Department of Labour
TE TARI MAHI

MINISTER	PORTFOLIO	DEADLINE
Hon Dr Nick Smith	Minister for ACC	**12 July 2010**

Action sought	For your decision	
Title	**REPORT ON HEARING LOSS CONSULTATION**	
Date	9 July 2010	
Security	N/A	
Copied to	N/A	
For referral to	N/A	
Agencies consulted	ACC, Ministry of Health, Ministry of Social Development, New Zealand Veterans' Affairs	
Contact information	[redacted] Senior Advisor	DDI: [redacted] MB: N/A
Authorising manager	[redacted] Manager, Accident Compensation Scheme Policy	DDI: MB: [redacted]
Tracker number	10/95599	

Minister's comments

Minister's feedback	Very Poor	Poor	Neutral	Good	Very Good
Quality of advice	1	2	3	4	5
Writing style	1	2	3	4	5
Quality of analysis	1	2	3	4	5
Completeness of information	1	2	3	4	5

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Department of Labour briefing
REPORT ON HEARING LOSS CONSULTATION

Executive summary

This paper briefs you on the results of the consultation on regulations for noise-induced hearing loss and based on this feedback seeks your decision on the options.

The consultation on hearing loss resulted in fifty-six submissions and over 19,000 form letters. Most of the submissions and the form letters were concerned with the policy of apportionment, rather than specifically addressing which of the two options presented would be preferable. The main concerns expressed by submitters were:

- the proposed limitations on fees, devices and repairs
- the scientific basis for determining the injury-related portion of hearing loss
- discrimination on the basis of age and the impacts on low-income people, Maori and Pacific Peoples
- implementation would be difficult especially in getting reliable Ear Nose and Throat (ENT) assessments.

Of those who expressed a preference for the options, seven supported Option 1 (percentages), three supported Option 2 (bands) and six liked neither. Some comment was also received concerning the proposed technical amendments to the regulations. A number of submitters expressed the opinion that the consultation was inadequate, and provided insufficient time and information for submissions. Some considered the process to be unlawful.

Officials have considered these concerns and responses to them are contained in the body of this briefing. On the basis of the consultation, ACC has finalised its recommendation to you. ACC are recommending Option 2 (bands) with a number of changes as a result of the consultation. The full recommendation is in the briefing with a summary table in Appendix 1.

New work is proposed for officials to pull together information for people with hearing loss about what assistance with hearing aids they can access through different government agencies and how they can access it. If Ministers wish they could also direct officials to scope the policy issue of funding hearing loss for claimants with both injury-related and non-injury related hearing loss and the implications for Ministry of Health policy.

Once you have made a decision on how the regulatory option (percentages or bands) you wish to proceed with, officials will draft a paper for the Cabinet Social Policy Committee.

Recommended action

It is recommended that you:

1 **Note** that the public consultation resulted in 56 Submissions and over 19,000 form letters and that the main themes of the submissions were concerns about:

1.1 the policy of apportionment

1.2 proposed limitations on fees, devices and repairs

1.3 the scientific basis for determining injury-related hearing loss

1.4 discrimination on the basis of age caused by ACC payments reducing as age-related hearing loss increased and the position of low-income people, the disabled, Maori and Pacific Peoples

1.5 implementation being difficult especially in getting reliable Ear, Nose and Throat (ENT) assessments

1.6 the adequacy and lawfulness of the consultation.

2 **Note** that ACC has considered the results of the consultation and as a result recommends that Option 2 (bands) be progressed, with some amendments. ACC considers that Option 2 provides more certainty for claimants, is more consistent with other funders, could have a positive impact on lowering prices in the market and could provide an incentive for claimants to choose less expensive hearing aids.

3 **Agree** to either

3.1 **Option 1:** ACC makes a contribution to hearing device and fitting fee costs based on each individual's percentage of injury-related hearing loss.

AGREE / DO NOT AGREE

3.2 **Note** that should you agree Option 1 there may be consequential changes (including removing the limitation on co payments) to the detail that would be presented to you in the Cabinet paper.

Or

3.3 **Option 2:** ACC makes a contribution to hearing device and fitting fee costs based on standardised bands of proportionate covered injury-related hearing loss (ACC's recommended option).

AGREE / DO NOT AGREE

And should you agree to Option 2:

3.3.1 **Agree** to remove the limit on co-payments for fees.

AGREE / DO NOT AGREE

3.3.2 **Agree** to remove the hearing needs assessment and hearing needs reassessment and review reports.

AGREE / DO NOT AGREE

3.3.3 **Agree** to align the hearing assessment reports at initial assessment and re-aiding.

AGREE / DO NOT AGREE

3.3.4 **Agree** to raise the minimum funding level for hearing devices from $444 to $500 (GST excl).

AGREE / DO NOT AGREE

3.3.5 **Agree** to re-align funding levels for hearing devices to match the banding logic of fitting fees.

AGREE / DO NOT AGREE

3.3.6 **Agree** to raise the rate of the binaural fitting fee from $1,100 to $1,200 and consequently raise the rate for binaural fitting at each band.

AGREE / DO NOT AGREE

4 **Agree** to the three proposed technical changes that were consulted on:

4.1 update the adjustment for age-related hearing loss.

AGREE / DO NOT AGREE

4.2 update the acoustical standard used for testing.

AGREE / DO NOT AGREE

4.3 remove Schedule 3 and references to base-line hearing tests.

AGREE / DO NOT AGREE

5 **Agree** that the Department of Labour prepare a paper for the Cabinet Social Policy Committee seeking agreement on the proposed changes.

AGREE / DO NOT AGREE

6 **Recommend** to Cabinet that they direct ACC (leading), the Ministry of Health, the Ministry of Social Development and Veterans' Affairs New Zealand to develop and make available to the public by 1 November 2010, co-ordinated information for people with hearing loss about what assistance with hearing aids they can access through different government agencies and how they can access it.

7 **Note** that further work is needed to consider the policy issue of funding hearing loss for claimants with both injury-related and non-injury related hearing loss and the implications that has for the Ministry of Health. A recommendation for this will be included in the Cabinet paper.

AGREE / DO NOT AGREE

8 **Note** that this work could have significant policy and funding implications for Vote: Health.

9 **Note** the process for the completion of the regulatory change with an implementation date of 1 November 2010.

[redacted]
Manager Accident
Compensation Scheme
Policy
for Secretary of Labour
..... / ..... / .....

Hon Dr Nick Smith
Minister for ACC

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10/95599

Department of Labour briefing
REPORT ON HEARING LOSS CONSULTATION

Purpose

1. The purpose of this paper is to:

   a inform you of the results of the consultation on regulations for noise-induced hearing loss;

   b present ACC's final recommendation on the detail of the regulation for your agreement; and

   c seek your agreement to the preparation of a Cabinet paper for Cabinet to agree the detail of the regulation.

Background

2 As required under ACC legislation and case law, and following your direction, consultation on a new regulation for ACC's responsibility for hearing loss and updating to the Accident Insurance (Occupational Hearing Assessment Procedures) Regulations 1999 was undertaken jointly by the Department of Labour and ACC between 24 May and 18 June 2010.

3 The consultation document as you agreed was placed on the website of the Department of Labour. ACC publicised the consultation on their web site and included links to the Department of Labour's website. The following were sent copies of the consultation document and invited to make a submission:

   a New Zealand Audiological Society

   b Hearing Instrument Manufacturers and Distributors Association

   c The New Zealand Society of Otolaryngology, Head and Neck Surgery (ENTs)

   d Australasian Faculty of Occupational & Environmental Medicine

   e Employers and Manufacturers Associations

   f Engineering Printers and Manufacturing Union

   g Grey Power

   h National Foundation for the Deaf

   i Accredited Employers Group

   j Business New Zealand

k Federated Farmers

l New Zealand Council of Trade Unions

m Deaf Aotearoa

n New Zealand Hearing Sector (industry group)

o National Hearing Care New Zealand

p Hearing Association

q Association of New Zealand Audiometry Incorporated

r Consumer Outlook Group (ACC-convened group including Age Concern and Citizens Advice Bureaux)

4 Fifty-six submissions were received and included in the analysis. There were also requests to the Department, ACC and the Minister's Office requesting an extension to the consultation period. This was not granted. A number of these letters also criticised the consultation process and questioned its legality. Over 19,000 form letters were sent to the Minister's Office in opposition to any reduction in ACC entitlements for hearing assistance. They did not cover the questions posed by the consultation document but the points raised have been included in the submissions analysis.

5 The Department received a further 16 submissions substantially after the closing date, which had been sent to the wrong government agency. These have not been formally included in the submissions analysis. However, they contain points that were already raised by the other fifty-six submissions and the Department feels confident that the late submissions have been represented in the analysis.

Main Themes from Respondents

6 Submissions have been analysed. The following summary provides the key themes and arguments from the submissions and the response to these from the Department and ACC. The full report on the consultation is attached (see Appendix 3).

Apportionment

Submitters' comments

7 A number of submitters considered that the proposed changes are unfair, discriminatory, especially to the elderly and disabled, and unnecessary. They were seen as likely to have an adverse effect on rehabilitation. Significant concern was expressed that some claimants will not be able to afford their portion of the costs and that this was likely to result in adverse outcomes.

Comment

8 ACC is a personal injury scheme. There are other agencies responsible for supporting people who have a disability caused by factors other than injury. ACC paying the total cost for hearing loss for non-injury and injury places an unfair burden on the levy payer.

9 A possible explanation for why submitters have considered the proposed changes to be unfair, discriminatory and unnecessary is because other agencies do not provide the same level of hearing loss support as ACC. It is likely that the proposals would not be considered unfair or discriminatory if people with mixed hearing loss could access support from both ACC and Ministry of Health at the same level.

10 Help is currently available from the Ministry of Social Development and Veteran's Affairs New Zealand. Financial assistance for hearing loss is potentially available from:

a the Ministry of Social Development has two last-resort loan programmes (one for beneficiaries and one for low income earners). Up to $1000 may be available to those on low income and limited cash assets. The programmes are available to meet shortfalls in part subsidies from District Health Boards, so could be available to those receiving part subsidies by ACC. Both programmes need to be repaid at a rate that is affordable to the client.

b Veterans Affairs' New Zealand has hearing aid assistance available to veterans and could assist with part-charges for some ACC claimants who are veterans.

c the Ministry of Health specifically excludes people with cover and entitlements from ACC from hearing aid assistance. A change to this policy could need new funding.

11 Officials need to work to make sure that all of the government's assistance for hearing loss is well coordinated and easy to access for ACC claimants who cannot afford to pay for the non-injury component of their hearing loss. Some policy changes may be needed. For example, a change to policy in Health coverage for ACC claimants could require Ministerial agreement and additional funding. If this occurred Health would be able to assist some ACC claimants where ACC's contribution does not cover the full cost of their chosen hearing services.

Preference for Options

Submitters' comments

12 Of the fifty-six submissions, seven supported Option 1 (percentages), three supported Option 2 (banding) and six liked neither option. The rest did not express a preference for the options.

13 Option 1 was seen as more accurate and simple and in keeping with the rationale of the National Acoustic Laboratories (NAL) Schedules. As it operates on a mathematical basis it was seen as avoiding the thresholds set by banding. It is fairer in that the ACC liability represents an actual % hearing loss to workplace gradual process.

14 Of those that expressed a preference and did not support Option 2 it was because:

a it was unfair as it means that a 0.1% difference in hearing loss allocated to injury, results in an 80%, 50% or 25% reduction in entitlement

b it would lead to "boundary" contests where a claim is close to a threshold and liability is based on broad-ranging bands

c the bands were arbitrary and would create unfair variations

d it removes individually tailored compensation and the highest subsidy for a hearing device in Option 2 is $500 less than in Option 1

e it does not include agreements with manufacturers as at present, and these provide incentives to clinics to encourage prescription of their products

f slippage and drifting will occur and it is cumbersome

15 On the positive side, Option 2 was seen as a simpler means of working out the portions of cost paid by ACC, it would be easier for ACC to manage and it was fairer.

16 Those who liked neither option considered that both options are:

a not good but if forced to choose then Option 2 is better

b unfair and will introduce new problems into hearing services

c financially unreasonable for private clinics, and will ultimately result in claimants not receiving the care they need

d complicated which will add to the cost of hearing loss claims through unnecessary bureaucracy

e likely to place a huge burden on ENT surgeons.

Comment

17 Comment on the options is contained in ACC's response to Option 2.

Limitations on fees, devices, and repairs

Submitters' comments

18 There were concerns about the limitations on the level of professional fees and the cost of devices. It was noted that some claimants whose hearing loss is totally caused by injury would need to make a co-payment if their chosen hearing devices cost more than the proposed $2,000 maximum ACC contribution. In addition, some submitters considered that the level of ACC's contribution to fees may drive some audiologists out of business or result in lower professional standards. Concerns were also expressed over the time and funding limits on fittings, testing and repairs, with some submitters noting that this was likely to lead to poorer outcomes and increased cost to claimants. Some considered that limiting co-payments on audiological fitting fees is ultra vires.

Comment:

19 As part of the contract negotiations with audiologists on the provision of audiology services, ACC commissioned an independent review of the prices that it pays and audiologists participated in a survey of fees. The results were used as a basis for the proposed regulatory fees and were closely correlated to ACC's review of audiology prices. ACC also looked at the fees paid in workers' compensation schemes in Australia. The proposed regulated fee is comparable to New South Wales Work Cover and the Victorian Scheme (particularly the binaural and monaural fitting fees, the management fee, and the maximum contribution towards hearing aids). ACC is of the view that the proposed fees represent a reasonable price for audiology services, while maintaining value for money for levy payers.

20 The limits on funding timeframes are based on experience under current practice. The re-aiding period of six years is the same as that stipulated by the Ministry of Health for its subsidy clients.

21 In response to feedback that requiring co-payments on audiological fitting fees is ultra vires, ACC agree and it is proposed that you agree to remove this restriction and allow the market to self-regulate this cost. ACC is liable for the cost of assessments under the Act, so claimants are not liable for any co payments as the regulated fees would be the entire cost. Therefore no regulatory change is required to address this issue.

The science

Submitters' comments

22 A number of submitters stated that there was no scientifically robust method for determining injury-related hearing loss. It was considered that this classification was subjective and likely to result in significant discrepancies between different practitioners, as well as placing an unreasonable burden on ENTs. Submitters noted that this was likely to lead to an increase in disputes and reviews. Some submitters considered that a needs-based approach would be more helpful.

Comment:

23 Audiologists (or ENTs in some cases) already provide ACC with the measurement of a client's total hearing loss as a percentage from the audiogram and the level of occupational noise-induced hearing loss as a percentage from the ENTs. ENTs

arrive at this percentage by using the results of the audiogram and any other relevant information (e.g. noise exposure levels in particular industries) as well as applying their professional clinical judgment and discussing the client's occupational and medical history. This is an established methodology that is currently used to accept or decline claims.

24 ACC claims with historical audiometric testing combined with a client's work history allow a reasonably accurate percentage of Occupational Noise Induced Hearing Loss (ONIHL) to be attributed. However, the diagnosis of ONIHL can be less certain in other cases. For example, the pattern of hearing loss may not be consistent with either average age-related hearing loss and/or ONIHL, and there are times when other pathologies are suspected.

25 As a result, establishing the percentage of hearing loss attributed to occupational noise exposure is based on a degree of professional clinical judgment, and absolute accuracy cannot be guaranteed. Training and clinical practice of ENT specialists means they are best able to attribute how the differing pathologies may have led to an individual's hearing impairment. Continued ACC engagement with ENTs to produce best practice medico-legal reports will improve the robustness of these assessments.

26 To further mitigate the effects of variable ENT assessments, a banded approach (Option 2) would reduce the incentive to challenge for most claims, except where the clients are close to the boundaries.

Discrimination

Submitters' comments

27 Concerns were expressed that reducing the component paid for by ACC on the basis of age was discriminatory. There was concern for low-income workers, the disabled and especially Maori and Pacific who have worked in high-risk industries.

Comment

Age

28 It is likely that claimants who have increasing age-related hearing loss will receive less from ACC as they age. If the client has more hearing loss at re-aiding than at initial aiding, the level of ACC funding will decrease unless it is shown that the increase in hearing loss is injury related. Reassessment of the need for entitlement as a client ages is consistent with the other parts of the ACC scheme.

Low Income

29 While some people will be able to afford the part of the cost that ACC is not paying, some will not. They may have access to the Government's hearing assistance from The Ministry of Social Development and Veterans Affairs' New Zealand The Ministry of Health specifically excludes people from hearing aid assistance if they have cover and entitlements from ACC. The implications of any change (and just what that change should be) needs to be worked through by officials. Officials are also preparing material to assist people access assistance from these other agencies and this will be available for when the regulation comes into force.

High-risk industries

30 This proposal is more likely to impact on European men who have been exposed to occupational noise in high risk industries. In particular, older men are likely to be affected as work-related hearing damage is not usually noticed until age-related hearing loss begins to be apparent. In addition the risks of noise was not recognised and prevented when many of these men were working. Maori and Pacific peoples could be affected by this proposal.

Disability

31 This proposal will impact adversely on some people with a hearing disability as it will reduce the level of entitlement provided by ACC. However, in most cases the level of hearing assistance that they receive from ACC is likely to still exceed that available from the other sectors and other funding could be available to address affordability issues.

Implementation

Submitters' comments

32 Submitters noted that the changes could be difficult to implement. It was noted that there was a need to ensure assessment was undertaken by someone with the appropriate level of expertise and that clear guidelines would need to be provided by ACC. There was also some confusion over how this would apply to existing claims.

33 It was considered by submitters that, should experience rating be introduced, it would be difficult to address the issue of multi-employer causation.

Comment:

34 While there will be challenges, ACC considers that the changes can be effectively implemented. ENTs, as independent, clinically-trained assessors with no financial interest in the outcome, are best placed to determine the causes of ACC clients' hearing loss. They already provide this information to ACC. Percentage hearing loss information (both total and injury-related) is already recorded on most claimants' files.

35 The forthcoming ENT workbook aims to improve the quality of reports to ACC and to increase awareness and availability of resources to assist ENTs in their clinical assessment of the causes of clients' hearing loss.

Other approaches

Submitters' comments

36 Some submitters considered that a subsidy approach would be preferable to the options presented. A number of submissions from the industry noted that the proposed regulations undermine the significant progress made by the Accord partners in reducing costs.

Comment

37 A subsidy was considered. However, it has not been progressed because it does not limit ACC's liability to injury-related hearing loss costs. It could result in both

under and over-servicing of client's hearing needs. For example claimants whose hearing loss is completely injury-related could receive the same level of funding as claimants with only a small portion of injury-related hearing loss. Also it does not provide a mechanism to manage claim volumes.

38 ACC recognises the progress that has been made by the Accord. However, the objective of the Accord was to find ways to manage hearing loss costs to ensure that they were sustainable. The policy objectives behind the regulatory proposals are different. While also seeking to ensure hearing loss costs are sustainable in the future, the primary focus is ensuring that ACC and levy payers are only liable for costs that are associated with injury-related and are not responsible for the costs of hearing loss from other causes.

Other comments from Submitters

39 Other comments included:

- no changes should be made until ACC's research into ONIHL is complete
- there needs to be a greater emphasis on prevention
- it is inappropriate to fund hearing loss that is not work-related from the Work Account.

Comment

40 ACC agrees that the best way to manage hearing loss claims is to prevent it but needs to respond to hearing loss claims where exposure to noise has already occurred. Clients lodge claims where their age-related hearing loss, alongside their occupational noise-induced hearing loss starts to negatively impact on their lives.

41 Further, the benefits of injury prevention initiatives typically do not manifest for about 30 years, because the effects of ONIHL are often not noticed until other factors (e.g. age) make the hearing loss worse. This long latency period means that such initiatives are unlikely to have a substantial impact on ACC's outstanding claims liability for hearing loss for some time.

42 The current research will not give guidance to this proposal. Massey University's research relates to intervention strategies to reduce noise-induced hearing loss (NIHL) in New Zealand and is expected to be complete mid-2010. This research may be useful in preventing future exposure to noise in the workplace and reducing ONIHL claims. However, it will not predict the number of claims lodged with ACC for work-related noise exposure that has already occurred. Nor will research on the current prevalence or incidence of NIHL in New Zealand estimate the number of claims to be lodged as claim lodgement is contingent on other factors e.g. greater awareness of assistance, marketing by industry groups, availability of better technology etc.

43 ACC agrees that employers should not be responsible for hearing loss costs that is caused by factors that are not related to work. The purpose of the Work Account is to finance entitlements for work-related personal injuries but is currently being used to fund hearing loss entitlements for hearing loss not caused by work. The fact that the average age at claim lodgement for hearing loss is 65 highlights that the Work Account is also financing age-related hearing loss.

Update the adjustment for age-related hearing loss (presbyacusis)

Submitters' comments

44 Of fifty-six submissions received, fourteen supported this change, two did not and forty were unsure or did not answer. A number of submitters noted that there were alternatives to the 1988 table being proposed.

Comment

45 Australian workers' compensation schemes continue to use this table for the same purpose as ACC. The methodology of the 1988 National Acoustics Laboratories Report has been accepted in all Australian jurisdictions as the defined method for calculating percentage loss of hearing and is used for the awarding of compensation to individuals who suffer hearing loss from workplace noise exposure. Providers are familiar with the current table which is similar to the proposed updated one. The tables used by assessors to determine the total percentage loss of hearing are also based on the 1988 NAL report. It makes sense to align these tables.

Update acoustical standard used for testing

Submitters' comments

46 Of fifty-six submissions received, ten supported this change, two did not and forty-four were unsure or did not answer. Concerns were expressed that this could be costly to implement.

Comment

47 ACC has commissioned a review of the evidence base to inform best practice for assessing NIHL claims. In their draft report (December 2009), Suzanne Purdy and Warwick Williams found that:

"Maximum permissible ambient sound pressure or noise levels (MPANL) in the test area shall meet the requirements of ISO 8253-1 Acoustics - Audiometric Test Methods, Part 1: Basic pure-tone air and bone conduction threshold audiometry for hearing threshold levels down to 0 dB HL. This is to ensure that there will be no uncertainty with the measured audiometric threshold levels introduced through the influence of unwanted external noise sources. Ambient noise levels above those prescribed in the standard will lead to uncertainties and errors in measurement".

48 The Australian version of this standard (AS ISO 8253-1) is considered to be relevant for Australia and New Zealand. Similarly, Britain uses a version of this standard (BS EN ISO 8253-1). These versions are identical to the original ISO standard.

49 While ACC acknowledges that meeting the requirements may involve compliance costs, ACC's priority is that it receives audiometric information that conforms to standards for diagnostic audiology to enable assessment of cover and entitlements, as will be provided by AS ISO 8253-1. The existing standard (ISO 6189) is only appropriate for workplace screening or monitoring audiology.

Remove Schedule 3 and the reference to base-line hearing tests

Submitters' comments

50 Of fifty-six submissions, eleven supported this change, five submissions did not, one submission had divided opinion and thirty-nine were unsure or did not answer. The importance of base-line testing in prevention was noted.

Comment

51 The issue is that references to baseline testing In Schedule 3 are remnants of the policy under previous Acts where clients could be disentitled for refusing to undergo baseline hearing tests. This provision cannot be enforced for claims under the Accident Compensation Act 2001. The aim of removing these provisions is to "tidy up" what should have been done in the past and to eliminate confusion.

52 ACC supports baseline testing and encourages claimants to provide all available audiometric tests to providers as part of their assessment. However, it is not within ACC's scope or power to enforce baseline testing. This responsibility lies with employers and individuals.

Consultation Process

Submitters' comments

53 A number of submitters expressed the opinion that the consultation was inadequate, and provided insufficient time and information for submissions. Some considered the process to be unlawful

Comment:

54 The Department considers that the consultation period is adequate. Section 324 of the Accident Compensation Act does not set specific requirements for time or the level of detail that must be provided for adequate consultation. It needs to be a case by case assessment according to the nature of the proposals. A period of four weeks for consultation on regulations is not unusually short and the consultation document contained a high level of detail about what is likely to be in the final regulations, except how it will be changed as a result of the consultation.

55 In addition, the issue was signalled to the sector in October 2009, and when the legislation was proceeding through the House, as well as in meetings with the Hearing Accord and with the Corporation as part of contract negotiations.

ACC's Recommendation

56 ACC has considered the feedback from the consultation and as a result makes the following recommendations for a new regulation regarding hearing loss.

Recommended option

57 ACC recommends Option 2, i.e. that ACC makes a contribution to hearing device and fitting fee costs based on standardised bands of proportionate covered injury-related hearing loss. ACC recommends Option 2, for the following reasons:

a clients will have the certainty and transparency of knowing upfront how much ACC will contribute to both hearing devices and fitting fees.

b a system of set levels of funding is consistent with other funders and familiar to clients. It will be easier for clients to understand, for providers to implement, and for ACC to communicate changes than with Option 1.

c the banding framework could extend to other agencies should they choose to part fund the non-injury-related component. For example, the Ministry of Health or Veterans' Affairs may choose to publish set rates of contribution at each band to complement ACC's contribution.

d establishing fixed contributions for hearing devices may have a positive effect on clients and other funders, making more products available at lower prices, as clients will have an incentive to choose less expensive devices when they face part of the cost.

e challenges by clients regarding the percentage of injury-related hearing loss will more likely occur at the margins of the bands, where it would be financially worthwhile to challenge, as opposed to challenging every percentage as is the risk with Option 1.

f most clients will need to make a co-payment but the minimum level of funding for hearing devices ($500) and fitting fees ($300 binaural or $225 monaural) allows clients with limited means to make their selection according to their means. Forty-three hearing aids on ACC's current price list cost less than $500 (in total, 285 of the 540 aids on the list cost $1,500 or less). Clients will still need to make a financial choice about the need for the hearing aid because audiology clinics are likely to charge for services in addition to ACC's contribution to fitting fees.

g the model's fixed contributions provide certainty of future costs for ACC. The model is administratively simpler for ACC.

h the estimated reduction in liability for the residual portion of the Work Account for Option 2 ranges from $451 million to $608 million. Final costs will be confirmed for Cabinet paper.

Proposed Changes to Option 2

58 In addition to Option 2, ACC recommends the following adjustments. A revised price schedule showing the changes to the original schedule is attached as Appendix A:

Remove the limit on co-payments

59 ACC considers that the proposed maximum fitting fee is a reasonable price for the full cost of the service. ACC does not have an explicit statutory ability to make regulations that cap client co-payments as the legislation is more focused on ACC's liability to pay or not pay. It does not extend to determining how much a provider charges a client.

60 In addition, capped co-payments are unprecedented and inconsistent with the way other providers can charge under regulations (e.g. physiotherapists). Therefore, ACC proposes that while ACC's contribution will remain set at the relevant percentage of the proposed maximums for audiological fittings, audiologists will be able to charge additional payments to clients. However, co-payments will not be able to be charged for assessment costs as ACC is liable under the Act for these costs.

Remove the "hearing needs assessment" and "hearing needs re-assessment and review" reports

61 While these were consulted on for Option 2, ACC now considers that it does not require separate hearing needs assessment reports where the type of hearing aid needed is determined under banding. It is expected that clients will still discuss their needs with their audiologist as part of the fitting and ACC will be able to monitor whether clients accept the aid they are prescribed when finalising the hearing aid trial. ACC propose to redistribute an element of the cost of assessments by increasing the rate of the binaural fitting fee, as well as by increasing the minimum level of funding for devices.

Align the hearing assessment reports at initial assessment and re aiding

62 The needs re-assessment for the type of aid needed will take place as part of the fitting. Hearing assessment includes testing and measurement of the total hearing loss. Because ACC will require hearing loss information for all clients at initial assessment and re-aiding, ACC proposes to pay the same cost and align the service requirements, that is $155 for each.

Raise the minimum funding level for hearing devices from $444 to $500 (GST excl.)

63 The initial rationale for the price of $444 was to align it with the hearing aid subsidy offered by the Ministry of Health, which is set at $500 including GST, and therefore is $444 at current GST rates. This will change with the GST increase on 1 October 2010. Given that the link to the Ministry's figure may be broken, ACC proposes a figure that is more consistent with prices for the higher bands.

Re-align funding levels for hearing devices to match banding logic of fitting fees

64 The maximum contribution for the fitting fee contribution has been calculated for each band as 25%, 50%, 75% and 100%. The logic for price banding for hearing devices was based on other agencies (the Ministry of Health pays $444 excluding

GST; Veterans' Affairs pays $800 excluding GST), but this is less relevant if the link to the Ministry's figure is broken. Therefore, we propose to apply the same logic to hearing devices as for fitting fees, with the exception of the lower band (to ensure that a reasonable range of hearing devices are available at that band).

Raise the rate of the binaural fitting fee from $1,100 to $1,200 (and consequently at each band)

65 We propose that part of the cost that was allocated to the hearing needs assessment be re-allocated to the binaural fitting fee (more commonly used than the monaural fee). Discussion of a client's hearing needs is likely to occur as part of the fitting, and this raised contribution recognises that aspect of work. An increase in this fee may alleviate some concerns of the audiology clinics regarding business sustainability.

Risk Management

66 ACC acknowledges that risks remain with Option 2. The main concern raised during consultation is the degree of confidence in the clinical method of quantifying the percentage of injury-related hearing loss.

67 Ear, Nose and Throat (ENT) specialists already provide ACC with information that establishes a client's total hearing loss as a percentage and their level of occupational noise induced hearing loss as a percentage. This methodology is already used to accept and decline ACC claims for entitlements. It is only now that this process is proposed as the means to apportion costs that the hearing sector has raised concerns about its efficacy. There is a clear unwillingness by certain groups to accept the clinical judgment of ENTs, which ACC considers is partly driven by the financial impact of these proposals.

68 ACC claims allow a reasonably accurate percentage of ONIHL to be attributed where clients have historical audiometric testing, combined with consistent client work history information. In other cases the diagnosis of ONIHL can be less certain. For example, the pattern of hearing loss may not be consistent with either average age-related hearing loss and/or ONIHL, and there are times when other pathologies are suspected.

69 Establishing the percentage of hearing loss attributed to occupational noise exposure is based on a degree of professional clinical judgment and absolute accuracy cannot be guaranteed. The training and clinical practice of ENTs means they are best able to attribute how the differing pathologies have led to hearing impairment. Continued ACC engagement with ENTs to produce best practice medico-legal reports will improve the robustness of these assessments.

Alternatives considered

70 ACC does not recommend Option 1. It is harder for clients to understand than Option 2, less workable for providers, and would create more difficulties than a banded approach for other agencies if they provide complementary funding. ACC's costs would also be less certain under this approach, as there is more opportunity for audiologists to influence clients to purchase higher-cost hearing aids that may not be needed. Without a contract with audiologists, ACC has no real ability to prevent or otherwise respond to this behaviour.

71 There are also concerns regarding the level of challenge that is likely to come from clients seeking to review, at every percentage, the level of injury-related hearing loss attributed by the ENT. Under normal circumstances, we would not be concerned about clients challenging clinical judgments that arrive at a percentage of impairment or injury as this already occurs with lump sum assessments. 'Whole person impairment' is a percentage-based assessment reliant on a level of clinical judgment to determine funding (particularly in the case of determining the level of impairment for mental injury).

72 These assessments are only occasionally challenged. However, the key difference is the role of the audiologist. Audiologists have an interest in the percentage of injury-related hearing loss attributed by the ENT, because every percentage increase will result in increased funding from ACC and less funding audiologists have to seek from clients. As the recent audiologist campaign to rally opposition among clients to the proposed changes demonstrates, audiologists are likely to encourage clients to lodge reviews to increase the ACC contribution as well as to discredit the process.

73 The estimated reduction in liability for the residual portion of the Work Account for Option 1 ranges from $466 million to $620 million (costs will be confirmed in any Cabinet paper).

Technical changes to Existing Regulation

74 ACC recommends proceeding with the technical changes to the Accident Insurance (Occupational Hearing Assessment Procedure) Regulations 1999 (the Regulations) that were proposed during consultation, specifically:

a replace the existing table prescribing correction for age-related hearing loss for work-related hearing loss claims in Schedule 2 of the Regulations with the newer version of this table as described in the 1988 NAL report

b replace the existing requirement that pure tone audiometry tests undertaken under the Regulations must comply with the technical and procedural standards of ISO 6189 with the requirement that they comply with AS ISO 8253-1: 2009

c remove Schedule 3 of the Regulations and all references to baseline testing in the Regulations.

Consultation

75 The following officials have been consulted in the preparation of this paper. Their views are:

Ministry of Health

76 The Ministry of Health has had less than a day to consider the specific proposal supported by ACC, which is insufficient to reach final views on the relative merits of the two options for moving toward part funding of hearing aids and associated services. Our initial view, however, is that Option 2 is preferable to Option 1 as it appears likely to be easier for people to understand and for agencies to administer, and is likely to have lower transaction costs than Option 1.

77 The Ministry of Health notes that under present policy and practice, people who qualify for hearing aid funding from ACC do not also qualify for hearing aid funding through Vote: Health. This approach would continue even if ACC changes its approach to funding hearing aids. The Ministry of Health does not support changing current policy and practice on this issue and would only consider doing so if there is a specific direction to do so by the Minister of Health or Cabinet. That is because existing funding constraints make it unlikely that additional funding could be made available for this, and because doing so would raise the risk of the inconsistent treatment of people that may be contrary to the Human Rights Act 1993 (leading to claims that cannot be successfully defended and which may have flow-on implications for government funding of disability supports more generally).

78 In addition, the Ministry of Health notes that under Option 2, the level of funding for hearing aids a person will receive from ACC will be almost always higher than they would receive through Vote: Health. That is because the lowest level of funding a person would receive through ACC if they have some covered hearing loss is $500 (plus GST), plus assistance with the costs of assessment and fitting fees. In contrast, most people who receive funding through Vote: Health receive $500 (including GST).

79 The only group who could receive a higher level of funding through Vote: Health than through ACC - and are therefore likely to approach the Ministry of Health for funding - would be a small group of people who have an injury covered by ACC that results in a relatively low percentage of their total hearing loss, and who qualify for fully funded hearing aids through Vote: Health. People qualify for fully funded hearing aids through Vote: Health if they:

a have a severe to profound long-term hearing loss from childhood, people who have dual disabilities and people who have had early onset of severe/ sudden hearing loss; or

b people who are on low incomes who are working, studying, doing voluntary work or caring for a dependent person full-time.

Veterans' Affairs New Zealand

80 Veterans' Affairs New Zealand has no concerns with the recommendations of this paper.

81 The Ministry of Social Development had no comment.

Further Work Needed

82 Officials need to undertake work to make sure that people with hearing loss have a clear understanding of the assistance that is available from different government agencies for hearing loss. It is proposed that ACC lead the development of coordinated information for people with hearing loss on the assistance that is available and how they would access it. It is envisaged that this can be in place by 1 November 2010 when the proposed regulations are intended to come into force.

83 If Cabinet directs, further work would be undertaken to identify whether any policy changes are needed in Health coverage for ACC claimants who have both injury-related and non-injury related hearing loss. This would include consideration of the basis on which this would occur and the impact this could have on additional funding requirements. Such a policy change could have significant fiscal implications for Vote: Health. It might also have significant implications for other conditions that have joint injury and non-injury causes. This work could not be completed by 1 November.

Process from Here

84 The following timetable meets the requirements of legislation and practice and will enable the regulation to be in force by 1 November 2010. Note that all of the milestones will need to be met if this deadline is to be achieved:

Completion Date	Process	Time Allowed
16 July	Prepare Cabinet paper. Internal and external officials' consultation. Confirm Regulatory Impact Statement	2 week
28 July	Officials' committee (OSOC), Ministers sign out, Papers submitted to SOC	1 week
4 August	SOC agrees proposed changes to regulations	1 week
9 August	Cabinet agrees proposed changes to regulations	Following Monday
11 August	Drafting instructions complete	1 week
22 Sept	Parliamentary Council Office prepares regulations	6 weeks
23 Sept	Cabinet Legislative Committee (LEG)approves regulations	1 week
27 Sept	Executive Council approves regulations	1 week
27 October	Gazetting	28 days
1 November 2010	Regulations in force	28 days after gazetting

Appendix 1: Option 2 – Summary of costs payable by ACC under regulations for hearing services [REVISED]

Service	Description	ACC contribution (ex GST)
Assessment : Hearing assessment report	Audiologist completes full audiological assessment (including pure tone audiogram and speech audiometry) and provides report to ACC	$155 *Payable once prior to first receiving a hearing aid, and once every six years thereafter*
Hearing devices: (aids, accessories, remotes and consumables)	Hearing device/s chosen by claimant following assessment by audiologist to determine most appropriate rehabilitative device	Maximum $ 500: Where claimant's covered injury-related hearing loss makes up between 0.1% and 24.9% of total hearing loss. *Payable once every six years*
		Maximum $750: Where claimant's covered injury-related hearing loss makes up between 25% and 49.9% of total hearing loss. *Payable once every six years*
		Maximum $1,125: Where claimant's covered injury-related hearing loss makes up between 50% and 74.9% of total hearing loss. *Payable once every six years*
		Maximum $1,500: Where claimant's covered injury-related hearing loss makes up between 75% and 100% of total hearing loss. *Payable once every six years*
Fitting fees Fitting fee (binaural)	Fitting of hearing aids including needs assessment, trial period of 2-4 weeks, follow-up service/s, handling and management	Maximum $300: Where claimant's covered injury-related hearing loss makes up between 0.1% and 24.9% of total hearing loss. *Payable once every six years*
		Maximum $600: Where claimant's covered injury-related hearing loss makes up between 25% and 49.9% of total hearing loss. *Payable once every six years*
		Maximum $900: Where claimant's covered injury-related hearing loss makes up between 50% and 74.9% of total hearing loss. *Payable once every six years*
		Maximum $1,200: Where claimant's covered injury-related hearing loss makes up between 75% and 100% of total hearing loss. *Payable once every six years*
Fitting fee (monaural)	Fitting of hearing aid including needs assessment, trial period of 2-4 weeks, follow-up service/s, handling and management	Maximum $225: Where claimant's covered injury-related hearing loss makes up between 0.1% and 24.9% of total hearing loss. *Payable once every six years*
		Maximum $450: Where claimant's covered injury-related hearing loss makes up between 25% and 49.9% of total hearing loss. *Payable once every six years*
		Maximum $675: Where claimant's covered injury-related hearing loss makes up between 50% and 74.9% of total hearing loss. *Payable once every six years*
		Maximum $900: Where claimant's covered injury-related hearing loss makes up between 75% and 100% of total hearing loss. *Payable once every six years*

Fitting fee (monaural, within one year of initial monaural fitting)	Fitting of hearing aid including needs assessment, trial period of 2-4 weeks, follow-up service/s, handling and management	$300: *Payable once every six years*
Fitting fee (failed, either binaural or monaural)	Claimant has undergone fitting process but has ultimately declined hearing aids (includes fitting of hearing aid/s and needs assessment, trial period of 2-4 weeks, follow-up service/s, handling/management)	$250
Repairs Hearing device repair (on-site)	Maintenance of hearing device/s as necessary to maintain proper function (includes consumables)	Maximum $50 per service. *Maximum two services per year*
Hearing device repair (off-site)	Repairs that cannot be completed on-site (e.g. replacement of microphone, amplifier and/or receiver; re-shelling)	Maximum $200 per service. *Not payable while device under warranty, then payable once every two years*

Appendix 2: Option 1: Summary of costs payable by ACC under regulations for hearing services

Note that if you prefer this option there may need to be changes presented in the Cabinet paper.

Service	Description	ACC contribution (ex GST)
Assessment : Hearing assessment and cover report	Audiologist completes full audiological assessment (including pure tone audiogram and speech audiometry) and provides report to ACC	$155
Hearing needs assessment	Audiologist assesses claimant's hearing needs and most appropriate device/s	$150: *Payable prior to fitting of initial hearing device(s)*
Hearing review and hearing needs re-assessment	Review of hearing and hearing needs where claimant has previously received hearing aids from ACC	$180:*Payable six years after first receiving a hearing aid, and once every six years thereafter*
Hearing devices Hearing devices (aids, accessories, remotes and consumables)	Hearing device/s chosen by claimant following assessment by audiologist to determine most appropriate rehabilitative device	Maximum $2,000 per covered ear: ACC contribution based on percentage of claimant's covered injury-related hearing loss as proportion of total hearing loss, as well as ACC's current price list specifying the cost of the device/s. *Payable once every six years*
Fitting fees Fitting fee (binaural)	Fitting of hearing aids, trial period of 2-4 weeks, follow-up service/s, handling and management	Maximum $1,100: ACC contribution based on claimant's percentage of covered injury-related hearing loss as proportion of total hearing loss. *Payable once every six years*
Fitting fee (monaural)	Fitting of hearing aid, trial period of 2-4 weeks, follow-up service/s, handling and management	Maximum $900: ACC contribution based on claimant's percentage of covered injury-related hearing loss as proportion of total hearing loss: *Payable once every 6 years*
Fitting fee (monaural, within one year of initial monaural fitting)	Fitting of hearing aid, trial period of 2-4 weeks, follow-up service/s, handling and management	$200: *Payable once every six years*
Fitting fee (failed, either binaural or monaural)	Claimant has undergone fitting process but has declined hearing aids (fitting of hearing aid/s, trial period of 2-4 weeks, follow-up service/handling/management)	$250
Repairs Hearing devices repair (on-site)	Maintenance of hearing device/s as necessary to maintain proper function (includes consumables)	Maximum $50 per service *Maximum two services per year*
Hearing devices repair (off-site)	Hearing device/s repairs that cannot be completed on-site (e.g. replacement of microphone, amplifier and/or receiver; re-shelling)	Maximum $200 per service: *Not payable while device under warranty, then payable once every two years*

Appendix 3: Consultation on Regulations for Noise-Induced Hearing Loss

Summary and Comment on Submissions July 2010

Introduction

Purpose of the consultation

1 Cabinet has noted (CAB min (09) 29/8) that ACC should pay entitlements (hearing aids) only for the proportion of a claimant's hearing loss that is injury-related, and noted that this may result in regulations. This decision is consistent with the Accident Compensation Act 2001 which specifically excludes from cover personal injury caused by the ageing process (section 26(4)) or other causes excluded from the personal injury definition under the Act.

2 Two options were developed that would give effect to this:

- Option 1: ACC makes a contribution to hearing device and fitting fee costs based on each individual's proportion of covered injury-related hearing loss; or
- Option 2: ACC makes a contribution to hearing device and fitting fee costs based on standardised bands of proportionate covered injury-related hearing loss.

3 In addition, the consultation also considered changes to how ACC assess work-related noise-induced hearing loss under the Accident Insurance (Occupational Hearing Assessment Procedures) Regulations 1999. It was proposed to ensure these regulations remain relevant and representative of best practice by making three technical changes:

- Update the adjustment for age-related hearing loss;
- Update acoustical standard used for testing; and
- Remove Schedule 3 and references to base-line hearing tests.

Apportionment

Preference for options

Submissions

4 Option 1 (ACC contribution based on each individual's proportion of covered injury-related hearing loss) was seen as:

- fairer, more accurate. (2, 14, 25, 29)
- in keeping with the rationale of the National Acoustic Laboratories (NAL) Schedules produced. (2)

- operating on a strictly mathematical basis, without the thresholds set by banding, which is good. (4)
- a fair approach, given the proposed cost-sharing for hearing loss, in that the ACC liability represents an actual % hearing loss to work place gradual process. (7)
- simpler. (17)
- accommodating a pro rata cause and effect system. (25)

5 However, the use of bands in Option 2 means that a 0.1% difference in hearing loss allocated to injury, resulting in an 80%, 50% or 25% reduction in entitlement, which is unfair. (54)

6 Option 2 (ACC contribution based on standardised bands) was seen as:

- a simpler means of working out the portions of cost paid by ACC and the claimant. (1)
- easier for ACC to manage. (5)
- fairer. (51)

7 On the other hand:

- experience of banding in is that slippage and drifting can occur i.e. borderline values tend to be rounded up. (4, 6)
- banding leads to “boundary” contests where a claim is close to a threshold of being in another band which may change the funding significantly. (4, 6)
- liability is based on fairly broad-range percentage hearing loss bands (7)
- bands in Option 2 are arbitrary, will create unfair variations when applied to claimants/employees. (14)
- Option 2 has arbitrary categories often create inefficiencies at the margins of the bands. (14)
- it is cumbersome. (17)
- may adversely discriminate against individuals who have a low level of hearing loss, but still require hearing aids. (29)
- a 100% ‘proportion’ attracts only a $1500 hearing aid payment. Payment of only 75% of the possible cost of a hearing aid in cases in which the proportion of injury-related hearing loss is 100% is unfair. (36, 54)
- removes any degree of individually tailored compensation, which is at odds with ACC’s requirement for individualised Hearing Needs Assessments. (42)

- the highest available subsidy for a hearing device in Option 2 is $500 less than Option 1. In some cases this may not be sufficient to ensure adequate rehabilitation. (53)

- claimants should have access to a hearing aid; Option 2 supports that. However, the requirement for co-payment of the fitting fee, when proportional cover is limited, may still prevent some claimants from attaining a hearing aid. (53)

- it does not include agreements with manufacturers. The current agreements ensure manufacturers are not providing incentives to clinics to encourage prescription of their products. (53)

- ACC should only pay for work-related hearing-loss, provided the methodology used is fair, but I do not consider that standardised bands are a fair method. (34)

8 One submission felt that the format of the proposal together with an inadequate submission process has the look and feel that this may be no more than a formality, and that the DOL and ACC have potentially predetermined the outcomes. (55)

9 Some liked neither option:

- one submitter considered that neither option was good but if forced to choose then Option 2 is better. (52)

- the Options are manifestly unfair and will introduce new problems into hearing services. (36)

- both Options are needlessly complicated, unfair to hearing loss claimants, financially unreasonable for private clinics, and will ultimately result in claimants not receiving the care they need. (12)

- no preference for one Option over the other. (32)

- both Options are extraordinarily complicated which will add to the cost of hearing loss claims through unnecessary bureaucracy. (12)

- both Options place a huge burden on ENT surgeons. (54)

- the two options presented were developed without consultation with stakeholders. (55)

Comment

10 ACC recommends Option 2 for the reasons outlined in Appendix 1 of this report.

General

Submissions

Consistency with the principles of the ACC Scheme

11 The ACC scheme and the various Acts were all based on a no-fault, no liability system. This was underpinned by a confidence that all medical legal arguments were to be removed from the scheme to give security to claimants, employers, and the medical profession. We believe that Regulations like the ones proposed, while correct and necessary, do add tension to the scheme. (32)

12 The Government and ACC should honour its commitments and obligations to the people of New Zealand who have had their hearing permanently damaged through no fault of their own. People who have contributed to New Zealand's growth and development want their government to help ensure that they continue to lead quality lives. (38, 55)

13 Even when the hearing loss is 100% attributable to covered injury-related hearing loss, ACC is still not necessarily proposing to cover 100% of rehabilitation costs. The proposals indicate a maximum hearing aid payment of $2000 (Option 1). (36)

14 The proposed co-payments are the thin edge of the wedge, and they undermine the principles of the ACC scheme: universality, no fault, compensation, community responsibility, and administrative efficiency. (31) The proposed changes will further erode the public perception about ACC and may result in negative opinions. (32)

15 If a claimant has a NIHL that warrants hearing aids, then the full cost of the aids and fitting should rightfully be ACC's as the need for the hearing aids is a result of their occupational hearing loss. If they did not have the NIHL, then they would not need the hearing aids. The claimant has worked in a hazardous work environment and has paid their taxes and ACC levies and they are entitled to full rehabilitation of their occupational hearing loss. (18)

16 Others supported the principle that ACC should only be responsible for injury-related components. Noise-induced hearing loss claims should be split between employers or the employers/non-earners account to ensure each fund correctly bears its responsibility. This is essential to ensure equity between accounts in terms of funding injury outcomes. (4)

17 Having ACC taking a direct part in assessing claims puts it in the position of needing to seek all avenues to refuse or reduce claims. Claimants are usually ordinary citizens without the resources of ACC. Their claims need to be assessed by independent and objective professionals purely on the basis of claimants' need for assistance to deal with the results of their accidental hearing loss. (10)

18 The contribution of fees payable by ACC will be through regulations. We are concerned that Regulations can be changed with ease and thus further alter the ACC scheme and its fundamental principles. (32) NIHL is permanent; ACC's obligation to cover it should be permanent also. (38) The new cuts are undermining the system to a degree that it is invalidated and no longer effective use of funds. (49)

ACC cover for non-injury-related aspects

19 Some submitters consider that ACC is not paying for non-injury hearing conditions as the submission document suggests. It is providing rehabilitation for hearing injury and any side-benefit is incidental, just as it is with other conditions ACC covers. The collateral benefits to concurrent health conditions, including hearing impairment of non-accidental aetiology, which may arise when treating the hearing injury is a benefit of coincidence. There is no extra cost to ACC. (9, 19, 20, 23, 26, 41, 44)

20 Educate the target groups who would not receive any cover but who can prevent further loss (i.e. recreational noise exposure). (2)

21 We note the increasing use of personal headphones/ear buds/ear phones (and the like) which are often set at such volume that they disturb others in the vicinity of the user. Where volumes of such devices are set at such a high level we are concerned that there is a possibility of self-inflicted noise-induced hearing loss. In this situation of self inflicted injury the hearing loss should not be able to be compensated under ACC. (4)

22 The ACC Scheme is under financial pressure, and loading additional cost on to the Scheme is unfair on employers who provide the funding. Costs should be attributed to those who cause injury (i.e. those who participate in non work-related noisy activities). (29)

23 There is an inherent anomaly in attempting to remove liability for cover that can be attributable to non-workplace cause for hearing loss, while at the same time ACC is charged with providing cover for such as sporting injuries and other accidental injuries which are clearly non-work related. (50)

24 Those who damage their hearing by foolish behaviours should not be entitled to cover. There are still a lot of workers who do not wear hearing protection. Nightclub, rock concert, shooting and chain sawing done outside work environments should likewise be excluded. (52)

25 The EMA supports the *concepts* within the proposal, but are concerned with possible downstream effects. (32)

Integration of Proposal with the Government's other hearing assistance

26 With regard to the integration of this proposal with the Government's other hearing assistance, submitters considered that:

- there was no explanation of the mechanism for interaction with the Health system nor on the mechanisms to claim other hearing aid subsidies in part-funded ACC cases. To introduce a part payment scheme before the mechanism for claiming other entitlements is established is unreasonable. (36, 41)

- costs of rehabilitation could be shifted from ACC to the: Ministry of Health via enable/*access*ible funding, e.g. for hearing aids, alerting devices; DHBs, through public audiology services, social work, mental health services, Aural Rehabilitation Contract; the Ministry of Social Development via Workbridge Contract for funding of services and equipment to enable people to remain in or find new employment; Work and Income via

the Recoverable Grant for hearing aids and Disability Allowance for hearing aid consumables; the Voluntary/Not for Profit Sector for providing support in the home or counselling services; The clients themselves for the cost of hearing devices (some of which are expensive, such as FM) or counselling? (47)

- if a claimant has 100% ONIHL and very complicated communication needs requiring hearing aids greater than $2000 per ear, are they responsible for these additional costs? I'm assuming that they are, but what if they are unable to afford this? Could they qualify for any additional funding (e.g. through Enable Subsidy, Accessible, etc…)? How would these funding agencies feel about needing to contribute to the costs to meet the needs for someone that has a fully occupationally related loss? (12)

- if the claimant has anything less than what is deemed a 100% ONIHL and the person has no (or insufficient) means to financially contribute to the remaining percentage of costs, what options do we have to meet their communication needs? I am certain that this will be the case for a large proportion of our patients. Would they qualify for any other funding through Ministry of Health, Enable, etc? If not, will they have to go without? Would we be able to fit a cheaper product so at least they have something? (12, 47)

- it is counter-productive to try and isolate components of hearing loss without also engaging with affected stakeholder agencies, in particular the Ministry of Health. (36)

- investing health resources in attempts to fairly apportion the costs in individual cases is an exercise in futility and a waste of expert time. Necessitating that claimants obtain funding from two sources is also a major additional administrative burden for claimants and health services. A sensible approach would be to determine an agreed contribution from the Ministry of Health towards the rehabilitation of ACC clients based on current subsidy schemes and payable in bulk to ACC. Unlike ACC liabilities, this portion of costs would not have to be pre-funded for claims potentially as far ahead as 2046. (36)

Liabilities

27 Section 6 on financial sustainability is misleading. It is our assessment that the increase in the Corporation's claim costs (according to the ACC annual reports and levy consultation documents over the last three years) result from poor rehabilitation practices allowing people to stay on the scheme longer than is necessary. The control for the Corporation's cost blowouts due to failed rehabilitation targets sit within the Corporation itself. As such, we see the changes to noise-induced hearing loss as tinkering with a significant factor, without addressing the real issues for the main cost blowout in ACC. (4)

- limiting liability is not the reasoning behind the no blame/no suing ACC system we have in NZ. (18)

- the overall tightening of ACC's approach to hearing loss claims indicates there is little need to regulate to control costs. (19)

- financial information about ACC's liabilities has been misrepresented. (21)

- the liability rate is artificial, under Labour the prices were less, National is being misleading. (27)

- the consultation document identifies the current and future financial burden of ACC and employers with regard to NIHL. What is not clear is how these figures were arrived at, given the increases identified. The figures released then where in the order of $130 million. This has ballooned out to 1.3 billion. (32)

- PricewaterhouseCoopers' most recent report on ACC's outstanding claims liability notes the significant drop in payments for hearing aid costs as an example of ACC successfully addressing cost areas of previous concern, and supports the proposition of savings through contract. (44)

- we question how a carefully calculated liability can increase 30% in the space of a few months, from $1 Billion in November 2009 to $1.3 Billion in 2010. (54)

- full-funding should be removed; it is the real reason behind what looks like huge liabilities. (20, 31)

Rehabilitation

28 Many submission asserted that the regulations will have an adverse impact of the rehabilitation of injured people suffering hearing loss: (19)

- breaches of the Woodhouse principles of 'community responsibility' and rehabilitation. (19, 20, 22, 31) and presumes that the costs of rehabilitating a hearing loss are directly and linearly proportional to the NAL% hearing loss. (26)

- poses a significant risk to the current level of care and rehabilitation, which is against our code of ethics. These proposed changes have the potential to render many workers uncompensated for their work-related injury and in turn force audiologists into compromised clinical practice. (42)

- capping and reducing payments for hearing aids will create a social cost, impact on provider sustainability, and reduce accessibility to services for claimants. (44)

- ACC is trying to implement a very prescriptive model to meet its obligations with NIHL claimants, but this model does not allow the rehabilitative hearing services to respond effectively to the complexity of the needs of this client group. Achieving positive outcomes for this client group is <u>not</u> as simple as it may appear on the surface. (47)

- there are similarities in the complexity and diversity of issues/needs of the group of ACC clients for whom a change in circumstances drives the need for hearing loss solutions and another group of ACC clients who also have a hidden disability, namely those with head injuries. To provide effective rehabilitation, both groups need a collaborative approach between the person, their significant others and health and other professionals. (47)

- apportionment is unrelated to the individual's costs of rehabilitation. The claimants' contributions specified in the regulations are therefore either a tax or a levy to be paid by claimants towards the costs of rehabilitating a work related injury. (26)

Comment

29 Help is currently available from the Ministry of Social Development and Veteran's Affairs New Zealand. The Ministry of Social Development has two last-resort loan programmes that could make up to $1000 available to those on low incomes and with very low cash assets. The programmes are currently available for part charges for DHBs so could be available to those with part charges from ACC. However these are loans and need to be paid back. Veterans Affairs' New Zealand has hearing aid assistance available to veterans and it appears likely that they could assist with part-charges for some ACC claimants who are veterans and who may be income tested out of Social Development funding. The NZ Audiological Society administers a Hearing Aid Bank- which may be available as a last resort.

30 The Ministry of Health specifically excludes people with cover and entitlements from ACC from hearing aid assistance. A change would need new funding and a policy change.

31 Officials need to undertake work to make sure that all of the government's assistance for hearing loss is well coordinated and easy to access for ACC claimants who cannot afford to pay for the non-injury component of their hearing loss. This could include work to consider if policy changes are needed. For example, a change to policy in Health coverage for ACC claimants would require Ministerial agreement and additional funding. If this occurred Health would be able to assist some ACC claimants with less than full cover.

Limitations on fees, devices, and repairs

Submissions

The Accord

32 The regulatory changes do not address the achievements of the Hearing Industry Accord with HIMSA; NZAS; hearing aid manufacturers; audiologists; and ACC which has produced significant savings. These savings are sustainable and provide the ACC claimant with the appropriate rehabilitation for their occupational hearing loss. (18, 20, 21, 23, 42, 54, 55) The Accord has worked well in reducing costs without reducing service and quality of care. If the Accord needs to be changed, then consultation with the providers of the rehabilitation services and devices is the only way forward. (18, 36, 54, 55)

33 The technology of hearing aids has improved to the degree that most claimants no longer require top tier technology to meet their communication needs and this trend will continue. (12)

34 ACC needs to work with NZAS and HIMSA on further solutions.

35 We acknowledge the savings made by the Accord, but for this body alone to recoup the savings is just not possible. (32)

36 Both options move from a "needs based", Accord based model – where the audiologist is charged with: fitting the most cost effective devices, maintaining a $1715 average price, and maintaining client satisfaction, which has shown to reduce costs to a client top up model without scientific basis. (54)

Audiology fees

37 There was extensive feedback on the proposals about audiology fees. They are:

- quotes for costs of hearing aids and fittings (including failed fittings) are unrealistic. Private practices may not be able to afford to see ACC clients, many will go broke. With such low fitting fees, audiologists will be under substantial pressure to finalise quickly and this is not in the best interests of patients. It wouldn't be worth the effort on the part of the private practice audiologist to attempt to work with those with complicated losses. (3, 5, 8, 9, 10, 12, 17, 18, 23, 30, 42, 45)

- fitting fees should be maintained at the existing levels including admin fee (i.e. binaural $1585 + admin fee)" (17) ACC is cutting back on other services that go with the rehabilitation – audiologist fees and the frequency of treatment. These changes are impractical and show a lack of understanding of the impact hearing injury has on a person's life. (9)

- the regulations will have an adverse impact of the sector resulting in closure of clinics and reducing access to services for those in rural districts. (19, 27, 30). proposed fee cut of around 40% insult audiologists and do not recognise study and professional costs needed to provide clients with the best service. It under values role of MNZAS audiologists. Employers are unlikely to retain experienced audiologists as this will not be viable (given the pittance we will receive doing ACC work compared to that which we can achieve seeing privately funded patients). The fee cuts do not reflect the time (multiple appointments) required to try different options with clients to ensure that they are fitted with what is audiologically best for their needs. $250 is considerably less than what we would charge our private paying clients so our clinics would be running at a loss should clients decide not to keep their hearing aids. (30)

- it is unfair that ACC intends to restrict what it pays audiologists, in spite of a recent survey that showed that audiologists were underpaid and that the amount they are paid has not been change since 2003. (40) ACC wishes to force audiologists to accept limited fees and limit how much the claimant can co-pay. (40) ACC, without reasonable notice, has proposed changes which will have an immense impact on audiology infrastructure costs, and they should have provided reasonable notice of at least one year before enforcing changes of such significant consequence. (42)

- MNZAS audiologists command higher salaries due to their qualifications and experience in the industry than other audiologists and audiometrists. If ACC wishes to maintain professional standards, accurate assessments and rehabilitation carried out by MNZAS audiologists, the proposed fee structure cannot be introduced, as it is not possible to offer the current level of service at the significantly reduced rate. (42)

- significantly reduced fees will mean less time per claimants to ensure they know how to use their devices, and that devices are tuned to meet individual needs. (54)

- slashing costs and fees paid to the industry providers will result in a compromised service provided to hearing impaired claimants along with flow-on effects such as unused hearing devices resulting in a myriad of other social costs and impacts. (55)

Manufacturers

38 Further erosion of the price ACC pays for hearing aids will make manufacturers as a central part in the rehabilitation process difficult to maintain financially. This will put even further pressure on ACC delivering cost-effective rehabilitation. Manufacturers also provide products, expertise and support, and contribute to satisfaction and effective rehabilitation, through build quality, service quality and flexibility and audiological support. (54)

Costs of devices

39 There was significant comment that hearing aids could be cheaper in New Zealand:

- introduce aids from smaller (and more economical) manufacturers (mostly European) typically 50% cheaper (2)
- use Pharmac to reduce medical costs by bargaining with suppliers of hearing aids and suppliers of audiology, fitting, and repair services. (10)
- more scope should be provided to fund more expensive hearing aids where it can be shown that a lower value aid is unable to meet the person's needs. (16)
- ACC and those not eligible for ACC compensation are being ripped off. We are on a falling market with hearing aids, as technology advances and functions are added. The manufacturing cost of a hearing aid should be in the range of NZD $20 to $40 so there is plenty of profit for the manufacturers to develop better technology, and also plenty for the distribution chain. Age Concern website's shows NZ prices are double the US prices, so somebody is earning a significant profit from the sale. The submitter does not know who this is. (48)
- with the price of hearing instruments rapidly decreasing the dollar values ascribed are not particularly relevant and will require constant review. It is not true that the greater the hearing loss the more the cost of hearing aids to treat it. (52, 54)

40 One submission assumed that the Accord Scheme's Price List system will continue, however, that scheme is predicated on confidentiality of discounts and wholesale prices. The new scheme proposes to disclose prices to clients whenever they are not 100% covered. Manufacturers may well refuse to participate under such conditions, and refuse to continue to hold hearing aid prices down. The assumption that ACC can continue to hold hearing aid prices down if the scheme to do so does not respect manufacturer confidentiality lacks credibility. (36)

Limiting repairs

41 The following difficulties were foreseen:

- limiting the number of on site service repairs per year and limiting repairs to once every two years is shocking. (12, 40)
- some hearing aids require more repairs than this (through no fault of the claimant) and it is unfair to force this cost on the claimants. (12, 40)

- when patients cannot afford the cost of repairs, will there be any other means for them to get their aids working? Or will they have to do without? (12, 40)

- the allowance of only two $50 services per year or a $200 repair bill every 2 years is unrealistic. An item that costs more than $2000 is not going to cost $50 to fix. An average repair bill is at least $200 per aid and most people need on average a repair per year (12, 40)

- ACC's expectation of being able to fix repair costs and limit the number of repairs is unrealistic and incompatible with margin erosion of the hearing aid sale. Our suppliers provide spare parts for up to five years after a product is sold. With the six-year replacement rule, there could be a period of up to a year for ACC claimants, during which spare parts are no longer available, and the aid cannot be serviced, regardless of costs, until the claimant is entitled to a replacement hearing aid by ACC. It is not practical to commit to being able to service hearing aids for longer periods of time. This means that the claimant could be facing even higher costs if the aid needs replacing at 5 years due to now parts relating to the shortening life cycle and therefore be without aids until the 6 years expires. Manufacturers do not generally carry spare parts for longer than 5 years. The older an aid gets, the greater the likelihood of major failures. The chance of a major failure post 5 years' is at its highest. This is the time when no spares are held locally and parts will need to be freighted in from Europe, driving up the cost and making a repair more likely to be uneconomic. (54)

42 One provider supports and agrees with initiatives which aim to increase the success of fitting hearing aids right first time. (53)

Capped figure

43 Any percentage payable should be of the actual cost of what is needed, not a percentage of the capped figure – otherwise the true percentage paid is likely to be grossly skewed. (8)

44 Prescribing the total amount payable for hearing aids by ACC and additionally the total amount payable for hearing aids by claimants is uncompetitive. (21)

45 Is it accurate that ACC will cover a maximum of $1500 per hearing device even if the claimant has a 100% occupational noise related hearing loss? This limits audiologists to fitting only basic products which have insufficient technology to function well in difficult listening environments. The majority of claimants' communication needs will require better hearing aids than this option will allow. What options will claimants have when more than ACC will allocate is required but they are unable to afford this? (12)

46 Co-payments are allowed for repairs, so this will assume that clients will pay the balance of costs. It is cumbersome for clinics to administer this, and needs more detail. (17)

47 If ACC covers only a portion of the cost it will not be able to dictate the total cost of hearing aids, opening the way for upselling. ACC would be foolish to ignore the Australian experience of co-payment which can lead to unethical and exploitative practice by some businesses. (36)

48 Making a claimant carry some of the costs will in many cases result in a double penalty, as self-employed persons who pay their ACC levy will then also be additionally paying a share of the costs of hearing aids. (37)

49 Concern was also expressed by Occupational Health Nurses re contracting for hearing aid services – how would this be managed (references to price, quality etc). (51)

50 There were queries around hearing aids seen by an Occupational Health Nurses member while working in the USA – much cheaper and seemingly effective. Members questioned whether technological advances in hearing devices were available in NZ or whether there were monopolies with specific suppliers linked to finding streams such as ACC (no judgements being made, because members genuinely do not know the answers to these queries). Any changes in contractual arrangements for supply of hearing aids would need to ensure conflict of interest potential was declared. (51)

51 Client part charges will encourage the fitting of cheap aids which may meet claimants' financial limitations, but will not necessarily meet claimants' needs. (54)

Six year reviews, Service fees

52 Option 1 doesn't mention ongoing clinical care such as annual reviews and fine tuning, which are needed. Hearing needs reassessment is generally only for when new aids are required. (17) This section appears to include clinical services that are usually carried out at review appointments. This section needs to be called repairs and maintenance and to include an additional service lone for fine tuning/adjustment. (17)

53 The regulations will reduce the frequency of audiology visits and the frequency of repairs. Scientists contend that noise-damaged hearing also impacts on other parts of our hearing and can accelerate age-related loss, so regular review and adjustment of the hearing aids is essential. (41)

54 Change for people with disabilities does not always occur within the person. If the client with NIHL can only receive a hearing review and hearing needs re-assessment once every six years, how can this client continue to participate when their environments change? (47) Without some provision for regular reviews, even biannually, it is likely you will find a lot of technology that is provided by ACC will not be used as it is not meeting the needs of the client. Six years is far too long. (28)

55 Automatic replacement after 6 years should be removed as they can go for much longer. Older people will find it hard to meet a cost difference on a 6 years cycle when they may be perfectly adequate for several more years of use. Technology is capable of upgrade without physical replacement, by the insertion of an updated programme by the audiologist at the annual check. Replacement after a minimum of 6 years and only after maintenance and repair costs become uneconomic would go a long way towards reducing costs and still providing for adequate assistance. (34)

56 ACC would be better to provide hearing aid vouchers redeemable every 6 years at any qualified Audiologist/Audiometrist premises and an annual service voucher. The vast cost of implementation of ACC regulations adds immensely to the cost of hearing Aid Service provision and in the end reduces the benefit for claimants both in terms of product and

service. This would also mean that claimants could opt for higher technology if they wished to top up the payment to the service provider. (52)

57 Hearing aids are worn in an environment hostile to electronics and the need for servicing is a fact of life. Servicing doesn't fit into a nice once every 2 years slot; there are so many variables involved. There are many factors affecting hearing aid maintenance and the need for servicing. Through no fault of their own, an ACC NIHL claimant needs hearing aids; ACC has an ongoing responsibility to provide the servicing of these hearing aids when and as needed. Audiologists work with claimants to ensure they have the hearing aids best suited to their abilities and ears; we provide ongoing instruction of how best to maintain the optimal function of hearing aids. (18)

58 Service fees are excessive and should only be annually but in proportion to the degree of cover and batteries should be the responsibility of the claimant. Many people still benefit from the free batteries ACC sends out who have not got their instruments through ACC but have been provided them by friends who do. (52)

Trial Periods and Failed Fittings

59 A 2-4 week trial period with hearing aids is insufficient for a person to determine that the hearing aids are meeting all of their communication needs in a number of listening environments to determine if there are any problems. People have to undergo an acclimatisation process which is variable depending on the individual but usually takes a few months. 2-4 weeks is inconsistent with best audiological practice and would violate NZAS audiologist code of ethics. If aids aren't fitted properly it will waste ACC's money. because it will encourage audiologists to get people to keep aids that will not be well used. (12, 17, 21, 27, 28, 42, 53, 54) The fee should be the same as a successful fit. (17)

60 Fit fee within a year is too low. If a second aid is fitted there is usually a good reason why two were not fitted initially. I imagine this is a rare occurrence and would be reasonable to bill as a monaural fit fee. (17)

Comment

61 As part of the contract negotiations with audiologists, ACC commissioned an independent review of the prices that it pays for audiology services. Audiologists participated in a survey of audiology fees. The results were used as a basis for the proposed regulatory fees and are closely correlated to ACC's review of audiology prices. ACC also looked at the fees paid in workers' compensation schemes in New South Wales Work Cover and in the Victorian Scheme (particularly the binaural and monaural fitting fees, the management fee, and the maximum contribution towards hearing aids). ACC is of the view that the proposed fees are a reasonable price for audiology services, while maintaining value for money for levy payers.

62 The limits on funding timeframes are based on experience under current practice. The re-aiding period of six years is the same as that stipulated by the Ministry of Health for its subsidy clients. In response to feedback that limiting co-payments on audiological fitting fees is ultra vires, it is proposed that this restriction be removed, and the market be allowed to self-regulate this cost. Co-payments would not be allowed on assessment costs, which are ACC's responsibility and considered to be appropriately priced.

No scientific method

Submissions

Evidence base

63 A number of submissions challenge the idea that there is an evidence base in support of apportioning the causes of hearing loss:

- these regulations endorse the application of a diagnostic process that is not accurate or evidence based. (41)
- the regulations require a Court to accept that the amount of rehabilitation being offered by ACC can be equated to the % ascribed to the work related hearing loss. This approach is flawed as audiometric thresholds are not a measure of need. (31)
- in Option 1, the subjective element of Occupational Noise-induced Hearing Loss (ONIHL) apportionment may mean that a subsequent re-assessment correctly places the proportion less than the original assessment (2)
- the differentiation of the cause of hearing loss can only be made by an Otolaryngologist following a complete and detailed history coupled with a careful examination (5)
- calculating hearing loss is sometimes difficult. Different specialists use different systems (subtraction, build-up). For an individual, there can be large discrepancies between levels of hearing loss ascribed to noise by differing specialists (6)
- often no-one knows what noise levels a particular client has been exposed to. Approximation by an occupational medicine specialist can be invaluable in these cases but specialists do not have much training in occupational noise hearing loss (6)
- where is the proof that in half of ACC patients hearing loss is age-related rather than noise-induced? (13) options are based on flawed premises (21, 37)
- there is no scientifically proven method or test for deciding if hearing loss is attributable to noise or to other factors. The effects combine; there are direct indications that ears with noise-exposure histories age differently from those without, accelerating overall hearing loss. See The ISO Standard ISO 7029: 2000 Acoustics – Statistical distribution of hearing thresholds as a function of age. (9, 12, 17, 21, 23, 26, 27, 30, 31, 36, 37, 41, 43, 44, 50, 54, 55)
- links to evidence supporting ongoing deterioration of hearing as a result of previous noise exposure (12)
- a major cause for hearing loss is idiopathic, meaning cause unknown. Increasingly other diseases and genetic factors are being found to have an impact on hearing loss. To assume that age and noise are the only major causes of hearing loss in the general population is incorrect. (6, 9, 31, 36, 41)
- ACC assumes that age-related, idiopathic and noise-induced hearing losses add arithmetically. This is not the case. The interactions between different pathologies are far more complex. Assuming arithmetic addition of different pathologies is unfair. (36)

- ACC's position on idiopathic deafness is grossly unfair. (36). The non-scientific manner currently employed to determine NIHL (work place) would be compounded (32)

- how will ENT specialists apportion work-related NIHL to a hearing loss claim? Many specialists never actually visit workplaces to understand the actual noise profiles compared to assumed noise profiles. (32)

- the evidence that ACC is using to calculate the effect of noise induced hearing loss verses aging is known to be incorrect and gives a false indication of the person's handicap. Refer Prof Harvey Dillon of Australia from the "Proceedings of the American Academy of Audiology April 2010 San Diego". (40)

- the proposal to introduce these regulations for apportionment and part charges should be deferred until the scientific validity, fairness, and equity of the process is robustly reviewed. (43)

- it has been proposed by several researchers that the difference between male and female thresholds as a function of age is due to environmental factors, the most important of which is noise exposure. (54)

- ACC should defer change until its research into NIHL prevalence is complete. (9, 30, 32, 36, 41, 42, 43)

Hearing Loss Calculations

64 To say that a claimant's total percentage loss of hearing, after it has been adjusted for age, is likely to be slightly greater, suggests that the noise component loss (award) will be greater. Of course the noise component in truth will be exactly the same whatever tables are used and a competent hearing assessor (using say ISO 1999) should come up with exactly the same noise component loss whatever presbyacusis factor is employed. (6)

65 Hearing loss calculations uses problematic maths (Specialists strip away other causes leaving the occupational noise component. When there are more than two causes of hearing loss the possible outcomes become complicated) (6)

66 ISO 1999 is often used unfairly and/or with no sophistication when calculating hearing loss apportionment. With different systems in place, consistency is needed, potentially by using the system of Dr McBride. (6). The NAL percentage already takes care of the age portion (even though the tables are skewed). However, they should have standard deviations. (13, 23)

67 Additional thresholds should be in formulae e.g. where age and other causes contribute less than 30% of the hearing loss ACC should still fund full costs. For such people they would probably not need a hearing aid at all were they not suffering from the noise or other accidental hearing loss. (16)

68 ACC assumes that individual degrees of age-related hearing loss can be determined from tables of average age-related hearing loss. This is incorrect and unfair as the tables are an average. There is wide variation in individual results. Consequently the application of an average to a claimant will be incorrect in virtually every individual case though "correct" when averaged over thousands of individuals. (36)

69 The two types of deafness are interrelated and cannot be separated either in terms of cause or in terms of cognitive process. (23, 27) The average percentage of hearing loss attributable to NIHL (workplace) is difficult to determine. It is therefore difficult to arrive at a figure that is both objective and transparent. (32)

70 The proposed processes are unfair for mild hearing losses where age-related and disease-related hearing loss can be a significant proportion of the total hearing loss, yet on their own might not be sufficient to warrant the use of hearing aids. The superimposition of injury-related hearing loss may well result in the need for hearing aids, by 'tipping' the hearing loss over the threshold at which hearing aids are warranted. (ACC regulations define this threshold as 6%.) The need for hearing aids would thus be 100% attributable to the superimposition of the occupational hearing loss, yet only half of the costs would be met. A system that pays only a portion of the cost of rehabilitation when the need for it is entirely attributable to a covered injury-related hearing loss is grossly unfair. (36)

71 Using a percentage proportion of hearing loss attributable to industrial noise exposure creates inequalities that do not fairly compensate the person for their specific noise-induced hearing loss. If two people have an identical hearing loss attributed to noise, but one has additional hearing loss due to other causes, such as aging or medical pathology, the person with additional hearing loss will receive a much lower subsidy. This does not make sense given the component due to noise exposure is identical for both people. (53)

72 America's National Institute for Occupational Safety and Health (NIOSH) does NOT recommend accounting for presbyacusis when looking for medical causation of a progressive hearing loss. (54)

Comment

73 ACC already receives the measurement of a client's total hearing loss as a percentage from the audiogram completed by audiologists (or ENTs in some cases), as well as the level of occupational noise-induced hearing loss as a percentage from ENTs. ENTs arrive at this percentage by using the results of the audiogram and any other relevant information (e.g. noise exposure levels in particular industries), as well as applying their professional clinical judgment and discussing the client's occupational and medical history.

74 While available audiometric testing combined with a client's work history allows a reasonably accurate percentage of ONIHL to be attributed, the diagnosis of ONIHL can be less certain in other cases. The pattern of hearing loss may not be consistent with either average age-related hearing loss and/or ONIHL, and there are times when other pathologies are suspected. As a result, the percentage of hearing loss attributed to occupational noise exposure is based on a degree of professional clinical judgment, and absolute accuracy cannot be guaranteed. However, training and clinical practice of Ear, Nose and Throat (ENT) specialists place them in a position to best attribute how the differing pathologies may have led to hearing impairment. Continued ACC engagement with ENTs to produce best practice medico-legal reports will improve the robustness of these assessments.

75 To further mitigate the effects of variable ENT assessments, a banded approach (Option 2) would reduce the incentive to challenge for most claims, except where the clients are close to the boundaries.

Discrimination

Submissions

Social Responsibility

76 The changes are unfair, discriminatory, especially to the elderly and disabled, and unnecessary. (8, 9, 13, 15, 19, 20, 21, 24, 31, 34, 35, 38, 39, 40, 41, 42, 44, 50). Given that rehabilitation is the right of every person with noise, and other, injuries, the proposals will deny those with noise-damaged hearing their rights. (9)

77 ACC is denying people rehabilitation for their hearing injury if they cannot afford to pay for part of it. They will be left isolated and depressed. How will ACC honour its legal obligation to those who are entitled to cover by cannot afford it? (9, 12, 20, 22, 24, 30, 31, 38, 39, 40, 41, 42, 46, 49, 53, 56). This proposal is about funding, not care. It should be focused on how to most cost effectively rehabilitate hearing impaired people as the Accident Compensation Act intended. (9, 15, 20, 21, 31, 35, 41, 44, 48)

78 Hearing injuries are being singled out by ACC for special treatment. (9, 41)

79 A serious anomaly will exist with mild to moderate losses in which the need for hearing aids is 100% attributable to the covered injury-related hearing loss (because the non-injury causes alone would not warrant rehabilitation), yet only a proportion of rehabilitation costs are payable under the proposed scheme. (36)

80 Under both options, the claimant will be notified of the dollar amount that ACC will contribute to the hearing aid and fitting fee costs. We note that this process occurs before a hearing needs assessment is undertaken. This deviates from ACC's Rehabilitation Framework that guides ACC's approach to claimants with other injuries. Refer to: http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_providers/documents/guide/prv00065.pdf (47)

81 Why is a different approach being used with NIHL claimants who have a sensory injury? If the claimant decides that they do not wish to continue the entitlements process, what will ACC offer to these claimants? (47)

82 Because of the restrictions on what ACC will pay for under the proposed regulations, people with noise injury becoming B-grade clients where audiologists can provide only a limited range of services based on what ACC will fund. This is an unwarranted penalty on these people. (41, 42)

83 Pensioners have been hit with increases in GST, the ETS, loss of savings through inflation, rising prices, and now this ACC decision. (56)

Low Income

84 Industrial hearing loss is more prevalent amongst manual workers who often earn less than other workers. This uncovered cost of the hearing aid and fitting will have a more adverse financial impact on them. (5)

85 These changes will have the greatest impact on those with a lower socioeconomic status, which unfortunately is disproportionally Māori and Pacific Island people who are already under-represented by ACC. It is essential to consider the known implications of people not receiving appropriate care [link to report on this matter, see submission 12]. (12, 30, 31, 44)

86 Those in the lower socio-economic group would be unlikely to be able to 'top up' the amount required for hearing aids (if this change was necessary). (51)

Age

87 Many considered that work-related hearing-loss should be covered by ACC regardless of age: (3, 40, 54)

- typical old age hearing loss is manageable without aids - it is the additional occupational hearing loss that largely causes the need for hearing aids (8)
- the regulations are ageist and conflict with the NZ strategy for positive aging (8, 9, 13, 15, 19, 20, 21, 24, 30)
- if someone had work-related hearing loss, as they got older would they not be as deaf as if they did not have the added portion of the noise-induced hearing loss - how would you quantify this? (13)
- NIHL claims need to be managed in a way that claimants are not denied rehabilitation. Their need for hearing aids due to noise damage does not decrease as they get older. If they need hearing aids because of noise damage when they are in their 50's, then that need does not decrease because age has started to change their hearing when they are 80. They should be entitled to 100% funding at any age. (18)
- if an individual has hearing loss due to occupational noise damage that is sufficient to warrant hearing aids, then 100% funding of hearing aids by ACC for NIHL is only fair. Their entitlement should be maintained irrespective of any further change in their hearing as the NIHL is a pre-existing condition that caused the need for hearing aids. Aging change does not remove ACC's responsibility to provide full rehabilitation for the occupational hearing loss. (18)
- older claimants could be disadvantaged because of the emphasis on hearing loss related to ageing and the consequential reduction in ACC support, whereas in our experience their increasing difficulties are related to changes in circumstances. (47)

88 On the other hand:

- if the scheme ends up covering self-inflicted hearing loss and age related factors it will rapidly become unsustainable. As such it is essential that ACC only pays for the injury-related portion of any hearing loss claim. (4)
- it is essential to ensure proper accountability and equity of funding of injury costs. A key component of the scheme is no fault loss. However someone has to pay for the injury consequences. The scope of the scheme is to cover unintentional injury. As such the environment where noise-induced hearing loss injury occurred should be funded by the appropriate account within the scheme. It is not the intention of the scheme to cover intentional injury or age-related factors. (4)

Impact of Hearing Loss

89 There has been no assessment on the effects this will have on citizens with hearing loss, and there should be. (35) There is evidence that hearing instrument use is positively related with greater earning potential; improved interpersonal relationships; a reduction in discrimination; a reduction in communication difficulty; a reduction in anger and frustration; a reduction in incidences of depression and depressive symptoms; enhanced emotional stability; a reduction in paranoid feelings, anxiety symptoms, and social phobias; improved belief that a subject is in control of their own lives; reduced self-criticism; improved health status and less incidences of pain; and enhanced group and social activity. (12)

90 Hearing loss has a negative impact on home relationships, social interactions, workplace productivity, mental health, and physical health. It is important to consider the big picture of what will occur in New Zealand as a result of these substantial changes in care. I am not looking forward to seeing the results. (12) It is estimated that for every person who has NIHL eight other people in their family group or friends will be impacted; if someone cannot afford a hearing aid these people will be affected too. (38, 41)

91 To add co-payments for hearing aids is a further burden placed on claimants, and one which sets a completely unacceptable precedent for other claims. (31)

92 The regulations are not needs-based and ignore personal impact. People could lose jobs, and become dependent on the state for welfare, because they do not have the ability to hear well enough. (41)

Comment

93 As occurs under current practice, age-related hearing loss will be deducted from the client's total hearing loss, as per the standardised tables in regulations, at the first ENT assessment. When a client presents for re-aiding, the audiologist sends a new audiogram showing the total hearing loss with the application for funding. If the total hearing loss shown on the audiogram has changed from initial aiding, ACC will adjust the proportion of injury-related hearing loss and therefore the funding.

94 An automatic deduction in line with the standardised age tables will not occur at re-aiding unless ACC sends the client for a fresh ENT assessment and the ENT is required to re-assess the percentage of injury-related hearing loss. ACC only sends a client for a fresh ENT assessment if the original assessment is considered to be no longer valid (e.g. there has been additional work-related noise exposure because the client has continued working since the original assessment, or the original assessment is considered to be flawed). ACC makes the assumption that the absolute level of injury-related hearing loss will not change at re-aiding based on the well-established principle that occupational noise-induced hearing loss does not change over time unless there is continued exposure to noise (as supported by the American College of Occupational and Environmental Medicine).

95 Re-assessment of the need for entitlement as a client ages is consistent with the other parts of the ACC Scheme.

Implementation

Submissions

Reviews and disputes

96 Many submitters consider that the changes would increase reviews and Appeals and:

- will create a medical/legal review industry. This is in complete contrast to the principles of the ACC Act. (21, 30, 32, 40, 42, 44, 54)

- Option 1 may create a legal debate about exact percentages and thus push costs out in other areas. Option 2 lessens this debate. (25, 32)

- introduce a significant challenge to both workplace hearing testers and audiologists who may then be faced with increased incidences of functional losses (exaggerating their hearing loss to obtain increased cover). This may increase number of tests, clinic time, and potentially more resources before a conclusive and accurate estimation of the claimants hearing is obtained. Returning to the past by requiring extensive and expensive testing to validate claims would be a seriously retrograde step, a waste of health resources, and a major increased cost for ACC. (30, 36, 42, 54)

Implementation

97 ENTs should not be part of the assessment regime at all as they are not hearing experts and have much less knowledge of accurate hearing loss assessment than audiologist and audiometrists. There are a significant number of ENTs in NZ who are in bed with audiologists and this does not lead to a healthy competitive environment. (52)

98 While the intention of the proposals is valid, the implementation will be problematic. (32) What will happen to those with existing claims, as it said that regulations will apply to new and existing claims? Will each claimant be re-evaluated by an ENT specialist when new aids are requested to determine the percentage they will be responsible for? How are the ENTs addressing the issue of the unknown degree to which noise exposure is affecting age related hearing loss? (12)

99 Part charges should not apply to existing claimants. (24)

100 I do not understand what the options mean when they says “regulations would apply to both new and existing claims” when the criteria changes for claims that have Date of Injury on or after 1 July 2010. (14)

Comment

101 ACC considers that while there will be challenges, the changes can be effectively implemented. ENTs, as independent, clinically-trained assessors with no financial interest in the outcome, are best placed to determine the causes of ACC clients’ hearing loss. They already provide this information to ACC. The forthcoming ENT workbook aims to improve the quality of reports to ACC and increase awareness and availability of resources to assist ENTs in their clinical assessment of the causes of clients’ hearing loss.

102 The same principle would apply to claims lodged prior to the regulations coming into force as to claims lodged afterwards. Percentage hearing loss information (both total and injury-related) is already recorded on most claimants' files.

103 In response to the concern that it would be difficult to address the issue of multi-employer causation, ACC is already required under the Accident Compensation Act 2001 to apportion costs where exposure occurred across different employers. At this stage of the design, it is proposed that experience rating will only apply to the current portion of the Work Account levy, it will not apply to residual claims which currently make up the bulk of hearing loss claims.

Other approaches

Submissions

104 A number of alternatives to the proposal were suggested:

- ensure Ear, Nose, and Throat Specialists (ENTs) examine in unbiased way, so both ACC and the claimant are fairly represented. (1)
- increasing the option of modular aids. (2)
- create in-house lab services for hearing aid construction (face-plates). (2)
- employ Audiologists in metropolitan regions. (2)
- create 'Awards' both national and regional (and maybe by industry) to promote the awareness of hearing conservation. (2)
- where multiple aetiologies exist, classification of Noise-induced Hearing Loss (NIHL) proportion can become unavoidably subjective. (2, 30)
- the threshold of 6% is far to low, as most people do not get assistance with hearing aids unless their hearing loss exceeds 30% - why should those who have shown scant regard for their sense of hearing in the workplace and in their leisure be any keener to improve their hearing? I would suggest a figure of 25% is fine and while generous to claimants will save considerable ACC expense. (52)
- as noise-induced hearing loss injury occurs over a prolonged period the method for assessment should be covered by gradual process provisions within the legislation. Then only noise-induced hearing loss claims that relate to work would be compensated. This would reduce the hearing loss entitlements. (4)
- hearing loss claims should be treated as gradual process injuries and only claims which are work-related should be funded. (4)

- ignore the “age component” and make the percentage the NIHL divided by the Non-NIHL. (5)

- fully cover only those where greater than 50% of their loss results from occupational noise exposure or accident, and not cover those whose loss is a majority other factors. If a claimant has majority loss due to other factors, they will have required hearing aids even if there was no occupational noise exposure. They should have to find funding through other means. This system is simple to understand, fair, and would be easier to implement. Audiologists, we could then focus on what other existing funding they may qualify for. (12)

- if the noise component of the hearing loss is more than 50% then ACC should pay 100% of the costs of the aids up to the figure specified. If it is less that 50% then the % should be calculated on a more favourable scale e.g. if 40% of the total hearing loss is due to noise ACC pays 60%. This would take into account some of the more disabling effects of NIHL compared with presbyacusis for example. (17)

- extend the time period for full-funding, go back to pay as you go, or fund hearing loss claims as they are lodged. (19)

- banding and/or a set contribution may be a fairer and more transparent method than the options presented. (25)

- ACC could contribute a set flat rate contribution amount for NIHL assessment, hearing aids, and fitting fees, and that any short fall over and above these fees are the responsibility of the employee, as these amounts would give certainty and remove any medical/legal review activity. (32)

- that ACC and the Accord work together to determine a better data set for hearing loss which is attributable to NIHL. Research is underway but not yet concluded. (32)

- and that employers are encouraged to undertake base line audiograms and exit audiograms. (32)

- diminishing hearing due to age should be ascertained by test over a period. (34)

- provide an exemption to the no fault principle to allow the injured party to seek redress against the employer for hearing aid costs as well as the permanent injury suffered. (37)

- many other countries have good subsidy systems, such as Australia. (42)

- maintain the current system. Untreated hearing loss will have follow-on effects and be a burden for future systems and the economy. (42)

- HIA is keen to continue to work actively alongside the ACC and the Minister to find a contract-based solution (as the regulations as proposed are not authorised by statute) to best meet the needs of claimants and to address cost and liability for the ACC. (44)

- establish a working-party to reach a solution within 3 months (addressing volume of claim numbers and the costs of hearing aids and fees, rather than regulation). (44)

- capitated scheme would allow ACC to continue to run a contracted service for the hearing sector. The providers of the service would enter into a contractual agreement to provide services for a fixed period. As is the case now, services would attract a fee. This addresses the need for cost and liability containment by introducing a capped budget for the services over the period of the contract. The budget would include both services and devices. (44)

- individual claimants, their treating GPs, and their specialists will not have an understanding of how the funding of hearing loss claims will be provided. We recommend plain-English factsheets be provided to all hearing loss claimants and to all GPs and, and training be provided for ENT specialists. (29)

- one stop-shop. ACC would procure a contracted service from the hearing sector. The service would be a "life-time" service for all appointments, device(s), consumables, insurance, and batteries. This option addresses the need for cash and liability containment by introducing a fixed cost for the services over the period of the contract. (44)

- make society more aware of the impact of hearing loss on the lives of individuals and those associated with them as a motivator to change behaviour that will prevent hearing loss. This would flow on to the attitudes about hearing protection in the workplace. Raising awareness can be done at a number of levels, such as individual, community, e.g. noise level in school activities, such as school concerts and discos and with legislative changes, e.g. linking the granting/renewing of liquor licences to acceptable noise levels in bars. Could use a collaborative approach between ACC, Ministry of Health and those with expertise in public health promotion. This approach is being effectively used to reduce the negative health outcomes from smoking. (47)

- by recognition of the complexity of hearing loss and referral to other professionals or services which may help address the hearing related needs/issues. Adjustment to and management of hearing loss may reduce the number of return visits to audiologists. (Refer to: Babeu, L. A., Kricos, P. B., & Lesner, S. A., (2004). Application of the Stages-of-Change Model in Audiology. JARA XXXVII, 41-56 [Copy attached]. (47)

- ACC could fund a pilot study on the effectiveness on delivering aural rehabilitation group sessions. There are current discussions at the international level on the value of these groups. Refer to: Ida Institute www.idainstitute.com, and Dr Louise Hickson, Professor of Audiology Co-Director, Communication Disability Centre, The University of Queensland. (47)

- the NZAS has been working very hard and has made significant changes to the process and has reduced overall costs to ACC. They are happy to discuss other options moving forward, as am I. (49)

- the preference for audiologists who are members of a club (NZAS) who has not independent oversight is unhelpful and unnecessarily expensive. Competition and transparency in provision of all aspects of hearing rehabilitation would be better to keep costs down and provide better help to claimants. (52)

- ACC should only be paying for the age corrected noise induced hearing loss of claimants due to work factors and accidents only. As there is no way ENT's , Audiologists or Audiometrists can determine the contribution of work and non-work factors in Noise Induced hearing Loss a very conservative regime should be promoted so that unnecessary and over-inflated claims are not paid out on. (52)

- the whole ACC cover for noise induced hearing loss is so inexact in assessment, especially of attributable causes, that it would be better left outside cover altogether. Individuals who wished to claim hearing loss due to employer negligence and not their own work or non-work history should have to prove it through the courts. (52)

- consideration could be given to a quantitative assessment of hearing loss attributable to industrial noise exposure, rather than percentage proportion of hearing loss attributed to noise exposure. This could be done by linking the funding level (or banding) to the quantitative level of hearing loss attributable to industrial noise or accident. This may provide a more equitable solution for claimants, and may be more acceptable to the wider community. Claimants can still have a choice to purchase a product above the funding band if they wish to select a higher specified product. (53)

- the current best practice of ACC is cumbersome and expensively implemented. The NZAS has continually lobbied against any change in the entitlement for its own self interest, not those of claimants. ACC provision should be opened up to Audiometrists as well as Audiologists, and membership of the New Zealand Audiological Society should not be a prerequisite for hearing aid fitting. As they are not a registered profession current ACC favouritism is grossly unfair to all other hearing aid professionals and also inflates the cost of service provision. (52)

- the sector wishes to engage positively with the ACC and the Department of Labour to explore alternative approached in order to ensure that the scheme is sustainable. (19)

- to ensure manufacturers cannot provide incentives to clinics to influence prescription of products, we suggest including restrictions for rebating clinics for hearing devices funded by government. (53)

- consideration should be given to the total distribution chain to ensure any necessary increase in administration will not cost more than the savings made in procurement. This may be particularly pertinent with any subject percentage process. To ensure an efficient processing system, we suggest all criteria be clear and measureable. (53)

- we are available for further discussions with the Department of Labour, the Accident Compensation Corporation, and the Minister. The solutions we propose should be considered commercially in confidence; therefore we seek to discuss our proposals outside this consultation process. (53)

- user part charges, value of replacement aids determined by length of time between re-aiding, opening up entitlement for ACC claimants to the Ministry of Health Hearing Aid Subsidy. (54)

- explore a ‘voucher’ system whereby a Claimant be allocated funds to be used towards hearing devices and fees at their discretion and under the guidance of their clinician. This

will reduce costs but at the same time allow flexibility for both top-up by the Claimant and at the other end complete (or near complete) payment by ACC which could be achieved for those who cannot afford to contribute towards devices by choosing entry-level devices, rather than missing out completely as will be the case for many under the proposals. (55)

- extend the range of providers who can fit and provide hearing aids, could lower the costs of delivery immediately on implementation. Currently only full members of the New Zealand Audiological Society (NZAS) can fit and provide hearing aids to ACC approved clients. There is no clinical justification for this demarcation in relation to ACC claimants. NZAS audiologists charge significantly more (on average 25% more) per hour than non-NZAS audiologists and audiometrists, based on respective average salaries. Yet audiometrists and non-NZAS audiologists are clinically trained to both fit and provide hearing aids. Allowing audiometrists and non-NZAS audiologists access to ACC work would lower cost. We believe the savings could be substantial. (55)

Comment

105 A subsidy has been considered as a possible option for managing hearing loss claims. However, it has not been progressed because:

- it does not limit ACC's liability to injury-related hearing loss costs;
- it would result in both under-and over-servicing of client's hearing needs (e.g. claimants whose hearing loss is completely caused by covered personal injuries would receive the same level of funding as claimants with only a small portion of injury-related hearing loss); and
- it does not provide a mechanism to manage claim volumes.

106 ACC recognises the good progress that has been made by the Accord. However, the objective of the Accord was to find ways to manage hearing loss costs to ensure that they were sustainable going forward. The policy objectives behind the regulatory proposals are different. While also seeking to ensure hearing loss costs are sustainable in the future, the primary focus is ensuring that ACC (and levy payers) are only liable for costs that are injury-related, and are not responsible for the costs borne from other causes.

Other comments

Submissions

Claim numbers

107 The claims for gradual process occupational noise exposure will and are decreasing significantly. (9, 12, 23, 24, 26, 30, 41, 42). The proposed regulations ignore university research funded by ACC suggesting its projected claim numbers are wrong. (41)

108 ACC is basing its projections on its current history of claims. It is looking at previous claim figures and making projections on the basis of these figures. University researchers say historical claims are no a good indication of the actual situation. (41)

Claims Costs

109 PricewaterhouseCoopers' most recent report on ACC's outstanding claims liability notes the significant drop in payments for hearing aid costs as an example of ACC successfully addressing cost areas of previous concern, and supports the proposition of savings through contract. (44)

110 The speed of technological enhancements to hearing aids, combined with the aging workforce, means that more of the working population are seeking more costly interventions. (29)

Employer Issues

111 Some opposed strongly to noise-induced hearing loss claims which are not work related being funded by the work account, because it is inappropriate and fiscally reprehensible to lump the cost of non-work related hearing loss claims into the work account. (4)

112 More emphasis on educating employers to ensure employees are protected from workplace noise hazards. (1, 24, 31, 42, 51, 54)

113 ACC should be actively taking steps to reduce the number of employees refusing a baseline audiogram, since a baseline audiogram is extremely valuable to both the employee (to receive confidential professional advice on hearing care) and the employer (to examine potential areas of concern as a long-term measure). (1, 2, 30)

114 Subsidise hearing conservation programmes in key industries (2)

115 It is essential that wherever possible employers are consulted about the noise exposure which may have occurred during a claimant's employment. This is essential in accepting claims which may be funded from the residual portion of the work account. (4)

116 Employers should be levied for work-place hearing loss effects only and ACC liability under the Work Account should have a similar constraint. (7, 29). Accredited Employers are not responsible for work related injuries. (14)

117 Have ACC do field visits to employers to coach/aid and improve working conditions and awareness in the workplace. ACC could provide greater assistance in reducing noise at the course by ensuring all employers have a suite of preventative measures available i.e. noise exposure surveillance, regular training, and appropriate PPE equipment. (14, 30)

118 There is no mention or mechanisms proposed to address the multi employer causation scenario. It is well known that the trades demographic are mobile and move from job to job. How will the ENT specialist attribute proportions to various employers or Premium groups? (32)

119 Only a small percentage of employers have reliable noise survey data to verify noise exposures. How will they be able to provide the “relevant available information from current or previous employers”? (32)

120 There is an amount of audiometric testing done at pre-employment and annually within some business sectors; other sectors have no reliable base line or current audiograms available. How will they be able to provide the “relevant available information from current or previous employers”? (32)

121 Employees will seek reviews to gain higher workplace percentage contributions from ACC and employers will review to decrease their exposures to claims costs/experience rating and perhaps their insurance risk profile. (32)

122 Given that Experience Rating (or possibly ACC as a private/competitive model) may return it is important for employers to have clean reliable work histories that will affect their experience rating profile. (32). Make the industries where hearing loss damage is prevalent pay a surcharge to cover the extra costs. (37)

123 To now change the rules and require an injured person to carry a part of the cost of dealing with the workplace injury is in effect punitive. The injured party will effectively end up carrying a portion of the fault despite the underpinning concept of a no fault regime. To now move the “goal posts” is iniquitous, as it apportions blame for an employer’s workplace failures. (37)

124 The idea that hearing is ‘protected’ (often quoted by workers) by annual audiometry screening is a real issue and audiometry monitoring programmes in workplaces need to be reviewed. (51). When comparing our Health and Safety in Employment Act versus legislation in other countries, compulsory audits of workplaces should be considered. (54)

Impact on Contracted Services

125 Service levels will be eroded in the absence of a contracted service. (27). Audiologists will no longer be under contract to ensure client satisfaction is maintained. (54). There is no incentive for manufacturers to stay under contract. (54)

Miscellaneous

126 The other causes should be attributed away where they would otherwise leave the person not needing aids and the other causes attributing should begin not form ‘perfection’ but from that point where aids are anyway needed. (8)

127 Do other countries have this system? (17) NIHL causes far more disability than the percentage loss signals. (17) Does co-payment mean that the client can pay the additional amount for a more expensive aid, or the clinic can charge an additional co-payment? (17)

128 Occupational Health Nurses discussed that many affected by NIHL did not seek help from ACC because of the ‘paperwork and appointments’ required. Changes in the legislation (regards to NIHL) over the years have contributed (often) to unrealistic expectations by claimants of ACC e.g. “my dad got $9,000 for his NIHL, so why can’t I?” (51)

Comment

129 Massey University's research relates to intervention strategies to reduce noise-induced hearing loss (NIHL) in New Zealand (expected to be complete mid-2010). This research may be useful in preventing future exposure to noise in the workplace and therefore reducing the number of Occupational Noise Induced Hearing Loss claims. However, the research will not assist in predicting the number of claims that will be lodged with ACC in future for work-related noise exposure that has already occurred. Nor will anticipated research on the current prevalence or incidence of NIHL in New Zealand help to estimate the number of claims expected to be lodged, as claim lodgement is contingent on other factors (e.g. greater awareness of assistance, marketing by industry groups, and availability of better technology).

130 Further, the benefits of injury prevention initiatives typically do not manifest for about 30 years, because the effects of ONIHL are often not noticed until other factors (e.g. age) make the hearing loss worse. This long latency period means that such initiatives are unlikely to have a substantial impact on ACC's outstanding claims liability for hearing loss for some time.

131 ACC agrees that the best way to manage hearing loss claims is to prevent the hearing loss in the first place. However, ACC also needs to respond to hearing loss claims where exposure to noise has already occurred, for which clients will start lodging claims in the future where their age-related hearing loss, alongside their occupational noise-induced hearing loss, starts to negatively impact their lives.

132 ACC agrees that employers should not be responsible for hearing loss costs that are associated with factors that are not related to work. The purpose of the Work Account is to finance entitlements for work-related personal injuries. It is clear that the Account is currently being used to fund hearing loss entitlements that are needed for hearing loss not caused by work. The fact that the average age of a client at the time of claim lodgement for a hearing loss claim is 65 highlights that the Work Account is also financing the effects of age-related hearing loss.

Technical Changes to the Regulations

Update the adjustment for age-related hearing loss (presbyacusis)

Submissions

133 Of 56 submissions received fourteen supported this change as a fairer estimation of the age-related component of the total loss:

- five Hearing Service Providers;
- three Audiology vendors;
- a large business;

- Massey University;
- the New Zealand Society of Otolaryngology Head & Neck Surgery;
- the Occupational Health and Safety Industry Group;
- Aon New Zealand; and
- one person with hearing loss.

- Two did not support the change (the New Zealand Occupational Health Nurses' Association and the Hearing Instrument and Manufacturers and Distributors Association).

- Forty were unsure or did not answer.

Concerns with Consultation:

134 The information provided about this change was seen to be lacking and consultation was not seen as transparent, falling below the standard required of consultation.

135 One submission thought that by adding changes to technical options in the consultation document ACC was trying to look more scientific. One thought these tables should only be used if there is no consistent indication of lesser reduction through annual tests.

Concerns with proposal

136 The age of the tables means that they do not reflect current research on the additive effects of hearing loss. The 1988 tables are based on ISO 7029:1984 Acoustics – "Threshold of hearing by air conduction as a function of age and sex for otologically normal persons." They use, for example, men of 56–80 years of age who were born between 1904 and 1928, and not today's 56–80 year olds, who were born between 1930 and 1954, and have a better diet and lifestyle. ISO 7029:1984 has in fact been withdrawn and replaced with ISO 7029:2000 "Acoustics - Statistical distribution of hearing thresholds as a function of age." This is under revision.

137 A comparison with the current tables shows changes, from no change (age 57) through to a 28% reduction (age 61), with a 12% average reduction in contributions.

138 The science is still subjective. Using the tables in the way suggested (to determine what percentage of a claimants hearing loss is due to noise and what percentage is due to aging) is not accepted best practice.

139 It is uncertain how the female/male banding difference would be applied in order to avoid "unfairness." This was perceived as discriminatory by modern standards, as females are now equally exposed to noise as males in many roles.

140 Some current employment surveillance shows increasing levels of hearing loss in younger people, where there is no previous history of exposure to noise at work. One suggestion was that the male banding apply to both sexes, to address the "noisier world we live in" and the more significant effect it has on presbyacusis.

141 The tables will reduce the component of hearing loss attributable to presbyacusis, and if all else remains the same, will increase the component of workplace hearing loss. There were concerns that this increase might cause an increase of the employer's contribution, and would become significant under "the ACC model and/or a private competitive insurance model", as currently only employers fund the Residual Account.

142 Four other questions were asked:

- Will re-assessments be classed according to the new table?
- Will ENTs be allowed to perform full assessments? They should not, as this is the area of audiologists.
- What is the basis for the 6% threshold or NIHL and how will the Department of Labour consult in the event of a change in threshold 2?
- Would the Department of Labour be considering raising the criteria for the serious harm threshold?

Alternatives suggested

143 Many were concerned that no alternatives were provided for this change, and some were suggested, including:

- The International Standard: ISO 7029:2000 Acoustics – Statistical: distribution of hearing thresholds as a function of age. They preferred this because:
    - this standard is the most current;
    - it provides descriptive statistics of the hearing threshold for populations of various ages for the range of audiometric frequencies from 125 Hz to 8000 Hz and for otologically normal persons from 18 years to 70 years inclusive;
    - it has data applicable for estimating the amount of hearing loss caused by a specific agent (such as noise exposure, Data Base A) in a population; and
    - the data may be used to assess an individual's hearing in relation to the distribution of hearing thresholds which is normal for the person's age group.
- The International Standard: ISO 1999 (1990). Acoustics: Determination of occupational noise exposure and estimation of noise-induced hearing Impairment.
- Australian Standard: AS ISO 1999 – 2003. Acoustics: Determination of occupational noise exposure and estimation of noise-induced hearing Impairment.
- ANSI [1996c]. American national standard: determination of occupational noise exposure and estimation of noise-induced hearing impairment. (New York: American National Standards Institute, Inc., ANSI S3.44-1996).

Comment

144 Australian workers' compensation schemes continue to use this table for the same purpose as ACC. The methodology of the 1988 NAL report has been accepted in all Australian jurisdictions as the defined method for calculating percentage loss of hearing and is used for the awarding of compensation to individuals who suffer hearing loss from workplace noise exposure. Providers are familiar with the current table, which is very similar to the proposed updated one. The tables used by assessors to determine the total percentage loss of hearing are also based on the 1988 NAL report. It makes sense to align this table with those ones.

Update the acoustical standard used for testing

Submissions

145 Of 56 submissions ten supported this change: three Hearing Service Providers;

a two Audiology Vendors;

b one person with hearing loss;

c Massey University;

d the New Zealand Society of Otolaryngology Head & Neck Surgery;

e Aon New Zealand; and

f the Hearing Instrument and Manufacturers and Distributors Association.

146 Two did not support this change (Air New Zealand and one Hearing Service Provider). Forty-four were unsure or did not answer. Concerns raised were:

- It added costs with no real benefit to rehabilitation. The cost of the standards change was a big concern, including follow-on costs to ENTs and audiologists. One asked if ACC will allow ENTS to increase their charges while audiologists' fees were pushed down.
- With a set contribution from ACC the test could be avoided altogether.
- The need would only apply if cases were reviewed, so if the coverage system was transparent then reviews would not be needed.
- The standards were arbitrary and irrelevant.
- Changes in ACC's approach would promote an opportunity for stakeholders to discuss the bigger picture, especially around prevention of NIHL.
- Members of NZOHNA felt that ACC and DoL documents and directives were not lining up on this issue.

- Upgrading testing facilities would limit hearing testing to main centres, and prevent testing in home environments or hospital environments that a claimant may not be able to leave due to mobility issues.

- Changes to recommended calibration procedures would involve significant costs for facilities to implement, potentially in the vicinity of $20,000, which would be prohibitive for any single operator. Unless clinics purchase the calibration equipment themselves, audiometers would also need to be sent for calibration every three months, versus the current biannual requirement.

- One submission asked about the monitoring of facilities, and who would carry the costs for this.

- One submission thought that by adding changes to technical options in the consultation document ACC was trying to look more scientific.

- Three felt that not enough information was provided about the change.

Services in Remote Areas

147 It was noted that many audiology clinics are satellites which visit remote areas. This allows access to hearing rehabilitation for those in rural or less central communities. It is not always practical or financially feasible for these visiting clinics to offer testing rooms which are anything more than sound-treated, and therefore the introduction of this standard would mean audiology providers would reduce services to these areas. As a result those in less accessible areas would be unable to receive care. However, given the variability that is seen, it was noted that ideally, audiometric testing should be conducted by an audiologist (or trained audiometrist) in a sound treated environment, and that standards should be kept up to date.

Clarification of the standards

148 One submission thought that the descriptions of the maximum noise levels for testing were wrong in both instances, being based on the idea that the test begins with perfect hearing and did not make allowances for hearing loss as a soundproofing agent in itself.

149 Another noted that any noise in the ambient environment can be mitigated by noise-excluding headphones, noise-cancellation headphones, and insert earphones. These factors are not allowed for in either standard. Clarification was requested as to what level of uncertainty is acceptable (+ 2 dB or + 5 dB), as this makes a difference to the room requirements.

150 Concerns were raised about the implications of this standard on producing previous hearing tests as evidence, as audiograms from ACC reports have often not accurately masked bone conduction thresholds. There was often a great degree of variability of thresholds between an audiogram which is conducted by a professional audiologist in a sound treated environment and that which a report was based on.

Effects on employers and employees

151 There was concern that:

- The changes were attempts to apportion and share the costs of NIHL claims, which involved passing a percentage of the cost to employers and employees.

- Apportionment of cost for claims would place a greater burden on employers and employees and would be a step back from the Scheme's original intent.

- If changes were made, those working directly with affected employees (and employers) would need to understand the implications. It was requested that any changes be conveyed to Hearing Instrument and Manufacturers and Distributors Association (HIMADA), union convenors, general practitioners, and those supporting employees affected by NIHL to ensure understanding.

Effects on Occupational Health Nurses

152 The New Zealand Occupational Health Nurses Society (NZOHNS) noted that:

- This change does not affect Occupational Health Nurses, as they complete audiometric testing according to the Management of Noise in the Workplace – 2002.

- While this test is not relevant for medico-legal compensation purposes, they are frustrated that an ISO standard is quoted in this document and under Code or Practice AS 1269:1989 Acoustics – Hearing Conservation or AS/NZS 1269:4:1998 Occupational Noise Management, Part 4: Auditory management are the standards quoted for monitoring purposes.

- This leads to confusion for employers, who may not want to pay for OHNs to monitor hearing if the tests are of little use to demonstrate a 'baseline' measurement.

Comment

153 ACC has commissioned a review of the evidence base to inform best practice for assessing NIHL claims. In their draft report (December 2009), Suzanne Purdy and Warwick Williams find that:

'Maximum permissible ambient sound pressure or noise levels (MPANL) in the test area shall meet the requirements of ISO 8253-1 Acoustics - Audiometric Test Methods, Part 1: Basic pure-tone air and bone conduction threshold audiometry for hearing threshold levels down to 0 dB HL. This is to ensure that there will be no uncertainty with the measured audiometric threshold levels introduced through the influence of unwanted external noise sources. Ambient noise levels above those prescribed in the standard will lead to uncertainties and errors in measurement".

154 The Australian version of this standard (AS ISO 8253-1) is considered to be relevant for Australia and New Zealand. Similarly, Britain uses a version of this standard (BS EN ISO 8253-1). These 'versions' are identical to the original ISO standard.

155 While ACC acknowledges that meeting the requirements may involve compliance costs, ACC's priority is that it receives audiometric information that conforms to standards for diagnostic audiology to enable assessment of cover and entitlements, as will be provided by AS ISO 8253-1. The existing standard (ISO 6189) is only considered appropriate for workplace screening or monitoring audiology.

Remove Schedule 3 and the reference to base-line hearing tests

Submissions

156 Of 56 submissions eleven submissions supported this change including:

- two Hearing Service Providers;
- one Large Business;
- the New Zealand Society of Otolaryngology Head & Neck Surgery;
- Air New Zealand;
- two Audiology vendors;
- the Occupational Health and Safety Industry Group;
- Aon New Zealand;
- the Employers and Manufacturers Association (Northern) Inc.; and
- one person with hearing loss)

157 Five submissions did not support this change (the New Zealand Audiological Society, two Hearing Service Providers, and two Audiology vendors).

158 One submission had divided opinion in group (The New Zealand Occupational Health Nurses' Association) and thirty-nine were unsure or did not answer.

159 Concerns raised were:

- there was not enough information and the aim was unclear
- they were unsure if they fully understood the potential implications.
- by adding changes to technical options in the consultation document ACC was trying to look more scientific.
- there were unlikely to be many ramifications if the change was made.

160 Suggestions were made around this change, including:

- Employers must undertake baseline and exit testing, as well as annual audiograms, so that this change not signal a reduction of testing, but increasing it.

- Under the Occupational Hearing Assessment Procedures Regulations 1999 section 3 there is specific mention of base line hearing tests, and the scope of these should be widened to encompass all industries, not just those highlighted in Schedule 3 of that Regulation.

- Workers should have occupational noise risk criteria for their jobs and from that the frequency of their occupational hearing assessments should be stipulated. This would allow noise effects at work to be more easily monitored and other contributory noise exposure to be more accurately assessed and disregarded for ACC responsibility.

- One submission did not want to imply or indicate that case line hearing tests be discontinued.

161 Another agreed to the extent that the removal of Schedule 3 is intended to enhance clarity and consistency between the Accident Insurance Act 1998 and ACA 2001.

162 One submission would like a working group to be established with ACC, DOL, OHNs and other professionals involved especially around updating the Code of Practice, and the appropriate education for those who are responsible for the majority of monitoring programmes in workplaces.

163 One felt that the ability to decline entitlements based upon refusal to undertake a baseline hearing test conflicts with the overall purpose of the Act.

Comment

164 ACC supports baseline testing being carried out and encourages claimants to provide all available audiometric tests to providers as part of their assessment. However, it is not within ACC's scope or power to enforce baseline testing being carried out. This responsibility lies with employers, and individuals.

165 The existing references to baseline testing are remnants of the policy under previous Acts whereby clients could be disentitled for refusing to undergo baseline hearing tests. This provision cannot be enforced for claims lodged under the Accident Compensation Act 2001. The aim of removing these redundant provisions is to 'tidy up' what should have been done in the past and eliminate confusion.

Consultation

Submissions

166 Many submissions considered that the consultation:

- period provided insufficient time so was unfair. (15, 19, 21, 22, 24, 26, 27, 37, 41, 42, 44, 45, 54, 55)
- process is inadequate and unlawful. (44)
- process and the proposed regulations are fundamentally flawed. (19, 26)
- did not make clear the options, how they apply, and what the amounts are that will be given by ACC. (16)
- process needed to be more balanced, involving independent, realistic debate and comment before becoming legislation. The regulations should not include standards that are imposed on the industry when it has not had an opportunity to be consulted with. (15, 19, 21, 23, 27, 55)

Consultation Document

167 One submitter considered that there has never been consultation on the concept of part charges and apportionment of noise and age-related hearing loss and thus the evidence to support the introduction of this into New Zealand has not been scrutinised and debated. (43)

168 It was asserted that there were errors in the consultation document:

- The banding limits in Option 2 in the first band have errors. (2)
- Submission document has errors that need clarification. (2)
- The formula used to calculate the percentage of costs covered is biased. The percentage is derived from the hearing loss due to noise-related work divided by the total hearing loss. The denominator in this case includes the component due to presbyacusis. This discriminates against older people as they will always have a higher presbyacusis factor. A less flawed method of apportioning liability for costs is to calculate the cost liability ratio using the applicable residual hearing as the denominator. To quantitatively apportion causative contributions to a hearing loss using an incorrect denominator as proposed would be both illogical and unfair, and would provide strong grounds for appeal of every case in which it was applied. (5, 36)
- The term “other causes” is vague, and the consultation paper fails to describe what this category might include. It is not clear if the allocation of “other causes” in the assessment process will be codified in regulations or will be a matter of practice only. (44)

- The parameters of rehabilitation in the consultation document are very prescriptive, focusing almost exclusively on hearing aids (and now a very limited range of hearing aid technology), as the solution to achieving rehabilitation. This does not allow for the individual variations across people with NIHL. (47)

- there is no mention in either option of assistance to manage tinnitus, hyperacusis, poor speech discrimination and distortion, which can all be associated with NIHL. Management of these problems takes extra time e.g. for adjustment counselling, reprogramming of hearing aids. How will this model of rehabilitation address these issues? (47)

- one question in the submission paper asks *Do you agree that ensuring the ACC correctly pays for only the injury-related component of claims is a fair way to assist ACC in managing the rapidly increasing costs of hearing loss entitlements?* The use of the term *correctly pays for…* is an assumption and misleading. (55)

169 How have the assessment fees been calculated in Option 1? What does "* under co-payment permitted" mean? The approach needs to be explained in more detail to better explain how the approach will be applied (14)

170 The advent of new technology and growing commercialism is not adequately dealt with in DoL's analysis. (23)

Use of Regulations

171 The Government has recently stated that reducing regulations and improving the quality of those which are necessary are considered priorities. Ministers and government agencies are to be fully satisfied that a regulatory solution is in the public interest and that all other alternatives have been considered before regulations are recommended, however, regulations have been put forward as the only option. (44)

172 The Government requires that a specifically strong case must be made for proposed regulations that are likely to impose additional costs on businesses or impair market competition. This has not been done. There is no information in the consultation paper that addresses this matter. This is indicative of a failure to consider properly any alternative means to regulation. (44)

173 We support the Government's initiative to better monitor public spending and to take the steps necessary to ensure ACC levies do not increase sharply. (55)

Legality of options presented

174 A number of submitters addressed the consistency of the proposal with:

- ILO conventions 17 and 42. (19, 20, 31, 41)

- The Accident Compensation Act 2001:

    - options are inconsistent with legislation and biased. Any ageing (or other non-work related factors) of less than NAL 6% cannot, by this principle, require rehabilitation (26)

- it does not focus on the rehabilitation needs arising from the work-related injury. (26)

- these regulations are not authorised by statute, the ACC cannot regulate the market by capping prices. The ACA does not permit ACC to regulate "assessments" of all injury-related hearing loss; it permits the ACC to regulate "testing" for injury that is caused by "work-related gradual process" only. (44)

Comment

175 The Department considers that the consultation period is adequate. Section 324 of the Accident Compensation Act does not set specific requirements for time or the level of detail that must be provided to allow for adequate consultation. It needs to be a case by case assessment according to the nature of the proposals. A period of four weeks for consultation on regulations is not unusually short. In addition the issue was signalled to the sector in October 2009, and when the legislation was proceeding through the House, as well as in meetings with the Hearing Accord, and in meetings with the Corporation as part of contract negotiations. The consultation document contains a high level of detail about what is likely to be in the regulations. In response to specific concerns:

- ***p 6*** *'percentage proportion' ACC's preferred terminology. Submitter wanted change to 'proportion' but 'percentage proportion' is correct. Possible that ACC will provide definition of the difference between 'percentage' and 'percentage proportion'.*
- ***p 7*** *agreed, should be ENT specialist in all instances, or ENTs.*
- ***p 10*** *should technically be 0.1%, but it is percentage proportion, not percentage, so this does make sense.*
- ***p 14*** *agreed, 'apportion' is better term.*
- ***p 17*** *agreed on spelling error.*
- ***p 17*** *AS ISO is Australian Standard, which has modified the ISO.*

Appendix A: List of submitters

Number	Submitter
1	Wayne Wilson (Contract Resources)
2	David Tayler
3	Melvyn J Hollis
4	Doug Pringle (Massey University)
5	Bren Dorman (New Zealand Society of Otolaryngology Head & Neck Surgery)
6	Joe Baker
7	Bernard Healy (Electricity Engineers Association)
8	A S Gibbons (Access Support Services)
9	J Harwood & H Procter (Hearing Association New Zealand)
10	George Broad
11	Jack Kerr (Grey Power NZ)
12	Jackie Clemmer
13	Sandra Pacheco (N.B. also #27)
14	Ruth James (Air New Zealand)
15	Dick Stark (Grey Power NZ)
16	Bevan Roy
17	Oriole Wilson
18	Alistair Richard-Howes
19	Maree Gunn (New Zealand Audiological Society)
20	Glenn Barclay (PSA)
21	Scott McLay (Whakatane Audiology)
22	Rowan Anderson (NZ Engineering Printing and Manufacturing Union)
23	Michael Coddington (Tauranga Audiology)
24	Lisbeth Gronbaek (Age Concern New Zealand)
25	Paul Jarvie (Occupational Health and Safety Industry Group)
26	Peter W Stubbing
27	Sandra Pacheco (N.B. also #13)
28	Maree Harper
29	David Wood (Aon New Zealand)
30	Veronica Hoffman
31	Tina McIvor (New Zealand Council of Trade Union)
32	Paul Jarvie (Employers and Manufacturers Association (Northern) Inc.)
33	Toby Lovell (Southern Audiology)
34	Wally Davison

35	John Sharland
36	Bill Keith
37	Wayne Thompson
38	Roger Hall Andrews
39	Sylvia Gates
40	Sally White
41	Louise Carroll (National Foundation for the Deaf Inc.)
42	V Lowe, K Mather & C Selvaratnam (Dilworth Hearing Limited)
43	Peter R Thorne
44	M Lawson, G Dodd (Hearing Industry Association)
45	Ian Fielding
46	Nigel S Smith
47	Susan Lennie (Hearing Therapists Association of New Zealand Inc.)
48	George Jones
49	Matthew Barker
50	Gordon Mather
51	Judith Vercoe (New Zealand Occupational Health Nurses' Association)
52	Alan D Ferguson (Applied Hearing Limited)
53	[Submitter requested submission remain confidential]
54	Karen Pullar (Hearing Instrument and Manufacturers and Distributors Association)
55	John Robertson (Association of New Zealand Audiometrists Inc.)
56	Peter Tillman