

# Review of services and technology supply in the Hearing Services Program

Department of Health  
Review of services and  
technology supply in  
the Hearing Services  
Program

April 2017

## Public Discussion Paper

April 2017

# Preface

In June 2016 PricewaterhouseCoopers Australia (PwC) was engaged by the Department of Health to undertake a review of the service items and fees in the Australian Government Hearing Services Program (HSP). Stakeholder feedback during the information gathering phase of the review identified a desire for a concurrent review into the supply arrangements of assistive hearing technology (AHT). As a result, PwC was engaged to initiate concurrent reviews of the HSP on the

- Review of Service Items and Fees (RoSIF), and
- Review of the Supply of Assistive Hearing Technology (RoAHT).

## Why is there one public discussion paper?

Combining the reviews will provide a more comprehensive and holistic analysis of certain components of the HSP, which has not been initiated through public consultation since the Voucher Scheme (VS) component of the HSP was established in 1997.

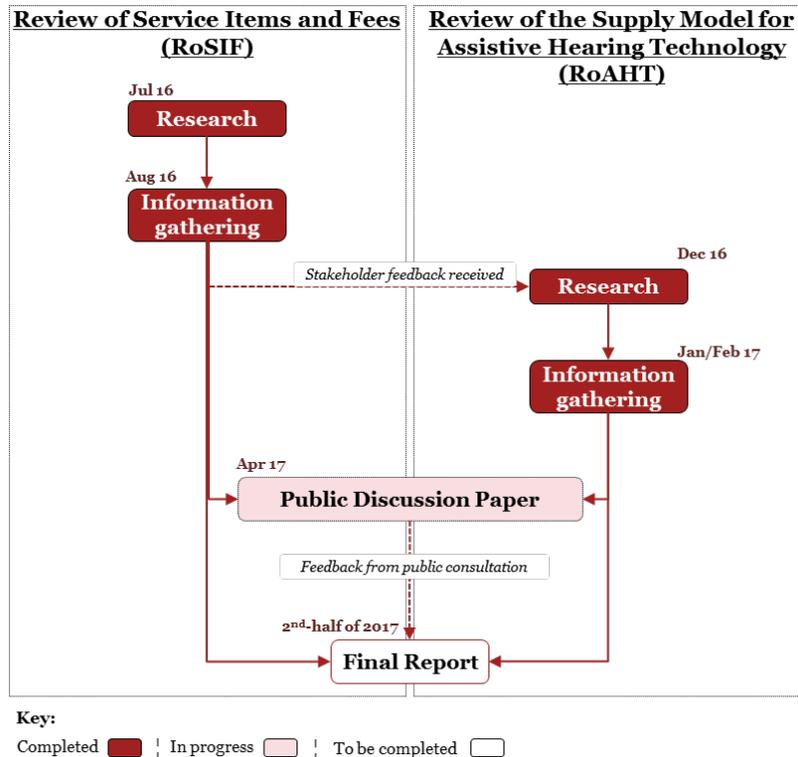
The major milestones of the reviews are outlined in Figure 1. The release of the public discussion paper for the RoSIF was delayed to coincide with the completion of the initial consultation phase of the RoAHT. Stakeholders benefit from this approach through the publication of one combined public discussion paper covering both reviews.

The public discussion paper will be released for public consultation for an 8 week period starting on 26 April 2017 and ending on 21 June 2017. Feedback received during this public consultation period will be analysed by PwC. This analysis will be used to inform the development of a final report that combines the major findings of the RoSIF and RoAHT with a set of recommendations. All feedback will be considered on its own merits and the recommendations in the final report may not align with the option most preferred by stakeholders. It is expected that the final report will be submitted to the Department of Health in the second half of 2017.

## Next steps

Following the delivery of the final report to the Department of Health, the government will determine any course of action based on the findings and recommendations. Further, the government may choose to consider options other than those presented in the public discussion paper or recommended in the final report. The Department of Health may also conduct further consultations with key stakeholders after it has received the final report.

**Figure 1 Review stages completed/to be completed**



## How you can respond to this paper

This paper is targeted at hearing sector stakeholders such as clinical practitioners, manufacturers, professional practice bodies and consumer interest groups. As a result, the paper contains language which some readers may consider of a technical nature. This should not preclude other stakeholders and members of the general public from reading and responding to this paper.

Stakeholders can respond to the questions in the red boxes seen throughout the public discussion paper. A consolidated list of questions is available at Appendix C. The actual response template will also be available for download on the Hearing Services Program website.

Responding to these questions is optional and stakeholders are encouraged to respond to those questions most important to them.

For accessibility reasons, please provide all responses in a Word, RTF, or pdf format only.

All responses should be sent to [AU\\_hearingservicesreview@pwc.com](mailto:AU_hearingservicesreview@pwc.com) by 21 June 2017. Any responses or comments received after this date will not be considered as part of the two reviews.

All responses to the public discussion paper are confidential, will be kept on PwC systems, and only de-identified aggregated responses will be published and shared with the Department of Health unless otherwise agreed with the respondent.

The [public discussion paper](#) is hosted and available for download on the Hearing Services Program website. The hosting of PwC material on the Hearing Services Program website does not affect the independence of the reviews and is purely a functional IT decision aimed at maximising accessibility for stakeholders.

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# Contents

Preface	ii
Contents	v
List of abbreviations	vii
1 Introduction	1
2 Benefits of the Hearing Services Program	3
2.1 Opportunities for clients	3
2.2 Benefits to providers	3
2.3 Predictive pathway	4
2.4 Minimum standard of AHT quality	4
2.5 Client choice	5
2.6 Competitive supply arrangements improve access to technology	5
3 Challenges for the Hearing Services Program	7
3.1 Input focused, rather than outcome focused	7
3.2 Growth in demand	7
3.3 Current funding structure potentially incentivises certain outcomes	8
3.4 Changes in the way clients can access AHT	9
3.5 Access to different types of AHT	13
3.6 Information asymmetry	13
3.7 Complex and rigid claiming rules	14
3.8 Inequitable access	15
4 Summary of alternative models	16
4.1 International Comparisons	16
4.2 Viability assessment of alternative models	18
5 Analysis of alternative models	21
5.1 Service items and fees	21
5.2 Supply arrangements	23
5.3 Integration of options	26
Appendix A Background	28

Appendix B Summary of International Models	31
Appendix C Questions in response template	36
Glossary	40
End notes	41

# List of abbreviations

<b>Abbreviation</b>	<b>Definition</b>
ABS	Australian Bureau of Statistics.
ABC	Australian Broadcasting Corporation
ACCC	Australian Competition and Consumer Commission
ALD	Assistive Listening Device
AH	Australian Hearing
AHT	Assistive Hearing Technology
CCAM	Multiaxial Classification Framework
CCG	Clinical Commissioning Group
CPI	Consumer Price Index
CPT	Current Procedural Terminology
CSO	Community Service Obligation
CSP	Contracted Service Provider
DRG	Diagnosis-related Groups
DS	Device Suppliers
DVA	Department of Veterans' Affairs
GP	General Practitioners
GST	Goods and Services Tax
Health	Department of Health
HSO	Hearing Services Online
HSP	Hearing Services Program
MBS	Medicare Benefits Schedule
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NHS	National Health Service
NZ	New Zealand
PHN	Primary Health Network
PwC	PricewaterhouseCoopers Australia
RoSIF	Review of Service Items and Fees
RoAHT	Review of the supply of Assistive Hearing Technology
TGA	Therapeutic Goods Administration
UK	United Kingdom
US	United States of America
VS	Voucher Scheme

# 1 Introduction

## Context

Since 1947, the Australian Government Hearing Services Program (HSP) has provided hearing services to those most vulnerable in our community. The HSP, which is administered by the Department of Health (Health), has since expanded to cover a wider range of eligible clients under two component programs, the Voucher Scheme (VS)<sup>1</sup> and the Community Service Obligation (CSO).<sup>2</sup>

The current arrangements for delivery of hearing services have remained largely unchanged since this expansion in 1997. A number of reviews since then have highlighted that the HSP has not kept pace with changes in the hearing sector, the broader health environment, or contemporary standards for regulation and legislation. However, a comprehensive review of certain components of the HSP has not been previously initiated.

As Australia's population ages there will be increasing pressure on the financial sustainability of the HSP due to an expected increase in the demand for hearing services. It is therefore timely for Government to consider options to restructure the HSP to develop longer-term arrangements that focus on quality and sustainability into the future.

The National Disability Insurance Scheme (NDIS) is a new way of providing support for Australians with a disability, their families, and carers. As an insurance scheme, the NDIS takes a lifetime approach, investing in people with disability early to improve their outcomes later in life.

The HSP is one of the government initiatives that will become part of the NDIS, with a portion of clients expected to transition to the NDIS by mid-2019. This means that people who meet the NDIS access requirements and are under the age of 65 may transition from the HSP to the NDIS by 2019-2020.

It is anticipated that the National Disability Insurance Agency (NDIA) will provide a schedule of supports that includes prices for hearing services, Assistive Hearing Technology (AHT), and therapies that are similar to those currently being offered by the HSP.

The HSP will continue to operate in parallel to the NDIS after it is fully rolled-out. When available, the NDIS access guidance will provide clarity about eligibility under the disability and early intervention requirements to become a participant in the NDIS. The NDIS funds reasonable and necessary supports that help a participant to reach their goals, objectives and aspirations, and to undertake activities to enable the participant's social and economic participation. This is different to eligibility for the HSP. An NDIS plan may therefore provide a participant with a broader range of supports that are not offered by the HSP.

## Scope

Health engaged PricewaterhouseCoopers Australia (PwC) to conduct two reviews into the HSP. As part of these reviews, PwC was to

- develop a list of compatible hearing service items and fees under the HSP and the NDIS
- consider alternative service and payment models which may better support client outcomes, improve business processes, and reduce the administrative burden on various stakeholders

- develop an efficient price model to test a comparable list of service items and fees under the HSP post 2018-19. This may also inform the NDIA's development of fee structures for hearing services in the NDIS
- conduct an analysis of the benefits and challenges inherent in the current AHT supply model, and
- consider whether other supply models may better support client outcomes, business processes and reduce the administrative burden on various stakeholders as well as ensuring the HSP is sustainable for government.

The following areas are outside the scope of both reviews

- pricing of AHT
- eligibility criteria for the HSP, and
- efficacy and potential minimum specifications of AHT for a new supply model.

## **Approach**

The approach taken for the reviews is outlined below

- gather information through literature reviews, surveys, and meetings with key government and external stakeholders
- develop options for alternative models
- test these options with the broader public through this discussion paper, and
- consider stakeholder feedback and present a final report with recommendations for improvements to the services items and fees, and supply arrangements under the HSP.

To date, PwC has undertaken a number of information gathering sessions with selected stakeholders including government, industry, consumer groups, and professional bodies to ascertain their views on the current benefits and challenges of the HSP and consideration of alternative service models. These have helped to inform the development of this paper.

## **Purpose of this discussion paper**

The purpose of this paper is to facilitate public discussion and comment on the HSP's

- current service delivery model
- major benefits and challenges, and
- potential options for reform.

Stakeholder feedback on this paper will enable PwC to identify how the HSP can continue to deliver quality hearing services and AHT for eligible clients into the future. Any reform will be considered in the context of fiscal strategies and high-level objectives adopted by Health in reforming Australia's health care system.<sup>3</sup>

# 2 Benefits of the Hearing Services Program

The major benefits of the HSP were identified through stakeholder consultations, and analysis of the Australian hearing sector and the HSP.

The questions asked in this section canvass stakeholder opinion on whether the current benefits are crucial to the delivery of hearing services and AHT. Stakeholders are encouraged to respond to the questions they consider most important to them.

## 2.1 Opportunities for clients

A significant benefit of the HSP is that it has minimal or no out-of-pocket costs for hearing services provided to clients. Government funds all costs of assessment, fitting of AHT, ongoing rehabilitation, and access to a range of quality AHT. Devices that are fully subsidised are commonly referred to as 'free to client' AHT.

Clients have the option to receive AHT with additional features, such as Bluetooth connectivity. However, the client is required to pay the difference between the retail price and the government subsidy. These are commonly called 'top up' or 'partially subsidised' AHT. The 'top up' amount can vary from a few hundred dollars to thousands of dollars depending on the level of additional features in the AHT.

Voucher Scheme (VS) clients with a fully subsidised AHT have an out-of-pocket cost of \$43 per year for maintenance contribution and, when required, a \$30 fee for an AHT replacement. However, specific cohorts, including some Department of Veterans' Affairs (DVA) clients, are exempt from these contribution fees.

A client may access a remote control for their AHT if their Contracted Service Provider (CSP or 'provider') documents that they are unable to manage their AHT without one. If a hearing aid is not suitable for a client, they may access an Assistive Listening Device (ALD). An ALD is a different type of AHT, generally used by people when they want help with hearing in one main type of situation (e.g. listening to the television in their household). A television headset enables a client to listen to the television at the same time as others. However, the client has the ability to adjust the volume to their preferred level without affecting the volume others hear.

### What do you think?

1. Are there any clinically appropriate services or Assistive Hearing Technology that are not covered under the Hearing Services Program?
2. How do we know if the wide range of services and Assistive Hearing Technology are working to improve outcomes for clients?

## 2.2 Benefits to providers

The hearing services industry has been involved in the HSP since the establishment of the VS in 1997. Industry has since worked closely with Health to streamline the VS, reducing the administrative and regulatory burden on providers and improving accessibility for clients. For example, the introduction of the Hearing Services Online (HSO) portal was well received by industry, giving providers the ability to more efficiently manage their clients irrespective of their business size.

Engagement between Health and practitioner professional bodies is acknowledged as beneficial to improving the HSP. It has resulted in industry wide collaboration to develop a unified Code of Conduct, and a draft safety and quality standards for the hearing sector.

## What do you think?

3. How could the Voucher Scheme be streamlined further?

## 2.3 Predictive pathway

Some in the industry see a benefit in the VS's predictive pathway because it assists clients in managing their journey through what is often a challenging period in their lives. Such a pathway allows clients to

- have their choice of service provider
- work with the same clinician from their initial hearing test through to the fitting of an AHT, if appropriate
- receive ongoing maintenance support to enable them to continue to manage their hearing loss and receive the most benefit from their AHT, and
- change providers at any point in their journey if they are dissatisfied with the service they are receiving or because of a change in their circumstances.

## What do you think?

4. How could changing the schedule of services improve a client's experience in the Voucher Scheme?

## 2.4 Minimum standard of AHT quality

Stakeholders indicated that minimum technical specifications for AHT are one of the most important benefits of the current supply arrangements. The specifications, found in Schedule 3 of the Deed of Standing Offer (the Deed), are the technical criteria AHT need to meet in order to be made available to clients. The specifications differ slightly depending on the type, model, and subsidy-status of the AHT (including certain accessories). At a high-level, different minimum specifications need to be met for

- ear moulds and shells
- fully subsidised AHT, and
- partially subsidised AHT.

Minimum technical specifications also provide assurance to providers and clients of the quality of AHT. According to industry, the quality of fully subsidised AHT has continued to improve despite the minimum technical specifications not having changed since 2012. The percentage of AHT that are 2 years or younger in age has increased over time, further contributing to the quality of AHT available through the HSP. In 2012-13, 30.3 per cent of fully subsidised AHT, and 64.8 per cent of partially subsidised AHT, were 2 years of age or younger. This grew to 60.4 per cent for fully subsidised AHT and 70.1 per cent for partially subsidised AHT in 2015-16.<sup>4</sup>

## What do you think?

5. Are minimum technical specifications needed to ensure the quality of Assistive Hearing Technology in the Hearing Services Program? Why or why not?
6. Who should be responsible for setting minimum technical specifications?

## 2.5 Client choice

Stakeholders view client choice as a core benefit of the current supply arrangements. Clients can choose their provider and have access to a range of AHT. The partially subsidised schedule provides clients with the choice to access a greater range of features.

The range of AHT are large enough to deal with a variety of consumer preferences. As of 7<sup>th</sup> February 2017, there were 1,645 AHT approved through the Deed.<sup>5</sup> Consequently, providers are able to dispense a variety of AHT that align with both the clinical needs of clients and their consumer preferences – resulting in a high level of client choice. A number of stakeholders noted the ease of adding an AHT to the schedule was one of the strengths of the HSP. However, there could be improvements to the mechanism for retiring AHT that are in very low demand or are superseded by new models with improved technology. Currently, manufacturers are responsible for retiring AHT from the schedules. However, given the current structure of the Deed, there is little incentive for manufacturers to retire an AHT and no mechanism to limit manufacturers from keeping older technology in the schedules.

## What do you think?

7. How long should Assistive Hearing Technology remain listed in the Hearing Services Program and what should be the process for their removal?
8. What can be done to improve the information for clients on Assistive Hearing Technology available in the Hearing Services Program?

## 2.6 Competitive supply arrangements improve access to technology

The current supply arrangements have fostered competition among both manufacturers and providers. Stakeholders suggest that competition among manufacturers has significantly contributed to the timely introduction of new technology into the Australian market. Specifically, industry asserts that the features of approved AHT have become more advanced as manufacturers attempt to differentiate their product. Another benefit to clients from competition is the more timely release of new AHT. However, AHT with new features is generally listed on the partially subsidised schedule first. Since the introduction of digital technology into the fully subsidised schedule in 2004-05, the transfer of AHT with new features has slowed.

The volume of HSP clients and competitive market forces have resulted in a total of 267 providers servicing the HSP in 2,973 sites (1,145 permanent and 1,828 visiting) across Australia, as at 30 June 2016.<sup>6</sup> The range of providers - independent chains, non-manufacturer owned retail chains,<sup>7</sup> the Australian Hearing (AH) network, and 'vertically integrated' clinics - all compete within the same market. This competition forces providers to maintain market relevance by stocking the latest technology for clients.

## What do you think?

9. What changes could the Hearing Services Program make now to ensure it can manage future technological advancements in the hearing sector?

To facilitate public discussion on the HSP, its major challenges need to be considered in tandem with the major benefits described above. The next section describes the major challenges of the HSP to allow stakeholders to be fully informed about the current situation and the major trends affecting the HSP.

# 3 Challenges for the Hearing Services Program

The major challenges of the HSP were identified through stakeholder consultations, and analysis of the Australian hearing sector and the HSP.

The questions asked in this section aim to determine the underlying causes of some major trends that have limited the effectiveness of the HSP. Stakeholders are encouraged to respond to the questions they consider most important to them.

## 3.1 Input focused, rather than outcome focused

The goal of Australia's health sector is to meet patient outcomes and clinical requirements effectively and efficiently. Hence, the aim, objectives, and success of the HSP should be outcome focused.

All stakeholders in the hearing sector agree that the aim is to assist clients to achieve a good hearing outcome. However, consultations indicated there was no agreed or widespread industry standard to measure client outcomes, or a mechanism for consistently capturing this information. Furthermore, there was no unanimous agreement as to whether this is as a result of the current structure of service items and fees or a more systemic issue in the hearing sector.

### What do you think?

10. If you are a client of the Hearing Services Program what are some of the main outcomes you have experienced personally?
11. What measures could government adopt to foster an outcomes based approach to delivering hearing services?
12. What role should client outcomes play in the Hearing Services Program?

## 3.2 Growth in demand

The aim of this review is not to reduce the costs of, or demand for, the HSP. In fact, the aim is to ensure that those who are eligible for assistance through the HSP can receive appropriate support. However, there are trends emerging in the HSP, which, if left unaddressed, may affect the long-term sustainability of delivering the programs objectives. In addition, advances in technology are likely to grow demand for hearing services and AHT through improvements in effectiveness, accessibility, multi-functionality, and reduction of stigma,<sup>8</sup> adding to the sustainability concerns facing the HSP. Consequently, the review will consider reforms to the HSP that can help to ensure its long-term sustainability.

### 3.2.1 Key growth components

Table 1 below outlines growth in key components of the VS from the 2012-13 to the 2015-16 financial year. It shows that the total expenditure of the VS grew at an average rate of 7.1 per cent per annum, culminating to a total expenditure of \$406.3 million in 2015-16, after controlling for inflation (i.e. in real terms).<sup>9</sup> This expenditure relates to those funds used to support the provision of hearing services and AHT, and not departmental costs related to the administration of the HSP.

During the same period, the number of active clients in the VS grew at 2.8 per cent per annum. Further analysis, which controlled for the effects of age structure, indicated that growth in the number of active clients was immaterial. This means that after accounting for age, there has not been a trend towards more people being active in the HSP. Contrasting the growth in active clients, is the volume of AHT sold growing at a faster rate of 8.2 per cent per annum.

The differences in the growth rates of number of active clients, supply of AHT, and VS total expenditure is made up of a complex set of factors. One theory explored in more detail below is that the current structure of service items and fees promotes the supply of AHT.

**Table 1 Changes in key Voucher Scheme variables (FY2012-13 to FY2015-16)<sup>10</sup>**

Item	FY2012-13	FY2015-16	Growth rate (per annum)
<b>Total expenditure</b>	\$331.0m	\$406.3m	7.1%
<b>Number of active clients</b>	636, 386	691,666	2.8% <sup>b</sup>
<b>Total volume of AHT sourced</b>	301,512	382,384	8.2%

**Source**

Office of Hearing Services and PwC Analysis.

**Notes**

- a. Total expenditure is the real expenditure associated with providing hearing services and AHT to eligible clients in the VS, and not departmental costs to administer the HSP. The monetary amount is expressed in real terms by applying an average Consumer Price Index (CPI) observed over a financial year to that financial year's total nominal expenditure.
- b. The 2.8% growth rate in the number of active clients is consistent with the growth, and natural ageing, of the Australian population. An analysis of age-standardised growth rates of active clients indicates there was no additional growth apart from the normal growth of the Australian population.

## What do you think?

13. What are the drivers of growth for Assistive Hearing Technology in the Voucher Scheme?

## 3.3 Current funding structure potentially incentivises certain outcomes

Some stakeholders suggest that the current structure of services payable under the VS incentivises providers to provide AHT to clients. Specifically, the bundling of fitting, rehabilitation, and maintenance services, which are focused around providing the AHT to the client. Stakeholders also reported a range of unintended outcomes.

### 3.3.1 Reliance on AHT as the main source of revenue for providers

Industry reported that because AHT is considered the primary solution for a client's hearing loss, providers are reliant on the revenue from the sale of AHT. They indicated insufficient reimbursement for service items (i.e. assessment, fitting, adjustments etc.) contributes to this reliance. Some stakeholders also implied that services listed on the current schedule are undertaken at-cost or that providers are making a loss in providing these services. However, the pricing of AHT, especially partially subsidised AHT, was seen as sufficient to cross-subsidise these loss-making services. This reliance on partially subsidised AHT to cross-subsidise hearing services could potentially incentivise certain clinical outcomes over others. It can also undermine and distort the value of all aspects of a patient pathway and lead to industry structures that do not focus on client outcomes as their core priority.

### 3.3.2 Clients devaluing the importance of hearing services

Stakeholders suggest the current structure reinforces clients valuing their AHT over the services provided by the clinician. Clients who receive a fully subsidised AHT may not value the AHT provided because they are not aware of the government subsidy for the AHT and have not had to contribute to its cost. Some argue that this contributes to the client not fully utilising their AHT.

### 3.3.3 Reduced emphasis on secondary remedies to treating hearing loss

The incentive to provide AHT could be limiting the access to alternative services, such as rehabilitation, which may also improve a client's hearing outcome. While the current schedule contains three items specifically for rehabilitation services, the uptake of these items has been low.<sup>11</sup> Furthermore, a provider can only claim two of these items after providing a client with a hearing aid. According to some stakeholders, clients need rehabilitation and psychosocial support not just following an AHT fitting, but throughout their journey.

### What do you think?

14. To what extent does cross-subsidisation between hearing services and the provision of Assistive Hearing Technology distort clinical and client outcomes?
15. What changes to service items and Assistive Hearing Technology schedules would remove cross-subsidisation to ensure all aspects of a patient's pathway reflect the value they deliver?
16. What role should rehabilitation and psychosocial supports have in the Hearing Services Program, and how should this role be reflected in the service schedule?

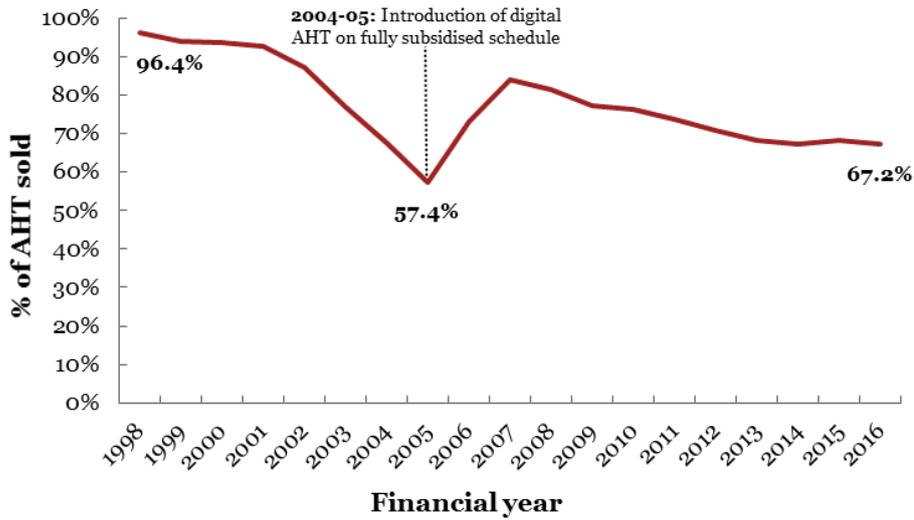
## 3.4 Changes in the way clients can access AHT

### 3.4.1 Trends in partially subsidised AHT

Stakeholders have indicated that technical features of both fully and partially subsidised AHT have improved significantly since the establishment of the HSP. Despite this improvement in technology, Figure 2 shows the supply of fully subsidised AHT as a percentage of total AHT sold in the VS has declined from 96 per cent in the 1997-98 financial year to 67 per cent in the 2015-16 financial year.

The fall in the number of fully subsidised AHT being sold between 1997-98 and 2004-05 reflects the introduction of digital AHT into the Australian market. The HSP introduced digital AHT into the fully subsidised schedule near the end of the 2004-05 financial year. This increased the proportion of fully subsidised AHT being sold during the 2006-07 financial year. Prior to this, clients were opting for partially subsidised AHT to obtain the digital technology.

**Figure 2 Proportion of fully subsidised AHT sold in the Voucher Scheme**



**Source**

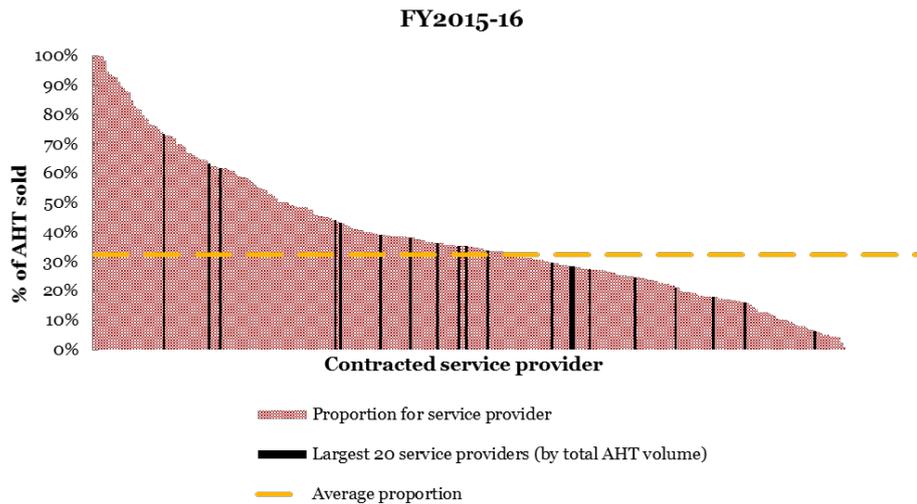
Office of Hearing Services and PwC Analysis.

**Note**

The year in the horizontal axis refers to the end of the financial year (e.g. 1998 refers to the financial year ended 30 June 1998).

Examining the proportion of partially subsidised AHT sold in the VS on an individual provider basis (see Figure 3) shows a significant divergence within industry. The industry average is around 32 per cent, implying that for every 100 people entering the VS, 32 receive a partially subsidised AHT while 68 receive a fully subsidised AHT. The largest 20 providers represent 84 per cent of the total volume of AHT sold in the VS. Of these, most were selling partially subsidised AHT at a rate close to the industry average. However, a few providers sell partially subsidised AHT at a rate significantly higher than the industry average.

**Figure 3 Proportion of partially subsidised AHT sold by providers in the Voucher Scheme (FY2015-16)**



**Source**

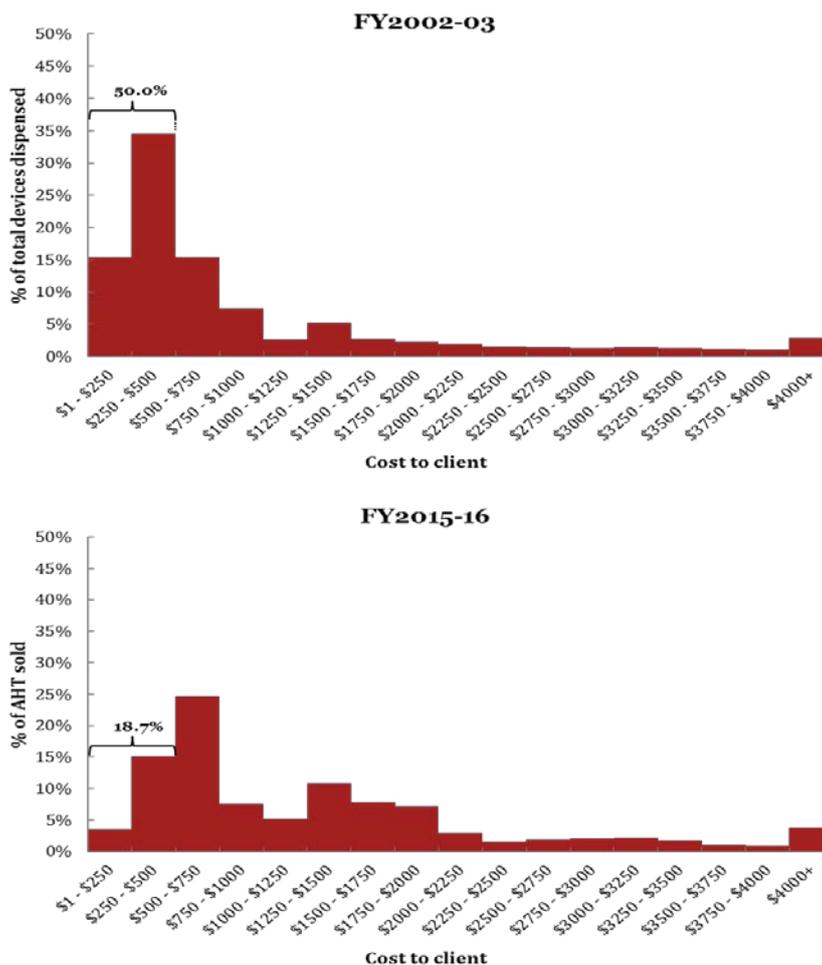
Office of Hearing Services and PwC Analysis.

## What do you think?

17. Does the trend in provision of partially subsidised Assistive Hearing Technology reflect current clinical expectations or population trends? What are the other factors are potentially influencing this trend?
18. What factors explain the range in the proportion of partially subsidised Assistive Hearing Technology supplied by Contracted Service Providers in the Voucher Scheme?

The additional price paid for these partially subsidised AHT in the VS has also shifted over this period. In the 2002-03 financial year, 50 per cent of clients who received a partially subsidised AHT paid less than \$500. During the 2015-16 financial year, the proportion had dropped to 19 per cent of clients, with both the average price paid for the partially subsidised AHT and the number of clients buying partially subsidised AHT increasing (see Figure 4). The distribution indicates that there has been a shift towards a greater number of higher-priced partially subsidised AHT being sold.

**Figure 4 Distribution of cost to client from partially subsidised AHT in the Voucher Scheme**



### Source

Office of Hearing Services and PwC Analysis

#### Note

Cost to client is the amount that eligible clients pay to the provider above the subsidy available for an AHT. Cost to client is expressed in real terms by applying an average (CPI) observed over a financial year to that financial year's cost to client values.

With improvements in the quality and performance of fully subsidised AHT, it is unclear why the volume of higher-priced partially subsidised AHT has increased. Potential explanations include changes in clinical practice, patient expectations, industry behaviour, or funding structures of the HSP. This trend also coincides with the Deed of Standing Offer not being amended since 2009, and the minimum specifications not being updated since 2012.

### What do you think?

19. What has driven an increase in the supply of higher-priced partially subsidised Assistive Hearing Technology?

### 3.4.2 Funding for partially subsidised AHT

Some stakeholders suggested the review should consider decommissioning the partially subsidised schedule. This would re-orient the HSP to focus on meeting clinical needs of eligible clients, and not necessarily on satisfying the clients' consumer preferences or 'wants'.

Most in industry suggest that fully subsidised AHT are of 'mid-range' quality. This assertion is supported by HSP data that shows the majority of clients acquire fully subsidised AHT.<sup>12</sup> Therefore removing the partially subsidised schedule would not adversely affect the majority of clients. However, it may reduce some of the consumer literacy and sales tactic issues highlighted by the Australian Competition and Consumer Commission (ACCC) inquiry.<sup>13</sup> Additionally, clients would not face out-of-pocket costs for features that they may not use or do not completely understand.

Revising the minimum technical specifications and price paid for fully subsidised AHT may also address a difference in availability of features that are driving clients' to acquire partially subsidised AHT. However, most manufacturers and providers believe such changes to the supply arrangements would require careful implementation and consideration of unforeseen impacts.

### What do you think?

20. What do you consider to be the advantages or disadvantages of a partially subsidised schedule?
21. What are the implementation issues associated with removal of the partially subsidised Assistive Hearing Technology schedule?

### 3.4.3 Independently purchased or 'bring-your-own' AHT

Connected with the growing demand for partially subsidised AHT has been the growth in the variety of AHT easily available to clients outside the HSP. Stakeholders noted the ability of clients to purchase good quality, lower cost aids online and through other retailers (e.g. Costco). In some cases, the cost of the AHT was less than if the client had obtained the AHT through the partially subsidised schedule.

Stakeholders held the perception that privately acquired AHT were not being supported through the HSP. AHT that is purchased online, or through a non-HSP approved party, may not be serviced in the HSP because different service software is used in different countries and regions. However, privately acquired AHT can be supported by the VS through access to maintenance and adjustments, even when the privately acquired AHT does not meet minimum specifications. Yet, clients cannot receive a rebate towards the cost of privately acquired AHT. Stakeholders also expressed concern that people accessing these AHT were not getting the expert support needed to correctly identify an appropriate AHT or have it fitted in the correct manner.

## What do you think?

22. How should the Hearing Services Program respond to the growth in easily accessible Assistive Hearing Technology and clients wishing to privately purchase their own Assistive Hearing Technology?

### 3.5 Access to different types of AHT

Individuals do not experience hearing loss the same way. A range of factors need to be considered when determining what solution works best for the individual needs of the client. To achieve the best individual hearing outcome, supply arrangements require flexibility to allow a solution that is most appropriate for the degree of hearing loss, demographic and environmental factors faced by the client.<sup>14</sup>

The ability of a client to acquire an AHT is different depending on whether the AHT is a hearing aid, ALD, or cochlear implant. For example, compared to a hearing aid, some stakeholders consider the process of providing ALD to be more cumbersome and restrictive.<sup>15</sup> Non-standard AHT (including ALD) make up less than 2 per cent of all AHT sold. This restriction poses a challenge to the effectiveness of the current supply arrangement because ALD can provide improved accessibility, convenience, and functionality relative to conventional hearing aids for certain individuals.<sup>16</sup>

## What do you think?

23. Are Assistive Listening Devices appropriately supported by the Hearing Services Program? Why or why not?

### 3.6 Information asymmetry

A number of stakeholders indicated clients are not as informed, or do not have access to the same information as providers, which may lead to information asymmetry. The Australian Competition and Consumer Commission (ACCC) inquiry into the hearing aid industry supports this assertion.<sup>17</sup> The ACCC found that some consumers did not trust clinicians to provide independent advice. In part, this was due to a lack of disclosure surrounding sales commissions and other financial rewards that may influence which AHT a clinician recommends. The inquiry also highlighted cases where the purchased AHT did not meet the clinical need or the budget of the consumer. Further, some consumers were dissatisfied with their AHT as performance did not meet expectations. Some consumers noted this dissatisfaction as a major reason for not using their AHT.

Given that the HSP represents a considerable share of the hearing services market,<sup>18</sup> it is likely HSP clients are also not as informed as providers when they interact with them. This can result in clients acquiring an AHT that does not meet expectations and could hamper the ability of the client to achieve their hearing outcomes. Likewise, uninformed purchases of AHT that do not meet the clinical needs of the client may be a source of wasted expenditure for the client, and the HSP, especially if the client stops using the AHT.

## What do you think?

24. What mechanisms could be examined to ensure clients receive independent advice?
25. How could consumer literacy on hearing loss and Assistive Hearing Technology be improved in the Hearing Services Program?
26. Should the government introduce measures that define the role of audiologists and audiometrists to address concerns raised in the Australian Competition and Consumer Commission report? If so, what could these measures be?

### 3.7 Complex and rigid claiming rules

Stakeholders suggest that the current schedule has complex and rigid claiming rules. Providers have stated that after providing a service to a client they often have to spend additional time and resources referring to service claims history and voucher claiming rules. In addition, providers see the current claiming rules as limiting the extent of professional and clinical judgement applicable in the treatment of a client.

There are also concerns in industry that the rules limit adaptability to technological advances in the delivery of hearing services. One example of this is tele-audiology, which requires two supporting individuals to be involved in order to service the client (the clinician, and a facilitator who may be either a qualified practitioner or an unqualified third party). However, rules only allow the provider to receive a fixed reimbursement that may not be commensurate with the number of personnel involved and the time required to provide services to the client. This may reduce access to the benefits of using tele-audiology such as increased access to hearing services for clients in remote locations and increased timeliness in the provision of services. It may also affect the willingness of providers to invest in the necessary infrastructure and training to deliver such services.

While clients view the flexibility to relocate between providers as a benefit, some providers see it as a challenge. Providers indicated that reassessing a client is a common first step after a client has relocated from another provider. Some reassessments may not be claimable under the current rules if the reassessment occurred relatively soon after the former provider assessed the client. Stakeholders also highlighted that this claiming issue was common in situations where multiple follow-up appointments were required.

## What do you think?

27. Is the current schedule of services too complex? If so, what can be done to simplify the schedule?
28. How can the claiming rules better reflect the cost of personnel required to service clients using tele-audiology?

### 3.8 Inequitable access

Some stakeholders have indicated that certain client groups have greater difficulty accessing hearing services through the HSP, specifically where the client

- is unable to leave their home
- lives in an aged-care facility
- is from a non-English speaking background, or
- lives in a remote region.

While the fixed appropriation CSO is responsible for servicing some of these clients, particularly those in remote communities, the VS does not have mandated service obligations. Consequently, stakeholders have indicated that additional costs in servicing such clients (e.g. providing an interpreter), mean that providers are less inclined to provide hearing services to these 'at risk' groups - impacting on the ability of such clients to improve their hearing outcomes.

#### What do you think?

29. How can government ensure equitable access to hearing services for 'at risk' client groups not covered under the Community Service Obligation?

# 4 Summary of alternative models

With an understanding of the benefits and challenges of the HSP, it is important to compare the Australian model of hearing services and supply of AHT against other countries. Insights drawn from the comparison can be leveraged to develop and evaluate alternative models of service delivery under the HSP.

Stakeholders are encouraged to provide responses on those alternative models most important to them.

## 4.1 International Comparisons<sup>19</sup>

A detailed summary of these comparative approaches is available at Appendix B Summary of International Models.

### 4.1.1 Service items and fees

**Figure 5 International service items and fees**

 <b>US Medicaid program in the State of New York</b> <ul style="list-style-type: none"> <li>• Reimbursement for hearing services dependent on provision of hearing aid.</li> <li>• 45-day trial period for a hearing aid/s.</li> <li>• Reimbursement amount differs depending on whether or not a written declaration of benefit, from use of the hearing aid, was made by the patient at the end of the trial period.</li> </ul>	 <b>US Medicare program</b> <ul style="list-style-type: none"> <li>• Reimbursement amount based on a calculation of a statutory formula that considers the costs associated with professional work, technical expenses and professional liability insurance.</li> <li>• Negative Payment Adjustments are made to claims by providers who do not meet reporting requirements.</li> </ul>
 <b>Private Providers of Audiological Services in the US</b> <ul style="list-style-type: none"> <li>• Unbundled model for pricing of services.</li> <li>• Adoption of Activity-Based Costing methodology to determine pricing of service.</li> </ul>	 <b>Germany</b> <ul style="list-style-type: none"> <li>• Publicly funded hospitals provide hearing services where the reimbursement is determined through Diagnosis-related Groups (DRG). Private practices are reimbursed through fee-for-service.</li> </ul>
 <b>United Kingdom</b> <ul style="list-style-type: none"> <li>• The National Health Service provides hearing services to eligible clients based on clinical need rather than ability to pay.</li> <li>• Price for providers set to a national tariff or by local Clinical Commissioning Group (CCG).</li> <li>• Providers compete on quality not price.</li> </ul>	 <b>New Zealand</b> <ul style="list-style-type: none"> <li>• The Ministry of Health has two hearing aid schemes which only fund the cost of an AHT not hearing assessment or fitting services.</li> <li>• As of July 2016, Enable NZ took over the management of the provision of hearing services for adults and children. Life Unlimited manages rehabilitation services.<sup>20</sup></li> </ul>
 <b>Canada</b> <ul style="list-style-type: none"> <li>• Hearing services benefits are closely linked to the provision of a hearing aid.</li> <li>• Criteria for payment includes the province/territory of residence, the age of the recipient of services, and whether or not a hearing aid is the end-result of the services provided.</li> </ul>	 <b>Sweden</b> <ul style="list-style-type: none"> <li>• Hearing healthcare system is publicly financed and administered by local authorities.</li> <li>• Depending on the county, the patient may be charged a co-payment for the testing and fitting of a hearing aid, or for entry to the health clinic.</li> <li>• Private firms also provide hearing services and aids, which are not government funded.</li> </ul>

## 4.1.2 Supply arrangements

**Figure 6 International supply arrangements**

 <p><b>United Kingdom</b></p> <ul style="list-style-type: none"> <li>• <b>Tender model</b> The National Health Service (NHS) Supply Chain exclusively procures AHT through a formal tender arrangement with 8 AHT manufacturers.</li> <li>• <b>Advantages</b> Economies of scale. Free AHT to clients. Dedicated account managers. Minimum quality of device assured.</li> <li>• <b>Disadvantages</b> Significant waiting times. Lower compliance and satisfaction rates. Limited range of AHT. Restrictions on technology available.</li> </ul>	 <p><b>Canada</b></p> <ul style="list-style-type: none"> <li>• <b>Provincial Coverage model</b> Provinces/Territories have jurisdiction on how to manage supply arrangements (e.g. eligibility requirements, subsidy amount, and range of AHT accessible).</li> <li>• <b>Advantages</b> Diverse range of AHT available. Up to 100 per cent of the cost of AHT and accessories can be covered.</li> <li>• <b>Disadvantages</b> Eligibility, subsidy, and approved AHT differ by province/territory. Cost to client differs based on procurement approach.</li> </ul>
 <p><b>US Veterans Affairs Rehabilitation and Prosthetic Services</b></p> <ul style="list-style-type: none"> <li>• <b>Tender model</b> The US Department of Veterans Affairs has contractual arrangements with 6 AHT manufacturers, allowing veterans to receive free AHT, repairs, and batteries.</li> <li>• <b>Advantages</b> AHT and certain accessories free to client. Clients can order accessories online.</li> <li>• <b>Disadvantages</b> Restriction on range of AHT. Additional administrative tasks required of client.</li> </ul>	 <p><b>US Multi-State Agreement</b></p> <ul style="list-style-type: none"> <li>• <b>Contractual arrangement model</b> A multi-state cooperative agreement between the State of Maine, Minnesota, Michigan, Wisconsin, and 10 AHT manufacturers offer significant discounts on AHT.</li> <li>• <b>Advantages</b> Price to pay for AHT, by manufacturer, publicly available. Reduced cost of AHT. Reduced cost available to municipalities, school districts, and other public entities.</li> <li>• <b>Disadvantages</b> Restriction on range of AHT.</li> </ul>
 <p><b>New Zealand</b></p> <ul style="list-style-type: none"> <li>• <b>Outsourced Intermediary model</b> The Ministry of Health set the terms and conditions of AHT provision and outsource the management of AHT supply to an intermediary (EnableNZ).</li> <li>• <b>Advantages</b> <b>Minimum standard of quality for AHT through approved AHT list. Information asymmetry reduced via publication of booklets. Key Performance Indicators imposed on intermediary. Up to 100 per cent of cost AHT can be covered.</b></li> <li>• <b>Disadvantages</b> <b>Reviewing applications creates added administrative burden. Concerns over eligibility and equity of access.</b></li> </ul>	

### What do you think?

30. What aspects of the international comparisons outlined above could be adopted in the Hearing Services Program and why?

## 4.2 Viability assessment of alternative models

Understanding international approaches to delivering hearing services provides insights on how to assess the viability of alternative models for the HSP. Analysis of HSP data and stakeholder input from the information gathering phase are combined to provide a rigorous viability assessment.

The viability assessment was conducted for both the alternatives to service items and fees (see Table 2) and the alternatives to the AHT supply arrangement (see Table 3).

Stakeholders are encouraged to provide responses on whether they agree with the viability assessment on alternative models most important to them.

### 4.2.1 Approach to viability assessment

The following approach was taken to determine whether an alternative model was potentially viable

1. Evaluate alternative models used in other countries
2. Analyse HSP data to determine the major factors and trends impacting the HSP
3. Analyse stakeholder feedback received during the information gathering phase
4. Develop a framework that allowed for comparability across alternative models
5. Assess the possible impact on clients, industry, and government, respectively
6. Determine the most material and significant advantage (+) or disadvantage (-) of each alternative model on clients, industry, and government, respectively
7. Assess whether the alternative model is potentially viable () or not viable () in an Australian context.

An alternative model was deemed as viable if at least 2 stakeholders (i.e. client, industry, or government) had a material and significant advantage.

Those options that were deemed as potentially viable are described in more detail in the subsequent section (see 5 Analysis of alternative models).

**Table 2 Viability assessment of service items and fees**

Option	Client	Industry	Government	Viability
<b>Maintaining the status quo</b> Retain the current schedule of service items and fees	+ Client receives predictive pathway and treatment	+ No operational changes required by industry	- Industry input focused, as opposed to client outcomes focused	<input checked="" type="checkbox"/>
<b>Fee for service (hourly rate)</b> Audiologists/audiometrists/rehabilitation therapists to receive an hourly fee for all hearing services provided	- May impose time constraints on consultations and fittings	+ Providers adequately reimbursed for the provision of their time	+ Allows more flexible mode of allocating funding within funding envelope	<input checked="" type="checkbox"/>
<b>Simplification of services with alignment of prices</b> Reduce number of service items, simplify claiming rules, and retain current service item groupings	+ Clients retain access to quality services	+ Reduced complexity in claiming process	+ Lower administrative burden with less items to process	<input checked="" type="checkbox"/>
<b>Simplification of services with separation of service items</b> Reduce number of service items, simplify claiming rules, and separate current service item groupings	+ Clients retain access to quality services	+ Services are valued and reimbursed in their own right	+ Lower administrative burden with less items to process	<input checked="" type="checkbox"/>
<b>Medicare Benefits Schedule (MBS)</b> Create a list of service items that would be listed on the MBS	- Current eligibility criteria incompatible with 'universality' principle of Medicare	- Requires additional practitioner registration requirements	- May impact sustainability of the HSP	<input type="checkbox"/>
<b>Block funding</b> Single service provider for the VS	- Limits access and range of services provided	- Major changes to industry structure	+ Reduces the sustainability pressures facing the HSP	<input type="checkbox"/>
<b>Contestable Block Funding</b> Introduce contestability to block funding arrangement	- Limits access and range of services provided	- Major changes to industry structure	+ Reduces cost of the HSP	<input type="checkbox"/>
<b>Capitation model</b> Primary Health Networks (PHNs) would receive capped payment for managing care of eligible clients	- PHNs may not be approved providers/ do not have hearing services capabilities	- Reduces competition in industry, with providers having to be part of a PHN	+ Reduces the sustainability pressures facing the HSP	<input type="checkbox"/>

**Table 3 Viability assessment of AHT supply arrangements**

Option	Client	Industry	Government	Viability
<b>Maintaining the status quo</b> Retain the current aspects of the supply arrangement	+ Quality, range, and technology offering of AHT remain	+ No disruption to industry	- Cost sustainability remains a threat to the HSP	<input checked="" type="checkbox"/>
<b>Amendments to the Deed arrangements</b> Change Deed clauses. Would affect AHT subsidised, conditions of AHT supply, and minimum specifications	- May adversely impact quality of AHT	+Reduces regulatory burden	+ Reduces cost of administrating the HSP	<input checked="" type="checkbox"/>
<b>Adopt contractual minimum performance requirements</b> Implement performance management principles in contract with providers	+ Can capture client outcomes as a performance requirement	- Increases regulatory burden	- May not be enforceable	<input type="checkbox"/>
<b>Market driven supply</b> Market determines AHT to supply and their specifications. Fixed rebate provided by Health	+ Minimal restrictions on AHT access and choice	+ Facilitates greater degree of competition (allowing self-regulation)	- Less accountability over use of subsidy	<input checked="" type="checkbox"/>
<b>Competitive Tender</b> Clearly define AHT requirements and procure from a limited number of suppliers	+ May result in AHT with higher specifications	- Major change to industry structure	+ Reduces HSP sustainability pressures through scale of procurement	<input checked="" type="checkbox"/>
<b>Third party verification</b> Verification process relating to approved AHT, conditions of supply, and minimum specification are outsourced by Health to a 3 <sup>rd</sup> party	- Assurances over quality of AHT disrupted	- Additional layer of regulation and removal of professional judgement	- Costly to contract 3 <sup>rd</sup> party	<input type="checkbox"/>

### What do you think?

31. Do you agree with the viability assessment of the alternative models? Why or why not?

# 5 Analysis of alternative models

The alternative models presented here canvass both alternatives to service items and fees (see 5.1 Service items and fees) as well as alternative AHT supply arrangements (see 5.2 Supply arrangements). They are based on the viability assessment presented in section 4.2 Viability assessment of alternative models.

Some stakeholders may find certain alternatives presented here contentious. In order to better evaluate potential options for reform, all potential models need to be understood and considered, including contentious options. This will allow evidence to be sought in a manner that provides a strong basis upon which the proposed model would or would not be advisable for government to consider.

We encourage stakeholders to respond to those questions most important to them, in order for the review to form a more complete picture as to stakeholder's willingness, concerns, and impressions of the options presented below. A consolidated list of questions is available at Appendix C Questions in response template.

## 5.1 Service items and fees

### 5.1.1 Maintaining the status quo

The current schedule of services and fees under the VS has not been comprehensively reviewed since it was first established in 1997. There are currently 48 service items that may be claimed by providers of which there are many duplicates with only minor variations. Also a number of service items integrally link the provision of the service to supply of an AHT. For example, there is a single bundled payment for the

- supply of a hearing aid
- fitting of the hearing aid to adjust it to the client's specific hearing loss and comfort, and
- follow-up visit by the client for further fine tuning and advice on the use of the hearing aid.

In order to ensure minimal disruption to clients and industry the current schedule of service items and fees will need to be cognizant of the finalised schedule expected to be proposed under the NDIS. Subsequently, this option would require government to make iterative changes to ensure that it is feasible to operate two different schedules of service items and fees.

### What do you think?

32. Are you broadly satisfied with the current Voucher Scheme and would prefer if it remained unchanged? Why or why not?
33. Does the current mix of fee for service and bundled services provide sufficient flexibility to provide customised services to clients? Why or why not?

### 5.1.2 Fee for service (hourly rate)

This option would provide an hourly fee for all services performed by an audiologist, audiometrists, or qualified rehabilitation therapist. The fee would either be commensurate to the level of qualification and the work effort required of the provider, or the fee could be based on the nature of the services provided, regardless of qualification.

The fee would be determined through the efficient price model and there could be a loading applied for clinicians working in regional and remote locations. The fee may only cover the costs associated with clinical contact time with clients and may not cover the indirect costs of providers other than a loading for services provided in regional and remote locations. There would be a limit on the number of services that a provider could claim for each client in a defined period of time.

#### What do you think?

34. Can this service model support the ongoing sustainability of contracted service providers in the industry?
35. How do contracted service providers currently manage the additional costs of delivering services for regional and remote clients?
36. Should fees be standardised based on the service provided? Or, is it appropriate for the fee to be based on qualification levels attained?

### 5.1.3 Simplification of services with alignment of prices

This option would retain the current approach to bundling services and AHT but would simplify the current schedule of services, and reduce the complexities around the claiming rules. For example, instead of the current 48 items on the current schedule there could be four items

- Rehabilitation – focusing on psycho-social support to facilitate increased use and effectiveness of the AHT. This includes empirically-viable strategies, training, and expectations management.
- Assessment – identify the severity and reasonable impact of the hearing loss affecting the client, make an informed assessment as to the factors contributing to the current state of hearing loss, and the common hearing environments that the client operates in.
- Fittings (initial and subsequent) – fitting an AHT to facilitate the attainment of hearing outcomes.
- Maintenance – costs and services to keep the AHT functioning over its expected life.

The schedule of services that could be claimed by a clinician would be simplified. There would also be a limit on the number of services that a clinician could claim in a defined period of time for each client.

#### What do you think?

37. What types of services are essential in a simplified schedule of services?
38. Can a single efficient price be determined for a broad service category, given there are likely to be variations in the services delivered within that category?

## 5.1.4 Simplification of services with separation of service items

This option would establish a simplified schedule of service items and fees that reflect the cost of delivering a specified service and would not be tied to the provision of an AHT. The schedule would better recognise the services delivered to a client prior to the fitting of an AHT and the ongoing rehabilitation that could be provided to clients.

Separation of the current service groupings and simplification of the claiming rules would also allow greater customisation of a client's journey and enable providers to focus on delivering services which deliver the most benefit to the client. Similar to the current VS, there would be a limit on the number of services a provider could claim for each patient in a defined time period.

### What do you think?

39. Why would unbundling enable providers to deliver a more customised and beneficial service to clients?
40. What are the different types of rehabilitation services and when in the client journey should they be delivered to maximise client benefit? For example, do clients actually want to receive rehabilitation services after their Assistive Hearing Technology has been fitted?

## 5.2 Supply arrangements

### 5.2.1 Maintaining the status quo

One option for the HSP is to retain the current AHT supply arrangement. This would entail the continuation of all the major aspects of the supply arrangement that was first adopted in 1997. The Deed of Standing Offer would continue to be periodically updated every couple of years, providing an opportunity to make gradual amendments to the conditions of supply and the minimum specifications. Both the fully and partially subsidised schedules would remain in their current form. The mechanisms to add or remove AHT would also be the same, with manufacturers being able to determine whether to list their AHT in the HSP, provided they meet appropriate minimum specifications. Clients would continue to benefit from access to the full AHT subsidy as long as the approved AHT is dispensed by an approved provider servicing the HSP. Health would continue engaging in contractual arrangements with providers, and the major benefits and challenges of the current supply arrangement would remain.

The relationship and purchasing arrangements between providers and manufacturers would be expected to remain the same as they are now, with Health fulfilling its role as HSP administrator through regulating the entry requirement processes, claiming rules, and compliance requirements of the HSP. Changes to the supply arrangements would occur as needed, and remain reactionary to major trends affecting the HSP.

### What do you think?

41. Do you think this supply arrangement is sustainable? Why or why not?
42. What role should the Department of Health have in the supply arrangements of Assistive Hearing Technology?

## 5.2.2 Amendments to the deed arrangements

The HSP currently governs the way AHT are supplied to the program through the Deed of Standing Offer (the Deed) – a binding commitment between Health and manufacturers. At a high-level, the Deed stipulates the

- registration requirements for a manufacturer to supply to the HSP
- terms associated with having an AHT approved for the HSP
- conditions of supply (e.g. quality and warranty requirements, and the range of supporting services to provide at no additional cost), and
- minimum specifications.

The option to substantially change the contents of the Deed – including, potentially, its removal - will most likely impact one of the four categories above, if not all. It would result in a fundamental change to the relationship existing between Health and manufacturers, and would likely reduce the burden of administrative duties associated with the development and agreement of clauses to the Deed.

Effectively, any changes to the Deed would likely result in providers being responsible for ensuring that AHT dispensed meet minimum quality standards (whether by explicit or implicit specifications), are clinically appropriate for their clients, and abide by consumer protection laws. Since providers treat clients and deal with a large volume of AHT on a regular basis, they may be more informed and better-placed to address issues such as warranty, timeframes for repairs, and requirements for partially subsidised AHT. Additionally, such requirements may already fall under the duty of care in fitting a client with an AHT.

Health would need to ensure that clients are not at risk of acquiring a poor quality AHT that could cause adverse impacts to their health, audit compliance, and limit the possibility of providers engaging in predatory business behaviour.

Making substantial changes to the Deed could also generate more flexible arrangements for manufacturers and providers, which may allow them to adopt arrangements that are optimal for their particular cost structures and operational environments.

### What do you think?

43. Do you think the Deed of Standing Offer is vital in regulating the Assistive Hearing Technology supply arrangement? Why or why not?
44. How can the Department of Health ensure that Assistive Hearing Technology quality standards are met without relying on the Deed of Standing Offer?

## 5.2.3 Market-driven supply

This option would provide a fixed rebate for all AHT dispensed as part of the HSP, and would allow the market to dictate what would be the best conditions for the supply of AHT. The current schedule of AHT would be removed. BYO AHT would be permissible into the HSP so long as they have been approved by the Therapeutic Goods Administration (TGA), and a provider is willing and able to provide supporting services for that AHT.

The Deed would no longer be applicable, with minimum specifications and matters of warranty, repairs, and supporting services all dictated by the market. The role of Health would be to audit compliance and ensure that clients are not being taken advantage of by industry. The contract between Health and providers would remain to ensure the provider is providing minimum quality assurances during their consultations and fittings. In the case that regional monopolies exist, Health would ensure that market failures are mitigated by additional compliance requirements similar to those already in place with the current supply arrangements.

This option may considerably reduce the administrative burden for manufacturers and providers. It would also provide clients with a greater level of choice around their AHT, and how they wish to source their AHT. The market would have to compete on price at an international level, with the possibility of TGA-approved AHT being imported into Australia from abroad by clients themselves.

Such a supply arrangement may increase the risk of a relatively low quality of AHT entering the Australian market. It also provides the opportunity for providers to restrict fitting and re-fitting services to clients who purchase an AHT from another source.

### What do you think?

45. Do you think a market driven supply option would affect client access to Assistive Hearing Technology? Why or why not?
46. What aspects of a market-driven supply arrangement are most important to you?

### 5.2.4 Competitive Tender

Similar to the supply arrangement adopted in the UK, this option would result in Health procuring AHT from a limited number of suppliers through a competitive tender process. This is expected to reduce the per-unit cost of AHT to the HSP, enabling economies of scale and easing some of the sustainability pressures currently being faced by the HSP.

As a result of the increased purchasing power of Health, AHT requirements regarding quality and price may be set in such a way that clients can benefit from fully subsidised AHT having a greater amount of features and increased quality. The prices for fully and partially subsidised AHT would be set through the competitive tender process. This could lead to more transparency over the prices agreed between the successful manufacturer/s and Health. And if Health were to keep the subsidy amount unchanged, the tender option could also reduce the out of pocket costs to clients if they elect to acquire a partially subsidised AHT.

In the short term, the cost to government in implementing a competitive tender option would be high and there would be friction in transitioning towards a new schedule of approved AHT (given the large number of AHT currently approved).

### What do you think?

47. How could a tender model provide a sustainable alternative to the current supply arrangements?
48. What aspect of the tender model is most important to you?

## 5.3 Integration of options

Given the range of options for the service items and fees, and the AHT supply arrangements presented above, an important consideration to make is how these options work together or 'integrate'. Any reform to the service delivery model needs to identify where any new approach to service items and fees and AHT supply arrangements are complementary. This is because the options presented will not work in isolation to one another, but form one component of a larger whole.

The integration of options template in Figure 7 has been designed to assist stakeholders to indicate their views on which combination of options would work best.

To answer the question in the 'What do you think?' below, please tick (✓) the box where you believe the options to be complementary. Please cross (×) the box where you believe the integration of these two options would not be complementary.

### What do you think?

49. Fill out the table below, ticking the box where you think the alternative models would integrate well or placing a cross in the box where you think the alternative models would not integrate well.

50. Which combination of options would best support client outcomes and how could this be implemented?

51. What is your preferred combination of options and why?

**Figure 7 Integration of options template**

AHT supply options	Service item options			
	Maintain status-quo	Fee for service (hourly rate)	Simplification of services with alignment of prices	Simplification of services with separation of service items
Maintain status-quo				
Amendments to the deed arrangements				
Market-driven supply				
Competitive tender				

# Appendices

Appendix A Background;	28
Appendix B Summary of International Models	31
Appendix C Questions in response template	36

# Appendix A Background

## Hearing loss in Australia

Hearing loss affects one in six Australians and is expected to rise to one in four by 2050 as a result of Australia's ageing population.<sup>21</sup> It is an impairment that can affect people of all ages to varying degrees. As many as 12 children per 10,000 are born with moderate or greater hearing loss, while 23 children per 10,000 will require hearing aids by the age of 17.<sup>22</sup> Age is the largest determinant of hearing loss, with over half of Australians aged 70 years or older experiencing some form of hearing impairment.<sup>23</sup> Regardless of age, inadequate hearing care is known to drastically reduce a person's everyday functioning ability, communication, social participation, and quality of life. As such, the Australian Government invests in providing care for affected individuals.

## The Hearing Services Program

The Hearing Services Program (HSP), managed and administered by the Department of Health (Health), provides eligible Australian Citizens and Permanent Residents with access to hearing services that aim to reduce the incidence and impact of hearing loss. As part of the HSP, fully or partially subsidised AHT, accessories, and associated services are made available either through the Voucher Scheme (VS) or the Community Service Obligation (CSO).<sup>24</sup> Both the VS and the CSO fall under the umbrella of the HSP, although the entry criteria differs between the two streams.

In the 2015-16 financial year, the HSP had 752,905 active clients comprising of 691,666 clients in the VS and an additional 61,239 clients in the CSO.<sup>25</sup> The VS delivers hearing services and AHT through 267 Contracted Service Providers (CSP or 'provider') in 2,973 sites<sup>26</sup> and in the 2015-16 financial year received 119 complaints.<sup>27</sup>

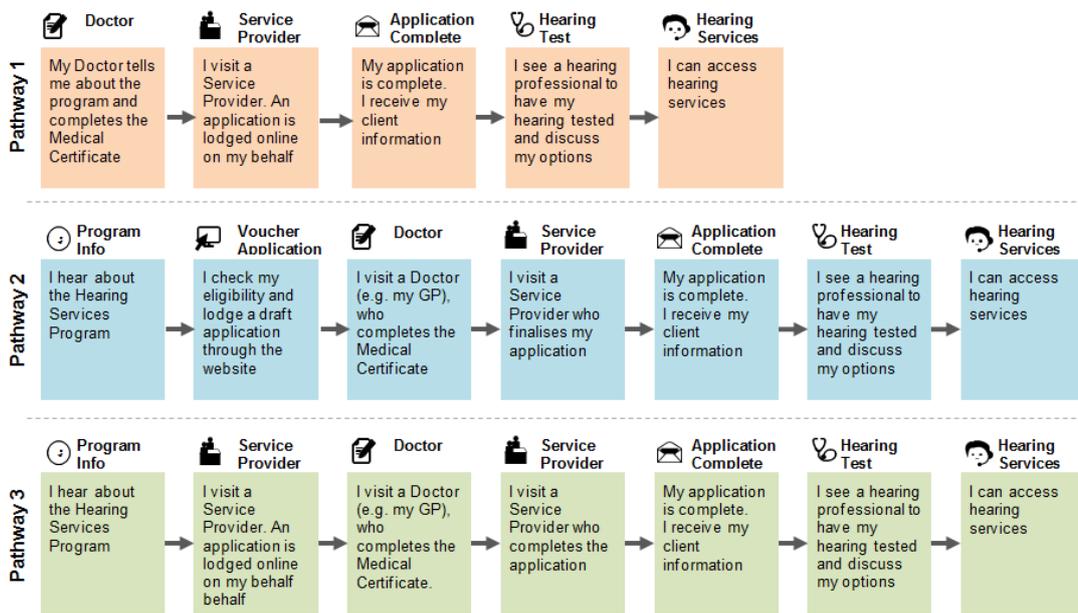
## Voucher Scheme

The Voucher Scheme (VS) issues electronically recorded vouchers to eligible clients, allowing them to access a range of specified services and AHT over a three-year period. There are multiple pathways to joining the VS

- doctor initiated pathway (Pathway 1)
- patient initiated pathway (Pathway 2)
- provider initiated pathway (Pathway 3).

The major difference among the three pathways is the extent to which the potential client is aware of the VS, with potential clients entering the VS through their own means or through consultation with a doctor or provider. All pathways require a valid Medical Certificate from a qualified general practitioner (GP), and a hearing test conducted by a provider, in order for a potential client to be eligible (see Figure 8).

**Figure 8 Clinical pathways to join the Voucher Scheme**



**Source**

Department of Health, Public User Guide 2 May 2014.

Health, as the administrator of the VS, is responsible for maintaining the schedule of service items, setting the fees payable to a provider, and determining the business rules associated with claiming. Currently there are 48 service items on the schedule, each accompanied by their own conditions for claiming.

The AHT supply arrangement in the VS facilitates the provision of AHT to eligible clients after a consultation and fitting with an accredited provider who enters into a contractual arrangement with Health. Providers are able to source their AHT from a range of Health-approved manufacturers who either manufacture or wholesale AHT. To ensure that the AHT supplied are compliant, a Deed of Standing Offer is entered into between manufacturers and Health. This states the terms of the approved AHT (which consist of the fully subsidised and the partially subsidised AHT), the conditions of supply (e.g. warranty, repairs, and supporting services), and minimum specifications.

**Community Service Obligation**

The CSO component of the HSP is delivered by Australian Hearing (AH) - the sole provider. It services mostly children and young adults under the age of 26, adults with complex hearing needs, and eligible Aboriginal persons and/or Torres Strait Islander people over 50 years of age. AH is responsible for operating the CSO within a fixed annual budget appropriation rather than on a fee for service basis. Since clients in the CSO have relatively more complex hearing loss, AH offers a greater range of services and a wider range of AHT options (e.g. funding of cochlear implant upgrades) in order to address their hearing needs. As a result AH sources AHT directly through its own tender arrangements.

**Impact of the National Disability Insurance Scheme**

The National Disability Insurance Scheme (NDIS) is expected to be rolled-out nationally in mid-2019. The HSP is one of the government initiatives that will become part of the NDIS, which means eligible clients in the HSP less than 65 years of age may transition to the NDIS by 2019-20. Currently, NDIS participants with a hearing loss (as a disability) are referred to the HSP to receive services. This is an interim arrangement and by mid-2019, it is planned that eligible NDIS participants will receive services under the NDIS arrangements with service providers.

While the current “in-kind” arrangements mean that the NDIS can rely on the HSP infrastructure for provision of hearing services and AHT to NDIS participants with hearing loss, this arrangement will cease by mid-2019. From that time, it is expected that the NDIS schedule of supports will include a similar range of AHT and therapies as currently available under the HSP, together with maximum price payable under the NDIS.

While the HSP is expected to operate in parallel with the NDIS after 2019-2020, it is uncertain whether the current CSO arrangements will remain under an annual bulk funding arrangement, as a separate program to the VS. However, it is important that all clients can continue to access the same level of services and AHT after mid-2019. Inequitable differences in the quality and coverage of services and AHT between the NDIS and HSP should also be minimised.

The Joint Standing Committee on the National Disability Insurance Scheme<sup>28</sup> is undertaking an inquiry into the provision of hearing services under the NDIS. It seeks to provide clarity on the eligibility criteria for access to the NDIS, service needs of deaf and the hearing impaired, accessibility, adequacy of funding, and other related matters. Submissions to the inquiry identified particular themes which pose potential conflicts between the HSP and the NDIS and which require further clarification as Health and the National Disability Insurance Agency (NDIA) facilitate the transition of clients to the NDIS. These include

- the uncertainty over eligibility criteria in terms of hearing loss for NDIS participants, and whether it will be consistent with those adopted by the HSP
- whether the minimum requirements for the list of approved AHT, and their benchmark price (i.e. subsidy limit), will be aligned with those currently adopted by the HSP, and
- other areas of potential incompatibility and arbitrage between the NDIS and Health.

## Recent hearing sector inquiries

In addition to the NDIS hearing inquiry, the Standing Committee on Health, Aged Care and Sport is currently conducting an inquiry into the ‘Hearing Health and Wellbeing of Australia’.

The Australian Competition and Consumer Commission (ACCC) also began an inquiry into the hearing aid industry in 2015. In part, this was a response to the investigative journalism undertaken by ‘Background Briefing’, which aired on Australian Broadcasting Corporation’s (ABCs) Radio National in late 2014. The documentary highlighted the perceived conflict of interest existing in the supply of AHT. In particular, concerns over the extent of potential consumer protection issues were highlighted. The supposed lack of transparency over ownership, supplier arrangements, and commissions received by audiologists or audiometrists were shown to make certain clinicians ‘upsell’ hearing aids for self-serving reasons.<sup>29</sup> Given the complexity and sensitivity surrounding the provision of AHT, such a practice was deemed as concerning, warranting the ACCC inquiry.

The ACCC published their report on the findings of the inquiry on 3<sup>rd</sup> March 2017.<sup>30</sup> The ACCC assessed that commissions, incentives, and other mechanisms used by participants in the hearing aid industry to drive sales were in conflict with clinical independence, professional integrity, and an obligation to consumers. They also found that consumers were generally not aware of the factors that influence the advice and recommendations provided by a clinician. To help raise consumer literacy and awareness, an information guide was also published to help consumers make an informed choice when acquiring hearing aids.<sup>31</sup>

## Other considerations of the reviews

The reviews specified that reducing demand for, or the costs of the HSP, is not the aim. However, the reviews need to be cognizant of the major trends affecting the HSP, its long-term structure, and the sustainability of achieving the HSP’s objectives. Against, the backdrop of an ageing population, these reviews seek to understand these trends, their drivers and, if necessary, look to ensure they are addressed early, in a considered manner, to ensure the long-term sustainability of the HSP.

# Appendix B Summary of International Models<sup>32</sup>

## United Kingdom

The United Kingdom (UK)<sup>33</sup> provides hearing assessments and AHT to eligible patients under the National Health Service (NHS). Eligibility is based on clinical need rather than ability to pay. Patients are required to visit their general practitioner who will then assess whether the patients are eligible to be referred to an NHS audiology specialist. Patients can choose to access services from an NHS specialist (as long as they are registered with the Health & Care Professions Council,<sup>34</sup> and are listed under the Any Qualified Provider scheme). Alternatively, patients can see a qualified private audiologist or hearing aid dispenser. The price paid to the provider by the NHS is set by the Clinical Commissioning Group (CCG) for the local area or is a national tariff. Providers can compete on quality only not price and there is a minimum quality standard. Providers are not guaranteed a certain volume of patients.

The UK adopts a Tender model as its preferred supply arrangement. As part of this arrangement the national provider, the NHS, manages the procurement of AHT and associated accessories for eligible clients.<sup>35</sup> Currently, there are 8 AHT manufacturers or wholesalers servicing the UK market.<sup>36</sup>

Many of these AHT manufacturers or wholesalers also operate in other jurisdictions such as Australia, and the USA (via the Multi-state agreement – see below), allowing them to provide the large volumes of AHT that are demanded in the UK through this supply arrangement.

By being able to procure such a large number of AHT, the UK supply arrangement benefits from economies of scale – or in other words, a significant reduction in the cost of the AHT, meaning significant savings for government. As AHT and reasonable accessories are free to the client, there are also minimal out-of-pocket expenses for the client. This applies to hearing aids, ear moulds, hearing aid batteries, and cochlear implants. In 2010, it was estimated the price paid by NHS for a hearing aid averaged £300-£400 (for the AHT alone), while the retail price was £725 or more.<sup>37</sup>

An additional benefit includes the use of dedicated account managers allowing a day-to-day contact for a clients' queries. By having dedicated account managers, the issues of a client can be answered in an expeditious manner by someone who is familiar with the environment and factors affecting the client. It also allows an invested 3<sup>rd</sup> party to evaluate whether the client is identifying and making the most out of possible saving opportunities.

The UK supply arrangement also provides quality assurances by ensuring that the procurement processes are compliant with the European Union (EU) procurement regulations. The quality of AHT is also regulated, with any new AHT required to be on the National Framework Agreement. Any AHT on the Framework has been clinically evaluated by the Audiology Supplies Group (ASG), ensuring a minimum quality in the AHT offered.

The Tender model results in clients facing significant waiting times, relative to private hearing aids. At present, the demand for AHT is greater than the number of hearing specialists able to supply the demand. This is due to the bottlenecks that exist in the clinical pathway, with clients having to visit a GP to get a referral to a hearing specialist prior to receiving an AHT.<sup>38</sup> This issue has been identified by NHS, resulting in the NHS adopting it as a key performance metric.<sup>39</sup>

Research into AHT supply arrangements found that the level of compliance and satisfaction ratings for the UK supply arrangement were relatively lower than equivalent EU programs.<sup>40</sup>

The range of AHT and technology available has also been identified as a major disadvantage of the UK supply arrangement. As a client, choice of AHT is restricted, making it likely that clients are fitted with Behind-the-ear or Open-fit model.<sup>41</sup> The Tender approach results in the available stock of AHT becoming restricted, relative to those AHT available through private channels.<sup>42</sup> New technology is also affected as clients are only able to access AHT that were included at the time of the tender agreement, with newer models not being made available to them after this time.

## Canada

Canada<sup>43</sup> provides free healthcare to eligible persons. With respects to hearing services, the healthcare system benefit is linked closely to the provision of a hearing aid. The criteria that determines whether or not a benefit is payable includes

- The jurisdiction (i.e. the province/territory of residence)
- The age of the recipient of services, and
- Whether or not a hearing aid is the end-result of the services provided.

The Canadian AHT supply arrangement differs depending on the province/territory that a client resides in. Although certain financing support is available to Canadian citizens and permanent residents through social security and/or disability programs, access to AHT is determined based on geography. The province/territory has jurisdiction on the management and administration of the AHT supply arrangements, which includes aspects like who is eligible, how much of a subsidy is available, and the range of AHT that is made accessible. The type and price of AHT is negotiated between the provincial government and the manufacturer or wholesaler directly in some cases, while in other cases, the AHT is procured from a cooperative agency like the Atlantic Provinces Special Education Authority (APSEA).<sup>44</sup>

Given that each province/territory deals directly with the AHT manufacturer or wholesaler there is a more diverse and sophisticated range of available AHT – although they are not uniform across provinces. This advantage is in part associated with the ‘flat-rate’ reimbursement system evident in various provinces.<sup>11</sup>

Another major advantage of the Canadian supply arrangements is that it can cover up to 100 per cent of the cost of AHT and accessories. Depending on the eligibility status of the client, and their particular circumstances, certain provinces provide relief through complete subsidisation of the AHT. This is seen, for example, in Newfoundland and Labrador where 100 per cent of the cost of the hearing aid is covered (excluding batteries). This applies for those under 18 years of age, full-time students, and adults deemed unable to pay as per a government financial assessment.<sup>45</sup>

Disadvantages of the program include the lack of uniform national coverage. As the supply arrangements are based on the province/territory where the client resides, eligibility, subsidy, and approved AHT are not equal for all. As a result the cost to the client differs significantly based on the procurement approach adopted.

In addition, the lack of coordination and collaboration between Provincial and government departments mean that potential synergies such as economies of scale are not fully captured.

## US Medicaid program in the State of New York

The US Medicaid program in New York<sup>46</sup> is an output-based model that is dependent on the provision of a hearing aid. The reimbursable amount varies, depending on whether the client signs a “written confirmation of benefit of use of the hearing aid” after a trial period of 45 days. In such a situation where the aid has rendered some benefit to the patient, the provider will be reimbursed an amount<sup>47</sup> for the hearing aid and a dispensing fee for the services provided to the patient. Where the hearing aid is deemed to be of no benefit to the patient after a 45-day trial period, then a portion of the total dispensing fee, which represents an administrative component, will be paid. Reimbursement for hearing aids also differ according to whether they are monaural or binaural.

## US Medicare program

The US Medicare program<sup>48</sup> - applicable to people over 65 and those with a disability – reimburses audiology services at different rates, depending on a number of factors. Not all services provided by an audiologist are covered by Medicare. The program also requires annual reporting by providers. In some cases, reporting needs to be done every time a particular type of patient visits. Given changes implemented by the *Medicare Access and CHIP Reauthorization Act* of 2015, rates associated with individual Current Procedural Terminology (CPT) codes are currently changing to reflect adjustments in the calculation of fees. If certain reporting benchmarks are not met in line with the Physician Quality Reporting System, providers will see a negative 2 per cent adjustment to their claims. The factors affecting the benefit payable includes

- The location of the services whether or not they were conducted at a hospital site, or off it (the payment for audiology services differ depending on setting, with rates for services provided at a 'facility' (e.g. at a hospital) lower than the 'non-facility' rates to factor in higher fixed costs)
- The particular CPT code applicable to the procedure
- The particular Relative Unit Value<sup>49</sup> applicable to the procedure
- The statutory conversion factor that applies to the procedure.

## US Veteran Affairs Rehabilitation and Prosthetic Services

For eligible US Veterans, the US Department of Veteran Affairs has adopted a Tender model as the means to supply them an AHT. The department established a contractual arrangement with 6 AHT manufacturers, which gives eligible veterans the right to receive free AHT, repairs, and batteries.

By negotiating directly with AHT manufacturers, and agreeing to a fixed price for particular types of AHT, the supply arrangements have enabled the provision of free to client AHT in a way that minimises the cost for the government. In addition, the supply arrangement caters to its clients by allowing them to order accessories and batteries online. This reduces the inconvenience of having to see a service provider every time they require new accessories or batteries.

As the contract limits the range of AHT to lock-in a better price for government, it may hamper clients in acquiring AHT that are relatively newer or have certain technology or features that were not common place at the time that the tender arrangement was agreed to. In addition, these supply arrangements do place certain administrative tasks back onto the client.

## US Multi-state Agreement

A supply arrangement between multiple states in the US has resulted in a 'contractual arrangement' model being adopted by the states of Maine, Minnesota, Michigan, and Wisconsin, and 10 AHT manufacturers or wholesalers. This is slightly different from a Tender model in that contractual arrangements are also entered into between the procurement arms of the respective state governments. The 'Hearing Aid Procurement Program' put the procurement contracts in place to service clients involved in State Department programs. Although these were the primary clients catered to, the program can be used by any state agency to achieve significant discounts on a select range of AHT.<sup>50</sup>

This supply arrangement allows significant reductions in the cost of an AHT. This is achieved based on the volume of AHT that are procured through the program – achieving economies of scale for AHT manufacturers. This means that there is also reduced cost to government from achieving a reduced AHT cost. The range of parties that have access to the prices negotiated in the contracts is also a major advantage. As such, relevant state agencies, municipalities, school districts, and other public entities are entitled to access the reduced costs of the AHT in the program.

Information on the range of AHT and their agreed-to price are publically available. This makes sure that all parties who have a right to receive the benefits of the contract are aware of the type of AHT and their price – increasing the eligible party’s consumer literacy. The contract does restrict the number of AHT available, as it is not dynamic to additions of new AHT.

## Private providers of audiological services in the US

Private providers of audiology services in the US<sup>51</sup> are adopting an unbundled model, which itemizes services provided to patients. In such a model, the price of the hearing aid is billed separately from the services provided. The way that pricing is formulated under this model is based on something similar to activity-based costing. The total cost of operating, plus a lump-sum amount for profit desired, is divided by the total number of hours worked, which provides the cost of service on an hourly basis. The costs of non-clinical staff, overheads, and equipment maintenance expenses are included in the total cost of operating.

## New Zealand

As of July 2016, Enable NZ took over the management of the provision of hearing services for adults and children.<sup>52</sup> Life Unlimited manages rehabilitation services.

Enable NZ administers two hearing services schemes

- Hearing aid subsidy scheme, and
- Hearing aid funding scheme.

Both are AHT focused and do not cover the costs of hearing assessments, fittings or maintenance in private practice but patients can receive hearing services at minimal cost in public hospitals. District Health Boards offer hearing assessments through a hearing therapist at no cost and patients eligible for Government funded services can be referred to a private audiologist.

The NZ Ministry of Health also funds Accessable and Life Unlimited. Accessable is able to fund the provision of hearing aids, equipment, and housing alterations for people with a disability.<sup>53</sup> Life Unlimited delivers free hearing therapy services, rehabilitation, and independent advice on using hearing aids and/or other AHT and communication strategies. Life Unlimited does not sell or fit hearing aids.

The NZ government adopts an ‘outsourced intermediary’ model to supply AHT to eligible clients. As part of this national model, the Ministry of Health sets the terms and conditions of AHT provision, while the day-to-day administration and management of AHT supply is outsourced to EnableNZ (a private enterprise).<sup>54</sup> Duties of EnableNZ include

- setting requirements for service providers to be able to claim for payment
- deliver services, including rules for provision of AHT
- manage and monitor services and AHT provided, and
- management of contracts with 10 AHT manufacturers and wholesalers.

For AHT to be available in NZ, AHT manufacturers have to provide compliance and testing information to the School of Population at the University of Auckland. As hearing aids are defined as a medical device in NZ, the AHT submitted for inclusion must have first passed the therapeutic device standards for entry into NZ – a service conducted by the New Zealand Medicines and Medical Devices Safety Authority (MEDSAFE).<sup>55</sup> These two screening processes allow for a minimum standard of AHT quality in NZ, while allowing specialists to ensure that eligible clients are given quality AHT that can meet their hearing needs.

As part of the NZ supply arrangements, AHT are available through the

- Hearing Aid Subsidy Scheme (which offers a fixed rebate of \$511.11 including GST per hearing aid to eligible clients),<sup>56</sup> and
- Hearing Aid Funding Scheme (which covers only the cost of the hearing aid and accessories essential for the clients hearing needs).<sup>57</sup>

Cochlear implants are treated separately from hearing aids in NZ. The Ministry of Health provides funding for cochlear implant to clients who meet all eligibility criteria. A total of NZ\$8 million is funded for implants and associated support each year.<sup>58</sup>

The NZ supply arrangements also provide significant publically available information to clients and other interested stakeholders. Access to information is available through multiple websites including those of the Ministry of Health and EnableNZ. Together, the information is provided in a clear way with minimal overlap in content. In addition, a booklet is produced for each scheme to inform clients on their rights. Information asymmetry is reduced by providing overviews on the difference between types of hearing aids and the price expected to be paid for them.

Given that the NZ supply arrangements are managed and administrated by a private-entity, key performance indicators are imposed on the intermediary. This allows the Ministry to push for improvements in the provision of AHT. Failure to do so might entail a loss of contract when it is up for renewal. Another advantage of the program is that vulnerable clients may have up to 100 per cent of costs of AHT covered.

## Germany

Germany<sup>59</sup> adopts a contribution-based social insurance model. This means that all citizens must have either public health insurance or private health insurance.<sup>60</sup> Hearing services are provided in public hospitals for those under public health insurance. Diagnostic-related Groups (DRGs) were adopted in public funded hospitals to determine the reimbursable amount for the provision of a hearing service (see Chap.VIII, Block. H90-95 in the ICD-10 International Classifications for specific DRGs related to diseases of the ear and mastoid process).<sup>61</sup> Adoption of a DRG-based model means that similar medical procedures are grouped together. These DRGs are then given a code for recording purposes, their values recorded, and an average price of the service determined using available data (which is updated on a yearly basis). This average price is what will be reimbursable for the provision of the hearing services. Those citizens who are covered by public health insurance will also have access to hearing aids, if they are required for medical reasons. A maximum outlay is in place, so if the cost of the hearing aid exceeds the outlay, then the individual will have to pay the difference. Private providers of health services are remunerated based on fee-for-service, and not on a lump-sum arrangement. This contrasts the reimbursement of publically funded hospitals, primarily due to private practices not adopting a DRG-based model. For those covered under private health insurance, the same maximum outlay exists for hearing aids.

## Sweden

The hearing healthcare system in Sweden<sup>62</sup> is public financed and administered by local authorities. The extent of the public funding differs according to county. While some counties cover the cost of hearing services, with a fixed limit of subsidies per hearing aid, other counties charge the client an additional fee for the testing and fitting of hearing aids. Furthermore, certain counties also charge a small fee to the client, whenever the client visits the health clinic. Private firms also provide hearing services on a fee-for-service arrangement, and with hearing aids subject to market rates.

# Appendix C Questions in response template

## Benefits of the Hearing Services Program

1. Are there any clinically appropriate services or Assistive Hearing Technology that are not covered under the Hearing Services Program?
2. How do we know if the wide range of services and Assistive Hearing Technology are working to improve outcomes for clients?
3. How could the Voucher Scheme be streamlined further?
4. How could changing the schedule of services improve a client's experience in the Voucher Scheme?
5. Are minimum technical specifications needed to ensure the quality of Assistive Hearing Technology in the Hearing Services Program? Why or why not?
6. Who should be responsible for setting minimum technical specifications?
7. How long should Assistive Hearing Technology remain listed in the Hearing Services Program and what should be the process for their removal?
8. What can be done to improve the information for clients on Assistive Hearing Technology available in the Hearing Services Program?
9. What changes could the Hearing Services Program make now to ensure it can manage future technological advancements in the hearing sector?

## Challenges of the Hearing Services Program

10. If you are a client of the Hearing Services Program what are some of the main outcomes you have experienced personally?
11. What measures could government adopt to foster an outcomes based approach to delivering hearing services?
12. What role should client outcomes play in the Hearing Services Program?
13. What are the drivers of growth for Assistive Hearing Technology in the Voucher Scheme?
14. To what extent does cross-subsidisation between hearing services and the provision of Assistive Hearing Technology distort clinical and client outcomes?
15. What changes to service items and Assistive Hearing Technology schedules would remove cross-subsidisation to ensure all aspects of a patient's pathway reflect the value they deliver?
16. What role should rehabilitation and psychosocial supports have in the Hearing Services Program, and how should this role be reflected in the service schedule?

17. Does the trend in provision of partially subsidised Assistive Hearing Technology reflect current clinical expectations or population trends? What are the other factors are potentially influencing this trend?
18. What factors explain the range in the proportion of partially subsidised Assistive Hearing Technology supplied by Contracted Service Providers in the Voucher Scheme?
19. What has driven an increase in the supply of higher-priced partially subsidised Assistive Hearing Technology?
20. What do you consider to be the advantages or disadvantages of a partially subsidised schedule?
21. What are the implementation issues associated with removal of the partially subsidised Assistive Hearing Technology schedule?
22. How should the Hearing Services Program respond to the growth in easily accessible Assistive Hearing Technology and clients wishing to privately purchase their own Assistive Hearing Technology?
23. Are Assistive Listening Devices appropriately supported by the Hearing Services Program? Why or why not?
24. What mechanisms could be examined to ensure clients receive independent advice?
25. How could consumer literacy on hearing loss and Assistive Hearing Technology be improved in the Hearing Services Program?
26. Should the government introduce measures that define the role of audiologists and audiometrists to address concerns raised in the Australian Competition and Consumer Commission report? If so, what could these measures be?
27. Is the current schedule of services too complex? If so, what can be done to simplify the schedule?
28. How can the claiming rules better reflect the cost of personnel required to service clients using tele-audiology?
29. How can government ensure equitable access to hearing services for 'at risk' client groups not covered under the Community Service Obligation?

## **International comparisons**

30. What aspects of the international comparisons outlined above could be adopted in the Hearing Services Program and why?

## **Viability assessment of alternative models**

31. Do you agree with the viability assessment of the alternative models? Why or why not?

## **Analysis of alternatives to service items and fees**

32. Are you broadly satisfied with the current Voucher Scheme and would prefer if it remained unchanged? Why or why not?
33. Does the current mix of fee for service and bundled services provide sufficient flexibility to provide customised services to clients? Why or why not?
34. Can the fee for service (hourly rate) model support the ongoing sustainability of contracted service providers in the industry?
35. How do contracted service providers currently manage the additional costs of delivering services for regional and remote clients?
36. Should fees be standardised based on the service provided? Or, is it appropriate for the fee to be based on qualification levels attained?
37. What types of services are essential in a simplified schedule of services?
38. Can a single efficient price be determined for a broad service category, given there are likely to be variations in the services delivered within that category?
39. Why would unbundling enable providers to deliver a more customised and beneficial service to clients?
40. What are the different types of rehabilitation services and when in the client journey should they be delivered to maximise client benefit? For example, do clients actually want to receive rehabilitation services after their Assistive Hearing Technology has been fitted?

## **Analysis of alternative AHT supply arrangements**

41. Do you think this supply arrangement is sustainable? Why or why not?
42. What role should the Department of Health have in the supply arrangements of Assistive Hearing Technology?
43. Do you think the Deed of Standing Offer is vital in regulating the Assistive Hearing Technology supply arrangement? Why or why not?
44. How can the Department of Health ensure that Assistive Hearing Technology quality standards are met without relying on the Deed of Standing Offer?
45. Do you think a market driven supply option would affect client access to Assistive Hearing Technology? Why or why not?
46. What aspects of a market-driven supply arrangement are most important to you?
47. How could a tender model provide a sustainable alternative to the current supply arrangements?
48. What aspect of the tender model is most important to you?

## Integration of options

49. Fill out the table below, ticking the box where you think the alternative models would integrate well or placing a cross in the box where you think the alternative models would not integrate well.
50. Which combination of options would best support client outcomes and how could this be implemented?
51. What is your preferred combination of options and why?

AHT supply options	Service item options			
	Maintain status-quo	Fee for service (hourly rate)	Simplification of services with alignment of prices	Simplification of services with separation of service items
Maintain status-quo				
Amendments to the deed arrangements				
Market-driven supply				
Competitive tender				

# Glossary

**Assistive Hearing Technology (AHT)** Assistive Hearing Technology includes hearing aids, assistive listening devices, and cochlear and other implant technology.

**Assistive Listening Device (ALD)** A sub-category of Assistive Hearing Technology that can be used as a stand-alone device or in combination with a hearing aid. Assistive Listening Devices help the user to hear in a range of listening situations. This includes over the telephone, over distance, and in hearing a television.

**Australian Hearing (AH)** Australian Hearing is a statutory authority constituted under the *Australian Hearing Services Act 1991*. It is the sole provider of hearing services to the Community Service Obligation Program, although it is still able to service clients in the Voucher Scheme. Australian Hearing also undertakes research into hearing loss and related topics through the National Acoustic Laboratories.

**Community Service Obligation (CSO) Program** One stream of the Hearing Services Program. The Community Service Obligation Program focuses on funding hearing services and AHT for children and young adults under the age of 26, adults with complex hearing needs, and eligible Aboriginal persons and/or Torres Strait Islander people over 50 years of age.

**Contracted Service Provider (CSP)** A Contracted Service Provider, or 'provider' is an entity that has signed a contract with the Office of Hearing Services to provide hearing service to eligible clients under the Hearing Services Program. A Contracted Service Provider goes through an accreditation process prior to being offered a contract under the Program. Contracted Service Providers must adhere to all clauses in the contract and the associated standards.

**Deed of Standing Offer** A Deed entered between the Australian Government and Device Suppliers. It details the list of approved AHT, the maximum price paid for approved AHT, the conditions of AHT supply, and minimum specifications.

**Manufacturers** Also known as Device Suppliers (DS), manufacturers provide AHT to eligible clients of the Hearing Services Program through the provision of AHT to Contracted Service Providers. Device Suppliers agree to a Deed with the Australian Government and must also seek approval of their AHT. Device Suppliers are also to be registered with the Office of Hearing Services.

**Diagnosis-related Groups (DRG)** A statistical system of classifying diagnoses into groups for the purpose of reimbursement.

**Hearing Services Online (HSO)** An online portal that supports the administration of the Hearing Services Program. The Hearing Services Online portal was implemented to transition the Hearing Services Program from paper-based processes to primarily electronic processes.

**Hearing Services Program (HSP)** Refers to the Australian Government Hearing Services Program, which was created to reduce the impact of hearing loss by providing eligible clients with access to hearing services and AHT. The Hearing Services Program is managed by the Department of Health.

**Vertically Integrated** Refers to the ownership or control by a firm of different stages of the production process.<sup>63</sup> Vertical integration can also refer to 'non-standard' contractual arrangements or 'hybrid forms'. This can include long term contracts, franchise contracts, non-linear pricing arrangements, resale price maintenance agreements, requirements contracts, joint ventures, dual sourcing, among others.<sup>64</sup>

**Voucher Scheme (VS)** One stream of the Hearing Services Program. The Voucher Scheme (VS) issues electronically recorded vouchers to eligible clients, allowing them to access a range of specified services and AHT.

# End notes

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- <sup>1</sup> The Voucher Scheme provides eligible clients with an electronically recorded voucher, which provides access to a range of specific hearing services over a 3-year period. Most clients are aged pension concession card holders.
- <sup>2</sup> Australian Hearing is the sole entity responsible for servicing the Community Service Obligation Program, which provides a more flexible range of services. These services are offered mainly to children and young adults to 26 years, adults with more complex hearing needs, and eligible Aboriginal persons and/or Torres Strait Islander people over 50 years of age.
- <sup>3</sup> The current budget focus and fiscal strategy emphasise the need to achieve spending that is efficient, effective, and as well-targeted as possible. Australian Government, *Budget Strategy and Outlook, Budget Paper No.1, 2016-17*, 2016 <<http://www.budget.gov.au/2016-17/content/bp1/html/>>. High level strategic objectives adopted by the Department of Health include 1. More patient-centred and effective for consumers. 2. To drive more efficient and effective use of public funding, and 3. To provide the system with the capacity to respond to future challenges. Department of Health, *Annual Report 2015-2016*, 2016 <[http://www.health.gov.au/internet/main/publishing.nsf/Content/annual-report2015-16-cnt1/\\$File/department-of-health-annual-report-2015-16.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/annual-report2015-16-cnt1/$File/department-of-health-annual-report-2015-16.pdf)>
- <sup>4</sup> Office of Hearing Services, *Hearing Services Program Data*, 2017.
- <sup>5</sup> See n.4.
- <sup>6</sup> Number of Contracted Service Providers sites is accurate as at 30 June 2016. Office of Hearing Services, *Hearing Services Program Data*, 2017.
- <sup>7</sup> Independent chains are those that generally have between 1 and 3 clinics within a confined local area. Non-manufacturer owned retail chains are clinics that operate within a retail network with many clinics across the country but are not owned by companies that manufacture AHT.
- <sup>8</sup> Dillon, H et al., *Likely future change in hearing rehabilitation*, National Acoustic Laboratories, 2017.
- <sup>9</sup> See n.4.
- <sup>10</sup> The analysis of key variables provided by Department of Health may mean a slight difference between the figures in this report and what has been sourced from Department of Health databases. This is due to the databases changing over the period being examined.
- <sup>11</sup> See n.4. Communio, *Review of the Rehabilitation Plus Program*, 2011.
- <sup>12</sup> In the 2015-16 financial year, approximately 32.8% of all assistive hearing technology dispensed were partially subsidised (see n.4).
- <sup>13</sup> Australian Competition and Consumer Commission, *Issues around the sale of hearing aids*, 2017. <<https://www.accc.gov.au/system/files/Issues%20around%20the%20sale%20of%20hearing%20aids%20-%20Consumer%20and%20clinical%20perspectives.pdf>>
- <sup>14</sup> The Senate of Australia, *Hear Us Inquiry into Hearing Health in Australia*, Community Affairs References Committee, 2010. Deaf Children Australia, *See it through Deaf eyes Health Deaf Minds final report on Deaf Children Australia's National Tour on the emotional and social wellbeing of deaf Australians*, 2010.
- <sup>15</sup> Stakeholders indicated that dispensing an Assistive Listening Device results in loss of eligibility for a future hearing services and AHT, which has resulted in certain clients opting for a hearing aid over a more appropriate Assistive Listening Device for fear of losing future benefits from the program.
- <sup>16</sup> Maidment, D.W., et al, *Effectiveness of alternative listening devices to conventional hearing aids for adults with hearing loss a systematic review protocol*, BMJ Open, 2016. <<http://bmjopen.bmj.com/content/6/10/e011683.full#ref-16>>
- <sup>17</sup> See n.13.

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- <sup>18</sup> A 2012 report prepared by KPMG forecasted that the Hearing Services Program would represent 69% of the Australian hearing services market in the 2016-17 financial year. KPMG, *Australian Hearing Report prepared for the Department of Human Services*, 2012. <<https://www.humanservices.gov.au/sites/default/files/documents/2012-11-23-australian-hearing-kpmg-report.pdf>>
- <sup>19</sup> All international comparisons are accurate as of March 2017 and are based on historical information sourced from referenced material. PwC makes no representation as to the accuracy of this information, and has not independently verified its content. The models described are subject to change, reflecting the political and economic factors apparent in the respective jurisdictions in which they operate.
- <sup>20</sup> Enable NZ, *Hearing Services*, 2016. <<https://www.enable.co.nz/services/hearing-services>>
- <sup>21</sup> Access Economics, *The economic impact and cost of hearing loss in Australia*, 2006. <<https://audiology.asn.au/public/1/files/Publications/ListenHearFinal.pdf>>
- <sup>22</sup> Australian Hearing, *Causes of hearing loss in Australia*, 2013. <<https://www.hearing.com.au/causes-hearing-loss-australia/>>
- <sup>23</sup> McCormack, A., Fortnum, H., *Why do people fitted with hearing aids not wear them*, 2013.
- <sup>24</sup> Fully subsidised AHT are also referred to as Free-to-client devices and are listed on the Main or fully subsidised schedule. Partially subsidised AHT are also referred to as Top-up devices and are listed on the Top-up or partially subsidised schedule. Assistive Hearing Technology includes hearing aids, assistive listening devices, and cochlear and other implant technology. This definition was adopted by the Office of Hearing Services in order to align with terminology adopted by the National Disability Insurance Agency through their 'Assistive Technology Strategy' paper (see [https://www.ndis.gov.au/html/sites/default/files/AT-Paper\\_0.pdf](https://www.ndis.gov.au/html/sites/default/files/AT-Paper_0.pdf)). Associated services are distinct from hearing services offered as part of the Hearing Services Program. Associated services, in this particular context, is taken to mean services related to the provision and use of an assistive hearing technology including a client exercising their rights to warranty, agreeing to a maintenance plan with a Contracted Service Provider, requesting repairs, and returning the assistive hearing technology.
- <sup>25</sup> The 2015-16 financial year began on 1 July 2015 and ended on 30 June 2016. Active clients are eligible clients to the Hearing Services Program that have used a range of services or have acquired an AHT in the financial year. Office of Hearing Services, *Hearing Services Program Data*, 2017.
- <sup>26</sup> Office of Hearing Services, *Annual Program Statistics 2015-16*, 2016. <[http://www.hearingservices.gov.au/wps/portal/hso/site/about/program\\_stats/annual-program-stats/](http://www.hearingservices.gov.au/wps/portal/hso/site/about/program_stats/annual-program-stats/)>
- <sup>27</sup> Office of Hearing Services, *Complaints Statistics*, 2015-2016. <[http://www.hearingservices.gov.au/wps/portal/hso/site/about/program\\_stats/complaints-statistics/](http://www.hearingservices.gov.au/wps/portal/hso/site/about/program_stats/complaints-statistics/)>
- <sup>28</sup> The Joint Standing Committee on the National Disability Insurance Scheme was established in order to determine ways to improve the implementation, performance, governance, administration, and expenditure of the National Disability Insurance Scheme (see [http://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/National\\_Disability\\_Insurance\\_Scheme](http://www.aph.gov.au/Parliamentary_Business/Committees/Joint/National_Disability_Insurance_Scheme)).
- <sup>29</sup> Australian Broadcasting Corporation Radio National, *Have I got a hearing aid for you!*, 2014. <<http://www.abc.net.au/radionational/programs/backgroundbriefing/2014-11-30/5920176>>
- <sup>30</sup> See n.13.
- <sup>31</sup> Australian Competition and Consumer Commission, *Hearing aids and devices – information to help make an informed choice*, 2017. <<http://www.accc.gov.au/publications/hearing-aids-and-devices-information-to-help-make-an-informed-choice>>

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- <sup>32</sup> See n.19.
- <sup>33</sup> National Health Service, *How can I get an NHS hearing aid?*, 2015. <<http://www.nhs.uk/chq/Pages/894.aspx>>
- <sup>34</sup> Health & Care Professions Council, *Standards of proficiency Hearing aid dispensers*, 2014.
- <sup>35</sup> National Health Service Supply Chain, *NHS Supply Chain*, 2016. <<https://www.supplychain.nhs.uk/>>
- <sup>36</sup> National Health Service, *Contract Information Hearing Aids and Accessories Key Benefits*, 2016. <<https://www.supplychain.nhs.uk/product-news/contract-launch-briefs/contract-information/hearing-aids-and-accessories/>>
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- <sup>38</sup> See n.34.
- <sup>39</sup> Action on Hearing Loss, *NHS Hearing Services and Waiting Times*, 2016. <<https://www.actiononhearingloss.org.uk/supporting-you/policy-research-and-influencing/policy/nhs-hearing-services-and-waiting-times.aspx>>
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- <sup>43</sup> The Canadian Hard of Hearing Association, *Canadian Hearing Aid Subsidies*, 2010. The Canadian Hard of Hearing Association, *Canadian Hearing Aid Subsidies and Workers Compensation*, 2015.
- <sup>44</sup> Ibid.
- <sup>45</sup> Ibid.
- <sup>46</sup> New York State Government, *New York State Medicaid Program Hearing Aid/Audiology Services Policy Guidelines*, 2014.
- <sup>47</sup> Not-for-profit providers are reimbursed the maximum of a) an amount determined by the Department of State, which is based on average cost of products representative of the item or b) the usual and customary price charged to the general public for the same or similar items. If no maximum can be determined, then the reimbursement fee will be either a) The acquisition cost, net of discounts or rebates or b) the usual and customary price charged to the general public for the same or similar items.
- <sup>48</sup> American Speech-Language-Hearing Association, *Medicare Fee Schedule for Audiologists*, 2017.
- <sup>49</sup> Relative Unit Value (RUV) is the sum of three components 1) Professional work 2) Technical expenses (or practical expenses) and 3) Professional liability (malpractice) insurance.
- <sup>50</sup> State of Maine Division of Purchases, *Hearing Aid Procurement Program*, 2015. <<http://www.maine.gov/purchases/contracts/hearingaids.shtml>>
- <sup>51</sup> Shaw, G., *Unbundling Hearing Healthcare Pricing Up-Front Work Pays Off*, The Hearing Journal, 2015, p.28-32. Coverstone J.A., *20Q Fee-for-Service in an Audiology Practice*, Audiology Online, 2012.
- <sup>52</sup> See n.20. New Zealand Ministry of Health, *Guide to Getting Hearing Aids Hearing Aid Funding Scheme*, 2016. <<http://www.health.govt.nz/publication/guide-getting-hearing-aids-hearing-aid-funding-scheme>>. Life Unlimited, *Hearing therapy services*. <<http://www.lifeunlimited.net.nz/hearing/>>

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- <sup>54</sup> Enable New Zealand, *Enable New Zealand wins national Hearing Aid Management Service contract – Media Release*, 2016. <[https://www.enable.co.nz/\\_data/assets/pdf\\_file/0008/128978/Media-Release-Hearing-Aid-Services-Management.pdf](https://www.enable.co.nz/_data/assets/pdf_file/0008/128978/Media-Release-Hearing-Aid-Services-Management.pdf)>
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- <sup>63</sup> OECD, *Glossary of Industrial Organisation Economics and Competition Law*, commissioned by the Directorate for Financial, Fiscal, and Enterprise Affairs, 1993.
- <sup>64</sup> Joskow, P.L., *Vertical Integration*, Massachusetts Institute of Technology, 2006.

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