Jill Waddell
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Dear Ms Waddell

Feedback: Service Delivery Framework for Hearing Care Services and associated documents: Practice Standards and the Quality Principles within the Framework.

Independent Audiologists Australia Inc (IAA) is an incorporated association whose mission is to promote and support clinical practices owned by Audiologists. Our members are all qualified audiologists who hold financial interests in audiology practices that are at least 50% owned by audiologists. Currently, our members operate more than 165 clinic sites across Australia. Most hold Office of Hearing Services (OHS) contracts and many are already providers under National Disability Insurance Scheme (NDIS) trial sites. As Audiologists/Directors, our members employ professional staff (including audiologists, audiometrists and other healthcare providers who offer associated services such as nurses, speech-language pathologists and medical practitioners) as well as support staff. Our Executive Officer (Dr Louise Collingridge) represented the IAA Executive on the Hearing Care Expert Reference Group established by Australian Healthcare Associates (AHA) on invitation from the Office of Hearing Services (OHS). Louise kept us informed of the process that was undertaken to establish a service delivery framework and we provided input into the various draft documents that were produced.

We welcome this opportunity to provide public comment on both the process and content of the Service Delivery Framework for Hearing Care Services and the documents associated with that model.

Made clear to the expert reference group was that the purpose of the Service Delivery Framework for Hearing Care Services would be to guide decisions in relation to the NDIS, given that audiology is not yet a registered profession under the Australian Health Practitioner Regulation Agency (AHPRA).

Public funds that have been to date administered by the Office of Hearing Services will pass directly to the NDIS and we acknowledge that government is responsible and accountable for the allocation of money, as detailed on the Department of Finance website. However, discussion about regulation was excluded from the terms of reference, as detailed on the initial documentation supplied to the expert reference group. Regulatory processes associated with the service delivery framework have neither been explained in meetings of the HCERG, nor in the documents issued for public consultation. OHS staff members expressed hope that the "hearing sector" would take ownership of the documents and that the standards will be applied to all sectors of service delivery - including services not delivered under any public funding framework. The role of OHS in funding the consultation process to arrive at the service delivery framework was included in the documentation. The OHS obligation to review the documents in future years was discussed at the HCERG meetings but has not been stated in the documents. The status of these documents points to the need for an appointed registration board to regulate the field in Australia. We remain hopeful that OHS and the other parties involved in the HCERG will recognise the incongruity of the current lack of regulation and use this example to call for reform to regulation of the audiology and audiometry professions in Australia. IAA has clearly expressed support for national mandatory registration for audiologists in Australia.

The service delivery framework refers to scope of practice for audiologists and audiometrists. Scope of practice was decided by OHS to be addressed in the service delivery framework by professional practitioner bodies that hold agreements with them (Audiology Australia, Australian College of Audiology and Hearing Aid Audiometrists Society of Australia). The minutes of the final meeting of the HCERG recorded a decision not to release the service delivery framework, national practice standards or quality principles before that scope of practice document was available. Members of the HCERG were notified by email that contrary to that decision, the documents would be released before the scope of practice documentation has been released.

The HCERG was informed on 11 May 2016 that public consultation on the documents was open until 31 May 2016. The documents were made available on the AHA website a section headed "Resources" but which was not publicly accessible without being provided with a link to that page. OHS placed information on the "Consultations" webpage, with a link to the AHA consultations, but called for comment on the service delivery framework, not mentioning the specific documents on national practice standards or quality principles. OHS did not provide a direct link to the documents that are open for public comment. We object to the short time frame allowed for public comment on documents and the lack of transparency and accessibility of those documents to members of the public who will be directly impacted by the content of these documents. The short time frame for consultation and the lack of direct access to the documents calls into question actual and perceived motivations of the drivers of the document and the purposes for which the documents will be used.

Further, the suggested feedback form would not be considered easy to read or understand without extensive knowledge of the context of OHS. The ease of reading of the document equates to a difficult level expected only to be understood by those in tertiary education. The same questions could be asked in an accessible way.

We strongly object to the short time frame, lack of accessibility and very restricted promotion of the public comment on documents and standards, which in our opinion remain, in spite of the consultation process undertaken, controversial. As our name is linked to the documents, we request that amendments to the consultation process be made. Specifically, we seek public consultation period to extend until the scope of practice document and the code(s) of conduct currently under review have been available to the public for sufficient time to allow interested and affected parties to consider the implications of all documents referred to under the framework. In the interest of engaging the public feedback, we request that the feedback form be rewritten to ensure that public engagement is fostered by clear and transparent language.

The service delivery framework confusingly shows links between different levels of the pyramid/triangle, but does not specify how those links operate. Nor does that information become evident in the documentation. The terminology used to describe “hearing services”, “”hearing care practitioners” and “providers” makes sense only in the context of OHS and the distribution of hearing aids in Australia.

We object to the use of “hearing care practitioner” as an umbrella term to refer to audiologists and audiometrists. Should a member of the public search for the term “hearing care practitioner”, through commonly used internet research methods (such as Google), their search would bring them back to the document under review only. We would urge that terms used to describe practitioners be specified as they are used in Australia (ie audiologist and audiometrist respectively) and call for this change to be effected in all documentation associated with the service delivery framework. Further, the documents suggest that audiologists and audiometrists both offer “hearing services” without acknowledging that audiologists undertake work in addition to the services that are offered also by both them and audiometrists. The training and scope of practice for audiologists positions our profession as an important contributor to the healthcare of Australians as related to hearing, balance, processing, cognition, communication, psychological well-being and participation in society for all those (individuals and significant others) affected by auditory and related conditions.

We do not believe that reference to a scope of practice document is sufficient in the context of the service delivery framework without also changing descriptions of services in all associated documents. “Hearing services” ought to be replaced the terms “audiological services” and “audiometry services”.

Additionally, to make sense of the difference between quality principles and practice standards, it is essential to highlight that responsibility for implementing quality principles rests with managers and business owners who, in Australia, need not hold any professional qualifications in audiology or audiometry. Along similar lines, clarification around the term "provider" is required. Currently hearing service providers with OHS (ie contract holders) are not necessarily practitioners. Without this knowledge, the quality principles document makes little sense. What ought to be made absolutely clear is that quality principles are needed because many business owners are not members of professional associations, nor are they healthcare providers regulated by healthcare complaints commissioners or the like in each state, so they are not regulated other than through avenues that apply to all businesses in Australia. The quality principles document refers in many places to "client". As agreed to in relation to the documentation by the HCERG, the term individual and/or their significant others should be used throughout all documentation. As explained to the HCERG, much of audiology is practiced in contexts where those being served would be seen as patients. The term individual was selected to be neutral.

The national practice standards offer scant acknowledgement of the complexity involved in addressing communication, auditory processing, emotion, balance or cognition in the individual and their partners / colleagues / significant others. A reader of the document could expect that complex conditions can be recognised and addressed by referral pathways without being able to monitor if they have been referred when appropriate. The public are left with no indication of when THEY would need to consult an audiologist or when an audiometry consultation might suffice. Professional boundaries need to be acknowledged in this document, in the way they are expected to be respected in practice. As an example, within the national practice standards, practitioners are expected to ensure Auslan interpreting services are provided "when available". Given that these guidelines are to be used by the NDIS, we would expect that access to services for those who are Deaf would be an essential requirement. A government-funded service for Auslan interpreters is available for consultations with audiologists through the National Auslan Interpreter Booking and Payment Services (NABS). Auslan users should, in the standard, be directed to audiologists (not any hearing care practitioner), specifying that professional interpreting services for Auslan users can thus be guaranteed. A second example is the way that qualifications are described. The level of qualifications for audiometrists refers to TAFE, so the level of qualifications for audiologists needs to refer to University. Current wording obscures the differences between these two different professions, as it is reasonable for the public to consider TAFE as a tertiary institution, given the usual pathway from high school to either TAFE or University in Australia.

The description of outcomes is stated in negatives, what so-called "hearing care practitioners" do not do. We request that this be reworded into positive statements about what can be achieved by audiology and audiometry services respectively.

The description of professional associations requires a reference to the Private Health Insurance (Accreditation) Rules 2011 from which the wording was sourced. Clarification is required that holding a certificate of clinical practice (soon to be promoted as accreditation by Audiology Australia) and not membership alone, is the criterion against which NDIS or other decisions about providers should be made, in the current context of self-regulation. Nowhere in the document is it made clear that one can be a member of a professional body but not hold a certificate of clinical practice.

Hearing aids are distributed in Australia under commercial sales arrangements, yet there is no requirement in the standards for the public to be informed of any commissions or sales targets that could affect or be perceived to affect advice and referrals. With a recent survey of audiologists indicating that many work under commission structures, ignoring this element of real or perceived conflict of interest is a serious omission.

IAA has taken the opportunity to provide extensive input into these documents through the HCERG process and through this public consultation. We expect our commentary supplied in this document to be reflected in any final documentation that is released and for our request for amendments to the process be made.

We would be pleased to meet with representatives of AHA consulting, OHS, NDIS or any other body that seeks to discuss these comments and we will be sharing our commentary with all of our members and associates.

Thank you again for the opportunity to raise our concerns via this public commentary forum.

Yours sincerely

Tricia Sharples (IAA President)

Elaine Melville (IAA Vice President)

Deborah Pallett (Treasurer)

Peter Altidis (Executive Member)

Grant Collins (Executive Member)

Mel Gray-Thompson
pp Mel Gray-Thompson (Executive Member)

Dr Celene McNeill (Executive Member)

Myriam Westcott (Executive Member)