounds include:

- limited health literacy, including knowledge of the health care system in Australia;
- health beliefs and cultural practices, impacting on perceptions of major life events, uptake of preventative health care, help seeking behaviour and understanding of and adherence to treatment;
- high level of stigma associated with some health conditions in some cultures e.g. mental health, developmental disability, cancer; and
- low levels of English language proficiency, especially in newly arrived communities and ageing communities.(103,104)

These challenges are as relevant to hearing health as they are to any health services and are compounded by systems issues, particularly inconsistent identification of ethnicity and limited access to interpreters and to translated health information.(105) CALD communities are not routinely involved by services or researchers in co-designing culturally appropriate solutions to health issues.(106)

The Deafness Forum and the Royal Institute for Deaf and Blind Children (now called Nextsense) referred to a possible lack of knowledge within the Hearing Services Program about the use of the Program by individuals and families from CALD backgrounds, due in part to shortfalls in data.(23,53)

The Expert Panel notes the additional challenges faced by people from culturally and linguistically diverse backgrounds, as well as the current shortfalls in Program data relating to these populations. The Expert Panel considers the Program could take a co-design approach to working with peak bodies representing culturally and linguistically diverse groups to address any identified issues impacting on access to services for eligible clients.

People living in rural and remote areas

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

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

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

The *Roadmap for Hearing Health* identified the shortage of regional, rural and remotely-based clinicians as an issue in providing accessible quality services in regional, rural and remote communities.(3)

Some provider groups stated that families aren't provided enough choice under the CSO stream, and proposed that, particularly in rural and regional areas, the Hearing Services Program could open up services to regional clinicians through a subsidy under the CSO stream, rather than have clients travel considerable distances to access Hearing Australia providers.(55,87,107)

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

Hearing Australia provides a safety net in many rural and remote areas because of its obligations under the CSO Program making services under the Voucher and CSO Program more accessible for people in those areas. If the CSO Program became competitive then it is possible it would lead to thin markets particularly in rural and remote areas as providers are likely to 'cherry pick' and deliver programs in easy to service areas and avoid delivering services in areas where they are likely to make a loss.(23)

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

The Expert Panel's *Interim Advice to Government – Implementation of Hearing Services Program Changes* considered the Government's changes to the Hearing Services Program's Voucher stream, which were announced in the October 2020 Federal Budget. The suggested changes included extending the Voucher period to five years, removing the 12 month warranty period maintenance payment, and replacing the annual maintenance payment in advance with quarterly payments in advance. The Expert Panel considered the implications of these changes for regional, rural and

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

The Panel's Interim Advice was that the Government consider the following three policy options, as possible courses of action, to maintain a viable service provider sector, and in turn to support ongoing consumer access to hearing services during the adjustment period that commences from 1 July 2021.⁽¹⁸⁾ These options would provide varying levels of adjustment support to the hearing services market and help mitigate the impacts of the FY 2020/21 Federal Budget announcements on providers and therefore their consumers, for the two year period of FY 2021/22 and FY 2022/23.

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

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

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

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

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

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

Option 3 would expand tele-audiology services available through the Hearing Services Program. Expanding the use of tele-audiology to deliver services in the Program would be an effective means of improving access to services for the majority of consumers and particularly those in thin markets, and would assist in addressing the revenue impacts from the 2020-21 Federal Budget measures. The

precise details of the implementation, and particularly the applicable fees and quality controls, would impact on the efficiency of this option in terms of value to taxpayers. However, a well-designed proposal could deliver the desired effectiveness in an efficient manner.

As some tele-audiology services are already in place, expanding this offering could be undertaken in a sustainable manner, both in terms of implementation and ongoing maintenance and quality control. It would also help to address equity concerns, particularly for those consumers who are particularly vulnerable and for their providers who may be unduly impacted by the 2020-21 Budget measures.

The Expert Panel considers this advice to still be applicable, with a preference for Options 1 and 3. The Panel also supports the following planned short term actions outlined in the *Roadmap for Hearing Health* with regards to increasing access to hearing services in rural and remote areas:

- incentivise hearing health professionals servicing rural and remote areas, particularly those who are servicing Aboriginal and Torres Strait Islander communities;
- make telehealth more accessible for hearing healthcare practitioners to provide services to consumers, particularly those living in rural and remote communities; and
- develop options to address the shortage of ENT clinicians, particularly in rural and remote regions.

Residents of Aged Care Homes

Older people who live in Aged Care Homes or who receive in-home care often have complex health care needs owing to other health conditions such as chronic illness, vision loss, physical disabilities and cognitive impairment, including dementia.

Professor Hickson, in her submission, noted that residents in aged care facilities were not well served in regards to hearing services and, given that they generally have other health conditions, they should be considered under the CSO stream of the Hearing Services Program as having complex hearing or communication needs.(58) Professor Hickson quoted findings from research by Bott et al. (2020) and Meyer and Hickson (2020) that hearing health services to residents in Aged Care Homes were too device-focused and did not address the fundamental communication needs of residents – matters considered of greater importance by care staff and families.(108,109)

Essentially, audiologists, care staff and families prioritized different practices for managing hearing impairment: audiologists emphasized hearing aids while care staff and family emphasized communication strategies. Hearing aid use in aged care facilities is problematic for many reasons e.g., residents require staff support to manage them, staff workloads and lack of education about hearing aids means they are frequently unable to provide the support required, lack of clarity around responsibility and ongoing support for hearing aid use.(58)

The average age of Hearing Services Program clients is 78 years(31) and it is likely that many clients are residing in Aged Care Homes or receiving in home supports. Based on data from the Aged Care Division of the Department of Health and prevalence data, there are potentially over 130,000 people

living in Aged Care Homes with mild (21 – 40 DB) or greater hearing loss who hold a pensioner concession card and could be eligible for the Hearing Services Program however only about 8,000 active Program clients have self-identified as living in an Aged Care Home.(31)

The Parliamentary Review *Still Waiting to be Heard* (2017) recommended that:

...the program consider the provision of hearing services to residents in aged care facilities. This review should consider issues including: the use of assistive listening devices for aged care residents; service provision for deafblind Australians in aged care facilities; and the education of aged care facility staff.(35)

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

- ensuring aged care assessment processes, including on entry to residential care, appropriately identified hearing loss and balance disorders;(3)
- lifting the quality of hearing care in aged care facilities with a particularly focus on identification, management and workforce training to ensure there was prompt recognition and action taken on hearing health; and
- developing and delivering hearing awareness training for aged care staff, from registered nurses to direct carers and the teams of Quality Surveyors employed by the Aged Care Quality and Safety Commission to monitor aged care facilities.

In the May 2020 Budget, following the release of the *Roadmap for Hearing Health*, the Australian Government announced funding of \$2 million for the development and testing of training programs for residential aged care workers that will help them support residents with hearing loss. This work is underway and will identify current workforce needs in the aged care sector.(3)

Recommendations

5. Engagement with consumer groups

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

6. Client decision-making support

6(a) The Australian Government should develop a range of illustrative client pathways on the website that clearly show the options for clients who are eligible for hearing services in the Voucher stream and the CSO stream. These should be reviewed at an appropriate time period following implementation to assess its usefulness. Specific pathways should be developed for clients who might benefit from targeted wayfinding information, including:

- children and young people under 21 receiving services via Hearing Australia;
- Aboriginal and/or Torres Strait Islander clients seeking hearing services;
- clients living in rural and remote areas;
- clients from culturally and linguistically diverse backgrounds;
- clients with complex hearing or specialist needs; and
- adults with cochlear/bone anchored implants.

6(b) The Australian Government, following consultation with stakeholders, should incorporate a set of linked Decision Aid Tools in the Program's website to assist prospective clients to make more informed choices before committing to join the Program. This should be reviewed within two years of implementation to assess its effectiveness and advise on improvements.

6(c) Following a review of the effectiveness of the set of linked Decision Aid Tools on the Hearing Services Program website, the Australian Government should consider including them in the Hearing Assessment process, with the data to be stored in the client's clinical file and made available to the clients.

7. Availability of translation, interpreting and Auslan services

The Australian Government should ensure that audiologists are made aware of the AUSLAN services available under the NDIS and the NABS programs and how to access these services. (The Panel recognises that a separate Australian Government process is underway to include audiologists and audiometrists as 'approved groups and individuals' with the national Translation and Interpreting Service.)

8. Delivering rehabilitation and support services

8(a) The Australian Government should undertake a review of the current Schedule of Fees to assess whether:

- there is an unintended bias in profit margins which favours the supply and fitting of hearing aid devices ahead of providing rehabilitation services, and undertake any necessary rebalancing of the fees; and
- the complexity of the current Schedule of Fees can be simplified from the current 55 items to under 20 service items to more clearly capture these rehabilitation interventions

8(b) The Australian Government should amend the scope of the Hearing Services Program to require service providers to offer a more holistic assessment of clients' needs and broader range of interventions to better address those needs. This would include:

- holistic assessment of clients' needs;

- rehabilitation alternatives prior to offering the option of being supplied and fitted with a hearing aid device; and
- rehabilitation services as part of providing a device; and
- psychosocial support alongside hearing assistance; and
- assessment and management plans better suited to diverse clients.

8(c) The Australian Government should consider developing and implementing a pilot to test the feasibility of the provision of independent rehabilitation services delivered by counsellors who can provide the necessary psychosocial support for clients, including clients with diverse needs.

9. Assessment of hearing loss

The Australian Government should redefine a hearing assessment to be a comprehensive process that involves an individual's communication and psychosocial needs and should be guided by the National Acoustics Laboratory (NAL) Report to be released in 2021 in redefining the minimum hearing loss thresholds and other communication and psychosocial needs criteria (also referred to as 'eligibility criteria' by NAL).

10. Improving access for Aboriginal and Torres Strait Islander people

10(a) The Australian Government should work with key Aboriginal and/or Torres Strait Islander stakeholders to co-develop alternative models of hearing service delivery that are culturally safe and accessible to increase the proportion of eligible Aboriginal and/or Torres Strait Islander people with hearing loss taking part in the Health Services Program.

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

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

11. Improving access for people from culturally and linguistically diverse (CALD) backgrounds

The Australian Government should develop a data base and undertake analysis of shortfalls in engagement with, and outcomes from, the Health Services Program for culturally and linguistically diverse populations. The Australian Government should undertake a co-design approach to working with peak bodies representing these groups to address any identified issues impacting on access for eligible clients to the Hearing Services Program.

12. Improve access for Regional, rural and remote communities

12(a) The Australian Government should maintain Hearing Australia's role as sole provider of CSO services, recognising the critical role that its service plays in maintaining access to hearing health

care for eligible people living in regional, rural and remote areas and the likelihood that increased competition would exacerbate service availability for people with hearing loss who live in thin markets.

12(b) The Expert Panel recognises the ongoing challenges for regional, rural and remote communities in accessing hearing health services and references its previous advice to the Australian Government regarding the changes to Hearing Services Program Voucher stream, this being:

The Australian Government should undertake further analysis and consultation with the sector and community on the following policy approaches:

- 1. Provide a loading on service items delivered in rural and remote regions (MM 3-7)*
- 2. Provide a loading on service items delivered by small and medium service providers*
- 3. Expand teleaudiology services available through the Program*

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

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

13. Improve access for residents of Aged Care Homes

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

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

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

CHAPTER 5 – DELIVERY OF SERVICES

Key Points

- Informed client choice and control should be the underlying principle guiding service delivery.
- Largely unbeknown to clients, their choice of service provider can affect how and what services they are offered (education and counselling and/or a hearing aid device), the quality of services received, and even likely determine the range of hearing aid devices they are offered.
- Service provider decisions about services and hearing device aids to be offered to clients can be shaped by corporate concerns such as their vertical integration with hearing aid device manufacturers.
- There is a need for increased transparency and accessibility of information to consumers on the range and pricing of available hearing aid devices
- The availability of fully and partially subsidised hearing aid devices under the Program may be creating a perverse incentive for service providers to market partially subsidised hearing aid devices in place of suitable full subsidised hearing aid devices.
- Technological advances are shaping consumer demand and service provider offerings to clients, however the Program schedule is not sufficiently keeping pace with these advances.
- More flexible modalities for service delivery will be welcomed by some clients, including tele-audiology and settings-based service delivery models, including delivery in residential aged care settings.

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

Hearing health care professionals and service providers

Under the Voucher stream, approximately 300 providers across Australia must ensure that services are delivered by a qualified practitioner (QP) or by a provisional practitioner under the supervision of a QP. The two professions – audiologists and audiometrists – belong to any of the three recognised Practitioner Professional Bodies (PPBs):

- Audiology Australia (AudA): 2,907 members in FY 2019/20(110);
- Australian College of Audiology (ACAud): 727 registered members (105 Audiologists and 431 Audiometrists currently working, the residual registered members not working) in FY 2019/20(111); or

- Hearing Aid Audiology Society of Australia (HAASA): 135 audiometrist members in FY 2019/20(112).

The scope of practice for the two hearing health professionals are differentiated below. The functions of each professional group are outlined in the joint PPB Scope of Practice.(113)

- **Audiologists:** work with clients of all ages – from infants to older adults – and clients with complex needs. They can assess hearing and auditory function, vestibular (balance) function, tinnitus, auditory processing function, and neural function by performing diagnostic tests. Audiologists provide rehabilitation as well as communication training, counselling and the prescription and fitting of hearing aid devices. Audiologists must have completed at least the equivalent of an Australian university Masters- level degree in clinical audiology;
- **Audiometrists:** primarily work with adult clients (including older adults) and provide a range of services to school-aged children. They focus on hearing and auditory function assessment and rehabilitation by applying a range of diagnostic tests and approaches including counselling and the prescription and fitting of non-implantable hearing aid devices. Audiometrists may also provide rehabilitation for tinnitus using education and hearing aid devices. Audiometrists must have undertaken at least the equivalent of an Australian Diploma-level Technical and Further Education (TAFE) vocational qualification in audiometry or a Bachelor of Audiometry from an Australian university.(114)

Audiology is a self-regulated profession that is not included as a specialty practice by the Australian Health Practitioner Regulation Agency. Like other unregistered healthcare practitioners, audiologists and audiometrists are covered by the *National Code of Conduct for health care workers*.(115) The joint PPB Code of Conduct(116) is founded on the National Code. Audiology Australia, on behalf of the Hearing Health Sector Alliance, is currently developing *National Competency Standards for audiologists*(117) and is developing standards and/or guidelines for paediatric audiology and tele-audiology.

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

The Program services available to eligible clients through the Voucher stream are set by legislation and outlined in the Schedule of Service Items and Fees. While there is a suite of services available, the specific services are funded on the basis of the clinical needs of the client and the service conditions being met. Services provided under the Voucher stream and delivered by Audiologists and Audiometrists are:

- hearing assessment, including:
 - identification of communication goals; and
 - identification of client attitude and motivation towards hearing rehabilitation;
- provision of rehabilitation services, including:

- education about the effects of hearing loss;
- communication tactics and strategies;
- referral to medical practitioners and/or support organisations; and
- follow-up services, including evaluation of outcomes and long term support;
- fitting of hearing aid devices, where appropriate; and
- device maintenance, repairs and replacements.

The first three services - assessment, rehabilitation and fitting of hearing devices – have been dealt with in the previous chapter, **Chapter 4**. This chapter deals with service delivery more broadly and the supply and maintenance of devices, as well as other ‘supply-side’ issues.

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

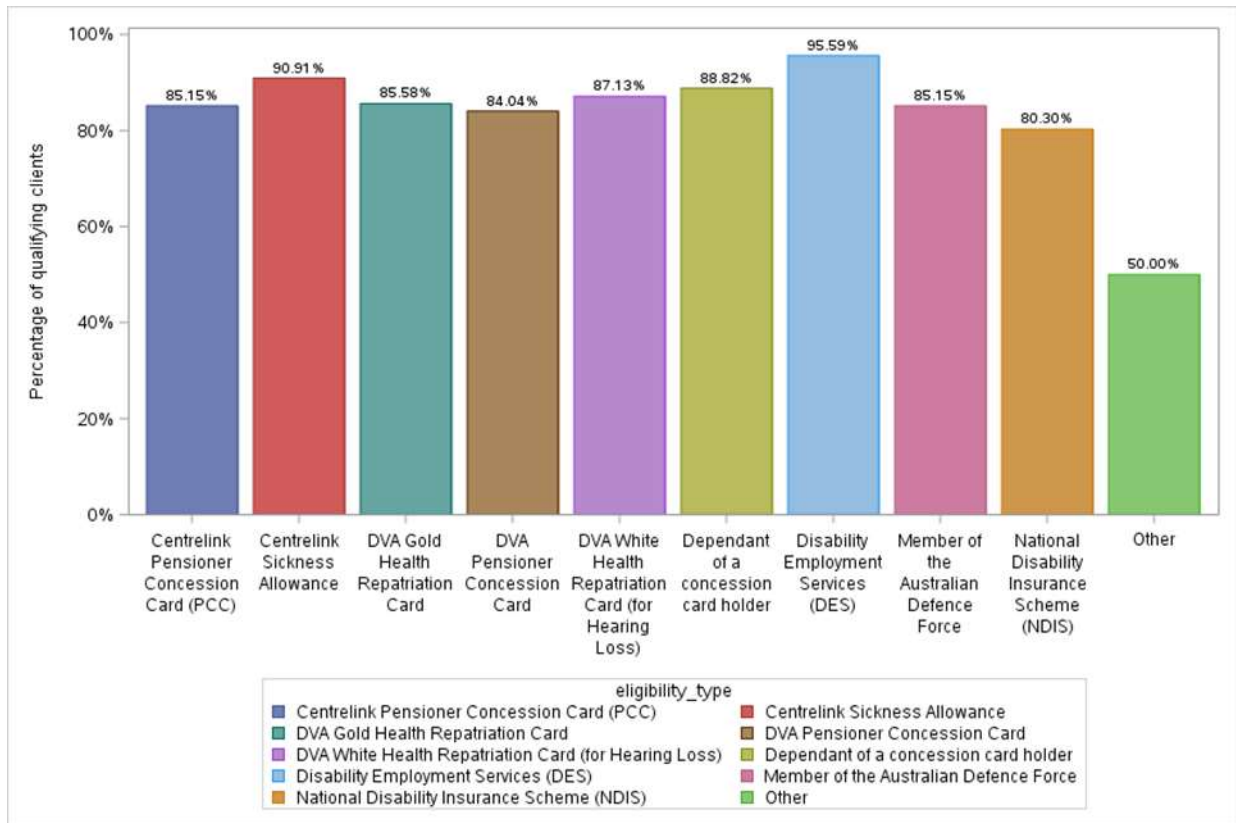
Client selection of a provider or practitioner

Selection of a provider of hearing services under the Voucher stream is one of the most important decisions made by a person (and/or their supporting family/friends) who is experiencing hearing loss. In practice, this decision will affect how and what services they are offered (education and counselling and/or a hearing aid device), the quality of services, and even likely determine the range of hearing aid devices they are offered.

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

Further, as shown by **Figure 5** (below), there is very little client movement between providers – at least 80 percent of clients remain with their ‘chosen’ provider for at least three years. There is no evidence before the Expert Panel which would enable it to comment on whether this indicates client satisfaction with the provider, or whether it means clients do not have enough knowledge about the sector to make an informed choice to change providers.

Figure 5: Proportion of voucher clients by eligibility type who choose to remain with their hearing service provider, aggregated three years (FY 2017/18 to FY 2019/20).



Supply side issues

Vertical integration in the industry

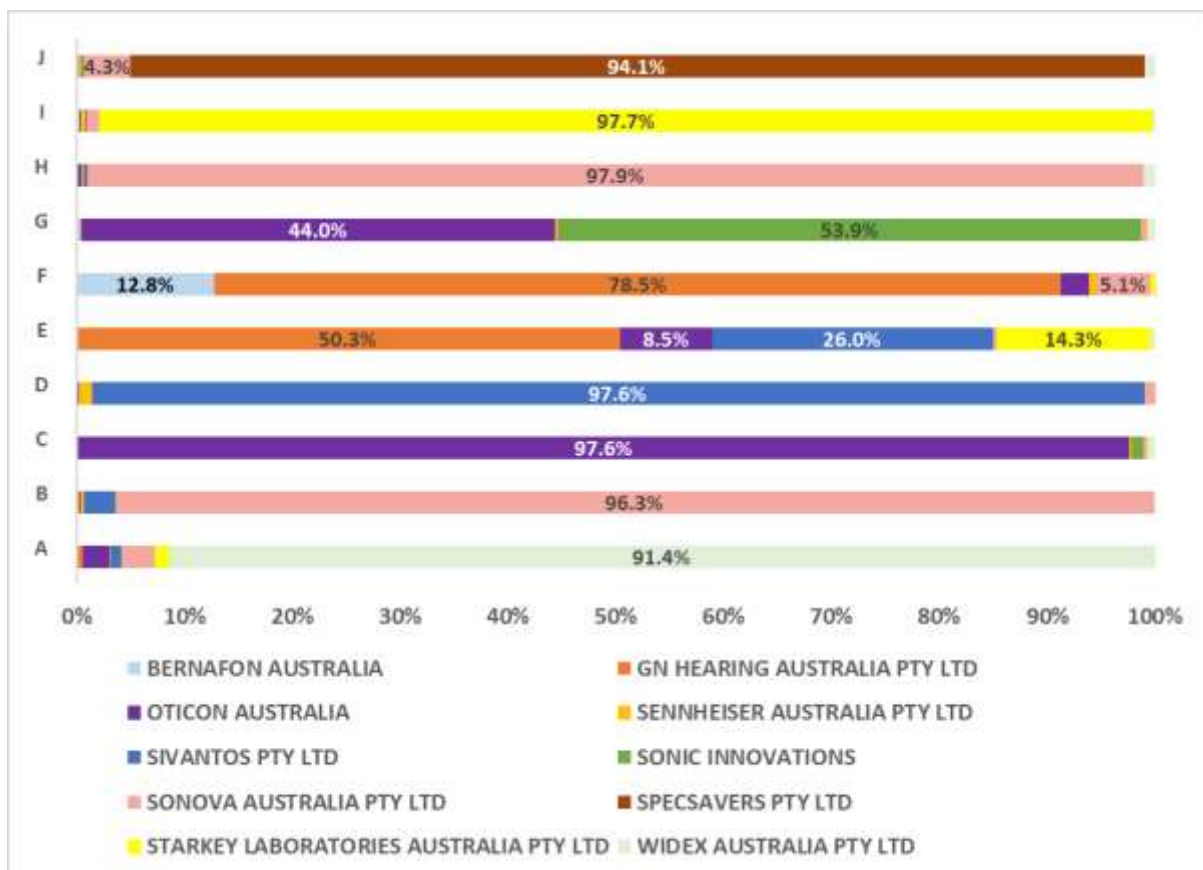
The structure of the hearing services industry has a significant bearing on the achievement of Program objectives proposed in **Chapter 2**. In particular the structure affects whether providers are supplying and pricing services and, in particular, hearing aid devices, in a manner which knowingly or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

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

Stakeholder feedback, anecdotal reports, and recent government reports (including the Australian Competition and Consumer Commission) all support this and suggest consolidation through vertical integration is becoming common place. However, there is limited publicly available information to verify such a claim.(72)

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

Figure 6: Distribution of hearing devices supplied to clients by hearing aid device manufacturer for major hearing service providers, aggregated three years (FY 2017/18 to FY 2019/20).



Pricing and product disclosure

Disclosure of vertical integration is addressed in one of the current legislative instruments which underpin the Hearing Service Program. The *Hearing Service Program (Voucher) Instrument 2019* (s28) requires that Providers disclose their hearing aid device supply arrangements:

A contracted service provider must inform a voucher-holder of device supply arrangements in accordance with the guidance published on the program website.(32)

Under the current (standard provider contract), providers are required to:

.....disclose in writing to the Voucher-holder whether or not

(a) the Service Provider or any Service Provider Personnel receives any direct or indirect benefit (whether pecuniary or non-pecuniary) in relation to, or in connection with, the Service Provider’s

purchase of Supplies from an Appointed Supplier, including, without limitation, exclusive supply arrangements, price discounts (including volume discounts), commissions, gifts or rewards

(b) the Supplies are provided or manufactured by

(i) a Related Party or

(ii) a person or entity which has provided significant financial support to the Service Provider, or has a financial interest in the Service Provider, or to whom the Service Provider has provided significant financial support or

(c) the Service Provider is also an Appointed Supplier, and Supplies are those supplied by the Service Provider. (118)

There are also legislative requirements to provide a range of devices (noting that a range is not defined and could be considered type of device not just the brand). In addition, there is a requirement that clients must be offered a fully subsidised device in the first instance as an indication of support for vulnerable Australians (s46 of the *Hearing Service Program (Voucher Instrument)*).

The PPB Code of Conduct and Program Standards also require providers to ensure they meet client need, and provide a hearing aid device that best suits the clinical need (and not, for example, be driven by the profit margin). Standard 6 of the PPB Code of Conduct states:

6.2: Members must make recommendations to clients based on clinical assessment and the client's needs, not on the basis of financial gain on the part of the member.(116)

The instrument and standard referred to above aim to ensure that there will be client choice on the hearing aid device that they are most comfortable with and which has the functionality that they consider most appropriate. However, the 2017 Australian Competition and Consumer Commission (ACCC) Report identified that clients had concerns about the transparency of hearing aid device supply and incentives paid to practitioners and upselling, dissatisfaction with the hearing aid device features and performance and confusion over the lack of standard language about hearing aid devices.(73) The ACCC raised particular concerns about providers' use of finance arrangements where particularly vulnerable clients were being sold partially subsidised hearing aid devices at considerable mark up and tied to ongoing financial payments.

Despite the legislated requirements of the Program, several submissions reported that clinicians whose clinics were supported by hearing aid device manufacturers might give preference to that brand of hearing aid device, and/or might upsell hearing aid devices beyond clients' needs (including Veterans). In their view, the business or profit motive instead of client need influenced the offer of a hearing aid device.(62,63,119)

The 2017 House of Representative Standing Committee Inquiry into Hearing Health(35) recommended the Program ban the use of commissions and other similar sales practices that were in place which could undermine the ability of hearing practitioners to provide independent and impartial clinical advice (Recommendation 12). The recommendation that the Program ban

commissions has not been adopted, in part due to the challenges in defining commissions and incentives.

The Department chose instead to implement an expanded disclosure statement in 2019. To address the risks of vertical integration and commissions and to address other issues identified in the Parliamentary Inquiry and the 2016 ACCC investigation (such as upselling and being pressured into buying a device immediately), providers are now required to give a device quote to all clients who are considering fully and partially subsidised hearing devices through the program. Prior to these 2019 changes, this was only required for partially subsidised devices.

All providers are required to offer a fully subsidised device option if considering a fitting and clients can choose to use the government subsidy to purchase a partially subsidised device. The disclosure and quote requirements aim to help give clients time to make a decision about devices: to understand if their provider has limited device options, whether there are sales incentives in place, understand the value of fully subsidised devices, compare prices, get a second opinion, or seek an alternative quote from other providers. The quote must include the value of the government subsidy, client contributions if any, maintenance, returns and warranty policies.

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

Although the information is made available to a client before a fitting, there is a paucity of comparative information on devices and prices that the person with hearing loss can research prior to undertaking the assessment and device choice journey with a particular provider. This is particularly relevant considering the significant variation in prices for partially subsidised devices between providers.

The 2019 program changes to disclosure have been implemented through variation to the Provider's contract with the Department. Providers are required, through their contract, to complete an annual self-assessment of their compliance against the program's legislative and contractual requirements. This includes a declaration that they provide the disclosure statement to clients. If there are issues, the Department's Compliance Team follows up with the provider. The 2020 Transition Readiness Survey supporting the implementation of the 2019 legislation changes sought certification that Providers have or would have the updated disclosure statement and the expanded quote requirements ready for the following April. Some Providers check for compliance by submitting their templates for review prior to use.

The Department's Compliance Activities are risk based. All providers must complete an annual Self-Assessment which requires providers to review their policies and procedures, including certifying that their device quotes and disclosure statements are compliant with program requirements. During compliance monitoring activities, client files are reviewed including device quotes and disclosure statements. If the quote/disclosure statement is not adequate, the provider is given an opportunity to rectify the issues.

To date, there has not been any evaluation of these latest requirements. The Expert Panel considers there is a need to improve on how Providers provide detailed information that enables a client to compare products and prices offered by their Provider and/or other providers before a choice has been made. The requirements should be strengthened in consultation with consumers to reorient the Program to be more client focused, including expanding the requirement placed on manufacturers and providers regarding the availability of information on pricing and device features and ensuring providers give the appropriate information before clients are required to make a decision about devices.

Pricing and product disclosure reform

Transparency of pricing of devices is limited: very few providers publicly list the retail cost of devices. Australian consumer law does not require business to disclose the price of their goods and services. However, the Australian Competition and Consumer Commission states on their website:(120)

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

When or where a business chooses to set a price for a good or service, or advertise a price, they need to be aware of any restrictions that various pricing activities(120) might have on the above transparency:

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

The Expert Panel has identified two options for greater pricing and specification transparency, essentially placing the onus on either the manufacturers or the providers.

Option 1 would be to introduce a Recommended Retail Price (RRP). The Department would consult with the hearing aid manufacturers to introduce a RRP for all hearing devices supplied in the Hearing Services Program and for the RRP and device features to be published. There would be a requirement that all quotes provided to clients would include the RRP of the hearing aid device being considered.

Option 2 would be to require providers to publish (as a minimum, on their website in an easily accessible manner) the price and features of the devices they supply under the Program. Such disclosure is normal practice for goods and services being sold in the market and the practices of hearing service providers represent an anomaly. The Department could amend its contract with hearing service providers to require that they provide information on the price of all hearing aids supplied in the Hearing Services Program at their business sites and on their website. Information on the function and features of the hearing aids should also be advertised.

Both options would enable Hearing Services Program clients to be able to access information on the price and features of hearing aid devices before they are fitted. On balance, the Expert Panel considers that **Option 1** should be adopted and the outcomes of this change monitored for two years, particularly in respect of increased pricing transparency for clients. If insufficient pricing

transparency is achieved with Option 1, then Option 2, which provides the greatest real-time information for clients and enables them to undertake comparison shopping before finalising the purchase of a device, should be reconsidered.

Upselling

On the issue of upselling, the following analysis of patterns of supply identify that nearly one third of all clients fitted with a hearing aid device are fitted with a partially subsidised model. Clients make up the rest of the cost from their own sources. Given that there are 242 models of hearing aid devices available on the fully subsidised list compared to 1,959 hearing aid devices on the partially subsidised list, it suggests that either the fully subsidised hearing aid list is significantly inadequate and/or that there is evidence of upselling.

Table 11: Number of hearing aid devices issued to clients annually including proportion of fully subsidised and binaural fittings FY 2015/16 to FY 2019/20.(31)

Type	2015-16	2016-17	2017-18	2018-19	2019-20
Devices Issued to Clients	382,384	395,829	404,912	398,874	392,598
Fully Subsidised Devices (%)	68%	68%	69%	69%	64%
Binaural Fittings (%)	85%	86%	86%	87%	89%

The Department of Veterans’ Affairs noted concerns regarding the marketing of hearing aid devices to veterans, including that fully subsidised hearing aid devices were being promoted as basic hearing aid devices rather than being technologically advanced even though the fully subsidised hearing aid device schedule had a reasonable range of hearing aid devices. Some of the marketing materials being used by providers, such as lifestyle charts, were giving the perception that veterans were being provided inferior hearing aid devices unless they bought a partially subsidised model and paid the balance.

The cost to clients for partially subsidised devices varied considerably between providers, ranging from zero cost to client contributions ranging from \$200 to \$15,000 for a pair of devices. The cost to the client can be up to twice the industry average. Providers can also charge clients a higher co-payment amount for maintenance. Clients can be unaware of the ongoing costs including having to repay the client co-payment if they lose the devices.

PwC noted that there are questions about the validity of the partially subsidised device schedule and its perceived role in the upselling of assisted hearing technology (Finding 10).

Industry members support the retention of the partially subsidised hearing aid device schedule citing clients being able to use the government subsidy towards higher technology hearing aid devices such as Bluetooth. However, the Expert Panel is attracted to the proposition that the partially subsidised schedule be deleted from the Voucher stream of the Program as suggested by PwC to re-orient the Voucher stream to be more focused on the clinical needs of clients. This should be complemented by a review and expansion of the minimum specifications for fully subsidised hearing aid devices.(72) The Expert Panel suggests ongoing monitoring of the impact of this change on the participation rate of providers in the Program, noting that some hearing aid manufacturers could

choose to withdraw from the Program if their owned service providers are unable to generate additional profits from partially subsidised hearing devices.

The Expert Panel considers that a stakeholder working group should be convened to advise on new minimum specifications for fully subsidised hearing aid devices, including a revision of the criteria for placing a hearing aid device on the fully subsidised list.

Hearing aid device technology framework and governance arrangements

Broadening the scope of technology

Manufacturers and suppliers sign a Deed of Standing Offer contract with the Department of Health that covers minimum specifications for hearing aid devices. Further, the Hearing Aid Manufacturers and Distributors Association of Australia noted that market competition at the manufacturer level means that eligible clients could potentially have access to a wide range of the latest hearing aid device technology, some of which exceeds the minimum specifications.(121)

All hearing aid devices have competitive warranties and consumer guarantees, trial periods (offered by the service providers and supported by the manufacturers) and maintenance support within the Program. This includes the Fully Subsidised (about 245 hearing aid devices) and Partially Subsidised hearing aid devices (approximately 1900 varieties - noting that the same device might be listed multiple times). However, the limitations faced by clients in their dealings with providers significantly lessens the level of competition at the retail end. However, as discussed earlier, the limitations faced by clients in their dealings with providers significantly lessens the level of competition at the retail end.

Submissions discussed several opportunities for the Hearing Services Program to broaden its technological options as listed below.

Improving connectivity

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

Rechargeable hearing aid devices

Stay Tuned noted that the Hearing Services Program could consider funding rechargeable hearing aid devices, claiming that many of the program's clients are older with other medical problems such as poor vision and poor dexterity. Rechargeable hearing aid devices would allow for ease of use and therefore contribute to higher hearing aid device retention and use. This would have the added advantage of reducing the number of button batteries in circulation, which are dangerous to children and very difficult to recycle.(122)

Assistive Listening devices

Some stakeholders raised concerns about the limited range of Assistive Listening Device (ALD) technology available through the Hearing Services Program and that ALDs are not available to clients

if they are fitted with a standard hearing device.(72) PwC (2017) noted that the variety of and access to ALDs under the program should be expanded (Finding 9).(72)

Such devices include hearing aids, hearables, remote microphone technology and cochlear and other implant technology. Hearing Australia noted that it is estimated that between 10 – 15 per cent of adults with a normal audiogram raise concerns about difficulty understanding speech when there is background noise, and these people may benefit from hearing support through ALDs.(54)

Hearables offer hearing enhancement but are not traditional hearing aid devices. They are less complex and cheaper than purchasing a traditional hearing aid device and improves the hearing experience of the listener by filtering out background noise. For people whose hearing loss does not yet warrant the use of hearing aid device hearables are a more cost-effective form of assistance.(54)

Mobile apps

The use of smartphones is changing the landscape for health care delivery. For those with tinnitus, it offers a more personalised form of therapy targeted towards the individual's specific area of need.(34) Accessing therapies via a mobile phone will also provide the conveniences of other telehealth services. It has the potential to deliver a sound therapy library as well as cognitive behavioural strategies to alleviate anxiety and depression induced by tinnitus. For patients who require a more intensive degree of intervention, a referral to a qualified psychologist through video-conferencing would be appropriate.

Binaural beamformer technology

The introduction of wireless audio streaming between both sides of the head has allowed the development of binaural beamformer technology.(123) The combined power of the directional microphones on either side of the head with the acoustic effects of the skull create different sound mixtures on each side of the head. The result is a super-directional microphone output that provides significantly greater speech intelligibility than is possible with directional microphones working independently on each side of the head.

Cochlear and other implants

Cochlear implants are being used by those who may have once accessed the Hearing Services Program for hearing aid devices (as well as by those who aren't eligible for the program).

Despite all of these technological options, submissions still acknowledged the role of a hearing care professional in properly addressing patient needs in delivering high quality patient outcomes. Audiologists and audiometrists are required to assess and review which devices provide the greatest value and best outcomes for their clients, in accordance with their obligations under the Hearing Services Program's Service Provider Contract and Professional Body Code of Ethics.

Maintenance agreements

In FY 2019/20, maintenance and repair claims accounted for 40% of all claims paid by the Program, resulting in over \$111 million in funding (some 24.4% of total Voucher stream costs).(31) The actual costs paid by providers for maintenance and repairs of program hearing aid devices is not clear. The minimum hearing aid warranty requires the hearing aid manufacturer to remedy defects and faults

attributable to the design, workmanship or component failure at no additional cost. There is still a cost for the consumables (domes, tubing, etc.) and the client also makes a co-payment for the cost of hearing aid batteries.(124) The costs can vary significantly depending on the location of the client, hearing aid device age, and the fitting arrangement and length of time since the fitting of a hearing aid device.

Nearly all Program clients are reported to be on a Maintenance Agreement, which creates a significant administrative burden for Providers and the Program, given it is addressed annually and for such a large proportion of the clients. Improvements to how the Program supports maintenance can be made both administratively and via review and simplification of the service items and fees structure. Annual maintenance agreements, client payments and claiming could be substantially reduced by the following:

- the Program simply paying actual repairs and costs of consumables for hearing devices outside the warranty period;
- increasing device warranty to 3 years which is the industry standard (except Hearing Australia which has negotiated a very low unit price cost in lieu of 3 years to have a one year warranty);
- making maintenance agreements for the life of the device as long as the client is confirmed to still be using their device; and/or
- paying providers automatically every quarter for the number of clients with devices to cover any maintenance costs.

The Expert Panel notes the changes to the hearing device maintenance arrangements in the 2020/21 Budget which will stop all hearing device maintenance payments from the Government during the minimum warranty period of 12 months after a hearing device has been fitted. However, the Panel considers that further reform is required and will be seeking further feedback from stakeholders in response to this Draft Report.

Replacements of hearing aid devices

Currently the Hearing Services Program allows clients to receive unlimited replacement if the hearing aid device is lost or damaged beyond repair. When a hearing aid device is lost, the client is asked to sign a Statutory Declaration documenting when and how the hearing aid device was lost and to pay a replacement fee (currently about \$40). For hearing aid devices damaged beyond repair, a letter from the manufacturer must be provided documenting that the hearing aid device cannot be repaired.

A replaced hearing aid device is not currently considered a fitting under the Hearing Services Program. This enables clients to receive a new hearing aid device five years after their original fitting, irrespective of how many replacement hearing aid devices they have had since the original fitting. **Table 12** compares the number of claims and the co-payments paid by clients for fittings, maintenance and replacements, across the 2017 to 2020 financial years.

Table 12: Approximate values of all co-payments FY 2017 - FY 2020

Service type	Total number of claims	Total co-payment	Average cost per claim
Fittings	544,539	\$352,924,455	\$648.12
Maintenance	1,794,845	\$76,191,077	\$42.45
Replacement	135,476	\$28,897,660	\$213.30
Other Services	1,802,295	\$9,655,171	\$5.36

On average a client receives one replacement every three years, however there are some outliers with clients receiving up to 10 hearing aid devices over a five year period. Anecdotal evidence, including notification from providers, has identified that hearing aid devices are sometimes reported as lost in order to obtain newer hearing aid devices. Clients can be asked to pay a co-payment for a replacement hearing aid device (currently about \$40), irrespective of whether the client is monaurally or binaurally fitted.

In FY 2019/20, replacements and spare hearing aid devices accounted for 3.3% of claims submitted to the Hearing Services Program (at a cost of \$35.8 million to the Hearing Services Program).

The role of tele-audiology

There is some evidence that almost all of the primary tasks defined in the scope of practice for audiologists and audiometrists can be conducted by telehealth, be they clinician-led, facilitator-assisted and/or self-led.(125) For services provided under the Hearing Services Program, telehealth is not funded for some assessments (otoscopy, pure tone audiometry and speech audiometry) and adjustments to a fitting, (unless the client’s device enables remote programming). These services must be delivered face-to-face. Other services can be provided via tele-audiology as long as Program requirements are met, there are no issues with comfort or sound quality and the services are delivered in accordance with the PB Scope of Practice and Code of Conduct. Telehealth assessments can be completed in aged care facilities or client homes as long as ambient noise is managed.(126)

Providers and industry groups highlighted the recent temporary amendments to the Hearing Services Program in response to COVID-19, which enabled expanded remote and telehealth service delivery. This included hearing aid device fittings, rehabilitation services and annual client reviews.

Several submissions to the review advised that the adoption of broader telehealth service models need to be evidence based, effective and support client outcomes. In this respect multiple submissions noted the benefits of telehealth in terms of convenience for clients. DVA noted in their submission that:

...the potential benefits of telehealth, not just for rural, remote or infirm veterans but also for younger active veterans who find it convenient to not attend a clinic. However, the use of telehealth technology needs to be carefully managed to ensure that it can accommodate those with hearing difficulties.(51)

Several submissions noted that while telehealth can reduce administrative costs and time, there are questions regarding the clinical benefit to clients and whether it contributes to better outcomes. A recent report on the evidence underpinning tele-audiology included a survey of more than 400 clients of a Western Australian audiology clinic which found that whilst clients generally have a positive attitude towards telehealth, the majority have not used telehealth for medical or audiology services. To date most tele-audiology services have been delivered by telephone, and the clients expressed concerns about communicating effectively in telehealth consultations; most would prefer face-to-face services.(125)

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

- the nature of the service e.g. clinical level assessments are currently not approved for provision via tele-audiology;
- the hearing aid device the client has will not allow connectivity to support remote programming – this can be particularly true of many fully subsidised hearing aid devices;
- the client preferring face-to-face services;
- the client having particular needs which are not well met through tele-audiology; and
- smaller providers not being able to make full use of tele-audiology due to the required investment and training in equipment and technology. (18)

Enhancing workforce capacity for tele-audiology is a part of the government support of the implementation of the *Roadmap for Hearing Health*.(3) This includes supporting the development of tele-audiology guidelines for use within the sector. Not all Hearing Services Program services will be deliverable by telehealth and some services will only be deliverable in that mode under certain situations, for example if appropriately skilled personnel are available on site with the client and certain equipment is in place. The tele-audiology guidelines should address issues such as these.

The Expert Panel has been advised by the Department that telehealth service provision has worked well during COVID19, and the Expert Panel notes the work underway in the audiology profession to develop tele-audiology guidelines to support this mode of service delivery. The Panel recommends the continued use of tele-audiology in the appropriate clinical services and even then, only when clients feel comfortable that they are receiving care that meets their needs.

Recommendations

14. Supply and client choice

The Australian Government should enable improved consumer choice by:

- (i) amending the Deed to require providers to publish (as a minimum, on their website in an easily accessible manner) the price and features of the devices they supply under the Program;

(ii) undertaking a detailed feasibility study into the impacts on clients, providers and manufacturers of deleting partially subsidised devices from the Program; and

(iii) convening a stakeholder working group, including consumer representation, to advise on new minimum specifications and other supply and technology issues.

15. Broadening the scope of technology

15(a) The Australian Government should continue its support of flexible service modalities such as tele-audiology and other technologies such as improving Bluetooth technologies as they are discovered and implemented, subject to evaluations of the benefits and costs of those modalities and the level of confidence and comfort felt by clients that their needs are being met.

15(b) The Australian Government should conduct a review of the benefits and costs of current Hearing Services Program technologies and pricing to inform changes to the Services Schedule, so that updated technologies can be available to all clients into the future

CHAPTER 6 – PROGRAM DESIGN AND ADMINISTRATION

Key Points

- Improvements can be made to the current administration of the Hearing Services Program to ensure that Program objectives are being met, that the providers, workforce and suppliers are appropriately regulated, and that the Program demonstrates value for money and has flexibility to adapt to emerging trends.
- There is a complex legislative, contractual and program policy framework underpinning the delivery of services through the Hearing Services Program. Positive steps have been made in simplifying the regulatory framework for the Program, but there is agreement that further work is needed to ensure the effective and efficient.
- There are no clear or adequate:
 - client clinical outcomes or standardised outcome measures;
 - program outcomes and associated measures; or
 - monitoring or program evaluation activities.
- Hearing aid device supply arrangements have not been comprehensively reviewed for almost ten years and may not be demonstrating value for money.

This Chapter addresses the following issues:

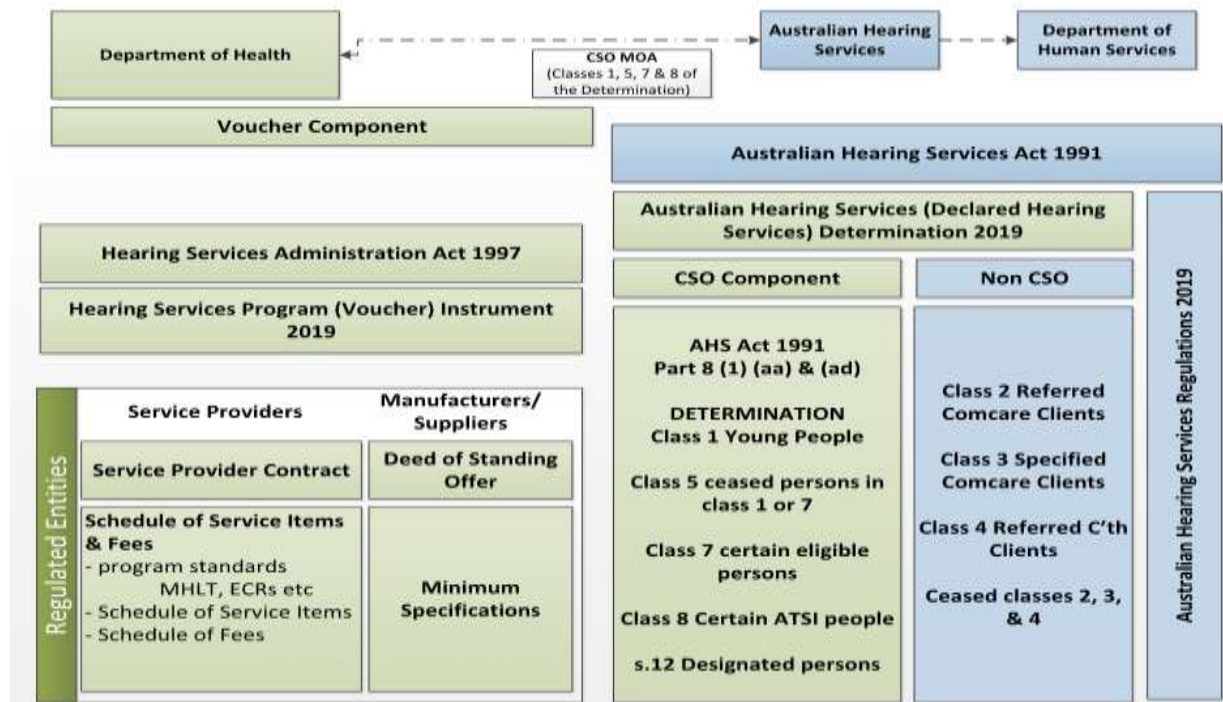
- Program design, regulation and administration
- Impact of Program design on demand and costs
- Hearing data collection and analysis
- Measuring, monitoring and evaluating Program outcomes
- Establishing a national hearing health data service

Design of the Hearing Services Program

Administration and governance of the Hearing Services Program

The Department of Health's administration of the Hearing Services Program is governed by specific legislation for the Voucher and CSO streams and is supported by contractual and program standards. The legislative and contractual overview is outlined in **Figure 7** below. (Note Australian Hearing and Hearing Australia are the one entity).

Figure 7: Legislative and contractual overview of the Voucher and CSO streams of the Hearing Services Program.



Appendix C summarises recent efforts to improve the regulatory practices of the Hearing Services Program. It includes the 2019 decision to replace five subordinate legislations with one consolidated instrument for the Voucher stream, as well as other regulatory changes that have occurred since that date.

Voucher stream

The Voucher stream is governed by the *Hearing Services Administration Act 1997*. A 2017/18 review (127) of the Hearing Services Program identified significant duplication and inconsistencies across the program’s underpinning five legislative instruments, and these were repealed in 2019 and replaced with a single simplified instrument – *Hearing Services Program (Voucher) Instrument 2019*.

Entities that are regulated under these remaining two instruments include:

- **Contracted service providers:** regulated via the Service Provider Contract and the Schedule of Service Items and Fees (Services Schedule), including several program standards.
- **Hearing aid device manufacturers and suppliers:** regulated via a Deed of Standing Offer with the Department of Health. The Deed is legally binding and outlines the obligations and arrangements for the supply of hearing aid devices to contracted service providers. The Deed also establishes the minimum specifications for fully and partially subsidised hearing aid devices supplied through the Hearing Services Program. Deeds are in perpetuity until terminated or renegotiated if either party (Department of Health or the

Supplier) request it, for example if the supplier changes its products. There is no time period specified in the Deed.

Community Services Obligations (CSO) stream

The CSO stream of the Hearing Services Program is governed by the *Declared Hearing Services Administration Act 2019* (Declared Hearing Act) under the *Australian Hearing Act 1991*. Not all classes of eligible people listed in the Declared Hearing Act are covered by the CSO stream. A Memorandum of Agreement (MOA) between the Department and Hearing Australia provides more information about those eligible, outlining that it is those in classes 1, 5, 7 and 8 who are eligible: and section 12 lists other designated persons. This MOA is currently under revision and will be replaced with a Memorandum of Understanding in July 2021. The Declared Hearing regulations further specify the types of services that are available to each class of people.

In addition to the Hearing Services Program specific legislation, other legislation applies to how the broader program operates, including:

- Privacy Act 1988 and the Australian Privacy Principles;
- Commonwealth and State and Territory consumer laws;
- National Archives Act 1983; and
- Public Governance Performance and Accountability Act 2013.

More details on the administration of the Voucher and CSO streams are provided in **Appendix D**.

Improving Program regulation and administration

Earlier proposals to improve efficiency

Numerous reviews and inquiries into the Hearing Services Program and/or the hearing sector have been conducted over the past 15 years and have highlighted areas where existing program administration can be improved (**Appendix A**). They have identified that clearer guidance is needed about the Hearing Services Program and its administrative requirements, and over the years, some providers and industry groups have also raised concerns about the levels of red tape.

As for more recent analyses, the PwC 2017 review (72) recognised the strength of the current service delivery model. Notwithstanding differing opinions on what changes were needed to improve that model, however, PwC reported options for more major reforms, including:

- incorporating program delivery through the Medicare system similar to the Dental and Mental Health programs that have been established in recent years;
- adopting an NDIS model of individual client plans and funding mechanisms;
- cash out arrangements with funding provided direct to clients; and
- activity based costing models.

The 2018 Department of Health Program Assurance review identified a need for improved program governance documentation, including a program logic, governance structures, roles and responsibilities, overall program risk management and a change management strategy:

The Hearing Services Program has demonstrated that oversight arrangements, compliance and controls are in place for providers and for administering the Program. The Program is strong in stakeholder and communications, quality, and legal and compliance with multiple channels providing access to information and for receiving feedback. Overarching program management was not as strong in risk, governance and change and the Program Assurance Team advise the Program to develop an approach and documentation to address these areas.(21)

This was supported by the 2020 internal report which also identified that a lack of clear program objectives was hampering the achievement of program outcomes, while also noting that the Hearing Services Program's compliance activities were:

...operating effectively driven by an effective and skilled team [and] ...the program's Compliance team had adopted a flexible approach to regulation.(22)

These reviews, including the current Expert Panel review, point to the need for improvements in the administration of the Program, acknowledging ongoing fiscal restrictions which have been exacerbated by COVID-19. Some activities are already underway, though, including consolidation of a range of program standards and schedules into a single source program requirements document (Schedule of Service Items and Fees), digitising client records, website redevelopment to improve communication, and portal redevelopment to support provider engagements with the Program.

Major and many minor reforms to the Program would require legislative changes to the Act and Voucher Instrument and potentially the *Australian Hearing Services (Declared Hearing Services) Determination 2019*. Depending on the scale of changes required, sufficient time would be required to not only have the matters addressed by Parliament but also to implement the new arrangements in a manner that would allow the Department of Health, providers and software vendors to amend policy documentation, processes and systems and to inform people with hearing loss of any changes to the available care and support.

Improved service planning and coordination

There are a number of hearing service and support programs available to eligible Australians (Voucher, CSO, NDIS, DSS) and it can be confusing for clients trying to navigate their way through the system to find the right services for their needs.

The Deafness Forum of Australia reported that:

There is a lot of confusion about the various programs, how to access them and what supports will be provided. This includes not only the HSP and the NDIS but also the Employment Assistance Fund and state and territory health and education services and the aged care system. The referral pathways, eligibility arrangements and the services and devices provided are different for each Program and people could miss out on the services and supports they need because it's too complicated to navigate the different systems or just

too hard to understand the various programs and how they might help particularly for those with low health literacy or from culturally and linguistically diverse backgrounds. There needs to be improved advice and information for consumers, more streamlined access pathways and more communication between Programs regarding individual clients.(23)

Clients would benefit from greater transparency about the services they can access, the eligibility thresholds, the providers and the costs and quality of their services, and any other consumer costs. Recommendation 6(a) has proposed the development and publication of a range of illustrative pathways on the Program's website that clearly show the options for clients who are eligible for hearing services, as well as providing advice to non-eligible people to help them manage their hearing loss.

The Hearing Services Portal

The introduction of the current portal significantly improved the administration of the Program, including by reducing wait times for clients to obtain a voucher, and supporting providers to more effectively engage with the portal. It is recognised positively by both providers and manufacturers, however there are areas for improvement.

Providers' experiences with the portal and the Department's use of it as a data source could be further improved with consideration of the following matters:

- Providers have to manage an array of patient management systems to engage with the Program, including Medicare Claiming Systems, HICAPs, patient records management and the portal system for program clients and claiming.
- While consumers can access their records under consumer and program legislation and policies, consumer choice would be enhanced by allowing clients to obtain a copy of their audiogram and other critical assessment information and being able to access their own information in the portal.
- The portal could be expanded to improve provider interaction with the Program and to improve administration of the Program through integration of other program administration functions such as accreditation and revalidations, which are all currently managed offline. The portal could also play a greater role in preventing invalid claiming by strengthened claiming rules and informing audit and compliance activity.
- The portal could be used and greatly expanded to improve the collection of qualitative and quantitative data for outcomes measurement, and support improved data collection and analysis of the Program – provided each information item was justified given the cost to industry of capturing and supplying data.

Program monitoring of Provider compliance

Clutterbucks noted the need to move towards outcomes based compliance monitoring such as monitoring poor treatment effectiveness, rather than simply monitoring compliance with the contract.(62)

Several submissions noted the need for clearer guidance on program requirements to allow providers to fulfil compliance requirements, for example:

...Provide greater protection and policing of the regulations: firstly, to ensure consumers are provided with the appropriate information regarding the services available to them; and, secondly, to prevent providers from taking unfair advantage of the system with inappropriate claims and behaviours as outlined in the 2017 ACCC report on the audiology industry; practices which continue to this day.(87)

Independent Audiologists Australia raised concerns that enquiries were sometimes answered with rote responses without interpretation, which left the provider having to determine how to interpret the Hearing Services Program requirements. This was of particular concern as there were punitive consequences if the providers failed to comply.(55) DVA noted they had a strong relationship with the Department of Health, however they:

...found it difficult to report on and manage audit and potential compliance issues related to hearing service requests and complaints to DVA.(51)

Impact of reforms to Program design on the demand for, and costs of, hearing services

The design of the Program, including the eligibility criteria, the services provided, how contracts are established and monitored, what and how outcomes are measured, and any program evaluation, can impact the demand for hearing services and the expenditure on publicly funded services.

The primary driver of demand for hearing services is the number of older people in the population. The average age of Voucher clients is currently 78 years. Australia’s population is continuing to age and therefore, on that basis alone, the numbers and proportion of people with hearing loss is growing. The number of people with hearing impairment is expected to increase by 12 per cent to 4.88 million by 2030 (7). Compared to one in six Australians having some form of hearing loss in 2016, it is estimated that this figure will grow to one in four by 2050.(72)

As of 30 June 2020, over 1.07 million clients were registered in the program, with more than 90 per cent of Voucher clients aged 65 years and over. The growth in demand for services in the Voucher stream of the Program from 2015 to 2020 is shown in **Table 13** below, as seen by the number of new applications for vouchers.

Table 13: Vouchers issued 2015 to 2020

Financial year	New vouchers	Return Vouchers
2015-2016	106,018	218,779
2016-2017	108,136	227,227
2017-2018	110,501	201,193
2018-2019	109,519	227,049
2019-2020	121,143	265,277

Source: HSP data

The Office of Best Practice Regulation reports that Expenditure on the Voucher and CSO streams of the program in 2019-20 represented approximately 53.9 per cent of total hearing expenditure (other expenditure being on hospital admissions, pharmaceuticals, GP costs, other hearing aids, research, Cochlear implants and other professionals), and 6.36 per cent of total health expenditure.(128)

Historically, the total Hearing Services Program (administered) and Departmental expenditure (as reported in the yearly Department of Health Annual Reports) has grown at 2.5 times the growth in client numbers, with this growth reported in 2017 to be outstripping growth in broader health spending.(72)

As detailed in **Chapter 3**, the expected annual cost increases (based on 2019-20 expenditure) if the Australian Government accepts the recommendations of this report (aimed at improving equitable access for vulnerable Australians) would be:

- Annual cost increase for expanding eligibility to low income earners: An expenditure increase increasing from \$5,153,700 to \$8,269,600 p.a. from FY 2021/22 to FY 2024/25. By FY 2024/25 the annual nominal increase in expenditure would represent a 0.3 per cent increase compared to FY 2019/20.
- Annual cost increase for expanding eligibility to Aboriginal and/or Torres Strait Islander people aged 25-49 years: An expenditure increase increasing from \$21,341.9 p.a. to \$33,907.9 from FY 2021/22 to FY 2024/25. By FY 2024/25 the annual nominal increase in expenditure would represent a 1.22 per cent increase compared to FY 2019/20.

These above changes would be the biggest source of cost increases. Other less significant expenditure increases are expected to arise from the removal of various barriers which currently inhibit people from accessing services, as proposed in Chapters 4 and 5. The *Roadmap for hearing health* awareness campaign is another example where there may be an increase in the uptake of program services as older people take the opportunity to have their hearing assessed and if eligible, access services to address any hearing loss issues. Each initiative will also bring even greater benefits, though not directly in terms of offsetting Australian Government revenue.

Program expenditure savings may arise, however, such as where a greater investment in rehabilitation services is more than offset by savings in the fitting and supply of devices which are subsequently discarded or underutilised. Further there would again be flow on benefits to the people with hearing loss, their communication network, workplaces and broader community.

The following sections expand on how the Program can improve what data are collected and analysed to more effectively monitor the program as its reach expands, and the corresponding outcomes from the reforms Improving Program data collection and analysis

Hearing data collection and analysis

Administrative data collected by any program can be a rich source of evidence from which to understand the state of the relevant sector to inform policy development(17), to design and administer programs and to monitor and evaluate the effectiveness of government interventions. The current collection and analysis of data under the Hearing Services Program has not kept pace

with accepted standards such as the Australian Institute of Health and Welfare's (AIHW) metadata online registry (METeOR)(129). Having basic metadata on the information that is collected is essential if the aim is to make program data more transparent and accessible to both internal and external stakeholders.

Client record

Providers are required by their contracts to have client records (classified as a Commonwealth Record according to the legislation). Providers upload to the portal details about the client's program eligibility, hearing history, assessments, average hearing loss at the low to mid tone frequencies for each ear, audiograms, progress notes, any hearing aid device prescription and all claims made. No allowance is made for clients who have better than normal hearing, have a 'no response' to the hearing test or have hearing loss at higher frequencies. This information is not uploaded by the provider onto the client's electronic My Health Record, should they have one.

While there is little information sharing between providers, most transfer their client record in the event of any transfer of clinical care, subject to the client's consent. The Hearing Services Portal registers the different provider number so that it is visible in each portal client record when they change provider and who the new provider is.

Departmental use of data

The Hearing Services Program releases de-identified program statistics and information through the website and periodically responds to data requests from the sector, as governed by the terms of relevant legislation.(17) Published data mostly relates to outputs such as vouchers issued, number of hearing assessments or hearing aid devices fitted. Hearing Australia provides CSO stream data to the Department each quarter. This comprises data on client numbers, client sex, and the number and type of services accessed for that time period (for example outreach or non-outreach).

The Department accesses provider and practitioner information and claiming data to support risk based compliance monitoring. Compliance data analytics examine variances in claiming patterns outside the Hearing Services Program average, including rates of partially subsidised hearing aid device fitting, client reviews and MHLT fittings, as well as costs to client.

In all data sharing activities and eligibility checking, the Department follows the Privacy Act (1988) and other cross-government data provisions, some of which are discussed further in the Governance of a national data service section in this chapter. The limitations of the Department's data collection are that it can only report on basic demographics and claims for service items described above, but is not able to report on client outcomes, effectiveness of interventions or the quality of the clinical care.(62) Most of the data collected under the Voucher stream does not indicate how the intervention has affected the client. Information on the type and effectiveness of audiological hearing rehabilitation provided to clients is difficult to attain as rehabilitation services are often provided as part of a claim for a service that bundles the fitting, follow-up and rehabilitation services together (as discussed in **Chapter 4**).

Information on the costs to business for service delivery in terms of transport, workforce, capital and equipment costs and the supply cost of hearing aid devices is not provided to the Department by

either Service Providers or Manufacturers who participate in the Hearing Services Program. There is no current information on the hearing workforce capacity or the time taken to deliver hearing services. That is collected in some form and analysed by professional organisations such as Audiology Australia. The Department's health workforce area tracks and reports on more broad health workforce data, but not specifically that linked to the Program.

A more strategic and comprehensive collection and analysis of client-centred administrative and clinical information, including their hearing impairments, their experience and their satisfaction within the program is a necessary part of continual improvement of the Hearing Services Program into the future.

Prevalence data

Data about hearing and the prevalence of hearing loss in the general community is a critical input into Government decision-making, especially in relation to forecasting and funding, identifying groups at risk of hearing loss for targeted outreach and developing public educational campaigns about hearing loss and protecting hearing.(74,121)

The Hearing Services Program does not collect data on the prevalence of hearing loss or other hearing health issues. This was identified as a research gap in the *Roadmap for Hearing Health* (2019) and is one of the activities funded by the 2020 Australian Government Budget. NHMRC is being funded \$7.3 million to undertake research into various issues, including the prevalence of hearing loss. This will go some way to address this data gap.

The Hearing Services Program does not link client service items or demographic data with other data sources such as Medicare, the Pharmaceutical Benefits Scheme, Aged Care, DVA or the NDIS and hence little information is known to the program about a consumer's non-hearing health status.

Any data associated with or collected through the Hearing Services Program should continue to be held by the Department of Health, as the Hearing Services Program owner(51,58) but should be shared with other relevant agencies, industry and researchers under strict privacy and relevance protocols. As discussed later in this chapter, information on Program performance and outcomes should also be publicly available in the interests of transparency and accountability and to guide reform.

Data arising from Program administration

The publication of outcomes and satisfaction with a program are commonplace, with examples being the MyHospitals website(130) and AIHW primary health network data publications.(131)

As Hickson argues, data on outcomes should be made available to providers and published to inform consumer choice.(58)

The outcomes data should be collected and held by the government department that funds the program and the data should be made available to providers and published to inform consumer choice. Such publication of outcomes and satisfaction with a program are common place in other sectors eg the Quality Indicators for Teaching and Learning for higher education(132)

Various submissions provided suggestions about the type of program data that can be published for different population groups, and why.

Voucher stream

Submissions suggested the Hearing Services Program report on and benchmark data including but not limited to:

- the number of services provided in each category on a year-on-year basis;
- the total number and breakdown of hearing aid devices provided;
- individual claim items (to provide further clarity of the services being received); and
- Hearing Rehabilitation Outcome statistics (reported by service provider) to help demonstrate the quality of services being provided and to guide the Australian public in their choice of provider.

Specsavers felt that by using population demography this data will allow for the modelling of prevalence and future requirements for the provision hearing services across the community.(87)

The Department of Veteran Affairs recommended that there be more formal, quarterly reporting on the Voucher Stream (similar to Hearing Australia reporting on the CSO stream). In addition, more granular or in depth data would be useful for policy, program and service delivery. Examples could include the numbers of veterans receiving services, their location and the number of hearing aid devices provided. The Department considered that this would show trends about the impact of prevention activities and better hearing protection.(51)

Cochlear Australia, Australia's branch of a global company that invests more than \$160 million a year in research and development of implantable devices(133), suggested publishing data on the referral of program clients for specialist hearing services under *Australian Hearing Services (Declared Hearing Services) Determination 2019* to support analysis of the effectiveness and timeliness of summing potential sensorineural hearing loss (S-P SNHL) diagnosis.(57) All Contracted Service Providers are under an obligation to notify the Department of Health if they believe a voucher holder client is eligible for specialist hearing services, which includes those with S-P SNHL (*s 50 Hearing Services Program (Voucher) Instrument 2019*). This should provide a starting point for understanding and tracking the treatment pathway of consumers with S-P SNHL through the program. This may be difficult to implement, but, as a minimum, Cochlear Australia argued that the Department of Health should be publishing data about the notifications.

Data on the hearing health of infants and children

Several submissions referred to the co-existence of two systems for children: a jurisdictional Universal Newborn Hearing Screening Program and the Hearing Service Program. The Australasian Newborn Hearing Screening Committee reports that these two systems operate entirely independent of each other regarding data management and client tracking.(134)

A range of stakeholders considered that a national database would be beneficial for clients, providers and the Department of Health. The Deafness Forum of Australia, Hearing Australia and

the Australasian Newborn Hearing Screening Committee strongly advocated for a national approach to data collection and management about hearing screening and hearing service delivery to infants and young children.(23,54,134) The Deafness Forum of Australia and the Royal Institute for Deaf and Blind Children added that more information on the outcomes for children should include longer term outcomes such as the level of educational attainment and employment. (23,53)

Effective strategies for data sharing would be a part of the discussion on a national database and/or data service. In particular, there is an opportunity to consider creating a common identifier for children within the data management systems of Universal Newborn Screening programs, the Hearing Service Program and the NDIS. Such a development has the potential to reduce the need for duplicate records about children across the various systems and programs.(53) In order to effectively measure outcomes, Deafness Forum of Australia proposes that information needs to come from a range of sources including Health, Education and the NDIS.(23)

The Australasian Newborn Hearing Screening Committee advocates that this national database includes data on permanent childhood hearing impairment, so Australia can have data on severity, aetiology, age of onset and manner of detection collected across every state, territory or health region of Australia.(134)

Hearing Australia also supports a national database, reporting that it would help monitor the effectiveness of programs and ensure that no children fall through the gaps between screening, diagnosis, hearing rehabilitation and early childhood early intervention programs.(54)

First Voice advocated that data be collected 'end-to-end' for the system, from universal newborn hearing screening through to engagement with specialist early intervention. These data could be standardised and publicly reported, with a custodian responsible for the collection of that data (to enable transparency and to measure the effectiveness and efficacy of the system).(77)

Such a database exists in the United States, being collated and reported by the Centres for Disease Control and Prevention (CDC) with 45 states contributing.(135) In Australia, the Longitudinal Outcomes of Children with Hearing Impairment (LOCHI) study is a population-based longitudinal study that is evaluating the development of a group of Australian children with hearing loss as they grow up. This study includes children whose hearing loss was diagnosed through either Universal Newborn Hearing Screening (UNHS), or standard care; and all of whom access the same post-diagnostic services provided by Australian Hearing.

The Expert Panel considers that the LOCHI study has demonstrated the value of accessing national level data to conduct population-based research into hearing loss and outcomes.(136) The Panel considers that, without a national database of children screened (newborn and through other universal early childhood developmental screening), it is not possible to know if there are children and families in need who do not receive a service.

Integrated and national ear health checks of children could contribute to such a national database. Cochlear Australia, First Voice and Telethon Speech and Hearing suggested different approaches to such screening activities across a range of ages, for example:

- Those aged 0-6 years and in particular those from Aboriginal and/or Torres Strait Islander communities have regular ear health checks and the results of these checks are recorded in a national database with the objective of no child ‘slipping through the cracks’.(57)
- Expanding the Hearing Services Program to deliver a national screening program for children 4-7 years of age.(57,77,137)

Data on the hearing health of Aboriginal and Torres Strait Islander people

The *National Agreement on Closing the Gap*(138) demonstrates a commitment from all levels of governments to changing the way policies and programs affecting Aboriginal and/or Torres Strait Islander people are developed and delivered. Shared decision making between Aboriginal and/or Torres Strait Islander people and government, strengthening the community-controlled sector, improving mainstream institutions, and improving data collection and access to Aboriginal and/or Torres Strait Islander data are the priority reforms that underpin the agreement.(33)

The Expert Panel considers that the Australian Government should ensure that Program data captures those who identify as Aboriginal and/or Torres Strait Islander so that data can be available to provide a greater understanding of hearing health and hearing needs, and to supplement data from other hearing programs that are specifically provided to this population group. In this respect, the Aboriginal Community Controlled Health Sector may also have hearing health data that would complement the data drawn from the Program.

Measuring, monitoring and evaluating Program outcomes

Consistent with this Review’s scope, and as the preceding sections of this chapter allude, the heart of the consumer experience should be an affirmation that service providers understand the person and their communication and related needs, respond to that person and deliver services that produce outcomes specific to their needs. Stakeholders have been clear that measuring client outcomes is a priority issue.

Currently there are no national guidelines in Australia on the client outcome measures that should be used, when, how, why or for which populations, under the Program. Numerous submissions expressed the view that monitoring and evaluation are hindered by the lack of clear measurable program and client outcomes.(23–25,53–56,62) An additional observation was made by one stakeholder that the Program has a transaction-level view of the type and number of services delivered, and as such it can only assume that these transactions will reduce the burden of disease.(62) Another argued that collecting and using client outcome data is important to ensure client satisfaction and to continually improve the client’s journey within the Hearing Services Program, regardless of whether or not they are supplied and fitted with a hearing device.(23)

The 2017 PwC review highlighted the need for the Program to transition to an outcomes focused model of care, and proposed that the hearing industry take the lead on this action.(72)

The Department of Veterans Affairs noted in its submission that some Veterans described their hearing needs as not being fully met through the Program. In this respect the DVA observed:

It is difficult to determine whether consumers are appropriately advised given the limited availability of reportable outcomes. The ability to report on the advice provided by hearing providers to clients would likely improve the consistency of outcomes.(51)

Domains for Measuring Program Outcomes

The need for clear and measurable outcomes for the Hearing Services Program was highlighted in a recent project by the National Acoustic Laboratories (NAL) *Defining Outcomes for the Hearing Services Program* (2020), conducted on behalf of the Department of Health. NAL consulted with key stakeholders to define which standardised client-centred outcome measures should be used by the Program as well as when and how.(139)

Chapter 2 of this report sets out the Expert Panel's views on an appropriate set of objectives for the Hearing Services Program. First and foremost are objectives relating to people with hearing loss who are eligible for services under the Program. Several objectives address quality of life issues such as being able to exercise informed choice and control over how to live with hearing loss, how to address communication needs and how to be supported in social and economic participation.

The *Defining Outcomes for the Hearing Services Program* identified the following domains which have a bearing on quality of life when living with hearing loss and addressing communication needs:

- Communication ability: including communication with other people in general, communication specifically with family members, and communication in group situations.
- Well-being: the presence of positive emotions and moods, the absence of negative emotions, satisfaction with life, fulfilment and positive functioning'.
- Personal relationships: the interpersonal interactions that people have, and the relationships that they develop as a result of those interactions.
- Reduction in participation restrictions: including in social, vocational, and recreational activities.(139)

Several other Program objectives focus on the Hearing Services Program's clinical outcomes delivered through rehabilitation services and the supply and fitting of hearing aid devices and other support. The objectives for people with hearing loss include having equitable access to services, being engaged in the planning, assessment, selection and delivery of Program services and being able to exercise choice and control over the selection of service providers. Objectives for providers and professionals include reference to them always acting in the best interests of the clients, providing culturally appropriate services and meeting all Program and professional standards and requirements.

Appropriate domains could include:

- achievement of the client's desired communication outcomes;
- provision of hearing aid device technology that was, or was not, fit for purpose;
- maintenance of clinical gains over time;

- client satisfaction with the quality of service provision, including the cultural appropriateness of the care and support provided; and
- provider and professional workforce compliance with all contractual and professional requirements and standards.

Tools to measure client outcomes

It is essential to have appropriate and sensitive outcome measures that are relevant to the areas of hearing health need. As noted in the NAL (2020) report:

These are not only helpful but are essential to both measuring an individual's progress towards desired goals as well as evaluating the overall effectiveness of audiology services and providers of hearing healthcare.(139)

The NAL report further reported on the current problem of the large number of tools which are available for a variety of outcomes, but them not being standardised for use across Australia:

The evidence is clear that auditory rehabilitation research lacks a single or even a few outcome measures that are widely used and accepted as being gold standard instruments. Furthermore, even though there is a large number and variety of measures out there, clinical trials of adult auditory rehabilitation interventions have overlooked outcomes such as adverse effects and quality of care that may be important to key stakeholders, especially patients, hearing healthcare professionals and commissioners of hearing healthcare.(139)

Other suggestions for improving data on outcomes include the mandatory use of tools such as the Client Oriented Scale of Improvement (COSI) at assessment, follow-up and annual reviews. The COSI is a clinical tool developed by NAL for outcomes measurement. It is a validated subjective assessment questionnaire for clinicians to use which allows them to document their client's goals/needs and measures subjective improvements in hearing ability.(140)

The COSI is useful for adult clients but is not appropriate for capturing the goals and needs of children, which are likely to be much more diverse than those of adults. (The COSI has scales that use the terms "Degree of Change" and "Final Ability", for example). The Client Oriented Scale of Improvement for Children (COSI-C) has been designed to try to incorporate the basic design of the COSI with some changes to make it more suitable to use with children.

Identifying, defining and testing measures for hearing clinical outcomes and quality of life outcomes could be a research priority, and is captured as such in **Chapter 7 Research**, so that Australia can have a set of standardised measures which are used and reported against across the country.

The perception of the industry is that layers of modifications over years appears to have obscured the original intent of many program rules, and the intended outcomes may no longer be relevant to contemporary practice. Independent Audiologists Australia submitted the following examples of decisions which, in their view, are not being driven by data:

...ongoing and unexplained requirements to use tools that are not underpinned with evidence, for example the Wishes and Needs Tool (WANT) but at the same time the guidelines for providers ask that interventions are evidence-based; and

...introduction of the rehabilitation plus service item that is restricted to new clients who have had their first hearing aid fitting which signals a focus on a hearing aid device distribution model rather than a person-centred audiological rehabilitation model.(55)

Designing a formal program evaluation could be the focus of a commissioned research activity, as discussed in **Chapter 7 Research**. An initial internal evaluation could be undertaken two years from the conclusion of this review, with a more formal evaluation five years after that date. Outcome measures and tools designed in the next few years could contribute to the evaluation.

Given the important role that administrative data play in understanding the hearing health sector, informing policy development and designing and evaluating programs, the current program data collection is manifestly inadequate. The Expert Panel considers that program outcome measures need to be more focussed on the clients' quality of living with hearing loss, achievement of communication goals and participation in social and economic endeavours rather than be focussed on transactional activity. The measures should include the collection of data on the effectiveness, quality and appropriateness of the provision of services by providers and by the professional workforce. Additionally, linking client data with other data sources such as Medicare, the Pharmaceutical Benefits Scheme, Aged Care, DVA, and the NDIS (subject to privacy considerations) was described by one stakeholder as a means of creating a fuller picture of participants' health status.(121)

Establishing a national hearing health data service

The Department of Veterans Affairs has argued that the current provision of annual or ad hoc data on hearing loss and hearing health has limitations in terms of understanding the hearing needs and concerns of various cohorts.(51) The *Roadmap for Hearing Health* (2019) identified numerous data and information priorities including the need for greater maturity of systems to collect national data. One of the objectives contained in the NAL study into outcomes measurement is: *'to identify mechanisms and systems for reporting of outcomes, and scope the potential for a national outcomes database'* and it subsequently recommended that an independent body be responsible for such a venture.(139)

To make progress on these priorities and help inform future decision-making there is an opportunity to establish a national hearing health data service. Hearing Australia has proposed that such a service should have the following goals:

- provide more clarity regarding the right/licence to use client data such that the data collection remains customer focused, secure and consistent with Australian Privacy Principles;
- improve data management and client tracking;
- establish a robust open data framework that encourages innovation;
- publish Australia's hearing health indicators on a more real-time basis so that citizens, organisations and policy makers can make better decisions; and
- leverage Artificial Intelligence to support evidence-based Public Health Policy decision-making.(54)

Good data governance would be critical to the success of this venture, to ensure safe data practices. The Department of the Prime Minister and Cabinet, in its 2020 guide *Trust in Government Data Use* describes the key elements of good data governance, examples of which are described below for its Framework comprising people, policies, process and products:

- **People:** good leadership and clarity of roles; possibly involving a data ethics panel or committee;
- **Policies:** Guidance about data responsibilities under whole of government and agency specific legislation;
- **Process:** Comprehensive decision support through complete and consistent processes; privacy by design embedded in data initiatives; and
- **Products:** Data collection and use statements should be clear and accessible; Catalogue of official data collections (e.g. scope, coverage, quality, and custodian).(141)

Another relevant key Australian Government resource is the Australian Data and Digital Council's *State of the Data and Digital Nation: An overview of data and digital government initiatives across the nation.*(142)

Telethon Speech and Hearing, First Voice and Cochlear proposed that the Hearing Services Program consider screening programs at certain life-cycle intervals e.g. for those turning 60 years of age, and capturing the results in a national database.

A national hearing health data service would provide a data repository not only for the agencies involved, but also for the Australian Institute of Health and Welfare in their reports on Australia's health, and also for other research projects (for example, the Murdoch Children's Research Institute's Generation Victoria.(143)). It would not be just a repository, but would also allow data linkage and provide a base for data on Program performance and outcomes.

Recommendations

16. A national data service

The Australian, State and Territory Governments should commission a feasibility study into the development of a national digital database of hearing screening of infants and children, recognising that the responsibility for universal newborn hearing screening and screening at any other age such as prior to starting school, lies with State and Territory Governments.

17. Program monitoring and evaluation

17(a) The Australian Government should develop and invest in a Data Plan for the Hearing Services Program that aims to support the monitoring of the Program's achievements of its objectives (as described in Chapter 2). The Data Plan should address:

- improving client clinical outcome measurement (hearing and non-hearing);
- qualitative and quantitative program outcome measurement, including client satisfaction measures;

- better use of the Hearing Service Portal to capture and analyse data; and
- ensuring clients can access their audiological records and assessment reports.

17(b) The Australian Government should undertake an internal Preliminary evaluation of the Program in two years, drawing on the improved data availability and measurement tools and a major external evaluation in five years.

CHAPTER 7 – HEARING HEALTH AND HEARING LOSS RESEARCH

Key Points

- The *2019 Roadmap for Hearing Health* and various Parliamentary inquiries have provided suggestions for future research.
- The Australian Government is supporting the *Roadmap* research recommendations through its \$7.3 million investment in research that will improve evidence to support better hearing outcomes. This research may include, but will not be limited to:
 - determining if population-based screening is appropriate and identifying intervention options;
 - identifying suitable methods to accurately measure the prevalence and severity of hearing loss in the Australian community; and
 - assessing the incidence of balance disorders.
- Other current research gaps include:
 - evaluating the benefit, satisfaction and cost effectiveness of interventions and hearing aid devices for hearing loss;
 - the relationship between risky behaviours and noise induced hearing loss and the design of effective hearing health and hearing loss prevention campaigns;
 - the relationship between ageing and hearing loss;
 - patterns of comorbidity associated with hearing loss;
 - preventing hearing loss caused by ototoxic substances; and
 - measuring and mitigating health, social and economic effects of hearing loss.
- This Review revealed research opportunities including:
 - the need for a more strategic approach to planning for research, including developing a Research Strategy;
 - researching service delivery models;
 - researching clinical and program outcomes and their measurement tools; and
 - program evaluation research.

As part of its remit, the Program supports research and prevention activities in relation to hearing health and hearing loss. Therefore the Expert Panel has considered the research component of the Program as being within the terms of reference for this Review.

Over the past two decades, there has been research into hearing health interventions, technological advances in hearing aid devices and several parliamentary inquiries or reviews with recommendations on how to improve Australia's assistance to people with hearing loss, and how to prevent hearing loss.⁽³⁵⁾ Research has been seen as being able to make an important contribution to these improvements.

The Parliamentary review *Still Waiting to be Heard* highlighted several key areas for hearing research including:

- longitudinal research on adults undergoing treatment for hearing impairment;
- Aboriginal and/or Torres Strait Islander hearing health issues;
- prioritisation on balance disorders and treatments; and
- genetic stem cell based treatments for hearing impairment.(35)

The 2019 *Roadmap for Hearing Health* outlined numerous opportunities for research across its six domains, with input from a broad range of stakeholders across the sector.(3) However, despite a growing international research effort into hearing loss and hearing aid devices, there are still critical knowledge gaps that exist in hearing health.

The remainder of this Chapter is divided into two parts:

- Existing research priorities: what research is happening now?
- Research gaps: What opportunities are there to improve the hearing health evidence base?

Existing research priorities: what research is being undertaken

National Acoustic Laboratories (NAL)

NAL is the research arm of Hearing Australia. Research undertaken by NAL is governed by the *Australian Hearing Services Act 1991*. Section 8 of this Act outlines the scope of research to be undertaken including assessment of hearing, hearing aids and fitting procedures, hearing rehabilitation, hearing loss preventions, the effects of noise on the community, the design and development of hearing services and the development of standards in relation to noise levels in the community.

NAL is funded under a Memorandum of Agreement (MOA) with the Department of Health for research and development activities that contribute to the development of improved policies and service delivery and better identify the needs of the community in relation to hearing loss. It also coordinates research and development projects with other parties and conducts commercially funded research.

Approximately \$4.5 million is paid annually to Hearing Australia under the MOU for baseline administration and research funding. In FY 2019/20, this was increased to \$10.7 million to cover extra projects on the costs of maintaining cochlear speech processors and research on the eligibility criteria for the Hearing Service Program.

Hearing Australia's 2019-20 Annual Report highlighted NAL's research activities for that reporting period as:

- six of the 17 projects initiated in FY 2019/20 were focused on the hearing health of Aboriginal and/or Torres Strait Islander peoples;

- the start of Wave 3 of the Longitudinal Outcomes for Children with Hearing Impairment (LOCHI) project that runs for five years, tracking the benefit of early intervention with hearing aids and cochlear implants for language ability to age 16 years;
- the completion of a behavioural insight project to help clients make better decisions about hearing health;
- several projects involving the development of tele-audiology tools and assessment of tele-audiology service outcomes; and
- report to the Department of Health on the state of hearing health care in Australia and recommendations for a hearing awareness campaign.(144)

NAL's research into hearing loss in Aboriginal and Torres Strait Islander people

Examples of some recent research into hearing loss and the prevention of hearing loss in Aboriginal and Torres Strait Islander people are described below.

- Developing and validating screening tools that can be used by primary health workers and early educators for detecting and identifying potential hearing and communication difficulties in Aboriginal and Torres Strait Islander children aged from birth to five years - the Parent-evaluated Listening & Understanding Measure (PLUM) and Hear and Talk Scale (HATS) for Aboriginal & Torres Strait Islander children aged from birth to five years.
- Investigating hearing loss and spatial processing disorder (defined as no measurable hearing loss but diminished ability to use location cues for listening in noise) in Aboriginal and Torres Strait Islander young people in youth justice centres and any associations these findings have with self-reported hearing difficulties, and general ear and hearing health.
- Developing an evidence base on the current knowledge about the effectiveness of early intervention and the effect of the timing of intervention on outcomes of young children with chronic otitis media and associated hearing problems, with a special interest on Aboriginal and Torres Strait Islander children.

The Longitudinal Outcomes of Children with Hearing Impairment Study (LOCHI study)(145)

NAL is overseeing the LOCHI study, a population-based longitudinal study that prospectively evaluates the development of a cohort of about 450 Australian children with hearing loss as they grow up. It commenced in 2005 and was the first study of its type in the world to provide evidence of the lifelong benefits from early treatment of hearing impairment with cochlear implants or hearing aids. To date the Australian Government has invested about \$7 million into the study.

The LOCHI study is unique in its inclusion of children whose hearing loss was diagnosed through either Universal Newborn Hearing Screening (UNHS), or standard care; and all of whom access the same post-diagnostic services provided by the national audiological service provider, Hearing Australia. The consistency of audiological services means that their results can be fairly compared, regardless of when and where their hearing loss was discovered.

The three study phases address the following research questions:

1. Does UNHS and early intervention improve the outcomes of children with hearing loss at a population level?
2. What factors influence the outcomes of children with hearing loss?
3. Can early performance predict later outcomes of children with hearing loss?

Phases 1 and 2 of the study were supported by the US National Institutes of Health and the HEARing CRC. The Australian Government funding for the HEARing CRC ceased on 30 June 2019.

LOCHI Phase 3 will measure outcomes for the study cohort after they turn 16 years of age. By tracking development of the children over a 20 year period, the LOCHI study will provide evidence on the long-term effectiveness of early intervention, and the cost-effectiveness of UNHS and early intervention for improving outcomes of children with hearing loss. The effectiveness and cost-effectiveness will be quantified through data measured across the longest span of a person's life ever measured for this kind of study.

The Expert Panel supports the Government continuing to fund this important project so that the benefits of the Universal Newborn Hearing Screening system can be evaluated across a person's lifetime.

National Health and Medical Research Council (NHMRC)

NHMRC provides funding for research through a competitive, investigator initiated grant system, with a transparent peer-review process to determine how funding is allocated. It also oversees Targeted Calls for Research – one off grant opportunities designed to stimulate research or build research capacity in a particular area of health and medical science. Research funding made available through the NHMRC is governed by the *National Health and Medical Research Council Act 1992*.

The Medical Research Future Fund (MRFF)

The MRFF is an ongoing research fund set up by the Australian Government in 2015. Whilst hearing health specifically is not listed as a priority in the MRFF Strategy for 2020-2022, it is relevant to other priorities that have initiatives underway including:

- **Aboriginal and/or Torres Strait Islander health** e.g. the Indigenous Health Research Fund, investing in Indigenous-led research tackling health issues facing Aboriginal and/or Torres Strait Islander people;
- **ageing and aged care** e.g. the Dementia, Ageing and Aged Care Mission aims to support older Australians to maintain their health and quality of life as they age, live independently for longer, and access quality care when they need it;
- **primary care** e.g. The Primary Health Care Research initiative will increase Australia's evidence base in primary health care through research to improve service delivery and patient outcomes;

- **comparing the value of different health interventions** e.g. the Clinical Trials Activity and Clinician Researchers initiatives;
- **testing public health interventions to reduce chronic disease** e.g. the Preventive and Public Health Research initiative; and
- **digital health tools** and supporting Australian biomedical and medical device development.

Roadmap for Hearing Health research initiative

The Australian Government is supporting the *Roadmap for Hearing Health* research recommendations through its \$7.3 million investment in research that will improve evidence for treatment, service delivery and the prevention of hearing loss. It will be led by the NHMRC and seeks to improve the lives of Australians at-risk, or impacted, by hearing loss as well as enhancing the hearing sector's capacity to deliver improved hearing outcomes.

At the time of writing this report, the research will include:

- determining if population-based screening is appropriate and identifying intervention options;
- identifying suitable methods to accurately measure the prevalence and severity of hearing loss in the Australian community; and
- researching the incidence of balance disorders.

Stakeholder consultation to inform this *Roadmap* research activity revealed the following options to enhance current research, including:

- encouraging a national strategy to integrating ear health checks in the first years of life;
- developing therapeutic treatments for hearing loss, to improve outcomes for hearing loss patients who use devices to assist hearing;
- hearing health surveys to inform key issues including developing a national database on hearing loss, facilitating standardised national reporting of hearing loss and supporting the current national set of key performance indicators for Aboriginal and Torres Strait Islander ear and hearing health;
- research around hearing loss prevention; and
- prevention of otitis media in Aboriginal and/or Torres Strait Islander children.

The Expert Panel notes that a number of academics in Australia are also engaged in conducting research into hearing loss and related matters. The Panel wishes to acknowledge the contribution that several academics have made to this review, either directly or through having published papers and contributed to reports which the Panel has drawn on.

Research gaps: opportunities to improve the hearing health evidence base

The Departmental website on Hearing Health Research states that gaps in the evidence base include, but are not limited to:

- accurate, descriptive and predictive models of hearing loss incidence, prevalence and impacts;
- an understanding of the relationship between ageing and hearing loss;
- an understanding of the stigma associated with hearing loss and mental health and wellbeing;
- an understanding of patterns of comorbidity associated with hearing loss;
- investigating the relationship between ototoxic substances and hearing impairment and the implications for preventing hearing loss;
- an understanding of the relationship between risky behaviours and noise induced hearing loss and the design of effective hearing health and hearing loss prevention campaigns;
- a mechanism to effectively measure and mitigate health, social and economic effects of hearing loss; and
- an evaluation of benefit, satisfaction and cost effectiveness of interventions and hearing aid devices for hearing loss.(146)

Other evidence, including submissions to this review identified several opportunities for improving the evidence base that will augment the above activities currently underway. They are examined in the following sections.

Development of a Research Strategy

The research output over the last two decades has occurred in a somewhat ad hoc manner, at the instigation of individual hearing health researchers and in response to sector and parliamentary driven reports and inquiries. Technology for hearing aid devices has made significant advances and the understanding of client focussed hearing health care has expanded to encompass all aspects of a person's life.

The Department of Health is well placed as the funder of the Hearing Services Program, and with its MOA with Hearing Australia, to develop and ensure a more strategic approach to identifying research priorities and activities and to map the milestones to a specified time period.

The Expert Panel considers that there is a need to develop and publish a Research Strategy in consultation with hearing services stakeholders. The Strategy should be annually refreshed and then reviewed on a medium term cycle. An important principle for the Strategy should be that research should be co-designed with relevant population cohorts and they should be involved in the conduct of the research, its analysis and in the dissemination of research findings.

Development of a National Strategy on hearing loss prevention

The Hearing Health Sector Alliance recommended that a national strategy on hearing loss prevention be developed and its implementation funded. It could be a component of the National Preventative Health Strategy that is currently being developed by the Department of Health.(147) This broader strategy is being guided by an Expert Steering Committee composed of experts from across the public health, research, health promotion, medical, allied health and nursing fields.

In 2007-08, the Australian Government, through the Hearing Services Program, funded a four year prevention research program in response to a 2006 Access Economics report. Funded projects included research into prevention of hearing loss for children, including specific projects addressing prevention of hearing loss in Aboriginal and/or Torres Strait Islander children, and prevention of work-related hearing loss.(148) Whilst this research was seen as valuable, there is no evidence that it has translated into measurable outcomes.

Nonetheless, Hearing Australia is currently drafting a new national strategy to reduce preventable hearing loss, acknowledging that some 30-40 per cent of hearing loss is preventable and that certain high risk communities, especially Aboriginal and Torres Strait Islander children and workers in high risk industries, suffer unacceptable levels of avoidable hearing loss.

The Expert Panel understands that the Department is working in collaboration with Hearing Australia on this strategy and its implementation and should continue to do so.

Research on models of service delivery

Research is needed on models of service delivery to identify evidence based approaches for improving clients' communication capacity including through the effective and efficient delivery of rehabilitation services and the supply, fitting and support in the use of hearing aid devices.

Several submissions recommended a model of service delivery which differed from the current focus on supplying and fitting hearing aid devices. This alternative would incorporate a management or care program to meet the communication and psychosocial needs of a person with hearing loss at any stage of their hearing care journey.

Possible research topics could examine how a more psychosocial or holistic health model of hearing health care could deliver improved health outcomes and assess the economic benefit of such a model.

Submissions indicated that the Hearing Service Program should improve how it meets the clinical needs of those people with hearing loss who do not want a hearing aid. There also may be an opportunity to pilot a more aural rehabilitative service delivery model for this cohort, with practitioners to include trained counsellors. As noted in Chapter 4, Soundfair submitted a proposal to the Review which would entail a pilot study of a service delivery model based on a whole-person, person-centred hearing services.

As mentioned earlier in the report, there is also a need for services to be provided in a culturally sensitive manner for Aboriginal and/or Torres Strait Islander people and for people from culturally diverse backgrounds. The Expert Panel considers that research into improving hearing health outcomes for these groups should be co-designed with them.

Such research should strategically focus on improving the cultural sensitivity of service delivery, and study designs should be based on a true and culturally appropriate sustainable partnership which continues for the duration of the research and beyond. Translational research that supports mainstream services to be responsive to the needs of their local community – regardless of whether it is mainly comprised of Aboriginal and/or Torres Strait Islander people, people from culturally and linguistically diverse backgrounds or other groups of people - is also important.

Funding could be sourced through a MRFF grant (which has both primary care and Aboriginal and Torres Strait Islander health grants) or seeking a targeted research through NHMRC.

To contribute to an enriched data base for research into issues such as hearing loss and ageing, dementia and related topics, it is important to provide access to Hearing Service Program data by research organisations. These include tertiary institutions, private research organisations, NAL and AIHW.(25,53) Such access would also contribute to analysis that is critical for policy formulation and for the improvement of models of service delivery.

Examples of other potential research questions

Chapter 6 highlighted the lack of adequate data on clinical and program outcomes, and the need for improved outcome measurement. This would enable Australia to have a set of standardised measures which can be used and reported against across the country to further enable improved data collection, and in turn, improved program evaluation.

The 2017 Parliamentary inquiry recommended that the Hearing Service Program and the National Acoustic Laboratories (NAL) prioritise funding for research to focus, amongst other things, on “longitudinal research on the experiences of adults undergoing treatment for hearing impairment”.(35)

Research is required to identify the extent of any thin markets in hearing services to inform policymaking aimed at improving accessibility to services.(121) The examination of fundamental research questions such as ‘What are the barriers and facilitators to improving access to services in areas of thin markets?’ may go part way to developing a greater understanding of this issue.

The Royal Flying Doctors Service (RFDS) reported a research opportunity to explore how it could use its assets to effectively and efficiently deliver further services, including hearing services, on behalf of the Commonwealth to areas where small populations across large geographic areas make it unviable for permanent, local services to exist.(149)

The Expert panel notes that there are several channels for stimulating research:

- encouraging a more strategic approach to research. This should include prioritising research topics using the objectives of the Hearing Services Program and any guiding principles;
- direct commissioning of research through the Hearing Service Program, or through Hearing Australia/NAL;
- raising awareness of ideas for research so individual researchers follow up on their own grant applications through existent schemes offered by the NHMRC, MRFF and the Australian Research Council; and
- publishing a strategic Research Strategy which would address the clinical and program outcome data needs described earlier in this chapter.

Recommendations

18. Research strategy

18(a) The Australian Government should develop a Research Strategy in consultation with hearing services stakeholders and publish it on the Hearing Service Program website. A guiding principle should be to ensure co –design with each relevant population cohort, with research priorities to include the removal of barriers to access to services and to facilitate the cultural appropriateness of service delivery.

18(b) Research funded through the National Acoustics Laboratory also needs to have a more strategic approach, aligning with this broader Research Strategy.

19. The Longitudinal Outcomes of Children with Hearing Impairment Study

The Australian Government should continue to fund the National Acoustics Laboratory to conduct the Longitudinal Outcomes of Children with Hearing Impairment (LOCHI) Study.

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APPENDIX A – HISTORY OF REVIEWS RELATED TO THE HEARING SERVICES PROGRAM AND HEARING HEALTH

Date	Organisation	Title	Synopsis of report
February 2006	Access Economics	Listen Hear!: The Economic Impact and Cost of Hearing Loss in Australia: a Report.(1)	Quantified the impact of hearing loss on the Australian population. Further research was recommended for a number of hearing loss related issues.
April 2006	Attorney-General's Department	Work-related noise induced hearing loss in Australia, April 2006.(150)	Identified that over a million employees in Australia may be exposed to hazardous levels of noise at work (in the absence of hearing protection), and reported the average cost of a noise-induced deafness claim. The 2001-02 calculated cost to the economy was \$31 million. The report identified the main industries of concern, as well as the prevention and audit activities undertaken in Australia to reduce work-related noise induced hearing loss.
May 2010	Senate Community Affairs References Committee inquiry into Hearing Health	Hear Us: Inquiry into Hearing Health in Australia(151)	<p>The Committee undertook an inquiry that received 184 public submissions and heard evidence on nine occasions at cities across Australia. The final report made 34 recommendations for action by both Commonwealth and State Governments. The Commonwealth Government supported most the recommendations that were subject to Federal control.</p> <p>Key topics: Causes of hearing loss, Costs of hearing loss, Impact of hearing loss on people and community, Adequacy of access to services, Adequacy of research, Adequacy of education and awareness programs, Hearing issues in ATSI communities.</p>
December 2012	MP Consulting	Review of the efficiency and effectiveness of the regulatory framework for hearing services(152)	The review found that the existing framework is complex, burdensome and overly prescriptive, with over 100 ongoing obligations imposed on service providers along with 30 discrete prohibitions. 23 submissions supported the need to streamline and simplify the regulatory framework.
May 2014	The Australian National Audit Office (ANAO)	Delivery of the Hearing Community Service Obligation(153)	<p>ANAO examined the effectiveness of the Department of Health's and Australian Hearing's administration of the Community Service Obligations (CSO) program for hearing services.</p> <p>The ANAO found that there is scope for the Department of Health to develop a methodology, in consultation with Australian Hearing, to enable reporting of service targets funded by a 2011–12 Budget measure; and other outcomes for the CSO.</p>

Date	Organisation	Title	Synopsis of report
March 2017	Australian Competition & Consumer Commission (ACCC)	Issues around the sale of hearing aids(73)	<p>This reported on issues involved in the sale of hearing aids. ACCC surveyed consumers and industry about the nature and extent of consumer protections in the hearing clinic industry. Three key issues were identified:</p> <ul style="list-style-type: none"> • sales may be driven by commissions and other incentives rather than consumer need; • cost and performance of hearing aids; and • treatment of vulnerable customers. <p>The ACCC indicated concerns about business practices in the hearing services industry. Focus was on the sales-based arrangements for clinicians. The ACCC requested that the hearing industry review incentive programs and performance measures to ensure no conflict of interest.</p>
June 2017	Siggins Miller Consultants	Examination of Australian Government Indigenous Ear and Hearing Health initiatives(154)	<p>This report examined the systems, processes and effectiveness of the six Australian Government Indigenous Ear and Hearing initiatives, including the demand for services and unmet need. The consultants sought stakeholder advice about how the investments could be strengthened or improved.</p> <p>There were 31 recommendations, with the conclusion that despite significant Government investment, there was scant evidence of improved health outcomes, and the burden of disease was not declining significantly.</p>
September 2017	Pricewaterhouse Coopers (PwC)	Review of services and technology supply in the Hearing Services Program(72)	<p>The review findings and recommendations supported a whole of government approach to the provision of hearing services and assistive hearing technology (AHT).</p> <p>The review identified 12 major findings for the current service delivery model:</p> <ul style="list-style-type: none"> • more can be done to focus on client outcomes; • the current Minimum Hearing Loss Threshold, and measures do not align to international definitions; • the current level of funding for services contributes to a higher prevalence of cross-subsidisation; • a greater focus on rehabilitation and support is needed; • the flexibility of the service pathway needs to be improved; • there is a need to improve the quality of information made available to clients; • minimum specifications are fundamental to ensuring access to high quality AHT; • effectiveness of AHT schedules could be improved; • access and types of Alternate Listening Devices (ALDs) available under the Voucher stream should be broadened;

Date	Organisation	Title	Synopsis of report
			<ul style="list-style-type: none"> • validity of the partially subsidised schedule, and its role in the perceived upselling of AHT; • most government subsidised hearing services are limited to clients who acquire AHT through the Voucher stream; and • NDIS uncertainty around the implementation and impact. <p>The review identified a series of recommendations for the voucher stream based on these findings.</p>
September 2017	The House of Representatives Standing Committee on Health, Aged Care and Sport	Still waiting to be heard...(35)	<p>The Committee reviewed the current state of hearing health in Australia , including looking at:</p> <ul style="list-style-type: none"> • the prevalence of hearing impairment in Australia and the costs imposed both on individuals and on the broader Australian community; • the state of hearing health within at-risk population groups. In particular, the impacts of otitis media infections among Aboriginal and/or Torres Strait Islander children. In addition, issues related to access of services and treatment for people from culturally and linguistically diverse backgrounds, people living in rural and regional areas, and older Australians; • programs to encourage Australians, particularly young Australians, to take action to protect their hearing and to increase awareness of the benefits of seeking treatment for hearing loss; • sales practices within the hearing aid clinic industry, including the payment of commissions and incentives to clinicians to encourage the sale of hearing aids; and • the introduction of the NDIS and the impact this will have on the delivery of hearing services. <p>The Committee made 22 recommendations.</p>
September 2017	The Joint Standing Committee on the National Disability Insurance Scheme (NDIS)	Interim report from the Joint Standing Committee on the NDIS on the provision of hearing services under the NDIS(155)	<p>The terms of reference for the inquiry were to examine the provision of hearing services under the National Disability Insurance Scheme (NDIS), with particular reference to:</p> <ul style="list-style-type: none"> • eligibility criteria for determining access to, and service needs of, deaf and hearing impaired people under the NDIS; • delays in receiving services particularly early intervention services; adequacy of funding in NDIS; • accessibility of hearing services, (rural and remote areas); • the principle of choice of hearing service provider;











Date	Organisation	Title	Synopsis of report
			<ul style="list-style-type: none"> • liaise with key stakeholders in the design of NDIS hearing services, particularly in the development of reference packages; • investment in research and innovation in hearing services. • any other related matters. <p>The committee made six recommendations in the final report, released on 21 June 2018.</p>
June 2018	The Joint Standing Committee on the NDIS	Final report from the Joint Standing Committee on the NDIS on the provision of hearing services under the NDIS(156)	<p>The Committee made three recommendations to address fundamental issues within the NDIS in relation to the provision of hearing services:</p> <ul style="list-style-type: none"> • National Disability Insurance Agency (NDIA) contracts Australian Hearing as the national early childhood early intervention partner for families of deaf and hard of hearing children. • NDIA reintroduce transdisciplinary package quotes from specialist service providers for children who are deaf and hard of hearing and require access to early intervention services. • Australian Government put in place an arrangements similar to Canadian model to ensure a child-first approach to the delivery of services for children with hearing loss.
April 2019	House of Representatives Standing Committee on Health, Aged Care and Sport, Australian Parliament	Inquiry into the 2017-18 Annual Reports of the Department of Health and Australian Hearing(35)	<p>The Committee examined the Government’s progress relating to its previous recommendations and the most up to date hearing health policy and programs more broadly.</p> <p>The Committee recommended seven changes:</p> <ul style="list-style-type: none"> • reiterate recommendations of the Still Waiting to be Hearing report 2017; • Australian Hearing remain the sole provider of hearing services for children aged from zero to six years; • COAG establish mandatory hearing screening program for children in their first year of school using Sound Scouts; • the Australian Government develop, implement and make public its plan for the Community Service Obligation program with the rollout of the NDIS on 1 July 2020; • the Department of Health consider development of a pilot hearing screening program for Australians accessing the aged care system; and • the Australian Government commission research into the possible causes of balance disorders and potential treatment options; and

Date	Organisation	Title	Synopsis of report
			<ul style="list-style-type: none"> the <i>Roadmap for Hearing Health</i> embed: a clear allocation of responsibilities between jurisdictions, timelines for implementation of key actions, and funding allocations. <p>The Australian Government is currently responding to this Inquiry.</p>
May 2019	Australian Government Competitive Neutrality Complaints Office, Productivity Commission (AGCNCO)	Australian Hearing Investigation No. 16(157)	<p>AGCNCO received two complaints that alleged Australian Hearing engaged in anti-competitive behaviour in the voucher services market, with market advantages over competitors as a result of government ownership. AGCNCO reported two items were outside of the competitive neutrality policy. Most other complaints were unsubstantiated except for Australian Hearing's advantage as a result of the workers compensation regulation.</p> <p>AGCNCO reported government provided a minor competitive advantage to Australian Hearing as a result of undue promotion on government websites and in Ministerial media releases.</p> <p>The Department of Human Services and the Department of Health have no record of a Ministerial direction limiting Australian Hearing's commercial activities in the private hearing services market. There is no record in the Federal Register of Legislation of such a Ministerial direction. Therefore, Australian Hearing's legislation does not preclude it from operating in the private market.</p>

APPENDIX B – HEARING AID DEVICES AVAILABLE THROUGH THE HEARING SERVICES PROGRAM

Hearing aid devices come in a range of sizes, shapes and styles. The following is a description of the types of fully subsidised hearing aid devices available through the Hearing Services Program.

Figure 8: Hearing Aid Devices

 	<p>Behind-the-ear (BTE)</p> <p>The hearing aid sits toward the top of your outer ear (behind your ear) and is attached by a tube to an ear mould sitting inside the bowl of your outer ear and into your ear canal. Sound travels from the hearing aid, through the ear mould and into your ear canal. These hearing aids are discreet, and are easy to clean and maintain.</p>
 	<p>High powered BTE</p> <p>These hearing aids are more powerful, for people who have a severe to profound hearing loss. They are often larger than other BTE hearing aids, as they require a larger battery.</p>
 	<p>Open fit BTE</p> <p>These hearing aids have a specially designed ear piece with very thin tubing which directs sound from the hearing aid into the ear canal. This type of hearing aid is useful for people who have good hearing for low pitch sounds, or who cannot wear an ear mould.</p>
 	<p>In-the-canal (ITC) and in-the-ear (ITE)</p> <p>The main part of these hearing aids sits in the bowl of the outer ear, with a portion extending into the ear canal to direct the sound into your ear. ITE hearing aids are more powerful than ITC hearing aids, and are slightly larger.</p>
 	<p>Completely in the canal (CIC)</p> <p>These are small and sit deeply in the ear canal. Due to their size, they may have less variety of features or power than the other styles of hearing aids. They are not suitable for all levels of hearing loss and may not be suitable for people with very narrow or 'bendy' ear canals, or those who have difficulty using their hands. Like ITC or ITE hearing aids, CIC hearing aids are more vulnerable to damage from wax and the conditions of your ear canal.</p>

(Source: Images - Audiology Australia, Source Descriptors - Hearing Services Program)

APPENDIX C – BETTER PRACTICE REGULATION – LEGISLATIVE AND REGULATORY CHANGES SINCE 2019

As well as the 2019 decision to replace five subordinate legislations with one consolidated instrument for the Voucher Stream, other administrative changes made over the past two years include simplifying the application processes to make the Hearing Services Program more accessible to clients, and changes to the Service Provider Contract for the Voucher Stream. Hearing Australia observed:

“Overall, the changes to the Service Provider Contract relating to administrative procedures have been well received.”(54)

Other regulatory improvements were also implemented including:

- removing the requirement for medical referral certification, which was identified as a barrier to timely access to hearing services;
- improving client education and support for informed decision-making, including improved quote and maintenance agreement requirements;
- simplifying the Service Provider Contract and making the contract in perpetuity unless terminated, thus reducing the regulatory burden of contract renewals; and
- removing the requirement for clients to sign claim forms.

There was a mixed reaction to these changes from stakeholders involved with this Review, with several stakeholders raising concerns about the lack of consultation with the sector. The Hearing Health Sector Committee referred to these concerns as it drafted the *Roadmap for Hearing Health* in 2019, and in the Committee’s final document, captures as a *Roadmap* guiding principle, that:

“...future changes and improvements are co-designed with those directly impacted, including consumers, providers, and other relevant stakeholders.” (3)

Further work is underway to consolidate and simplify multiple program level documents including program standards, Schedule of Service Items, claiming conditions and evidence requirements. These initiatives are supported by key stakeholders including providers, Practitioner Professional Bodies (PPBs) and industry groups.(55)

APPENDIX D – PROGRAM ADMINISTRATION – DETAILS

Administration of the Voucher stream

Voucher Issuing

The *Hearing Services Administration Act* (1997) (the Act) stipulates requirements for the establishment of a system to support the issuing of vouchers to eligible persons to receive hearing services. The Act further allows for rules to be established about the duration and replacement of vouchers. The Voucher Instrument documents the legislated Voucher Rules as required by the Act, which establish that:

- clients, or their contracted service provider (on behalf of their clients) can apply for a voucher on an approved form with the required information supplied;
- the Voucher can be issued to an eligible person, if the form was properly completed and has been approved by the department via the Online Portal;
- vouchers are for a set period which is currently three years, however from 1 July 2021 will be for a five year duration; and
- the issuing of a voucher entitles the voucher holder to receive available hearing services.

Information about eligibility and recommendations from this Review about eligibility are discussed in **Chapter 3**.

There is no requirement for one of the above groups to have any identified hearing issues or functional challenges resulting from hearing loss before obtaining a voucher. The issuing of a voucher entitles the client to obtain an assessment through the Hearing Services Program to then determine the appropriate rehabilitation plan for the client, including if they need hearing aid devices.

Provider Accreditation

Hearing providers, who wish to deliver and claim for services for program clients, must be accredited in accordance with the Accreditation Scheme as required by the Act and Voucher Instrument. To become accredited with the Hearing Services Program, providers must apply to the department on the approved form demonstrating how they comply with the conditions of accreditation, including capacity to comply with the Rules of Conduct. If accredited the provider enters into a Service Provider Contract with the department.(118)

As of 1 March 2021, there were 298 contracted service providers accredited to deliver hearing services under the Hearing Services Program. The number can fluctuate month by month however is usually around 300. Providers are currently operating at over 3,000 sites across Australia, with a mix of permanent and visiting site locations. There is no clear definition of what is deemed to be permanent or visiting sites. Providers are classified as very large, large, medium and small, depending on the revenue received from the Hearing Services Program each year. A breakdown on how many applications were received over the last three years by provider is outlined in **Table 14** below.(31)

Table 14: Number of Voucher applications received by provider type 2017 - 2020

Provider size	Number of applications
Very large providers (>\$10M per year)	232,997
Large providers (\$1M to \$10M per year)	38,361
Medium providers (\$200K to \$1M per year)	28,719
Small providers (<\$200k per year)	10,860

Source: Department of Health – Hearing Services Program Data and Statistics (Internal).

In 2019, the Hearing Services Program reviewed its accreditation processes and released a streamlined more risk focused accreditation process. This has reduced the time taken and cost to submit accreditation forms. A 2020 review of these processes has shown a reduction in the time it has taken providers from their first submission to a complete application reducing from 42 days for the paper based system, to 13 days for the online semi-automated form(158). Prior to the 2019 legislation changes, providers were also not able to transfer their accreditation to a new entity. Amendments have enabled easier and timelier processing.

Accredited and contracted service providers have a range of regulatory obligations regarding practitioners, record keeping and insurance as described below.

Practitioners

Unlike other allied health professions, audiology is not a profession regulated through the Australian Health Practitioners Regulation Agency (AHPRA). The legislative framework underpinning the Hearing Services Program has established minimum standards for providers and practitioners who deliver services to program clients, including requirements for Practitioner Professional Body (PPB) membership for audiologists and audiometrists. PPBs have developed a Code of Conduct and Scope of Practice, and over the past ten years the sector has evolved substantially to ensure appropriate regulation of the delivery of services. In 2015, the then COAG Health Council(159) released a National Code of Conduct for unregulated health care workers. This code has since been adopted and tailored for use by the PPBs and all contracted providers with the Hearing Services Program must ensure staff are delivering services in accordance with the PPB Scope of Practice and Code of Conduct.

Audiology Australia, the largest PPB has obtained accreditation with the National Alliance of Self Regulating Health Professionals (NASRHP).

Requirements for PPB status has been long established in program legislation:

- PPBs must be an Australian body that is formally constituted for the interests of the professions of audiology or audiometry or both;
- membership is based on appropriate industry recognised professional qualifications; and
- the PPB supervises and enforces a code of ethics and requires members to participate in continuing professional development.

Three PPBs are recognised by the Hearing Services Program as meeting the legislative requirements, Audiology Australia Limited (AudA) for Audiologists, Australian College of Audiology (AcAud) for Audiologists and Audiometrists and Hearing Aid Audiology Society of Australia (HAASA) for Audiometrists. Any hearing practitioner must receive a Qualified Practitioner (QP) number before delivering and claiming for services through the Hearing Services Program. This number is separate to the practitioner's assigned Medicare practitioner numbers.

The Voucher Instrument requires all services to be delivered by a QP, except Maintenance Services. Some rehabilitation services can be delivered by groups with the skills to do so, however these must be supervised by a QP and can only be claimed for from a contracted service provider. The current legislative framework and Accreditation Scheme only provides for contracted service providers to be funded to deliver program services.

Record Keeping

The records created by providers for program clients are covered by the *National Archives Act 1983* and the National Archives Authority (NAA) (2011/00396196). Under this NAA, Class 47469 stipulates that all clinical and client records maintained by contracted service providers have minimum periods of disposal. To meet this obligation, the Service Provider Contract deems that client records are Commonwealth Records making the Commonwealth the owner of all client records.

The relevant National Records Authority (NRA) stipulates that clinical and client records are subject to the NRA and its disposal requirements¹. The department is unaware of any other Commonwealth program that has client records listed under the NRA.

When a client relocates or a provider closes, the client record must be transferred to the new provider or returned to the Commonwealth for custody. Status as a Commonwealth Record, requires providers to have in place processes to meet the obligations of both the National Archives and other record keeping requirements such as privacy and tax legislation. Removal of the NAA stipulation and Commonwealth records status would allow for the reduction in administration for providers and the Hearing Services Program.

Record keeping requirements to substantiate services and claiming were identified as onerous by some providers and industry groups. Independent Audiologists Australia also noted that while the NDIS have service items for the preparation of clinical notes, the Hearing Services Program (deeming client records as Commonwealth Records) does not cover the costs of time for record keeping.(55)

Hearing Services Online Portal

In 2015, the Hearing Services Program launched the Hearing Services Online Portal (the portal), which enabled real time eligibility checking and voucher issuing. It also enables providers to access and manage provider and client information and process manual claiming. The portal has made significant improvements in the time taken to access hearing services and has given providers

¹ [2011/00396196 \(Internal document\)](#)

greater access to manage their own information, reducing the time to receive a voucher from six weeks to real time in almost all cases.

Prior to 2019, the claiming was split across Department of Human Services (97% of claims) and the portal (3%). All claims are now submitted via the portal and the payments are processed by this department.

The portal is used alongside other patient management systems that providers are required to manage for the Hearing Services Program and their general service delivery. These include Medicare Claiming Systems, HICAPs (health insurance claiming system) and specific patient records management systems. The portal acts as a data repository, including some data on over 1.4 million program clients, however it is used mainly to support administration of the Hearing Services Program.

Other Provider Obligations

In addition to practitioner and record keeping requirements, contracted service providers are responsible for the ensuring compliance with a range of other legislative and contractual requirements including insurances, ambient noise and equipment calibration standards, hearing aid device supply arrangements, and claiming.

Program Compliance

The Act and Voucher Instrument provide a high level framework for the management of compliance monitoring for the Voucher Stream, including for voucher issuing, accreditation, practitioners, provider compliance, and recoveries. For the Voucher stream, the Hearing Services Program currently monitors compliance with a small team of Compliance Officers and as part of other existing personnel roles such as complaints and accreditation.

The following table provides the main compliance activities:

Compliance Activity	Explanation
Voucher Issuing	Government to Government eligibility checking occurs between DHS/DVA prior to issuing a voucher to a client. Eligibility checking occurs each time a client applies for a new voucher. Manual processes are in place to check eligibility for current serving members, NDIS and Disability Employment Service participants.
Accreditation	Service providers who wish to deliver services to program clients must be accredited in accordance with the Act and Voucher Instrument. The Hearing Services Program has recently revised the administration of accreditation by streamlining and semi-automating the accreditation application process.
Provider Compliance	Provider compliance is managed in accordance with the Compliance Monitoring and Support Framework.(160) The Hearing Services Program takes a risk-based proportionate response to monitoring compliance underpinned by provider education and awareness raising. The framework details the range of supports in place to support provider compliance, including provider factsheets, notices, communication materials and

	<p>website content. To support providers to review their policies and processes, providers complete an annual self-assessment.</p> <p>The framework outlines that provider compliance monitoring is focused on four key risk areas:</p> <ol style="list-style-type: none"> 1. client safety and well-being; 2. management of public funds; 3. program integrity; and 4. protection of client records and personal information. <p>In addition to the prevention education and support provided, the Hearing Services Program monitors compliance utilising a risk-based approach using risk signals such as claiming data analysis, complaints and tip-offs, previous audit history etc. Three tiers of compliance monitoring may be implemented from claims reviews, to limited scope audits to full provider audits depending on the scale of risk identified. Compliance actions taken as a result of non-compliance depend on the seriousness of the non-compliance, and the willingness and the capacity of the provider to comply. Potential compliance actions are outlined in the Compliance Pyramid available in the framework.</p>
Practitioners	<p>The PPB MOU sets out information sharing, reporting and compliance arrangements for practitioners, including the issuing of QP numbers. If a practitioner does not have a QP number, it is the obligation of the provider to request a QP number through the portal and the providers must check qualifications and maintain practitioner links and details on an ongoing basis.</p>
Services Schedule	<p>The services available to clients are prescribed by legislation and the Schedule of Service Items and Fees (Services Schedule). The Act(28) specifies that the issuing of a voucher for a specified period entitles the person to one or more specified hearing services. The services may be subject to particular conditions outlined within the legislation, service provider contract, and Schedule of Service Items and Fees, including program standards.</p> <p>The Hearing Services Program’s compliance monitoring activities are routinely audited by the ANAO and has been subject to two internal departmental audits.</p>

Hearing aid device Supply Arrangements

Hearing aid devices supplied through the Hearing Services Program must be purchased from an Appointed Supplier (manufacturers and suppliers), who is contracted with the Department of Health and commits to meet the minimum specifications and other conditions including warranty and returns. The Deed of Standing Offer(124) which sets out these supply arrangements has not been comprehensively reviewed or updated since 2012. Where required, hearing aid devices supplied through the Hearing Services Program must also be registered with the Therapeutic Goods Administration’s Australia Register of Therapeutic Goods. Private hearing aid devices can be brought onto the Hearing Services Program for maintenance purposes as long as the hearing aid device is listed on a Schedule of Approved Devices.

Hearing aid device Supply Arrangements Disclosure

The 2017 Standing Committee Inquiry into Hearing Health(35) recommended the Hearing Services Program ban all commissions and equivalent sales practices. While this was not implemented, the Hearing Services Program further expanded the requirement for providers to disclose to clients if they had a 'preferred supply relationship arrangement' in place. The Hearing Services Program also strengthened the consumer information required to be provided to clients to assist clients make informed decisions about the Hearing Services Program, including hearing aid device quotes and maintenance agreement information.

Minimum Specifications

The Deed of Standing Offer outlines the minimum hearing aid device specifications for each Device Schedule and separately for ear-moulds and non-standard devices.

Hearing aid device Schedules

If hearing aid devices meet the minimum specifications as referred to above, they can be listed on either the fully or partially subsidised Device Schedule. Listing of hearing aid devices is managed by appointed suppliers who have a Deed with the department, and is completed online through the HSO portal. Fully and partially subsidised hearing aid devices have separate minimum specifications. Device Schedules are maintained in real time, i.e. updated when suppliers make changes, add or delist hearing aid devices from the schedules.

As of 1 March 2021, there were 235 hearing aid devices listed on the fully subsidised device schedule and 1,934 hearing aid devices listed on the partially subsidised device schedule(31). A range of hearing aid devices available through the Hearing Services Program are categorised as: behind the ear (BTE), completely (CIC) or in the canal (ITC), in the ear (ITE) or non-standard devices. The Schedule of Fees, which is indexed annually sets the fees for hearing aid devices based on these categories.

Administration of the Community Service Obligations (CSO) stream

The CSO stream is administered under a Memorandum of Agreement (MOA) between Department of Health and Australian Hearing Services Pty Ltd trading as Hearing Australia. Funding is allocated through the Portfolio Budget Statements to the Department of Health and is then paid quarterly upfront to Hearing Australia.

The MOA outlines the governance arrangements for the delivery of the CSO stream in accordance with the *Hearing Services Administration Act 1997*, as well as the *Australian Hearing Services (Declared Hearing Services) Determination 2019*.

Joint coordination meetings are held between the department, Hearing Australia and Services Australia on a quarterly basis. Hearing Australia provides quarterly financial and activity reporting, including the populations covered and services provided.

APPENDIX E– STAKEHOLDERS WHO CONTRIBUTED TO THE REVIEW OF THE HEARING SERVICES PROGRAM

STAKEHOLDER NAME	CONTRIBUTION TO THE REVIEW OF THE HEARING SERVICES PROGRAM					
	Meeting with Expert Panel prior to drafting of Consultation Paper	Written Submission to Consultation Paper	Meeting with Expert Panel regarding Consultation Paper	Met with or provided more information to the Department to inform Review	Attended Virtual information session on Draft Report	Written Submission to Draft Report
<i>Individuals and Consumer, Advocacy, Community and Education Groups</i>						
NH (individual)		√				
MS (individual)		√				
PL (individual)		√				
Dennis Leembruggen (individual)		√				
Bert Hoebee (individual)		√				
Frank Tidswell (distributor)		√				
Dubbo and District Parent Support Group (Hear our Heart Ear Bus project)		√				
Airforce Association		√				
TPI Federation (Australian Federation of Totally & Permanently Incapacitated Ex-Servicemen & Women)	√ (14/10/20)	√				
Royal Flying Doctors Association		√				
Australian Small Business & Family Enterprises Ombudsman		√				
Deafness Forum of Australia Consumer Advocacy Group	√ (22/9/20)	√	√ (14/12/20)			

STAKEHOLDER NAME	CONTRIBUTION TO THE REVIEW OF THE HEARING SERVICES PROGRAM					
	Meeting with Expert Panel prior to drafting of Consultation Paper	Written Submission to Consultation Paper	Meeting with Expert Panel regarding Consultation Paper	Met with or provided more information to the Department to inform Review	Attended Virtual information session on Draft Report	Written Submission to Draft Report
Better Hearing Australia	√ (9/10/20)					
Soundfair	√ (18/9/20)	√	√ (11/12/20)			
First Voice		√	√ (2/12/20)			
Australasian Newborn Hearing Association		√				
Royal Institute for Deaf and Blind Children (now called Nextsense)		√				
National Aboriginal Community Controlled Health Organisation (NACCHO)		√				
<i>Service Providers</i>						
Neil and Sue Clutterbuck		√				
Stay Tuned Hearing		√				
Hearing Australia	√ (2/10/20)	√	√ (21/12/20)			
MK (also an Audiologist)		√				
Odio Tech		√				
MQ Health Speech and Hearing Clinic - Macquarie University		√				
Telethon Speech and Hearing		√				
Audika Australia		√	√ (21/12/20)			
Specsavers		√				

STAKEHOLDER NAME	CONTRIBUTION TO THE REVIEW OF THE HEARING SERVICES PROGRAM					
	Meeting with Expert Panel prior to drafting of Consultation Paper	Written Submission to Consultation Paper	Meeting with Expert Panel regarding Consultation Paper	Met with or provided more information to the Department to inform Review	Attended Virtual information session on Draft Report	Written Submission to Draft Report
<i>Practitioners</i>						
Derek Moule		√				
<i>Professional Bodies</i>						
Independent Audiologists (IAA)	√ (9/10/20)	√	√ (14/12/20)			
Audiology Australia	√ (18/09/20)	√	√ (14/12/20)			
Australian College of Audiology	√ (22/09/20)	√				
Australian Society of Rehabilitation Consultants (ASORC)		√				
<i>Industry representative bodies</i>						
Hearing Business Alliance (HBA)	√ (24/09/20)	√	√ (14/12/20)			
Hearing Care Industry Association (HCIA)	√ (13/10/20)	√	√ (14/12/20)			
Hearing Aid Audiology Society of Australia (HAASA)	√ (2/10/20)		√ (14/12/20)			
Hearing Health Sector Alliance (HHSA)	√ (14/10/20)	√				
<i>Manufacturers</i>						
Hearing Aid Manufacturers and Distributors Association of Australia (HAMADAA)	√ (2/10/20)		√ (21/12/20)			
Sivantos		√				

STAKEHOLDER NAME	CONTRIBUTION TO THE REVIEW OF THE HEARING SERVICES PROGRAM					
	Meeting with Expert Panel prior to drafting of Consultation Paper	Written Submission to Consultation Paper	Meeting with Expert Panel regarding Consultation Paper	Met with or provided more information to the Department to inform Review	Attended Virtual information session on Draft Report	Written Submission to Draft Report
Cochlear	√ (19/10/20)	√				
<i>Academics/Research</i>						
Professor Louise Hickson (University of Queensland)	√ (19/10/20)	√	√ (11/12/20)	√		
Honorary Professor Anthony Hogan PhD (Faculty of Health Sciences, University of Sydney)	√ (9/10/20)			√		
National Acoustics Laboratories (NAL)			√ (11/03/21)	√		
<i>Government Bodies</i>						
Department Veterans' Affairs	√ (9/10/20)	√	√ (14/12/20)			
New Zealand Ministry of Health				√ (25/02/21)		

APPENDIX F – ABBREVIATIONS USED IN THIS REPORT

Abbreviation	Definition
ACAud	Australian College of Audiology
ACCHOs	Aboriginal Community Controlled Health Organisations
ACSQHC	Australian Commission on Safety and Quality in Health Care
AIHW	Australian Institute for Health and Welfare
ALD	Assistive Listening Device
APS	Australian Psychological Society
ASL	Australian Sign Language
AudA	Audiology Australia
BAHA	Bone Anchored Hearing Aid
BTE	Behind the Ear
CALD	Culturally and Linguistically Diverse
CDEP	Community Development Employment Projects
CDP	Community Development Program
CHERE	Centre for Health Economics Research and Evaluation, University of Technology Sydney
COSI	Client Orientated Scale of Improvement
CSO	Community Service Obligations
CSP	Contracted Service Provider
CSPN	Contracted Service Provider Notice
DVA	Department of Veteran Affairs
ENT	Ear, Nose and Throat
FAHL	Frequency Average Hearing Loss
HA	Hearing Australia
HAASA	Hearing Aid Audiology Society of Australia
HBA	Hearing Business Alliance

HCIA	Hearing Care Industry Association
HHSA	Hearing Health Sector Alliance
HRO	Hearing Rehabilitation Outcomes
HSO	Hearing Services Online (the Portal)
HSP	Hearing Services Program
ITC	In the canal device
ITE	In the ear device
LOCHI	Longitudinal Outcomes of Children with Hearing Impairment
MHLT	Minimum Hearing Loss Threshold
NACCHO	National Aboriginal Community Control Health Organisation
NAL	National Acoustic Laboratories
NDIS	National Disability Insurance Scheme
NHMRC	National Health and Medical Research Council
PPB	Practitioner Professional Body
QP	Qualified practitioner
RACF	Residential Aged Care Facility
RFDS	Rural Flying Doctor Service
WANT	Wishes and Needs Tool

APPENDIX G – GLOSSARY OF TERMS USED IN THIS REPORT AND BY THE SECTOR

Accreditation

Accreditation is the process used by the Australian Government Hearing Services Program (the program) to assess and approve a provider of hearing services. Being accredited means that the provider has been found to meet the requirements necessary as set out in the Hearing Services Providers Accreditation Scheme 1997 to deliver hearing services to clients of the Hearing Services Program.

Accreditation Scheme

The Accreditation Scheme sets out the requirements for applicants and empowers the Minister for Health to make decisions to accredit Hearing Services Providers.

Australian Hearing Specialist Program for Indigenous Australians (AHSPiA)

The AHSPiA is Australian Hearing's outreach service. It is delivered in a culturally sensitive way in localities that encourage Indigenous people to use hearing services. The services are designed to meet the audiological needs that arise in Indigenous communities, caused by the high prevalence of otitis media and its associated hearing loss.

Air conduction

Air conduction tests evaluate the sensitivity of the entire hearing system. Earphones are placed over the ears or inserted into the ear canal. The hearing practitioner presents single frequency ("pure") tones produced by a calibrated audiometer. The softest sounds heard by the client at each pitch are recorded as the thresholds.

Assistive Listening Device (ALD)

ALDs are devices which assist someone with a hearing loss to hear and understand what is being said more clearly. ALDs commonly include headphones and microphones. ALDs are sometimes referred to as Assistive Listening Devices.

Assessment

An assessment is the test undertaken by a hearing practitioner to determine if a client has a hearing loss and the type of loss.

Audiogram

An audiogram is a graph which plots hearing loss. Hearing thresholds are graphed to show how close a client's hearing is to the 'normal' range. An audiogram helps to determine the level of hearing loss and identify the location of the hearing problem. The audiogram is split into two sections: frequency (range of hearing) and intensity (or loudness).

Audiologist

Audiologists are university graduated allied health professionals with postgraduate qualifications in Audiology or equivalent training. Audiologists have expertise in non-medical areas of hearing services including complex hearing assessment and rehabilitation of hearing impairment.

Audiology Australia Limited

Audiologists are represented professionally by Audiology Australia Limited. Audiology Australia Limited is a Practitioner Professional Body under the Hearing Services Program. Previously known as the Audiological Society of Australia (ASA).

Audiometrist

Audiometrists have completed a diploma course in hearing aid prescription and evaluation.

Audit

An audit is a systematic, independent and documented process of obtaining and evaluating audit evidence to determine whether specified criteria are met. An audit enables the program to check whether a hearing services provider has the systems, processes and governance arrangements in place to meet the requirements of the program.

Audit and Compliance Framework (the framework)

The framework describes the Department of Health's risk based approach to audit and compliance. The framework provides a plan for monitoring and encouraging compliance from Hearing Services Providers, in delivering hearing services to clients.

Australian College of Audiology (ACAud)

Audiometrists and some audiologists are represented professionally by the ACAud. ACAud is a Practitioner Professional Body under the Hearing Services Program.

Behind the Ear (BTE)

BTE is a type of hearing device where the main part of the device, including the electronics and battery sits in a case behind the ear.

Bilateral CROS (BiCROS)

BiCROS is a type of hearing device which allows sounds to arrive at either ear with the strongest ear processing the sound.

Binaural Fitting

A binaural fitting is when a hearing device is fitted in both ears.

Bone Anchored Hearing Aid (BAHA)

A BAHA is a surgically implantable system for the treatment of hearing loss. This device allows sound to be conducted through the bone rather than the middle ear - a process known as direct bone conduction.

Bone conduction

Bone conduction testing uses a small bone-conduction vibrator which is placed on the mastoid bone behind the ear. Sound is transmitted through the bones of the skull to the inner ear, bypassing the outer and middle ear. A difference between air and bone conduction thresholds indicates a hearing loss caused by a problem with the outer or middle ear.

Client

A client is a person who is eligible for the Hearing Services Program either as a voucher holder, or eligible for the Community Service Obligations component.

Client Rights and Responsibilities

The rights and responsibilities of a client under the Hearing Services Program.

Clinical Hearing Services

Services which include a hearing assessment, device fitting and evaluation, training and advice.

Cochlear implant

A cochlear implant is a surgically implanted device which enables a person to experience sounds by sending electrical signals to the nerve endings in the inner ear (the cochlear).

Community Service Obligations (CSO)

The CSO enable Australian Hearing to provide specialist hearing services to people who are an Australian citizen or permanent resident and are younger than 26 years an Aboriginal and Torres Strait Islander who is over 50 years an Aboriginal and Torres Strait Islander participant in the Remote Jobs and Communities Program (now known as the Community Development Programme) an Aboriginal and Torres Strait Islander participant in the Community Development Employment Projects Program, who received hearing services before 30 June 2013 a client who meets Voucher stream eligibility and has a profound hearing loss or hearing loss and severe communication impairment or a client who meets voucher stream eligibility and lives in a listed remote area of Australia.

Australian Hearing is the sole provider of CSO services. This information is general advice only.

Complaint

A complaint is an expression of dissatisfaction with any aspect of the Hearing Services Program. Please refer to the OHS Complaints Policy.

Client with complex or specialised needs (Specialist Hearing Services)

A client who has severe to profound bilateral hearing loss or whose communication is limited due to significant physical, intellectual, mental, emotional or social disability. These clients are entitled to receive specialist hearing services through Community Service Obligations. They were previously referred to as 'complex clients'.

Confidential information

Confidential information means facts or knowledge that are not publicly available, by its nature confidential, or designated by the Commonwealth as confidential.

Contracted Service Provider (CSP)

A hearing services provider who has been accredited and contracted with the program to provide services to clients of the voucher stream.

Contracted Service Provider Notice (CSPN)

E-mail and web-based information provided to hearing services providers containing announcements and updates relating to the Hearing Services Program. (Previously known as 'SPAs')

CROS aid

CROS aids are hearing aids where one aid contains a microphone, and the other the amplifier and receiver. CROS aids can be used by people who have one good hearing ear and one ear where the loss is so great that a hearing aid will provide no benefit. Essentially, a CROS aid is a hearing device with a microphone on one side carrying sound from that side of the head to the other side.

Date of Services

In relation to any particular aspect of the services means that date as defined in the Schedule of Service Items.

Deaf (and hearing impaired)

A person who cannot hear. When referring to a Deaf person - it is accepted in the community that we use 'Deaf' and if referring to deaf people in general - we use 'deaf'. For additional information on this topic, see National Association for the Deaf website.

Department of Health (the Department)

The department is the Commonwealth department responsible for the Australian Government's priorities for health. Hearing Services operates within the department.

Dependant

To be eligible as a dependant under the Hearing Services Program a person must be 21 years of age or above and the spouse or de facto spouse of an eligible person or a person who is between the age of 21 and 24 inclusive (under 25) receiving full time education at a school, college or university not

receiving a disability support pension and wholly or substantially dependent on the eligible person or the spouse or de facto spouse of an eligible person.

[Eligibility criteria for refitting](#)

Eligibility criteria that must be met in order for a client to be refitted with a new hearing device.

[Entity](#)

Entity means an individual, or a body corporate, or a partnership, or an authority of the Commonwealth, a State or a Territory, or a Department of the Government of the Commonwealth, a State or a Territory.

[Expert Panel](#)

The Expert Panel was established in July 2020 to lead the Review of the Hearing Services Program. Members are Professor Michael Woods and Dr Zena Burgess, with secretariat services provided by the Department of Health.

[Fully subsidised device schedule](#)

All fully subsidised hearing devices are listed in the Main Schedule of Approved Devices.

[Fully subsidised device](#)

Fully subsidised devices approved by the Hearing Services Program, available to eligible clients.

[Hearing Australia \(HA\)](#)

Hearing Australia is a hearing services provider under the Hearing Services Program. AH is a statutory authority (Government owned) that reports to the Minister for Human Services, and provides services to clients eligible under the Community Service Obligations component of the program. Also referred to as Australian Hearing.

[Hearing Aid Audiometrist Society of Australia \(HAASA\)](#)

Audiometrists are represented professionally by the HAASA. HAASA is a Practitioner Professional Body under the Hearing Services Program.

[Hearing Care Industry Association \(HCIA\)](#)

The HCIA provides input to Hearing Services on policy and administrative matters that impact upon its corporate membership and the hearing industry.

[Hearing Aid Device](#)

Hearing aid devices that are listed in the Schedule of Approved Devices for the program. Also known as an approved device.

Hearing device

Goods for purposes in connection with hearing rehabilitation, including the ear mould and any other attachments necessary for the operation of the device. Also known as an approved hearing device.

Hearing loss

There are three types of hearing loss: conductive hearing loss (when sounds are blocked from reaching the hearing nerve), sensorineural hearing loss (when sounds can reach the hearing nerve but are not sent to the brain) and mixed hearing loss (a combination of conductive and sensorineural hearing loss).

Hearing Loss Prevention Program (HLPP)

The HLPP funds research that contributes to the development of improved policies and service delivery and/or enables the Department of Health to better identify the needs of the community in relation to hearing loss.

Hearing practitioner (practitioner)

A hearing practitioner is a person who has been engaged by a contracted service provider to provide hearing services to clients of the Hearing Services Program. A hearing practitioner may be an audiologist or audiometrist.

Hearing Rehabilitation Outcomes (HRO)

The HRO document the results intended to be achieved by practitioners in providing services to clients.

Hearing Health Roadmap (the Roadmap)

Released by the Australian Government in February 2019, which has been created to improve the lives of the millions of Australians affected by hearing loss.

Hearing services

Hearing services may include assessment of hearing loss and hearing rehabilitation.

Hearing Services Online (HSO or the portal)

The online portal and website developed by the Department of Health to support the administration of the voucher component of the Australian Government Hearing Services Program. The online portal is based in the web environment and improves access to the program for clients and providers. Clients can use the portal to confirm eligibility for the program, submit an application for a hearing services voucher, and view the hearing services provider directory in a searchable map.

Hearing Services Program

The program is administered in Department of Health. The program provides access to hearing services to eligible people.

Hearing services provider (provider)

A contracted services provider who has been accredited and contracted by the department to deliver services to clients of the Hearing Services Program.

In the canal device (ITC)

A hearing device that sits inside the ear canal.

In the ear device (ITE)

A hearing device that sits inside the ear.

Main Schedule of Approved Devices

The Main Schedule for Approved Devices lists all approved hearing devices under the Hearing Services Program.

Maintenance service

Maintenance services for a hearing device includes supply of batteries, servicing and repairs. Includes any of the following services servicing a hearing device to ensure it operates effectively giving advice to a client about the use or servicing of a hearing device providing and replacing hearing device batteries.

Manual claim

A manual claim is an online or paper claim for services lodged by a contracted service provider. Manual claims are processed by Hearing Services.

Medical practitioner

A medical practitioner is a person who, under the law of a State or Territory, is a legally qualified medical practitioner.

Minimum Hearing Loss Threshold (MHLT)

The MHLT for fitting a hearing device to a client under the Hearing Services Program is a 3 Frequency Average Hearing Loss of more than 23dB.

Monaural fitting

A monaural fitting is when a hearing device is fitted in one ear only.

National Disability Insurance Scheme (NDIS)

The NDIS funds individualised support for eligible people with disability.

Non-Routine Client

A client found to have one or more of the following audiometric presentations:

- An air bone gap of 20dB or greater at 500Hz, 1kHz or 2kHz;

- Speech discrimination poorer than expected given HTLs; and
- Evidence of fluctuation in audiometric thresholds.

New voucher

A new voucher is issued to clients who have been found eligible for the Hearing Services Program (the program) who have not previously received services under the program.

Partially subsidised device

Partially subsidised devices approved by the Hearing Services Program. Partially subsidised devices have additional features.

Partially subsidised device schedule

A list of all partially subsidised devices currently available through the Hearing Services Program.

Permanent site

A permanent site is a location or facility operated by a Hearing Services Provider where hearing services are provided on an ongoing basis.

Practitioner Professional Body (PPB)

A PPB is an Australian body which meets all of the following criteria the body is formally constituted for the purpose of representing the interests of the professions of audiology or audiometry or both and membership of the body is based on appropriate industry recognised professional qualifications for audiometrists or audiologist or both and the body supervises and enforces a code of ethics for the professions of audiology or audiometry or both and the body requires members to continue their professional development.

Provisional audiologist

A provisional audiologist is a person who is in an approved membership category of a Practitioner Professional Body for provisional audiologists.

Provisional audiologists must be supervised by a Qualified Practitioner when providing hearing services to eligible clients.

Provisional audiometrist

A provisional audiometrist is a person who is in an approved membership category of a Practitioner Professional Body for provisional audiometrists.

Provisional audiometrists must be supervised by a Qualified Practitioner when providing hearing services to eligible clients.

Qualified practitioner (QP)

A QP is a qualified Hearing Services Practitioner (audiologist or audiometrist).

Qualified practitioner (audiologist)

A qualified practitioner (Audiologist) is a person who is in an approved membership category of a Practitioner Professional Body for qualified practitioners (audiologist).

Qualified practitioner (audiometrist)

A qualified practitioner (audiometrist) is a person who is in an approved membership category of a Practitioner Professional Body for qualified practitioners (audiometrist).

Qualified Practitioner Number (QP number)

A QP number is the unique number allocated to a qualified practitioner by the Minister for Health under rule 25 of the Rules of Conduct of the Australian Government Hearing Services Program.

Residential Aged Care Facility

A RACF is a special-purpose facility which provides accommodation and other types of support, including assistance with day-to-day living, intensive forms of care, and assistance towards independent living, to frail and aged residents. RACFs are accredited by the Aged Care Standards and Accreditation Agency Ltd.

Records

Records are any information, data or documents about clients maintained by a hearing services provider.

Rehabilitation Plus (Rehab Plus)

The Rehab Plus service offered under the Hearing Services Program provides clients with additional support in managing their hearing loss through group sessions and individual appointments. Rehab Plus Group Services means support and assistance provided in a group setting to clients who have been fitted for the first time with a fully subsidised hearing device under the voucher system to maximise their communication abilities and to better manage their hearing loss.

Relocation

A relocation is when a client moves from one hearing services provider to another within the Hearing Services Program.

Replacement (device)

The fitting of a new hearing device when an existing device has been lost or damaged beyond repair, or become obsolete.

Return voucher

Voucher issued to a client who has previously received services under the Hearing Services Program.

Rules of Conduct

The Hearing Services ROC 2012 outlines the requirements and standards that hearing service providers must adhere to when providing services to eligible voucher-holders under the Hearing Services Program.

Schedule of Fees

The Schedule of Fees lists the fee paid by the Hearing Services Program to Hearing Services Providers for each service item and hearing device category.

Schedule of Service Items

The Schedule of Service Items lists each service item with a description and conditions for claiming.

Screening test

A partial hearing test to determine if a person may require further audiological assessment.

Self Assessment Tool (SAT)

Hearing Services Providers are required to complete and submit an annual SAT. The SAT assists Hearing Services Providers to check if they have systems in place to meet the requirements of the Hearing Services Program.

Service Provider Contract (SPC, the Contract)

The Contract sets out the terms and conditions under which a Hearing Services Provider must deliver the Hearing Services Program.

Service Provider Number

Contracted Service Providers, who are accredited with the Hearing Services Program are issued an individual identification number at the start of their contract.

Tele-audiology

The utilisation of telemedicine to provide audiological services and may include the full scope of audiological practice.

Voucher

An authority (in paper or electronic form) issued by the Department of Health to eligible clients of the Hearing Services Program enabling them to have their hearing tested and devices reviewed. Vouchers are current for a period of three years. See also return voucher.

Voucher details

Voucher details include the date of issue the service or services for which the voucher has been issued the date by which the voucher must be first presented to a Hearing Services Provider for a hearing assessment the name of the voucher-holder and any other relevant matters.

Voucher stream

When referencing the voucher component of the Hearing Services Program.

Wishes and Needs Tool (WANT)

The Wishes and Needs Tool is a legislated client self-report instrument for evaluating a client's attitude and motivation level for the fitting of a hearing device.

Young adults

In the context of the Hearing Services Program (the program), young adults are those under 26 years of age who are eligible for hearing services through the Community Service Obligations component of the program.