

# **The Hearing Services Program Review**



**SOUNDFAIR**

## **Consultation Paper Response from Soundfair**

## BACKGROUND

The hearing health system isn't working. It is confusing, expensive, cumbersome. People are not receiving the care and consideration they deserve when it comes to hearing health. Millions of people in Australia are suffering and their lives are falling apart due to unaddressed, unsupported, unaffordable hearing health care and rehabilitation.

The situation is dire.  
– Victoria

Soundfair acknowledges and thanks the numerous people with lived experience of hearing conditions whose personal experiences and stories, preferences and needs have informed this submission.

**Soundfair welcomes the opportunity to respond to the Hearing Services Program Expert Review Panel's Consultation Paper. We would especially like to thank the Minister for Regional Health, Regional Communications and Local Government, the Hon Mark Coulton MP, and the Australian Government critical public health issue that affects one in six Australians.**

Soundfair sees this review as an opportunity to re-focus the Hearing Services Program (Program) on the people who most need its support – the one-in-five Australians who live with a hearing condition. We see this as an opportunity to be innovative, responsive and cost-effective; and to foster social and economic inclusion.

Soundfair's service delivery is informed by a social model of disability approach, which considers social determinants of health when designing person-centred service strategies. The WHO's Structural Determinants of Health Model states that complexity defines health.<sup>1</sup> Social structures, norms, and institutions are influential in the extent to which a person thrives in life. And this is no less true for people with hearing conditions.

Soundfair's evidence-based position acknowledges the vast diversity in lived experience, needs and preferences of people with hearing conditions, and considers that substantive hearing health programs require urgent re-balancing to focus on consumers and accessibility. It is time to look beyond individual-focussed interventions to solve this complex social challenge. In this submission, we present positions and recommendations centred on the experiences and needs of people living with hearing conditions.

### **\*Terminology note**

Hearing conditions, like people, come in many different forms, from vestibular disorders to tinnitus, from profound deafness to mild hearing loss. Equally, each person relates to their hearing condition in their own way – each perspective on lived experience is valid and should be respected. Soundfair uses 'hearing conditions' to encompass all the variety of lived experiences and uses hearing loss, deaf, Deaf and d/Deaf, as appropriate, to distinguish between people who use Auslan as their primary language (and/or consider themselves to be culturally part of the Auslan-using community) and those people who live with, or identify as having, a hearing loss.

<sup>1</sup> See [https://www.who.int/health-topics/social-determinants-of-health#tab=tab\\_1](https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1) accessed 7 December 2020.

## EXECUTIVE SUMMARY

It's not just about going to the audiologist and having a hearing test, it's about having the right hearing aid to use; having people around you that can support you; that understand it.

– Dale

I guess a lot of it is the journey of coming to terms and acceptance of the new norm. I have arrived at that point and I've got a massive toolkit now, a bank of strategies up my sleeve that I can always work with. But it's never perfect and hearing conditions – if we don't have an inclusive society – the impacts are not just physiological, the impacts are emotional, they're psychological, they're social and we need to take this into account when designing strategies to support people to navigate it.

– Maxine

As an audiologist, I think we focus so much on the technical side of things and the identification of a hearing loss. Handing out a little piece of paper to the clients, 'here's some strategies, see how it goes' or to families 'this is the expectation'. I'm a very big, strong advocate of, for even the audiology student, your first job should be being an advocate for your client. Number-one priority.

– Rebecca

By taking a social perspective on hearing conditions and utilising the structural determinants of health model, Soundfair sees health services as one part of a complex system influencing an individual's health and wellbeing. Through this lens, for the Hearing Services Program (Program) to meet community needs and expectation, the Program should offer individuals control over their options, consider diversity in delivery, and balance of offerings and combinations of services that offer meaningful support across the lifespan and across society.

**People with hearing conditions are more than just their ears – they are diverse, capable of making complex decisions and have needs that go beyond their ears. Not surprisingly therefore, living well with a hearing condition requires more than just devices.**

### SOUNDFAIR RECOMMENDATIONS:

1. Orientate the Program towards the needs of consumers, not providers:
  - o Simplify entry and navigation of services, minimise barriers to help seeking and access to funding programs
  - o Flexible service offerings that focus on outcomes for individuals and families in the real world
  - o Minimise the influence of the commercial market over consumer choice and control
2. Position the Program as a platform for society-wide prioritisation of hearing health across the lifespan by offering:
  - o Targeted health promotion and prevention programs that focus on life-stages or diverse sub-populations
  - o Capacity building across society for psychosocial support and social connection that goes beyond biomedical service providers
  - o Capacity building and education for health professionals (including GPs, ear, nose and throat (ENT) surgeons, psychologists and mental health practitioners etc)
  - o Specific support options for vulnerable populations
  - o Research and quality monitoring
3. Support service delivery that aligns with existing evidence that hearing aids are just part of the solution that are only suitable for some people:
  - o Embed and appropriately fund psychosocial and social-focussed support (such as social prescribing, behavioural approaches, and tactics) as required services
  - o Coordinated care that utilises multiple disciplines to meet the individual needs of consumers

**Within this submission, Soundfair offers a solution that would overcome many of the considerations listed above and look forward to discussing this with the Panel.**

# RESPONSES TO CONSULTATION DISCUSSION QUESTIONS

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

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

Currently, the primary objective of the Program is 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. While the 11 listed functions (S.8)<sup>2</sup> in the Australian Hearing Services Act 1991 include broad community education, the emphasis of the objective is still largely device-centric. Similarly, while 'declared hearing services' as defined by the Australian Hearing Services (Declared Hearing Services) Determination 2019<sup>3</sup>, includes rehabilitation, the program still focusses largely on the administration of devices, and doesn't clearly define the nature and extent of rehabilitation.

Given the recent work around the Roadmap for Hearing Health and the volume of supporting research around determinants and associations with good hearing health outcomes, it is timely that the objectives be reviewed and that the program is rebalanced. Having clear objectives that go beyond service delivery towards changing the narrative and public behaviours through evidence-informed, quality programs will modernise and increase the value proposition of the program. Broader objectives could include:

### Why

- The Australian Government's Hearing Services Program contributes to the health and wellbeing of all people across Australia by supporting hearing-health-targeted health promotion programs, best-practice support and community initiatives so that people with hearing conditions can access and participate in life in ways most meaningful to them.

### What

- Population health and health promotion activities across the community
- Targeted research
- Financial support for all required services
- Overseeing quality assurance of services

### How

- Working with service providers, community organisations and consumers
- Working alongside State/Territory Governments to delivery complimentary funding arrangements
- Overseeing transparent and consumer-centred administration and operations of the program

<sup>2</sup> Australian Hearing Services Act, 1991, c.2, s8.

<sup>3</sup> Australian Hearing Services (Declared Hearing Services) Determination 2019, c.6, s1 (5)



If one cannot afford \$3000 to \$15,000 to purchase hearing devices and on-going counseling and rehabilitation to help with the hearing issue then what? The patient is left untreated, isolated and despairing. Where do they go from here? Where? Who? How do they find the ethical professionals who CAN help them on their tinnitus/hearing journey? Can they afford this care? Why is it free to see and so dear to hear?

– Victoria

## 2. Which consumers should be eligible for Program subsidies?

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

Funding accessibility for people with hearing conditions is complex and inherently inequitable, in that it is exclusive in who it serves, and the exclusivity is not clearly linked to need. That is, many pensioners living with few daily impacts due to their hearing conditions are eligible and receive devices that are often not used; yet a working-age person who is substantially impacted by their hearing condition, but who may not be eligible for NDIS, is ineligible for the Hearing Services Program and self-funds or leaves the workforce.

Hearing services (and especially devices) are expensive relative to other health management options. There are a substantial number of people who do not and cannot benefit from funded hearing services. While Soundfair does not propose an NHS (UK) model, we do acknowledge that greater clarity, coordination and clearer expectations of Australian Government and state government-funded hearing services would ultimately benefit people living in Australia who currently, or may in the future, experience hearing conditions. If this is achieved, the Australian community and economy will benefit through greater participation in the workforce, increased productivity, and reduced healthcare expenses – particularly in old age. The greatest opportunity for benefit is to those most vulnerable across the country.

Ultimately, Soundfair strives for hearing equality. At a minimum, hearing equality requires access to appropriate psychosocial support and technology; and ideally, includes a society-wide approach combining a social model of disability and public health model that encourages the community to make accessibility changes so that the onus is not entirely on the individual with a hearing condition. Many of the consumers Soundfair interacts with find themselves unable to access basic hearing services, or are significantly disadvantaged by having to spend anywhere between \$20,000 and \$180,000<sup>4</sup> to maintain their place in the workforce

<sup>4</sup> Based on a scenario of a person diagnosed with hearing loss at age 30, an average lifespan of 5 years for a device, and a range of device, maintenance and battery costs.

(over a number of years) and in meaningful relationships due to their hearing condition. The sub-populations of consumers who aren't served and are disadvantaged due to ineligibility are further explored in answer to Question 8; however, the primary people who we see as being most in need of consideration for eligibility are those who are of working-age, but un- or under-employed.

In the absence of substantive Medicare funding for hearing services and state-based programs, the Program carries the weight of supporting populations considered most in need (at the time of program development). When compared to other schemes, such as those targeting dental, vision or diabetes, the role of the Australian Government is substantially different. We see an opportunity to clarify the roles of the Australian and state governments and ensure the states/territories contribute in a comparable way to other health conditions in supporting access to hearing services. In a similar vein to the Australian Government's approach to diabetes funding, vision and dental care funding (all of which have some commonalities to hearing), the model overleaf is suggested.

### Recommendations:

1. Broaden the scope of the Program to include a more holistic range of hearing support services that are linked to improved health outcomes and greater social participation
2. Seek greater contributions from the state/territory governments in serving vulnerable and disadvantaged groups in their jurisdictions
3. Seek greater contributions from private health insurers and support alternative sustainable service models such as hearing (aid) banks to enable equitable access across the population

Table 1. Alternative Funding Model.

Australian Government	State/Territory Governments	Other Funding Mechanisms
<p>Hearing Services Program: Public health and health promotion: regarding prevention of hearing conditions, increasing awareness, and reducing stigma to increase help-seeking</p> <ul style="list-style-type: none"> <li>• Research</li> <li>• Outcomes collection and reporting via a non-government organisation</li> <li>• Workforce audits</li> <li>• Consumer support and information: via non-government and non-commercial sources</li> <li>• Initial help-seeking consultation</li> <li>• Service provision: financial packages including support and devices based on needs for eligible people (including CSO populations)</li> </ul>	<p>Public hearing services for those eligible, including anyone not eligible for HSP and who:</p> <ul style="list-style-type: none"> <li>• are aged 2-17 years whose family receive Family Tax Benefit Part A (or similar) to fund diagnosis and monitoring</li> <li>• hold a healthcare or concession card, or who are dependents of concession card holders</li> <li>• in justice custodial care</li> <li>• are seeking asylum or refuge in Australia</li> <li>• Aboriginal or Torres Strait Islander people aged 28-49</li> </ul>	<p>Private Health Insurance: increase subsidy to include hearing-related psychosocial support and audiology consultations (i.e., not device only) and increase rebates for hearing aids</p> <hr/> <p>Tax deductibility for out-of-pocket expenses for hearing aid purchase</p> <hr/> <p>A mechanism to allow the leasing of hearing devices</p>
<p>Medicare Benefits Scheme:</p> <ul style="list-style-type: none"> <li>• Hearing monitoring item</li> <li>• Chronic disease management (specifically including hearing-related providers)</li> </ul>	<p>Workplace injury cover (WorkSafe or equivalent) for people whose hearing conditions are the result of workplace injury</p>	<p>Hearing Banks: community and philanthropically funded services that offer low- or no-cost services to people who do not meet the criteria for funding via other mechanisms or as a service delivery pathway for delivering services for vulnerable people</p> <ul style="list-style-type: none"> <li>• This may require Government seed funding may be required to ensure the quality and coordination of these services</li> </ul>
<p>NDIS for people whose hearing condition substantially impacts their daily function (via subjective and objective measures)</p>		
<p>AHPRA practitioner quality and standards assurance</p>		

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

The Program has historically focused on provision of biomedical or technical rehabilitation. This was appropriate at the outset of the program, but this model is not achieving contemporary health outcomes for consumers; is device-centred and paternalistic<sup>5</sup>; and ultimately supports a lucrative, provider-focused business model of high-volume, rather than high-quality, services and meaningful outcomes for consumers. Put simply, the Australian Government and taxpayers are not getting a good return on their investment.

The primary and most obvious omission from the Program are services that address the psychological and social needs of an individual or family.

As with most chronic health conditions, hearing conditions have vast psychosocial consequences not remediated through biomedical means (i.e. hearing aids) and require input from multiple professionals.<sup>6</sup> Decades of evidence reveals that the current model of providing hearing services (modelled on the Program funding scheme) leads to services that<sup>7,8,9,10,11</sup>:

- Lack individualisation
- Lack accessibility (in terms of quality information, appropriate health literacy, time for decision making)
- Lack of inclusion (consumers rarely have the option to choose their remediation other than the level of payment)
- Lack trust and a therapeutic relationship

Equally, evidence reveals the substantial consumer benefits and economic case for providing at least basic psychosocial rehabilitation.<sup>12</sup>

### **The process through which rehabilitation and hearing aids are offered to consumers perpetuates a practitioner-centred model that disempowers consumers from the outset**

Most consumers' first contact with a hearing provider is for a hearing test or a free screening. In this same appointment, most people are recommended, offered, and sold hearing aids. The conflation of this process and disregard for consumers' control over decision-making detrimentally affects outcomes for many people. It is broadly acknowledged in help-seeking literature that for consumers to get optimal outcomes and successfully self-manage their conditions, several criteria must be met: 1) the person needs appropriate information to inform decision making, 2) time to consult significant others and 3) genuine options that are explained in a meaningful way.

To address these issues, an alternative approach to hearing services is presented, like that used in mental

5 Hogan A, Donnelly D, Ferguson M, Boisvert I, Wu E. Is the provision of rehabilitation in adult hearing services warranted? A cost benefit analysis. *Disability and Rehabilitation*. 2020;1-6.

6 Bennett RJ, Fletcher S, Conway N, Barr C. The role of the general practitioner in managing age-related hearing loss: perspectives of general practitioners, patients and practice staff. *BMC Family Practice*. 2020;21:1-10.

7 Grenness C, Hickson L, Laplante-Lévesque A, Meyer C, Davidson B. The nature of communication throughout diagnosis and management planning in initial audiological rehabilitation consultations. *Journal of the American Academy of Audiology*. 2015;26(1):36-50.

8 Ekberg K, Meyer C, Scarinci N, Grenness C, Hickson L. Family member involvement in audiology appointments with older people with hearing impairment. *International Journal of Audiology*. 2015;54(2):70-6.

9 Grenness C, Hickson L, Laplante-Lévesque A, Meyer C, Davidson B. Communication patterns in audiological rehabilitation history-taking: Audiologists, patients, and their companions. *Ear and Hearing*. 2015;36(2):191-204.

10 Ekberg K, Grenness C, Hickson L. Addressing patients' psychosocial concerns regarding hearing aids within audiology appointments for older adults. *American Journal of Audiology*. 2014;23(3):337-50.

11 Grenness C, Hickson L, Laplante-Lévesque A, Davidson B. Patient-centred audiological re-habilitation: Perspectives of older adults who own hearing aids. *International Journal of Audiology*. 2014;53(sup1):S68-S75

12 Hogan A, Donnelly D, Ferguson M, Boisvert I, Wu E. Is the provision of rehabilitation in adult hearing services warranted? A cost benefit analysis. *Disability and Rehabilitation*. 2020;1-6.





I didn't know where to go for help there wasn't anything staring me in the face. I wasn't channelled through the system in terms of: speaking to this person, speak to this particular type of coach, speak to this particular type of audiologist, or therapist, or health professional. I wasn't given any of that information, so for me it was all around self-advocacy and self-empowerment and that took a long time.

I have to say it took probably a lot longer than I think it should have taken, had I been given the professional help from the beginning. So, yes, I definitely shied away. I definitely socially isolated and, you know, it even became an issue with relationships because, for example, my husband would want to go do things and instantly I would just knock it on the head and say no, not doing it. So it would impact relationships as well.  
– Maxine

health triaging (see Head2Help in Victoria). A proposed approach to the funding of this model includes:

- Rather than funding a blanket amount for all eligible people, the Program funds tiered packages (akin to stepped care) to match the needs of the individual.
- Tiered packages (as illustrated in Figure 1) are based on extensive and evidence-based needs assessment beyond hearing thresholds (which is shown to be an inappropriate proxy for need<sup>13</sup>).
- The initial consultation with the case worker is funded under the Program for any person concerned about a hearing conditions (including tinnitus, balance or other – in line with the recommendations of the Roadmap for Hearing Health, chap 5, rec 9).
- The case manager is tasked with finding the appropriate funding for the consumer, and supporting them to move into that pathway, thus overcoming the complexities of navigating different funding mechanisms (NDIS, Workcover, Program, private health).

This methodology of service provision would offer an independent and supported pathway for those consumers who aren't yet ready for hearing aids immediately, or who need access to appropriate information, education and additional supports (and perhaps medical attention) before progressing to hearing devices, and to do so in a non-commercial environment. The requirements for this are:

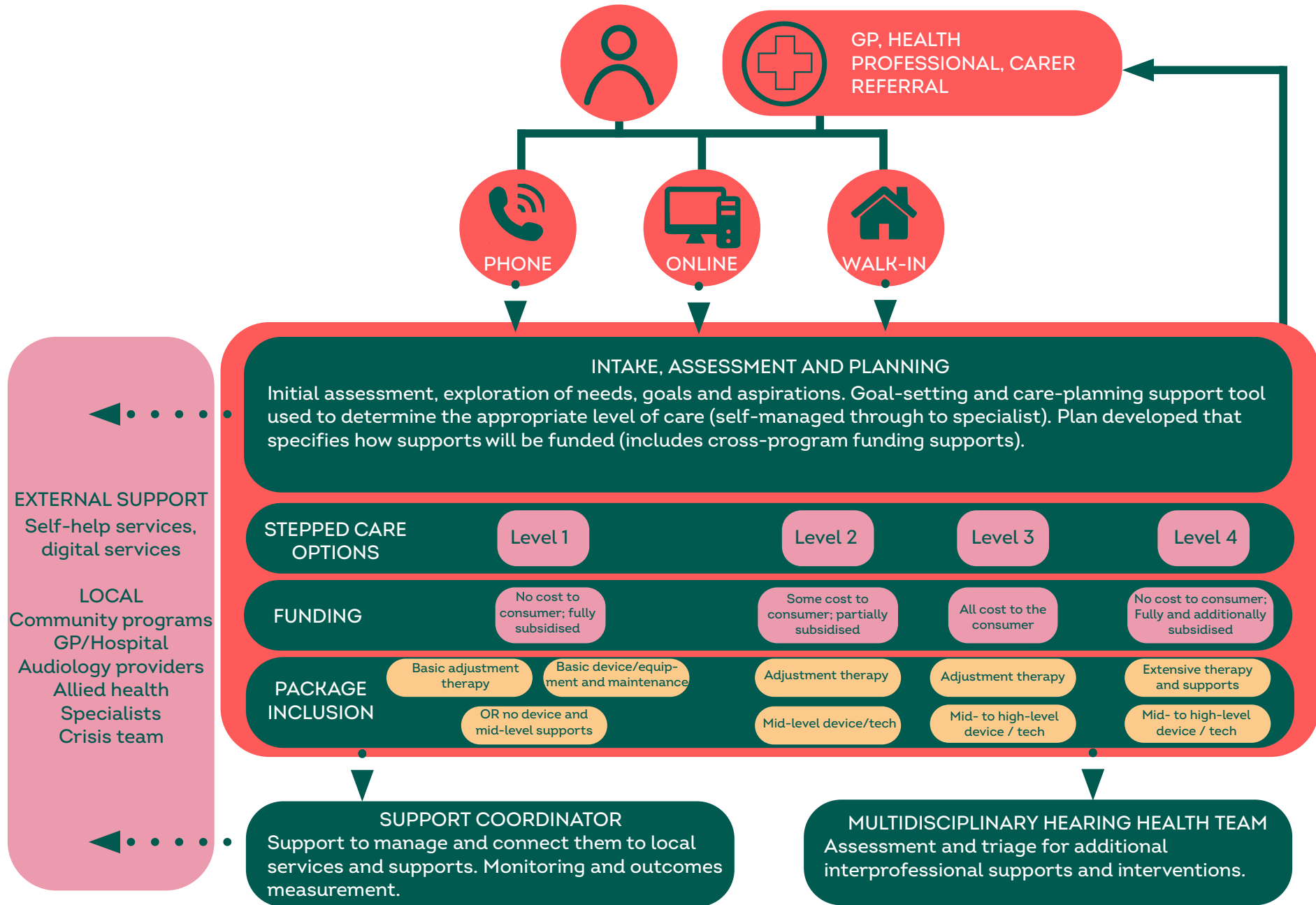
- Any person can access this support via any path (GP, other professional, self-refer) to receive a needs assessment (at a pre-determined maximum frequency)
- The needs assessment is based on a whole-person assessment, not just an audiogram
- An independent person (e.g. case manager) works with the consumer to determine which package level is appropriate given their needs.
- The consumer and case manager develop a plan and make connection to all relevant people fully integrating a truly inter-professional approach that is based around the needs of the consumer (e.g. including audiologists, ENT surgeons, rehabilitation counsellors, psychologists, occupational therapists, local support groups) in the possible support package),
- Some services are offered within the organisation who offers this model (e.g. non-device rehabilitation) and some are offered by referring externally (e.g. fitting hearing aids, referring to an ENT surgeon)
  - o Needs assessment is based on a validated whole-person assessment
  - o Support packages are tiered and based on the consumer's level and types of needs

<sup>13</sup> Meyer C, Hickson L. What factors influence help-seeking for hearing impairment and hearing aid adoption in older adults? International journal of audiology. 2012;51(2):66-74.

Figure 1. An alternative model for hearing services.

EMPOWERING. HEARING. EQUALITY.

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## Recommendations:

1. Implement a model of hearing care that starts with a 'no wrong door' approach that separates initial assessment and information from hearing aid provision (see Figure 1)
2. Revise 'Rehab+' item number such that it is:
  - o A compulsory claim for all hearing aid fittings
  - o Can be claimed for any client, irrespective of whether a device is prescribed
  - o Has a fee that is appropriate, given the skills and complexity of the work undertaken
  - o Can be claimed by an appropriately trained professional, based on the needs of the consumer
3. Contract a rehabilitation provider who can provide non-device-related support and advice to a high standard outside the current HSP model, but complementary to all providers

I have found that the hearing aid industry as such often rips older people off with prices at shopping malls. They double the prices of a reputable dealer and/or con people into buying bad equipment. They take advantage that it takes us a week to ten days to get used to the hearing aids. That's got to stop. We don't have the luxury of having many shops to choose from and it's stressful enough as it is.  
- Frank

## 3. How well does this Program Interface with other schemes?

Do the interactions between consumer pathways through the hearing services schemes lead to good consumer outcomes? Is there enough information about the scope and eligibility criteria of the various schemes? Can they lead to people with similar hearing loss and similar financial capacity, for instance, to have different services and levels of subsidy?

Soundfair frequently serves consumers from across Australia who are confused and misinformed about help-seeking pathways, options and funding entitlements related to hearing. There are at least four reasons for this:

1. Consumers are influenced by the information or direction offered by other health professionals, particularly GPs, ENTs or other primary health care professionals. Soundfair often hears of misinformation, consumers being put off taking action or, worse, being told to 'it's all in your head', regarding their hearing conditions. Recent research conducted by Soundfair reveals that GPs in particular are poorly equipped to fulfill their important role in hearing health of the public<sup>14</sup>.
2. Consumers are influenced by the information they receive from the hearing provider they happen to find themselves at. That is, the commercial interests of many providers trump the necessity to provide general information and the recommendations offered to clients do not clearly align with consumers' needs. The absence of an independent initial assessment means that consumers' access to funding, recommended rehabilitation options and, therefore, outcomes is substantially influenced by which provider they find. Results of EarTrak surveys report that more than hearing aid manufacturer, level of technology or style of hearing aid – the most influential factor in outcomes is the clinician.
3. The interactions between and criteria for funding and access to hearing services are complex and convoluted.

<sup>14</sup> Bennett RJ, Fletcher S, Conway N, Barr C. The role of the general practitioner in managing age-related hearing loss: perspectives of general practitioners, patients and practice staff. BMC Family Practice. 2020;21:1-10



Seven years ago, a roaring sound arrived in my head. It was as if white noise static had meshed with an ear-piercing ringing and it was here to stay. I was filled with the greatest anxiety and fear.

I visited my GP. I visited my ENT. I visited my dentist. I had MRIs, scans, audiology tests and x-rays. In the end, I was diagnosed with mild upper frequency hearing loss as well as 'garden variety' tinnitus. These were the exact words used by my ENT. I was told 'not to stress' (no-one told me HOW to do this) and that it would go away in time and I would stop noticing it (I continue to notice it and it HASN'T gone away). I was prescribed anti-depressants and sleeping tablets, which I didn't take.

I walked away from this process feeling depressed and let down by the medical community. I started to think: "I've had a good life. If I die now, then I will be at peace. If the ringing won't go away from me, then I will go away from the ringing." These were the darkest moments of my life. My thoughts frightened me, but at the same time offered a bizarre type of comfort. I had an answer to the ringing. I had an 'out'. I had control.

– Victoria

4. There is a paucity of quality, unbiased information about hearing services, support to find appropriate funding and places to ask questions/question what has been recommended.

### **Interactions between funding pathways**

The transition from Community Service Obligation (CSO) support for children and young adults into the private market or NDIS is a challenging one for young adults. The Hearing Services Program, or the hearing sector for that matter, appears to not have appropriate mechanisms for connecting young adults with an organisation that can support their transition out of the Program/CSO program and Hearing Australia and into the world of private hearing services. Soundfair has heard several stories of young people finding themselves at a hearing provider aged 30 with little knowledge about what they should be looking for in a professional; what to expect; and, thus, feeling disempowered. This disempowerment lasts for many years unless they find a way to get informed through their own research.

*Jess was 28 when she was informed that she has three months left on the Program subsidised program. She was fitted with new hearing aids and given a pamphlet on other audiology services in her area. After a quick Google, Jess realised the pamphlet was out of date. Jess had been seeing her audiologist for several years, though they never deeply connected as it was usually about hearing aids. But how was she meant to navigate this world now? And how was she ever going to pay for new hearing aids while she was finding her feet in work and building a family?*

A second area of concern where interactions between government programs introduces complexity and inequity is for adults over 65 years who would otherwise be eligible for NDIS funding including those who meet the CSO criteria.

*Maria received her cochlear implant (CI) when she was 58; it made a huge difference to her life once she persisted through the adjustment period. Overtime, the processor has become less battery-efficient and she often reads about all the new functions of the current processors which hers don't have: most relevant is the connectivity to her phone which would allow her to talk on the phone which she sorely misses. Now that Maria is 66 and on a pension, she is eligible for hearing services under the Program, but this does not include an update to her CI processor. If only she just needed hearing aids – she'd be able to get new ones every five years.*

*Jack is 72 and has a moderate-severe hearing loss bilaterally. Jack doesn't qualify for CSO funding, but given the functional impact his hearing has on his daily life (unable to safely run his dairy farm), he is likely to be eligible for NDIS funding if he were under 65 years of age. Jack therefore does not receive individualised package including appropriate technology, assistive devices for the home and farm and counselling for him and his family as he would under a NDIS plan. Jack's outcomes are poorer, and he retires early.*

### Interactions between clinical offerings

Of concern to Soundfair is the frequently reported impact of commercially motivated behaviours being put ahead of consumer outcomes and preferences. That is, the Program rewards a clinic for keeping a client on their books rather than striving for optimal outcomes. For example:

- Service providers not on-referring a consumer for CIs when this is clinically appropriate or at least worth consideration. We receive reports that this behaviour is particularly present in Victoria. The disjointed funding between hearing aids and CIs can mean that a hearing service provider 'loses' their client and some funding when they on-refer to cochlear implants. The separation of these service offerings also means that consumers find themselves inconvenienced by having at least two providers, having to travel to receive CIs support where their hearing provider may be local.
- Service providers not on-referring to another audiology clinic who might specialise in a particular area or offer different branded devices (e.g., tinnitus, hyperacusis or vestibular).
- Service providers not on-referring to other professionals (psychologists, counsellors, speech pathologists or physiotherapists) or community organisations (e.g., Hear For You, Soundfair, Hearing Matters Australia) to meet the additional and lifelong psychosocial needs of a consumer.

### Recommendations:

1. Invest in capacity building and education for associated health professionals (with particular emphasis on GPs) regarding hearing loss and tinnitus, balance conditions etc.
2. Enforce clinical standards so that clinicians must put the interests of consumers before their own or their organisation. This may require further consideration around AHPRA registration and quality assurance regarding standards and competencies.
3. Transition all individuals currently on the CSO, Specialist Hearing Service scheme, to NDIS where any qualified hearing services provider can deliver and receive funding for services.
4. Develop a non-commercial transition package for young adults exiting the CSO program
5. Enable hearing providers to access out-patient funding for Cochlear Implant services.
6. Fund a community organisation to provide a life-long relationship with consumers, irrespective of where they receive their services, where they can seek information, education and guidance to ensure they are enabled to make informed choices throughout their hearing journey and enable an array of rehabilitation options to be coordinated across an array of different service providers and funding programs.
7. Implement a public-health-focussed service delivery model (Figure 1) or similar.

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

Answering this question is somewhat of a summary of all our responses across this consultation paper:

- Invest in population health and community-based initiatives that deliver unbiased, culturally meaningful education and supports across the community to ensure that all people who need support know how to get it and can.
- Develop and integrate multiple funding sources to minimise the sub-populations who are ineligible for any hearing funding, but not in a position to appropriately self-fund (Figure 1).
- Develop a service model that puts the consumer in the driver's seat from the beginning (Figure 1).
- Ensure the hearing system is appropriately individualisable and flexible to account for the vast differences in approaches and support options needed by consumers.
- Invest in service delivery that goes beyond hearing aid provision and integrates psychosocial supports alongside measuring outcomes of all offerings.

#### **4. Does the Program sufficiently support hearing loss prevention?**

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

The current Program does not address hearing loss prevention.

Based on the proposed model presented in Figure 1, modifications to the Program would see greater focus on public health and health promotion activities that include increased investment in hearing loss prevention and awareness. This change is in line with the recommendations contained in the Roadmap for Hearing Health.

#### **Recommendations:**

1. Australia-wide funding of ongoing and diverse health promotion activities relating to hearing loss (see National Diabetes Services Scheme and sub-program offerings) that encourages interdisciplinary collaboration:
  - o Behaviour change interventions
  - o Apps and technology to track hearing and tinnitus
  - o Age-group or sub-population specific programs (school age, musicians, farmers, culturally and linguistically diverse [CALD] etc)
2. Embed prevention as a focus in future research funding
3. Implement a service delivery model (Figure 1) that embeds public health by enabling any person to access information and monitoring of their hearing at whichever life-stage they are

I had to learn. I guess to self-educate and teach myself strategies because, as I mentioned, back then I didn't know where to go for help there wasn't anything staring me in the face.

– Maxine

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

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

Data on the prevalence of hearing loss, coupled with data on uptake, use, and outcomes with hearing aids suggest that consumer needs are not being met.

As proposed in Figure 1, we advocate for:

- An option for separation of independent assessment and advice from rehabilitation provision (as modelled in the Head2Help mental health model currently in place in Victoria)
- Genuine rehabilitation options for all consumers. All consumers should, at a minimum, receive basic psychosocial support alongside provision of a hearing aid.



- Integration of funding stepped-care model ensures that rehabilitation options (including hearing aids) are tailored and individualised as a package for the consumer, and not based on financial benefit to the provider.
- Build the capacity and offerings of the community-sector and non-audiological professional (i.e., other professionals, consumer advocates, consumer charities) to provide psychosocial, and socio-cultural offerings that are focussed on community-based prevention, connection with lived experience, peer support and education.

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

Shifting away from a biomedical model, and towards a biopsychosocial and socio-cultural model that brings together the strengths of the audiological expertise and of the community more broadly will benefit consumers. By ensuring society (families, friends, workplaces, educators, social event providers etc) plays a role in hearing equality, the burden is lifted from the Program directly and a more consumer-centred and whole-person offering is delivered. Ultimately, this also lifts the burden from individuals with hearing loss.

Soundfair believes that moving away from a provider and business-driven model will provide a more sustainable hearing health landscape into the future, despite an ageing population.

I remember being asked what my goals are: I couldn't think of much other than being able to follow the conversation when out with my friends. The audiologist insisted that I need more goals and went on to write down things like: "hear better on the phone; understand my husband better around the house". I said I'm not worried about that and he said to me "well, I think this is what you're saying and it will help get better hearing aids."

– Jane

## **6. Is the Program supportive of consumer choice and control**

Do consumers receive sufficient information to make informed choices? Do they have adequate control and flexibility over the hearing services that would be in their best interests? What changes, if any, should be made? Should any changes be made to the CSO Scheme?

Choice and control is a central tenant of the development of the NDIS. To enable choice and control, research has indicated the following are required:

- Services are designed with people with lived experience
- Planning is critical (having access to information, time to plan and access to people who can support planning such as case coordinators)
- Consumers need to be trusted to make their own decisions (i.e., clinicians must genuinely hand over the control)
- Minimisation of red tape and complexities (or support to overcome)
- Clear pathways between systems and services (rehabilitation and education and social programs)

These factors should be considered in the Program. Under the current system, services are rarely designed or modified alongside people with lived experience; there is no funding for planning or for a case supporter to facilitate planning and decisions separate to the providers; and consumers' decisions are often undermined.

Moreover, mismatches and administrative challenges between funding programs and a lack of unbiased information about pathways means that consumers are often at the mercy of the provider they find themselves with. This may result in a great outcome for the client, or a poor outcome.

The lack of diversity in rehabilitation options provided means that many consumers find that their only decision to make is 'yes' or 'no' to hearing aids. This does not acknowledge the vastly different needs that an individual might present with. For example, Dr Caitlin Barr's PhD research<sup>15</sup> observed of over 60 consultations across Australia and found that all consumers who were diagnosed with any level of hearing loss or tinnitus were recommended hearing aids and that in just 8 per cent of cases was an alternative offered. Alternatives were only offered after hearing aids were declined. This is not choice nor control.

The funding mechanism under the Program (focussed primarily on the device) also limits the flexibility of hearing service package provided. Soundfair sees an opportunity for the Program to consider a stepped-care model where funding levels are commensurate with need, and funding packages are built based on individuals' needs and assessments rather than a blanket voucher scheme (Figure 1).

Under the current CSO model, there is an untested assumption that having one provider ensures a level of quality and standards for consumers. The counterargument is that while a consistent standard may exist, it is likely that this consistent model cannot fully meet the needs of diverse and unique individuals. Like the NDIS model, handing control to consumers (with appropriate supports) will, via market forces, encourage diverse service offerings to meet these diverse needs. The activities funded under CSO fit with the biomedical model and there is an opportunity to include funding for CSO clients that better addresses their psychosocial needs (which are greater in this population).

## Recommendations:

1. Implement a new model of hearing care (Figure 1) that facilitates consumer choice and control separate to service providers
2. Improve quality of information and education available to consumers
3. Ensure consumer safety and quality by developing appropriate safeguards to ensure a minimal standard for service provision to vulnerable populations (e.g. 0-27-year olds)
4. Put consumers in the driving seat by opening CSO funding to a contestable market to better match the models used across health and disability within the Australian Government
5. All providers delivering services to clients (CSO) eligible for appropriate funding (i.e., not Hearing Australia specific)

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

Hearing Australia is a unique service provider in the Australian landscape. While the model of Hearing Australia (that is, being the government provider) has been invaluable for vulnerable Australians for many years, the benefits that Hearing Australia brought are now frequently questioned by consumers and, in many cases, lead to confusion and reduced consumer control as they now exist in the marketplace alongside many other providers,



rather than providing wholly unique offerings to different populations. For example, from the perspective of an adult under a voucher scheme, the experience of seeking services at Hearing Australia is not materially different to that of accessing any other provider.

Where unique services to different populations do exist (i.e., for a young person under 27 years), there are benefits to shifting to a coordinated approach and shared standards to provide services towards offering families and young people choice and control; that is, a model that supports them to find the supports (that go beyond hearing devices) that suit them and their individual needs. While the contestability of the market (note: Soundfair finds describing young people as a market problematic) has been previously debated, we believe that once appropriate standards are in place to ensure quality and safety for service providers in the paediatric space, this conversation should be re-visited.

Service delivery and programs targeting Aboriginal and Torres Strait Islander people do benefit from a coordinated approach; however, Soundfair understands that the complexity introduced between federal and state funding of the same groups has led to inefficiencies. Soundfair believes that Aboriginal and Torres Strait Islander people are equally in need for choice and control and need greater autonomy over their health programs.

Based on the recommendations highlighted in this submission, Soundfair sees the following options for the role of Hearing Australia in the future of hearing services:

- Develop, monitor, and upskill professionals based on national standards for paediatric services
- Re-visit the need for contestability in for people who are eligible for CSO services, through the lens of consumer choice and control

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

Consumers are increasingly interested in emerging technology, including hearables, over the counter and lifestyle technology, as it arises. Consumers' motivation for this include: the need for cost-effective technology, interaction with services and supports that are convenient and meaningful to them, and distrust of the current system. It should be acknowledged that technology moves faster than research and evidence and having the 'system' determine appropriate supports 'for' consumers perpetuates this lag.

With an increased focus on outcomes, not the device or support offered within the package, the program can be agile and person-centred into the future.

### **Recommendation:**

1. That the Program allow for individuals to make decisions about their own package (and technology and services therein), in the context of what is evidence-based and meets quality and professional standards, will ultimately lead to better outcomes for consumers.

What are the advantages and challenges of having hearing appointments by telehealth? Are there other technologies, or service delivery channels, that consumers could benefit from in the Program?

The introduction of funding for telehealth is a positive step forward for the Program. From a consumer perspective, having access to their hearing care provider at a time and place of convenience aligns with person-centred care and increases the likelihood of seeking help.

The implementation of telehealth is more complex than providing funding alone. This has been shown via the results of the recent survey conducted by Audiology Australia, Australian College of Audiology and Soundfair, where many respondents reported either not using telehealth or not completing the survey as they felt they didn't receive telehealth. For many consumers, social determinants reduce the accessibility of services such as this. We also cannot overlook the inherent demographics of adult-onset hearing loss, which is strongly correlated with age. With more than 70 per cent of the over 75s requiring hearing services, relying increasingly on digital literacy in order to access services risks creating an unbridgeable divide that is not just digital, but one that embeds health inequities into the very system meant to address them. We simply cannot assume access to technology, understanding use of new modes or comfort with privacy is well embedded across society. Targeted support is required to optimise how consumers use telehealth including education and reassurance that the quality of care and relationship with the provider will remain.

### Recommendations:

1. Development of support packages and unbiased information regarding the benefits and challenges of telehealth.
2. Funding a consumer organisation to develop a suite of resources and coaching mechanisms to support consumers to engage in telehealth and troubleshoot to minimise cost to audiology providers.

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

Are hearing services accessible to those who require them, irrespective of where they live or the size of the consumer group with particular needs? Are the range and levels of government supports effective or are there further issues that need to be addressed?

One of the Guiding Principles of the Hearing Health Roadmap<sup>16</sup> is to ensure a priority focus on vulnerable individuals and communities. Soundfair believes that vulnerable populations should include the following groups – which goes well beyond what is traditionally considered 'vulnerable' (older adults in aged care, Aboriginal and Torres Strait Islander people aged under 28 and over 49 years) – people who are:

1. living in aged care and residential homes
2. newly arrived in Australia (seeking asylum or refuge)
3. culturally and linguistically diverse
4. under- or unemployed
5. experiencing homelessness or displacement
6. living in regional and remote areas

<sup>16</sup> Hearing Health Sector Committee (2019) Roadmap for Hearing Health - supporting all Australians who are deaf or hard of hearing to live well in community, AGPS, Canberra

7. Aboriginal or Torres Strait Islander people
8. Identify as LGBTIQ+

Hearing services and the prevailing model of individual (rather than family-unit), face-to-face, hearing aid-focused services and one-size-fits-all protocols result in substantial service gaps. The current model does not have the internal flexibility to meet the needs of people whose needs or preferences sit outside the standard biomedical model in metro/regional centre settings, nor place any responsibility on society at large for reducing barriers for people with hearing conditions. For several of these groups the Program provides no material support in its current form (i.e., 2, 4, 5, and 7, when aged between 28 and 49). Moreover, there exists little alternative supports for these groups across Australia.

We see opportunities for more equitable funding mechanisms across vulnerable groups to be implemented by a) broadening the offerings under the Program; b) implementing new initiatives at State/Territory Government levels. Additionally, considering alternative service models (such as social enterprises and Hearing Banks) as an important part of the landscape will minimise the service gaps. One example of an alternative service model that has arisen due to thin market gaps is Soundfair's unfunded Hearing Bank, which serves people who find themselves unable to access funding for hearing services but in need of support to contribute to society, communicate and remain healthy. Soundfair estimates that around 250,000 people across Australia are unable to access hearing services due to financial constraints – which is a small number relative to the total number of people with hearing loss, but a substantial and important group whose vulnerabilities put them at greater risk of continued poverty and poorer health. Another example of working alongside under-served groups outside the Program is Soundfair's unfunded work with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO). We are working together to develop a targeted hearing program for Aboriginal adults aged 28–49 across Victoria. Programs like this and many others would benefit from seed funding, where the scope is beyond that of the Program long term.

While we agree that Government programs need to better serve these groups; we believe that simply expanding the current service model to more people is not the solution. Taking a social determinants of health view, understanding the specific needs of these groups and working with them to develop offerings is likely to be far more effective and efficient. This might include targeted programs to offer education and support (e.g., targeted education for refugees in collaboration with resource centres) and implement a social model of disability approach (i.e., consider free field amplification in aged care and building design) rather than device provision. Public health programs created with communities for communities are shown to have positive outcomes, including increased help-seeking and adherence to treatment. The ultimate response to addressing diverse and complex community needs is to embed population and community-based initiatives and flexible and customisable service offerings.

## Recommendations:

1. Complimentary funding models at Australian and state government levels (Figure 1) that minimise the population gaps in service offerings
2. Funded health promotion programs addressing diversity and minority groups (such as CALD, LGBTIQ+, people seeking asylum and refugees)
3. Seed funding to increase the capacity of hearing aid banks (such as Soundfair's Hearing Bank) to ensure no one who is vulnerable, slips through the cracks

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

What data should be collected by the Program? Who should hold the data? What data should be published, and for what reasons? Is there a need for more data about hearing and hearing loss in the wider community beyond the Hearing Services Program? Other than the department, who or what government agencies should be able to access the data and for which purposes and with what consumer privacy protections?

Data (and specifically outcomes) are critical for transparency and quality assurance for funders and consumers of services. Gathered and used appropriately, data is an essential ingredient in person-centred services, in the creation of a model where consumers' powers and rights are substantial and in keeping service providers accountable. To have these impacts, data collection and reporting needs to be done in specific ways, including:

- Data collection (questions and process) occurs in a consumer-centred way. That is, health literacy is considered; questions go beyond hearing devices; consumers are ensured privacy (i.e., they can choose whether their identifiable responses are accessible by their provider)
- Data is collected, stored, and presented via an independent source, such as a market research company, academic institution, consumer organisation or outcomes measurement company.
- Data is stored securely.
- Data generated via Hearing Services Program funding is publicly available
  - o Consumers can access an aggregated summary of outcomes to assist in informing their help-seeking decisions.
  - o De-identified demographic information should be collected and stored to support creation of a data bank for research including longitudinal and quality assessment research into the future.
- Individual providers should get access to their own data (de-identified) and be required to publish their aggregated results. A good model to explore is used by EarTrak here in Australia.

### **Recommendations:**

1. The Program implement mandatory outcome measurement and quality assurance process that is not burdensome to clinics and is meaningful to consumers and useful for researchers.
2. Data is presented publicly in a useable form.

## SOUNDFAIR TEAM

### **Dr Caitlin Barr, CEO**

Dr Barr (early publications under Caitlin Grenness) has a background in psychology, is a clinical audiologist, and holds an honorary senior clinical research position at the University of Melbourne. Caitlin's thesis and postdoctoral research focussed on understanding older adults' needs from audiological services and defining the unmet needs of this group through the lens of person-centred care. Dr Barr has 40 peer review publications with over 770 international citations and an H-index of 14. Caitlin is passionate about transforming the system and society to be truly inclusive and accessible to people with hearing conditions and believes that real change requires putting people with lived experience at the centre and amplifying their voices.

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### **Dr Jessica Vitkovic, Innovation and Experience Lead**

Dr Vitkovic is a trained audiologist and holds an honorary senior clinical research position at the University of Melbourne and has over two decades' experience in design and delivery of audiology tertiary programs in Australia. Jessica's research focussed on consumer- and family-centred models of service delivery for vestibular clients and improvement in vestibular services broadly. Dr Vitkovic has 18 peer review publications and over 500 citations with an H-index of 10. With her MBA, government and innovation experience, Jessica ensures that service design occurs using methodologies that embed lived experience throughout.

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### **Melissa Klunder, Clinic Lead**

Melissa Klunder has brought authenticity and exceptional person-centred focus to the hearing sector for the last 26 years. Starting her career as an audiologist, Melissa has been part of purposeful transformation across various roles across the Australian audiology landscape including government, clinical service delivery, student supervision, device manufacturing, marketing and training and development. While respectful of historical foundations, Melissa has actively sought to never be restricted by 'what has always been done', and

is passionate about ensuring hearing services are person-centred and whole person focussed. A strong supporter and advocate of early intervention, Melissa served on the board of an Early Intervention Agency for Hearing impaired children for 15 years. As Clinic Lead at Soundfair, Melissa ensures our clinic lives and breathes Soundfair's values and showcases how an innovative approach can deliver accessible, quality hearing care that meets the social, emotional and physical needs of people – from all walks of life.

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### **John Smith, Community Lead**

John Smith has worked to create more inclusive, connected, and fair communities for more than 30 years. His work in community-facing, consulting and management roles in the homelessness and local government sectors in Victoria, Queensland, New Zealand and Northern Ireland has engaged diverse communities to imagine and co-create impactful local projects. His more than 40 research and consulting projects build on his Social Science training and include impact evaluation, narrative research with rough sleepers, strategic planning, community and stakeholder engagement and facilitation. John's work at Soundfair is informed and impelled by his lived experience of hearing loss and tinnitus.

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### **Lisa Westhaven, Engagement Lead**

Lisa Westhaven has worked in the health communications field for two decades, for start-ups, corporates, not-for-profits and membership organisations in the UK, US and Australia. Her belief in the power of storytelling to catalyse change in society and the centrality of lived experience informs every aspect of her work – from communicating complex biomedical research to lay audiences to creating empathy, understanding and action for social-change projects. Building the narrative into experience, Lisa has devised and delivered international scientific conferences for more than 1200 delegates as well as an impactful one-day summit for leading thinkers in women's health at which Minister Hunt announced the launch of a second national women's health strategy.

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# SOUNDFAIR

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