The Committee Secretariat
Joint Standing Committee on the National Disability Insurance Scheme
PO Box 6100
Parliament House
Canberra ACT 2600

6 March 2017

Dear Committee Secretary

Supplementary statement to the Joint Standing Committee on the NDIS – Hearing Services

Thank you for the opportunity to provide clarification on points raised during the public hearing related to this inquiry, which took place in Melbourne on 20 February 2017.

We wish to clarify the roles of hearing services provider, practitioner, registered NDIS provider and the problems associated with delivering services as an unregistered profession within the rules of the NDIS.

SCENARIO

As an Australian visiting any healthcare provider, one expects that the healthcare practice would not be owned or hold close business ties with a pharmaceutical or medical device company, or that the healthcare provider did not have a sales target set to issue a certain number of prescriptions for drugs or devices per month. One would not expect the healthcare provider to be paid a commission (hidden or disclosed) each time a particular drug or device was issued, sometimes with higher commissions on more expensive items. If the healthcare practitioner referred to a particular third party, one would be surprised to learn that the healthcare practitioner received any form of kickback for that referral. One would also be surprised if the healthcare practitioner was regulated to a code of conduct only if he or she volunteered to belong to a practitioner body and that the group deciding on matters of conduct were elected by the healthcare providers themselves. In fact, if any of these were true, one would distrust the advice from that healthcare practitioner and probably end up abandoning their advice, prescription or prescribed device. Yet, the above scenario is common and accepted practice in Australia in the world of “hearing services”.

These same concerns, mentioned above, have been raised in the recently published ACCC report into the hearing aid industry. The ACCC report highlights commissions and sales targets as inappropriate to healthcare, described by them as having the potential to cause widespread consumer detriment, especially for consumers who are vulnerable or disadvantaged (see ACCC report attached).

HEARING SERVICE PROVIDERS AND QUALIFIED PRACTITIONERS

Understanding the difference between hearing services providers and qualified practitioners under OHS and Medicare is essential. Hearing services being delivered by those who are under qualified or unqualified poses significant risks for participants in the National Disability Insurance Scheme (NDIS).

Hearing service providers who contract to the Office of Hearing Services (OHS) can be businesses – no clinical qualifications are required. In fact, hearing services providers who contract to the Office of Hearing Services (OHS) are most commonly businesses that are not owned by audiologists or audiometrists.

Hearing service providers can be multinational companies and many do have close associations to the hearing device manufacturing and distribution industry. Hearing service providers who are not clinically qualified have to employ OHS qualified practitioners (audidologists or audidometrists) to attend to OHS voucher patients.

Audiologists' postgraduate university qualifications prepare them to work with all ages and types of auditory and balance disorders. Audiometrists' TAFE diploma qualifications prepare them to assess the hearing of adults for the purpose of fitting hearing devices. In spite of vastly different scopes of training, OHS does not differentiate between audiologists and audiometrists in terms of how they are funded to provide rehabilitation to voucher holders as qualified practitioners. As a consequence, many business owners and some audiometrists choose to make little distinction between these two differently trained groups of professionals.

Medicare does make a distinction between audiologists and audiometrists as relevant Medicare items can only be claimed if the allied healthcare provider (audiologist) is a university qualified (or equivalent) practitioner (ie audiologist) in their own right. The Health Insurance (Allied Health Services) Determination 2014 further requires audiologists who provide services funded by Medicare to be members of a self-regulating professional body and hold clinical certification.

Privately funded devices / services do not typically require membership of a professional body. Very few private health funds specify that services to their members must be provided by a member of a professional body. IAA produces a table of private health fund benefits each year. In 2016, three funds were identified as requiring services to be delivered by an audiologist. As public and private health funding for audiology is typically very limited, many members of the public pay for audiology services out of their own pockets and in those cases, no regulation requirements apply.

SELF-REGULATION AND VOLUNTARY MEMBERSHIP OF PROFESSIONAL BODIES

Without mandatory registration to undertake work in the audiology field, no enforceable age cut- offs apply as to whom audiometrists can assess or treat. We are aware of audiometrists who offer services for children. No mandated referral pathways exist for individuals with complex disorders whose needs are not met by audiometry alone. We are aware of members of the public with complex disorders who have been fitted with hearing aids by audiometrists but not referred to audiologists for further intervention, even when their outcomes from hearing device fitting are less than optimal.

We are aware of business owners without qualifications in either audiology or audiometry who are selling hearing devices directly to the public – including hearing aids and other devices used to "treat" complex auditory disorders. Ear Nose and Throat specialists may, under Medicare, employ anyone to undertake audiology work on their behalf. We are aware of companies whose receptionists who are given clinical responsibilities by their employers.

We are aware of community hearing advisors who are employed to undertake clinically related tasks and provide advice to members of the public. None of the above scenarios are illegal under the current system. However, they do not reflect international standards that increasingly recognise audiology as a field requiring mandatory registration and recognised qualifications to work in the field.

SAFEGUARDS FOR THE NDIS

Proposed NDIS safeguards recommend that NDIS registered providers meet the requirements of the 2014 determination for allied healthcare providers. Yet, the NDIS lists businesses as providers, not individuals, making it difficult to understand how the provision of services by qualified professionals will be ensured or regulated for those professions that are not registered with the Australian Health Practitioner Regulation Agency (AHPRA).

NDIS participants who self-manage their plans will be able to select providers who are *not registered with the NDIS*. Those NDIS participants will have no guarantee of being provided services by qualified practitioners, because *anyone* can provide audiology related services in Australia, outside of the publicly funded schemes such as OHS and Medicare. Further, there are no controls within the NDIS to ensure that businesses that employ audiometrists will refer those with complex conditions (by virtue of age or type of disorder) to audiologists for rehabilitation. We have been advised that currently relatively few NDIS participants self-manage, but taking the ACCC report into account, predatory sales tactics and aggressive marketing could influence NDIS participants to select to self-manage.

REGULATION OF UNREGISTERED HEALTHCARE PRACTITIONERS

A code of conduct for unregistered healthcare practitioners, similar to that which currently operates in South Australia, New South Wales and Queensland has been agreed by COAG to apply nationally at some future stage. Codes of conduct for unregistered healthcare practitioners operate on a system of negative licencing, on the basis of complaints. The NSW Healthcare Complaints Commissioner, in a presentation to members of Audiology Australia in 2011 advised that complaints investigated by their office are typically associated with patient death or disease progression. Once the code of conduct is applied nationally, individuals who are restricted from practicing in one state will be restricted from practicing in all states.

IAA members in all states, including South Australia, New South Wales and Queensland where codes of conduct *already* apply, report being approached by business owners offering to supply patients in exchange for payment of a percentage of professional fees or device charges or who collect payment for devices and services as a third party. We interpret such arrangements to be contrary to the code of conduct for unregistered healthcare practitioners, as well as contrary to the code of conduct for members of practitioner bodies that self-regulate. When challenged, at least one of those businesses identified their status as a business, not a healthcare practitioner, and stated that that as a business they were not subject to the code of conduct for unregistered healthcare practitioners.

When the above concerns were raised by our members with one of the self-regulating professional bodies, their response has been that they can *only regulate the practices of their own members, not of the businesses employing them*. Reports of sales targets, (undisclosed) commissions, preferred supplier arrangements as identified in the ACCC report - all practices that would be considered unacceptable in healthcare practices – are met with similar comments from the practitioner body: that those practices are outside of the regulation of professional bodies because they can only regulate the practices of members, not of businesses practices set by those who are not their members. This significant limitation of self-regulation of members of professional associations was re-stated in Audiology Australia's media release responding to the ACCC report into the hearing aid industry (see highlight section in the Audiology Australia media release attached).

NDIS – AN OPPORTUNITY FOR REFORM

IAA calls for reform in the regulation that applies to audiology and audiometry.

Neither self-regulation by professional bodies nor regulation of unregistered healthcare practitioners in those states in which the system applies, has avoided the practices recently reported by the ACCC and referred to in our submissions to this inquiry. IAA is concerned that significant change to public protection will not occur with either "tightening up of self-regulation" as proposed by Audiology Australia or national regulation of unregistered healthcare workers. The practices reported by the ACCC have taken place under the watch of both self-regulation by professional bodies and the regulation of unregistered healthcare practitioners in three states and in spite of existing consumer laws. Given that business ownership and profiteering from the sale of products is interwoven with healthcare service provision in the audiology field, regulation ought to be overseen by the authority appointed by government to safeguard the public in the sphere of health. IAA urges this inquiry to recommend that COAG consider including audiology and audiometry as registered professions under AHPRA, affording protection of title, enforced professional boundaries and regulation by an appointed professional board.

Under the terms of the NDIS, those on self-managed plans can choose a provider who need not be registered with the NDIS. Business practices of setting sales targets for the dispensing of hearing devices, payment of commissions by employers for selling top end products and providing kickbacks for referrals will influence the way that products and services are delivered to NDIS participants because they *already* influence the way that services and products are delivered to the Australian public under the OHS scheme and to the fee paying public. Of major concern is that even the minimalist regulation offered under OHS requiring qualified audiologists or audiometrists to deliver services may not apply to the NDIS under self-managed or managed plans if those plans involve services or devices prescribed outside the OHS framework. Important to note too is that cochlear implant related services, which would be expected to feature in NDIS plans, are not covered by the current OHS voucher scheme.

Deafness Forum has commented that predatory sales tactics are inappropriate in relation to the provision of hearing aids and related services. We believe that for the NDIS to serve the interests of all Australians, the profession of audiology needs to be regulated within the system and standards already in place for registered *healthcare* practitioners, restricting the provision of services to those qualified to do so, with scope of practice for audiologists and audiometrists defined and enforced in keeping with their training. Our stance is supported by audiologists (97% of whom responded to a survey indicating they support mandatory registration), prominent bioethicists, consumer and advocacy groups – including representatives of Self Help for Hard of Hearing (Shhh), Better Hearing Australia (BHA), Parents of Deaf Children and Aussie Deaf Kids.

Thank you again for the opportunity to provide input into the inquiry into hearing service provision under the NDIS. We look forward to reading the final report and recommendations of the committee.

Yours sincerely

Dr Louise Collingridge
B.Sc (Logopaedics) M.Sc (Audiology) PhD
M.AudA (Accredited Audiologist)
Executive Officer

Mr Grant Collins
B.Psych (Dist)., M.AudSt
MAudA (Accredited Audiologist), MIAA., MAICD
Vice President

Australian Competition & Consumer Commission

Issues around the sale of hearing aids

Consumer and clinician perspectives

3 March 2017

Executive summary

The Australian Competition and Consumer Commission (ACCC) was alerted to potential consumer protection issues in the hearing aid industry through ABC RN's Background Briefing program, *Have I got a hearing aid for you*.

To better understand the issues, the ACCC conducted enquiries with consumers and industry participants.

As a result of these enquiries, three key issues relating to the sale of hearing aids were identified:

1. Sales may be driven by commissions and other incentives rather than consumer need
2. Cost and performance of hearing aids, and
3. Treatment of vulnerable consumers.

We are concerned about sales-based remuneration arrangements and performance frameworks, which create incentives for clinicians (audiologists and audiometrists) to supply hearing aids that are unnecessary or more expensive than a consumer needs. This has the potential to cause widespread consumer detriment, especially for consumers who are vulnerable or disadvantaged.

We recognise that not all clinics or clinicians engage in the kind of conduct that was brought to our attention. Some consumers indicated positive experiences dealing with hearing clinics and clinicians.

The survey

The ACCC conducted a survey in the latter half of 2015 to obtain information from consumers and industry about the nature and extent of consumer protection issues in the hearing clinic industry. We asked for information to assist the ACCC to assess whether there were broader issues within the hearing clinic industry, rather than to resolve individual concerns.

The ACCC received 85 survey responses: 59 from consumers and 26 from industry.

We contacted a number of survey respondents to obtain further information about their experiences.

The ACCC also contacted the 10 largest hearing clinic operators[1] to obtain information about their sales practices.

Key issues raised in the survey

1. Sales may be driven by commissions and other incentives rather than consumer need

The survey and subsequent discussions indicated that sales commissions and incentives are commonly used to motivate clinicians to sell hearing aids, particularly in clinics run by major operators. Commissions can be as much as 15 percent and may be calculated in a number of ways, including by gross profit margin or net fees paid by consumers. More expensive hearing aids generally attract higher commissions.

[1] By combined total of permanent and temporary clinic locations.

Commissions and other incentives are generally not disclosed to consumers during consultations. If disclosure does occur, it is often in the terms and conditions of sales receipts that are only available to the consumer after a decision has been made to purchase a particular hearing aid and the transaction is completed.

Some major clinics provide sales training to clinicians and set sales performance measures. These measures may include average selling price per hearing aid, number of hearing aids sold, number of assessments that result in sales, number of high end devices sold, and number of "top ups" for consumers with vouchers to purchase subsidised hearing aids as part of the Australian Government Hearing Services Program.

Clinicians expressed a range of concerns, including:

- several of the large hearing clinic operators in Australia are owned by hearing aid manufacturers
- some hearing aid manufacturers offer inducements to clinicians to sell their products, including all-expense paid travel to overseas conferences and consumer electronics
- some clinicians consider their employers are more focussed on sales than providing independent advice, with some choosing to change employers to avoid the pressure to sell hearing aids
- some hearing clinics focus on sales and profits at the expense of consumers' best interests and devices may be recommended based on commissions rather than consumers' needs
- the failure of clinicians to meet sales targets or key performance indicators may result in performance management up to, and including, termination of employment
- sales performance, including underperformance, is regularly reported at staff meetings, and
- hearing clinic operators encourage clinicians to display their qualifications and to reinforce their professional experience when dealing with consumers in order to encourage consumers to rely on their professional advice.

Consumers raised a different set of concerns, including:

- feeling pressured into purchasing hearing aids or more expensive hearing aids
- feeling they could not trust clinicians to provide independent advice and recommendations
- being left with the impression that clinicians were more interested in selling hearing aids than providing independent healthcare advice
- being advised to purchase hearing aids and later learning that their hearing impairment was the result of an undiagnosed, treatable medical condition, and
- being unable to independently verify clinicians' advice and recommendations.

2. Cost and performance of hearing aids

Hearing aids range in price from around $1,500 to over $15,000 per pair. During the survey we heard debate around the extent of additional benefits offered by high end devices. We also found dissatisfaction among consumers with the performance of hearing aids across the price range.

Some consumers identified price as a barrier to purchasing hearing aids. Some clinicians expressed concern about older consumers re-mortgaging their homes or entering into finance plans to pay for high end hearing aids.

In addition to concerns about price, a number of consumers indicated that the performance of their hearing aids did not meet their expectations. Several consumers reported that their hearing aids were difficult to use, uncomfortable to wear, and required recurrent adjustments. Some consumers reported that high end hearing aids were of limited assistance in noisy environments, such as in restaurants. Several consumers indicated that they do not use their hearing aids due to dissatisfaction with their performance.

Several clinicians stated that the key difference between the prices of hearing aids is software that can provide extra functionality to consumers. For example, a consumer who enjoys live music may prefer hearing aids with software that offers certain features over basic ones. However, a number of clinicians noted that many older consumers do not lead a lifestyle that requires the increased functionality of high-end hearing aids.

Clinicians indicated that the information relied on to recommend that a consumer purchase high-end hearing aids is often scant. A number of clinicians expressed concerns that consumers are not provided with adequate information to make an informed choice about which hearing aid is appropriate for their needs and budget.

Both clinicians and consumers raised concerns about consumers being offered only one or a limited selection of suitable hearing devices during consultations.

There was also a suggestion that hearing aids are more expensive in Australia than in other countries. Consumers outlined difficulties in having hearing aids that were purchased online from other countries, such as the United States, fitted and serviced in Australia, despite being the same models as sold here.

3. Treatment of vulnerable consumers

Our enquiries revealed that consumers who purchase hearing aids are often vulnerable as a result of their hearing impairment, age, age-related health issues, disability, income level, or a combination of these factors. Such consumers may be more vulnerable to persistent sales techniques and methods.

The treatment of vulnerable consumers is of particular a concern in the context of the Australian Government Hearing Services Program, which is intended to provide eligible people with access to a range of fully subsidised hearing services. People who are eligible for assistance under the program are generally vulnerable due to their age, health or income level.

The ACCC heard many stories from family members of vulnerable consumers about their experiences in dealing with unscrupulous clinicians.

In one instance an elderly and disabled resident of an assisted living home was visited by a clinician and sold hearing aids with no one else present during the consultation or sales transaction. The clinician’s visit was arranged by the assisted living home. A family member later helped the consumer obtain a refund.

In another instance, an older consumer with dementia attended a free seminar run by a hearing clinic operator at a local community organisation. The consumer, who receives a government pension, subsequently purchased a pair of $13,000 hearing aids through a two year finance plan from the hearing clinic operator. The hearing aids are unsuitable for the consumer’s needs and abilities, and are not used. Despite the efforts of the consumer’s family member, the finance plan could not be cancelled.

ACCC assessment

Hearing tests and the sale of hearing devices take place in a private healthcare setting with clinicians. As with other healthcare professionals, consumers expect that these clinicians will provide independent and impartial advice and have as their primary consideration the wellbeing and best interest of the consumers they are consulting.

However, commissions, incentives and other mechanisms designed to drive sales can create a conflict with clinical independence, professional integrity and the primary obligation to consumers. This conflict is particularly troubling in the sale of hearing aids, given that consumers who require hearing devices are often disadvantaged or vulnerable due to their hearing loss, age, other medical conditions, disability, income, or a combination of these things.

Remuneration arrangements based on rewarding clinicians for more or higher value sales, and performance measures linked to the sale of hearing aids, create incentives for clinicians to supply hearing devices that are unnecessary or more expensive than a consumer needs. During the survey the ACCC heard several anecdotal examples from both consumers and clinicians about this form of upselling. Further, sales techniques and payment plans may only reinforce the sales-driven nature of the service provided by clinicians.

Rather than being a clinical consultation by an independent healthcare provider, the interaction between the clinician and the consumer may take on the characteristics of a sales exercise. This type of environment is more likely to encourage, rather than discourage, unscrupulous conduct by clinicians.

Consumers are generally not made aware of the factors that may be influencing clinicians' advice and recommendations, and are not aware of the financial benefits that accrue directly to the clinicians who have sold them particular devices.

What will the ACCC do?

Based on the information gathered during its inquiries, the ACCC is concerned about a range of business practices in the hearing services industry.

We are particularly concerned about sales-based remuneration arrangements for clinicians that create incentives for clinicians to supply hearing devices that are unnecessary, or more expensive than a consumer needs. This has the potential to cause widespread consumer detriment, especially for consumers who are vulnerable.

The ACCC has communicated directly with industry participants to encourage further consideration of commissions and sales practices in the context of the Australian Consumer Law. We have requested hearing clinic operators review their incentive programs and performance measures to ensure that they do not create a conflict between independent healthcare advice and sales.

The ACCC has developed information to help consumers make an informed choice when purchasing hearing aids and devices, which is available on the ACCC's website.

Having placed the industry on notice, we encourage consumers and clinicians to contact the ACCC Infocentre on 1300 302 502 to report any specific consumer protection concerns about the sale of hearing aids. The ACCC will assess these reports on a continuing basis, and where we assess there to be misleading or unconscionable conduct we may take enforcement action as a result, including legal proceedings.

audiology australia

Media release

Audiology Australia supports the ACCC's Report

Audiologists are tertiary educated health professionals. Audiologists work with clients of all ages to help them to preserve, manage and improve their hearing, their ability to process and understand sounds, and their balance.

Audiology Australia is the peak professional body for audiologists with over 2,500 members, which is estimated to be almost all of the clinical audiologists currently practicing in Australia. Audiology Australia provides the highest standard of self-regulation for its members and strives to meet the National Alliance of Self-Regulating Health Professions (NASRHP) Standards. Central to this self-regulation is the clinical certification program which includes:

- completion of an Audiology Australia Accredited Australian Masters-level degree and the intensive one-year Audiology Australia internship;
- meeting the rigorous Recency of Practice and Continuing Professional Development Requirements, and;
- adhering to the Code of Conduct that all members of Audiology Australia must abide by. Our Code of Conduct is in line with the National Code of Conduct for Health Care Workers and must be displayed, or a copy made available, at all premises where they deliver services.

Clinical certification by Audiology Australia is a requirement to provide government-funded audiological services. Additionally, private healthcare funds also require that the audiologist is a member of Audiology Australia for hearing service fees to be reimbursed.

In accordance with our Code of Conduct, Audiology Australia members must make recommendations to clients based on clinical assessment and the client's needs, not on the basis of financial gain on the part of the member. In addition, Audiology Australia members must not engage in any form of misinformation or misrepresentation in relation to the hearing services or devices they provide.

"Audiology Australia takes the ACCC's claims that employment conditions may be encouraging clinicians at hearing aid clinics to supply hearing aids that are unnecessary or more expensive than a consumer needs very seriously. We encourage any member of the public who has concerns regarding the clinical services provided by an audiologist to contact Audiology Australia.", Audiology Australia CEO Dr Tony Coles said.

"If the clinician is a member of Audiology Australia, anybody with concerns regarding the clinician's conduct can lodge a formal complaint regarding a potential breach of our Code of Conduct. If the clinician is not a member of Audiology Australia, we can help them to find another organisation or body that can help them."

Audiology Australia is responsible for ensuring the standard of clinical services its individual members provide. Audiology Australia is not responsible for the regulation of businesses. Based on our membership statistics, over 90 % of our members are employed by an organisation which they do not own. The majority of Audiology Australia members' remuneration models are therefore largely out of their own personal control.

"Audiology Australia welcomes the Australian Competition and Consumer Commissioner's statement that 'Hearing clinics should be conscious of the incentives they offer and consider remuneration structures that reward service and quality advice ahead of sales.'", Dr Coles said.

Audiology Australia has been included in consultations between peak industry groups, the Australia Government's Office of Hearing Services and the Australian Commission on Safety and

Quality in Health Care regarding the implementation of a Service Delivery Framework which would include standards hearing aid clinics must adhere to. If implemented, Audiology Australia believes the Service Delivery Framework will provide further assurances to the public regarding the safety and quality of services provided by hearing aid clinics.

Audiology Australia urges any person who has concerns about their hearing to seek audiological services from one of our clinically certified members. Those who have questions or concerns about ethical behaviour or professional conduct of any member of Audiology Australia are encouraged to contact the Ethics Committee at

Media contact:

Savio D'Sa, Marketing and Events Manager