Senate Finance and Public Administration Legislation Committee

ANSWERS TO QUESTIONS ON NOTICE

Finance & Administration Portfolio

Department of Human Services

Additional Estimates February 2005

Question: HS55
Outcome 1, Output 1.1 - Effective delivery of Australian Government services to eligible customers
Topic: Australian Hearing Service – business management
Hansard Page/Written Question on Notice: Written

SENATOR CROSSIN asked on 15 February 2005:

Question 1

a) I understand Australian Hearing has introduced incentive schemes to help retain staff. Could you explain how the "voluntary clinical bonus" on the sale of particular devices works?
b) Wouldn't the scheme be less effective where audiologists are serving more disadvantaged clientele say in remote areas?
c) Do you have a mechanism to overcome this so remote staff don't miss out?

Question 2

a) The states are essentially responsible for testing hearing of newborn babies and those with problems might be referred to Australian Hearing. Can you provide figures on the growth of referrals of newborn children to Australian Hearing?
b) Can you briefly explain why there is such an increase?
c) Are the referrals of newborns spread evenly across Australia in each jurisdiction?

Question 3

I understand each hearing centre is set up on a business basis and is paid a flat rate by Australian Hearing for each child it services. Is there a method of giving a weighting to these payments or reimbursing remote area hearing centres for their extra overheads such as extra staff leave, the cost of recruiting and relocation staff to remote areas?

Answer:

1 a) The clinical incentive bonus is payable on the sale of hearing aids with a higher level of technology (known as "top up" aids) than the fully subsidised devices available free of charge under the OHS Voucher Scheme. These clients choose to make an additional co-payment (ie a "top up") to the cost of their aids under the OHS voucher scheme. This also applies to clients fitted with hearing aids for compensation purposes.

The Australian Hearing clinical incentive scheme is a voluntary scheme for staff. The bonus paid to the clinician is a very low percentage of the price paid by the client. The hearing aids are categorised according to their level of technology and price.

To receive the bonus, the clinician must have:

- documented reasons for selecting particular features and hearing aids
- selected the features of the hearing aid on the basis that they will assist the client in meeting their specific hearing goals
- ensured that the features and benefits of the hearing aids are consistent with the client's hearing loss
- ensured the client is aware that they also have the option of a fully subsidised device.

Australian Hearing's Quality Assurance program ensures that the bonus cannot be paid until the credit return period has expired (55 days). The Regional Manager must also certify that the requirements of the programme have been met in order for the bonus to be paid. Random file audits are conducted to ensure that quality standards are met and Clinicians may be asked to repay the bonus if file audit indicates that the fitting does not satisfy the quality requirements.

1 b) The majority of clients who elect to purchase a "top up" aid select a hearing aid from the "economy" top up range. It is observed across the industry and Australian Hearing that when clients are provided with information to make an informed choice, demographic variables have little impact on the proportion of clients electing to purchase a "top up" device.

1 c) Australian Hearing's clinicians who undertake a high proportion of CSO work potentially have less opportunity to participate in the clinical incentive bonus. A new Clinical Specialist allowance has been introduced for clinicians with high CSO caseloads. In addition, these clinicians are included in a team bonus scheme that is payable on a quarterly basis. These measures ensure that clinicians working in remote centres and in centres with high CSO caseload are not disadvantaged. Australian Hearing is currently in the process of reviewing all bonus schemes.

2 a) Newborn hearing screening programs are at different stages of implementation in each State. New South Wales was the first State to introduce a universal newborn hearing screening program. This program commenced on 1 December 2002.
The Australian Capital Territory now has a universal hearing screening program in place. Other States have programs implemented in designated hospitals.

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Data on the number of children under 6 months fitted by State since 1995 is shown below.

by Year of Birth, and State / Territory and Nationally

Year of Birth	NSW	VIC	QLD	WA	SA	ACT	NT	TAS	National
2004 *	41	31	13	8	4	3	0	0	100
2003	48	22	7	6	5	2	1	0	91
2002	19	18	13	4	3	1	1	1	60
2001	9	22	7	5	2	1	0	1	47
2000	9	21	7	3	3	1	0	0	44
1999	12	12	9	1	0	0	0	0	34
1998	16	9	4	3	2	0	1	0	35
1997	13	8	6	1	1	1	0	0	30
1996	7	13	3	3	1	0	0	0	27
1995	0	13	6	0	0	0	0	1	20

Data as @ 27 Feb 2005 for Birth Years 1995 to 2004
NB. * Some children born in 2004, may not have been identified with a hearing impairment or fitted with a hearing aid by 27 February 2005

2 b) Newborn hearing screening programs will identify children with hearing loss at an earlier age, rather than detect a higher incidence of hearing loss. The incidence of hearing loss is reasonably stable and is documented in research. Mechanisms have been put in place to ensure that children identified with hearing loss are referred to Australian Hearing for hearing aid fitting as quickly as possible at designated specialist Centres.

2 c) The referrals are not spread evenly across Australia as the number of children diagnosed is dependent on the population demographics and the type of screening program that has been implemented in each area.

3. The Office of Hearing Services indicates the expenditure levels that Australian Hearing should allocate for each of the Community Service Obligation (CSO) client groups. Australian Hearing has an internal mechanism for attributing revenue to each Hearing Centre for work undertaken. The revenue is attributed on the basis of time spent with each client. There is a loading applied for remote locations to recognise the higher costs of delivering services in these areas. The locations are based on the Department of Health and Ageing Accessibility/Remoteness Index of Australia (ARIA).